

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

PRINTED: 05/19/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185336</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>05/19/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SPRINGFIELD NURSING &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 EAST GRUNDY AVENUE</b> <b>SPRINGFIELD, KY 40069</b>
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{F 000} INITIAL COMMENTS

An offsite revisit was conducted and based on the acceptable Plan of Correction (POC) the facility was deemed to be in compliance as alleged on 05/11/14.

{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.

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NAME OF PROVIDER OR SUPPLIER  SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069	
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F 000	INITIAL COMMENTS  An Abbreviated Survey investigating KY00021586 was initiated on 04/15/14 and concluded on 04/16/14. KY00021586 was substantiated with deficiencies cited. F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP SS=D  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility Incident Reports, it was determined the facility failed to revise the comprehensive care plan for two (2) of four (4) sampled residents (Residents #2 and #3). Resident #2 and Resident #3 were noted to have	F 000  F 280	Submission of this Plan of Correction is neither an admission to nor an agreement with the Deficient Practices noted below, but provided as required under the Conditions of Participation  Criteria #1 Resident #1 was placed on regular pressure reduction mattress when she returned from the hospital, Stat II bariatric bed and mattress the next day 3/26/2014. Resident #1 was re-assessed for risk of fall on 3/26/2014 by Cindy Osborne, Director of Nursing and the care plan was reviewed and updated on 3/26/2014 by Linda Young, Assistant Director of Nursing to include Bilateral floor mats due to air mattress and physician to review labs from Spring View Hospital. Resident #2 was re-assessed for risk of fall on 4/29/2014 by Cindy Osborne, Director of Nursing and the care plan	RECEIVED MAY 16 2014 BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *ADMINISTRATOR* (X6) DATE *5-9-14*

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

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F 280	<p>Continued From page 1</p> <p>had numerous falls; however the facility failed to revise the care plan in a timely manner after the falls to prevent additional falls.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON) on 04/15/14 at 3:40 PM revealed the facility's care plan policy did not cover revision so the facility followed the Resident Assessment Instrument (RAI) Guidelines. The DON stated her expectation was for nurses to revise residents' care plans with the interventions after a fall.</p> <p>1. Observation of Resident #2 on 04/15/14 at 12:13 PM, 1:48 PM, 3:53 PM, and 5:50 PM revealed the resident lying on the bed which was in the lowest position with a bed sensor alarm in place. Observation at these times also revealed Resident #2 had non-skid socks on his/her bilateral feet and the over bed table was beside the bed with water and a juice in the resident's reach.</p> <p>Review of Resident #2's medical record revealed the facility admitted the resident with diagnoses which included Schizophrenia, Alcohol Abuse and Senile Dementia. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 03/12/14, revealed facility assessed Resident #2 to have a Brief Interview for Mental Status (BIMS) score of twelve (12) which indicated the resident had moderate cognitive impairment. Further review of the MDS revealed the facility assessed Resident #2 as requiring moderate to extensive assistance with Activities for Daily Living (ADLs).</p> <p>Continued review of the record and of the facility's Incident Reports revealed Resident #2 had fallen</p>	F 280	<p>was reviewed and updated on 4/5/2014 by Linda Young, Assistant Director of Nursing to include Therapy to screen for balance. Resident @3 was re-assessed for risk of fall on 4/18/2014 by Cindy Osborne, Director of Nursing and the care plan was reviewed and updated on 4/6/2014 by Linda Young, Assistant Director of Nursing to include scoop mattress, bed in low position and gripper socks.</p> <p>Criteria #2 All residents listed on the fall log for the last 90 days were reassessed by Kelly Elder, R. N. completed on 5/8/2014. The residents' care plans were reviewed and updated as needed to ensure that they had a current and appropriate intervention in place to prevent any further falls.</p> <p>Criteria:3 All licensed nurses were re-educated on 5/8/14 by Trena</p>		

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F 280	Continued From page 2 five (5) times from 12/31/13 to 04/05/14. Review of record and Incident Reports revealed one (1) fall had occurred on 02/01/14 at 11:30 AM, when Resident #2 was found on the floor in the room and assessed to have no injuries. Review of the record and Incident Report revealed the resident stated he/she was looking for his/her drink and slid off the bed. Review of the Incident Report revealed the "immediate post-incident action" was documented to be, "Put bedside table with drinks on it by" his/her bed so he/she could "see it". Review of Resident #2's Comprehensive Care Plan revealed no documented evidence the care plan was revised to add this intervention until 02/03/14.  Further review of the facility's Incident Reports revealed Resident #2 experienced a fall on 04/05/14 at 5:31 PM in the dining room. The Incident Report noted Resident #2 had "hit" his/her left elbow on the chair and there was "some redness" to the area with no other injuries noted. Further review of the Incident Report revealed the "immediate post-incident action" was documented to be "check" on the resident "every thirty (30) minutes". Review of the record revealed an Interdisciplinary Team (IDT) Note dated 04/07/14, which indicated Resident #2 had "went to sit down in" the dining room chair and "missed" the chair; and, had a red area noted to the left elbow. Continued review of the Note revealed the "root cause" of Resident #2's fall on 04/05/14 was determined to be "poor judgement of position of chair" and the interventions included a therapy screen. Review of Resident #2's Comprehensive Care Plan revealed no documented evidence the care plan was revised to include additional interventions to assist in preventing further falls until 04/07/14, when the	F 280	Lee, Education Director that when a resident falls or incurs any type of accident that they are to be assessed immediately and the incident should be investigated to determine how or why the resident accident occurred and what can be done immediately to prevent any further accidents for the resident. The intervention should then be placed in handwritten form and dated on the resident's care plan under the fall care plan interventions. The incident should be documented on the 24 hour shift report so that they next business day, it can be reviewed in the daily clinical morning meeting to ensure that the care plan was updated with an intervention and if a device was initiated, that the device had an order and placed on the treatment record and accunurse for placement and function monitoring.		

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F 280	<p>Continued From page 3 therapy screen was added to screen for balance.</p> <p>2. Observation of Resident #3 on 04/15/14 at 12:15 PM, 2:00 PM, and 4:00 PM, revealed the resident to be in the room lying on the bed which had a scoop mattress (defines the mattress perimeter) in place, half side rails up times two (2), and the call bell in reach.</p> <p>Review of Resident #3's medical record revealed the facility admitted the resident to the facility on 09/27/13, and readmitted on 01/20/14 with diagnoses which included Cerebrovascular Accident (CVA), Chronic Pain, Presenile Dementia and Anxiety. Review of the Quarterly MDS dated 01/04/14, revealed the facility assessed Resident #3 to have a BIMS score of fifteen (15) indicating no cognitive impairment. Further review of the MDS revealed the facility assessed Resident #3 to require moderate assist with ADLs.</p> <p>Continued review of the record and Incident Reports for Resident #3 revealed the resident had fallen six (6) times from 11/16/13 to 01/15/14, with no injuries noted from the falls. Review of the Incident Reports revealed on 11/16/13, Resident #3 fell when standing from the toilet and slid to the floor between the door and wheelchair. Review of Resident #3's Comprehensive Care Plan revealed no documented evidence the care plan was revised to include additional interventions to assist in preventing further falls until 11/18/13, after the IDT meeting, when an intervention to place non-skid strips to the floor in front of the toilet was added.</p> <p>Further review of the facility's Incident Reports revealed Resident #3 experienced a total of four</p>	F 280	<p>Criteria #4 The Director of Nursing or designee will monitor daily Mon through Friday and the weekend Nurse manager will review all new orders to ensure any falls or new orders are updated on the residents' care plan as appropriate. Any trends noted that the orders are not getting updated immediately when necessary on the residents' care plan will be brought to the Quality Assurance Committee for review and further recommendations monthly x 3 months then quarterly for 6 months for further recommendations</p>	5/11/2014

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F 280	Continued From page 4 (4) falls on 01/14/14, at 8:23 AM, 7:00 PM, 9:00 PM and 9:15 PM, when the resident was noted to have rolled from the bed to the floor due to increased psychotic behaviors. Review revealed Resident #3 experienced another fall on 01/15/14 at 10:30 AM, when he/she rolled from the bed to the mat at bedside. Review of the Incident Report for the 01/15/14 fall revealed the resident was sent to the hospital for evaluation and treatment related to "mental status changes". Review of the record revealed an Interdisciplinary Team (IDT) Note dated 01/15/14, which indicated a "fall mat" was placed beside Resident #3's bed after the first fall on 01/14/15. However, review of the Comprehensive Care Plan revealed no documented evidence the care plan was revised to include the fall mat beside the bed until 01/15/14.  Interview with the Assistant Director of Nursing (ADON) on 04/16/14 at 2:55 PM, revealed nurses were responsible for updating and revising the care plan with the interventions when completing the Incident Reports. She stated the nurses had not updated Resident #2's and Resident #3's care plans. The ADON stated the Daily Clinical Review (DCR)/IDT had reviewed the falls and updated the care plans for these residents. She indicated however, updating the care plan two (2) days after falls was not timely.  Interview with the Director of Nursing (DON) on 04/15/14 at 3:40 PM, revealed even though her expectation was for nurses to revise residents' care plans with the interventions after a fall, she did not know if the nurses had received training on care plan revision. Continued interview with the DON on 04/16/14 at 7:30 PM, revealed all fall incidents were reviewed within two (2) days and	F 280			

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F 280	Continued From page 5 the care plans were revised with interventions as needed. She further stated however, updating the care plan two (2) days after a fall was not timely.	F 280		
F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</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 ensure services were provided in accordance with each residents' Comprehensive Care Plan (CCP) for one (1) of three (3) sampled residents (Resident #1).</p> <p>Resident #1's CCP intervention to have bilateral fall mats on the floor by the bed was not followed on 04/25/14, when Resident #1 fell from the bed to the floor.</p> <p>The findings include:</p> <p>Review of the facility's, "Care Plan Policy Statement", undated, revealed an individual CCP was to be developed for each resident which included measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs. Interview with the Director of Nursing (DON) on 04/16/14 at 7:30 PM, revealed she expected residents' care plans interventions be followed.</p>	F 282	<p>Resident #1 was placed on regular pressure reduction mattress when she returned from the hospital, Stat II bariatric bed and mattress the next day 3/26/2014.</p> <p>Resident #1 was re-assessed for risk of fall on 3/26/2014 by Cindy Osborne, Director of Nursing and the care plan was reviewed and updated on 3/26/2014 by Linda Young, Assistant Director of Nursing to include Bilateral floor mats due to air mattress and physician to review labs from Spring View Hospital.</p> <p>Resident #2 was re-assessed for risk of fall on 4/29/2014 by Cindy Osborne, Director of Nursing and the care plan was reviewed and updated on 4/5/2014 by Linda Young, Assistant Director of Nursing to include Therapy to screen</p>	

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F 282	<p>Continued From page 6</p> <p>Review of Resident #1's closed medical record revealed the facility admitted Resident #1 on 11/19/13, with diagnoses which included Heart Failure, Diabetes, Alzheimer's Disease and Depression. Review of the Admission Minimum Data Set (MDS) dated 11/26/13, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of five (5) out of fifteen (15) which indicated severe cognitive impairment. Continued review of the MDS revealed the facility assessed Resident #1 not to have a falls history prior to admission.</p> <p>Review of the CCP, dated 11/26/13, revealed Resident #1 was at risk for falls related to Musculoskeletal Factors, as he/she was status post right total knee replacement, and Cognitive Factors. Continued review of the CCP revealed an intervention for Resident #1 to have bilateral floor fall mats at bedside dated 03/24/14.</p> <p>Review of the facility's Incident Reports revealed Resident #1 experienced six (6) falls between 11/26/13 and 03/11/14. Review of the Incident Report dated 03/11/14, revealed Resident #1 fell from the wheelchair, striking his/her head on a door frame, resulting in a laceration. Review of the Incident Report revealed Resident #1 was transported to the hospital where he/she was diagnosed with a right femoral head fracture also.</p> <p>Review of the facility's Re-admission Data Set documentation dated 03/21/14 at 5:00 PM, which included a fall risk assessment revealed a Fall Risk Assessment score of fifteen (15) and indicated a fall care plan with appropriate interventions was to be initiated based upon the assessment.</p>	F 282	<p>for balance. Resident #3 was re-assessed for risk of fall on 4/18/2014 by Cindy Osborne, Director of Nursing and the care plan was reviewed and updated on 4/6/2014 by Linda Young, Assistant Director of Nursing to include scoop mattress, bed in low position and gripper socks.</p> <p>Criteria #2 All residents listed on the fall log for the last 90 days were reassessed by Kelly Elder, R. N. completed on 5/8/2014. The residents' care plans were reviewed and updated as needed to ensure that they had a current and appropriate intervention in place to prevent any further falls.</p> <p>Criteria:3 All licensed nurses were re-educated on 5/8/14 by Trena Lee, Education Director that when a resident falls or incurs any type of accident that they are to be assessed immediately and the incident</p>	
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F 282	Continued From page 7  Interview with the Assistant Director of Nursing (ADON) on 04/16/14 at 1:35 PM, revealed the facility did not have a legend or system that guided nurses on the fall risk scores.  Interview with the DON, on 04/16/14 at 7:20 PM, revealed Resident #1 was readmitted to the facility on 03/21/14 and on 03/24/14, the care plan was updated with an intervention to place fall mats on the floor beside the bed. The DON stated on 03/25/14, Resident #1 experienced a fall from the bed and the fall mats were not in place on the floor beside the bed. However, she stated the fall mats should have been in place.  Interview with Registered Nurse (RN) #3 on 04/16/14 at 3:58 PM, revealed assistive devices were placed on residents' Treatment Administration Records (TARs), and nurses were to sign the appropriate block, to indicate the device had been checked for placement and functionality. She stated she had informed State Registered Nursing Assistant (SRNA) #1, at the beginning of her 3:00 PM to 11:00 PM shift on 03/24/14, Resident #1 needed bilateral fall mats on the floor beside the bed. RN #3 stated SRNA #1 told her the fall mats were locked up and she told the SRNA she needed to get the fall mats in place by Resident #1's bed. She stated however, she did not ensure the fall mats were placed on the evening of 03/24/14, but did pass the information regarding the intervention along to the oncoming shift. Continued interview revealed she was the nurse caring for Resident #1 on the evening of 03/25/14, when he/she fell at 5:15 PM. She stated she had not ensured the fall mats were in place as care planned, when she came to work that morning.	F 282	should be investigated to determine how or why the resident accident occurred and what can be done immediately to prevent any further accidents for the resident. The intervention should then be placed in handwritten form and dated on the resident's care plan under the fall care plan interventions. The incident should be documented on the 24 hour shift report so that they next business day, it can be reviewed in the daily clinical morning meeting to ensure that the care plan was updated with an intervention and if a device was initiated, that the device had an order and placed on the treatment record and accunurse for placement and function monitoring. Also included in the education was re-educating nurses and nursing assistants to check accunurse, the treatment record and where the devices are located and the keys to get to the devices.		

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F 282	Continued From page 8  Interview with SRNA #1 on 04/16/14 at 6:43 PM, revealed she was unable to remember RN #3 asking her to put fall mats down on the evening of 03/24/14. Continued interview revealed she did not know where the locked up fall mats were kept. SRNA #1 stated nurses could get a key for any locked area from the key box in the conference room to obtain necessary items.  Continued interview with the DON on 04/16/14 at 7:20 PM, revealed the fall mats should have been initiated on 03/24/14 on the 3:00 PM to 11:00 PM shift. She stated the charge nurse was responsible for making sure care plan interventions were implemented, and indicated Resident #1's fall mats should have been in place at the time of the fall on 03/25/14.	F 282	Criteria #4 The Director of Nursing or designee will monitor daily Mon through Friday and the weekend Nurse manager will review all new orders to ensure any falls or new orders are updated on the residents' care plan as appropriate. Any trends noted that the orders are not getting updated immediately when necessary on the residents' care plan will be brought to the Quality Assurance Committee for review and further recommendations monthly x 3 months then quarterly for 6 months for further recommendations. The nurse who executes the order will immediately assure that the order is carried out, report to the Director of Nursing that the order was implemented. The Director of Nursing will personally check 10 % of all orders each day and will report to the QA Committee each week for 3 weeks and monthly thereafter that the order was implemented.		

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>100412</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>05/19/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SPRINGFIELD NURSING &amp; REHABILITATION C</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069</b>
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(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) COMPLETE DATE
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{N 000}	<p><b>INITIAL COMMENTS</b></p> <p>An offsite revisit was conducted and based on the acceptable Plan of Correction (POC) the facility was deemed to be in compliance as alleged on 05/11/14.</p>	{N 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  100412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  C 04/16/2014
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NAME OF PROVIDER OR SUPPLIER: **SPRINGFIELD NURSING & REHABILITATION C**  
STREET ADDRESS, CITY, STATE, ZIP CODE: **420 EAST GRUNDY AVENUE  
SPRINGFIELD, KY 40069**

(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) COMPLETE DATE
N 000	INITIAL COMMENTS  A Complaint Survey investigating KY00021586 was initiated on 04/15/14 and concluded on 04/16/14. KY00021586 was substantiated with deficiencies cited.	N 000	Submission of this Plan of Correction is neither an admission to nor an agreement with the Deficient Practices noted below, but provided as required under the Conditions of Participation.	
N 192	<p>902 KAR 20:300-7(4)(b)3. Section 7. Resident Assessment</p> <p>(4) Comprehensive care plans. (b) A comprehensive care plan shall be: 3. 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 observation, interview, record review and review of the facility Incident Reports, it was determined the facility failed to revise the comprehensive care plan for two (2) of four (4) sampled residents (Residents #2 and #3). Resident #2 and Resident #3 were noted to have had numerous falls; however the facility failed to revise the care plan in a timely manner after the falls to prevent additional falls.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON) on 04/15/14 at 3:40 PM revealed the facility's care plan policy did not cover revision so the facility followed the Resident Assessment Instrument (RAI) Guidelines. The DON stated her expectation was for nurses to revise residents' care plans with the interventions after a fall.</p> <p>1. Observation of Resident #2 on 04/15/14 at 12:13 PM, 1:48 PM, 3:53 PM, and 5:50 PM revealed the resident lying on the bed which was in the lowest position with a bed sensor alarm in</p>	N 192	<p>Resident #1 was placed on regular pressure reduction mattress when she returned from the hospital, Stat II bariatric bed and mattress the next day 3/26/2014. Resident #1 was re-assessed for risk of fall on 3/26/2014 by Cindy Osborne, Director of Nursing and the care plan was reviewed and updated on 3/26/2014 by Linda Young, Assistant Director of Nursing to include Bilateral floor mats due to air mattress and physician to review labs from Spring View Hospital. Resident #2 was re-assessed for risk of fall on 4/29/2014 by Cindy Osborne, Director of Nursing and the care plan was reviewed and updated on 4/5/2014 by Linda Young.</p>	

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

TITLE

(X6) DATE

SEE FORM

0902

RKQET1

5-9-14  
If continuation sheet 1 of 8

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  100412	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  C 04/16/2014
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NAME OF PROVIDER OR SUPPLIER  SPRINGFIELD NURSING & REHABILITATION C	STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069
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N 192	<p>Continued From page 1</p> <p>place. Observation at these times also revealed Resident #2 had non-skid socks on his/her bilateral feet and the over bed table was beside the bed with water and a juice in the resident's reach.</p> <p>Review of Resident #2's medical record revealed the facility admitted the resident with diagnoses which included Schizophrenia, Alcohol Abuse and Senile Dementia. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 03/12/14, revealed facility assessed Resident #2 to have a Brief Interview for Mental Status (BIMS) score of twelve (12) which indicated the resident had moderate cognitive impairment. Further review of the MDS revealed the facility assessed Resident #2 as requiring moderate to extensive assistance with Activities for Daily Living (ADLs).</p> <p>Continued review of the record and of the facility's Incident Reports revealed Resident #2 had fallen five (5) times from 12/31/13 to 04/05/14. Review of record and Incident Reports revealed one (1) fall had occurred on 02/01/14 at 11:30 AM, when Resident #2 was found on the floor in the room and assessed to have no injuries. Review of the record and Incident Report revealed the resident stated he/she was looking for his/her drink and slid off the bed. Review of the Incident Report revealed the "immediate post-incident action" was documented to be, "Put bedside table with drinks on it by his/her bed so he/she could "see it". Review of Resident #2's Comprehensive Care Plan revealed no documented evidence the care plan was revised to add this intervention until 02/03/14.</p> <p>Further review of the facility's Incident Reports revealed Resident #2 experienced a fall on 04/05/14 at 5:31 PM in the dining room. The</p>	N 192	<p>Assistant Director of Nursing to include Therapy to screen for balance. Resident @3 was re-assessed for risk of fall on 4/18/2014 by Cindy Osborne, Director of Nursing and the care plan was reviewed and updated on 4/6/2014 by Linda Young, Assistant Director of Nursing to include scoop mattress, bed in low position and gripper socks.</p> <p>Criteria #2 All residents listed on the fall log for the last 90 days were reassessed by Kelly Elder, R. N. completed on 5/8/2014. The residents' care plans were reviewed and updated as needed to ensure that they had a current and appropriate intervention in place to prevent any further falls.</p> <p>Criteria:3 All licensed nurses were re-educated on 5/8/14 by Trena Lee, Education Director that when a resident falls or incurs any type of accident that they are to be assessed</p>	
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NAME OF PROVIDER OR SUPPLIER  SPRINGFIELD NURSING & REHABILITATION C	STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069
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N 192	<p>Continued From page 2</p> <p>Incident Report noted Resident #2 had "hit" his/her left elbow on the chair and there was "some redness" to the area with no other injuries noted. Further review of the Incident Report revealed the "immediate post-incident action" was documented to be "check" on the resident "every thirty (30) minutes". Review of the record revealed an Interdisciplinary Team (IDT) Note dated 04/07/14, which indicated Resident #2 had "went to sit down in" the dining room chair and "missed" the chair; and, had a red area noted to the left elbow. Continued review of the Note revealed the "root cause" of Resident #2's fall on 04/05/14 was determined to be "poor judgement of position of chair" and the interventions included a therapy screen. Review of Resident #2's Comprehensive Care Plan revealed no documented evidence the care plan was revised to include additional interventions to assist in preventing further falls until 04/07/14, when the therapy screen was added to screen for balance.</p> <p>2. Observation of Resident #3 on 04/15/14 at 12:15 PM, 2:00 PM, and 4:00 PM, revealed the resident to be in the room lying on the bed which had a scoop mattress (defines the mattress perimeter) in place, half side rails up times two (2), and the call bell in reach.</p> <p>Review of Resident #3's medical record revealed the facility admitted the resident to the facility on 09/27/13, and readmitted on 01/20/14 with diagnoses which included Cerebrovascular Accident (CVA), Chronic Pain, Presenile Dementia and Anxiety. Review of the Quarterly MDS dated 01/04/14, revealed the facility assessed Resident #3 to have a BIMS score of fifteen (15) indicating no cognitive impairment. Further review of the MDS revealed the facility assessed Resident #3 to require moderate assist</p>	N 192	<p>immediately and the incident should be investigated to determine how or why the resident accident occurred and what can be done immediately to prevent any further accidents for the resident. The intervention should then be placed in handwritten form and dated on the resident's care plan under the fall care plan interventions. The incident should be documented on the 24 hour shift report so that they next business day, it can be reviewed in the daily clinical morning meeting to ensure that the care plan was updated with an intervention and if a device was initiated, that the device had an order and placed on the treatment record and accunurse for placement and function monitoring.</p> <p>Criteria #4 The Director of Nursing or designee will monitor daily Mon through Friday and the weekend Nurse manager will review all new orders to</p>	
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NAME OF PROVIDER OR SUPPLIER  SPRINGFIELD NURSING & REHABILITATION C		STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069		
(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) COMPLETE DATE
N 192	<p>Continued From page 3</p> <p>with ADLs.</p> <p>Continued review of the record and Incident Reports for Resident #3 revealed the resident had fallen six (6) times from 11/16/13 to 01/15/14, with no injuries noted from the falls. Review of the Incident Reports revealed on 11/16/13, Resident #3 fell when standing from the toilet and slid to the floor between the door and wheelchair. Review of Resident #3's Comprehensive Care Plan revealed no documented evidence the care plan was revised to include additional interventions to assist in preventing further falls until 11/18/13, after the IDT meeting, when an intervention to place non-skid strips to the floor in front of the toilet was added.</p> <p>Further review of the facility's Incident Reports revealed Resident #3 experienced a total of four (4) falls on 01/14/14, at 8:23 AM, 7:00 PM, 9:00 PM and 9:15 PM, when the resident was noted to have rolled from the bed to the floor due to increased psychotic behaviors. Review revealed Resident #3 experienced another fall on 01/15/14 at 10:30 AM, when he/she rolled from the bed to the mat at bedside. Review of the Incident Report for the 01/15/14 fall revealed the resident was sent to the hospital for evaluation and treatment related to "mental status changes". Review of the record revealed an Interdisciplinary Team (IDT) Note dated 01/15/14, which indicated a "fall mat" was placed beside Resident #3's bed after the first fall on 01/14/15. However, review of the Comprehensive Care Plan revealed no documented evidence the care plan was revised to include the fall mat beside the bed until 01/15/14.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 04/16/14 at 2:55 PM, revealed nurses</p>	N 192	<p>ensure any falls or new orders are updated on the residents' care plan as appropriate. Any trends noted that the orders are not getting updated immediately when necessary on the residents' care plan will be brought to the Quality Assurance Committee for review and further recommendations monthly x 3 months then quarterly for 6 months for further recommendations</p>	5/11/2014

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NAME OF PROVIDER OR SUPPLIER  SPRINGFIELD NURSING & REHABILITATION C	STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069
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N 192	<p>Continued From page 4</p> <p>were responsible for updating and revising the care plan with the interventions when completing the Incident Reports. She stated the nurses had not updated Resident #2's and Resident #3's care plans. The ADON stated the Daily Clinical Review (DCR)/IDT had reviewed the falls and updated the care plans for these residents. She indicated however, updating the care plan two (2) days after falls was not timely.</p> <p>Interview with the Director of Nursing (DON) on 04/15/14 at 3:40 PM, revealed even though her expectation was for nurses to revise residents' care plans with the interventions after a fall, she did not know if the nurses had received training on care plan revision. Continued interview with the DON on 04/16/14 at 7:30 PM, revealed all fall incidents were reviewed within two (2) days and the care plans were revised with interventions as needed. She further stated however, updating the care plan two (2) days after a fall was not timely.</p>	N 192		
N 194	<p>902 KAR 20:300-7(4)(c)2. Section 7. Resident Assessment</p> <p>(4) Comprehensive care plans. (c) The services provided or arranged by the facility shall: 2. Be provided by qualified persons in accordance with each resident's written plan of care.</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 ensure services were provided in accordance with each residents' Comprehensive</p>	N 194	<p>Resident #1 was placed on regular pressure reduction mattress when she returned from the hospital, Stat II bariatric bed and mattress the next day 3/26/2014. Resident #1 was re-assessed for risk of fall on 3/26/2014 by Cindy Osborne, Director of Nursing and the care plan was reviewed and updated on 3/26/2014 by Linda Young, Assistant Director of Nursing</p>	

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N 194	<p>Continued From page 5</p> <p>Care Plan (CCP) for one (1) of three (3) sampled residents (Resident #1).</p> <p>Resident #1's CCP intervention to have bilateral fall mats on the floor by the bed was not followed on 04/25/14, when Resident #1 fell from the bed to the floor.</p> <p>The findings include:</p> <p>Review of the facility's, "Care Plan Policy Statement", undated, revealed an individual CCP was to be developed for each resident which included measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs. Interview with the Director of Nursing (DON) on 04/16/14 at 7:30 PM, revealed she expected residents' care plans interventions be followed.</p> <p>Review of Resident #1's closed medical record revealed the facility admitted Resident #1 on 11/19/13, with diagnoses which included Heart Failure, Diabetes, Alzheimer's Disease and Depression. Review of the Admission Minimum Data Set (MDS) dated 11/26/13, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of five (5) out of fifteen (15) which indicated severe cognitive impairment. Continued review of the MDS revealed the facility assessed Resident #1 not to have a falls history prior to admission.</p> <p>Review of the CCP, dated 11/26/13, revealed Resident #1 was at risk for falls related to Musculoskeletal Factors, as he/she was status post right total knee replacement, and Cognitive Factors. Continued review of the CCP, revealed an intervention for Resident #1 to have bilateral floor fall mats at bedside dated 03/24/14.</p>	N 194	<p>to include Bilateral floor mats due to air mattress and physician to review labs from Spring View Hospital.</p> <p>Resident #2 was re-assessed for risk of fall on 4/29/2014 by Cindy Osborne, Director of Nursing and the care plan was reviewed and updated on 4/5/2014 by Linda Young, Assistant Director of Nursing to include Therapy to screen for balance. Resident @3 was re-assessed for risk of fall on 4/18/2014 by Cindy Osborne, Director of Nursing and the care plan was reviewed and updated on 4/6/2014 by Linda Young, Assistant Director of Nursing to include scoop mattress, bed in low position and gripper socks.</p> <p>Criteria #2</p> <p>All residents listed on the fall log for the last 90 days were reassessed by Kelly Elder, R. N. completed on 5/8/2014. The residents' care plans were reviewed and updated</p>	
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NAME OF PROVIDER OR SUPPLIER  SPRINGFIELD NURSING & REHABILITATION C	STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069
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N 194

Continued From page 6

Review of the facility's Incident Reports revealed Resident #1 experienced six (6) falls between 11/26/13 and 03/11/14. Review of the Incident Report dated 03/11/14, revealed Resident #1 fell from the wheelchair, striking his/her head on a door frame, resulting in a laceration. Review of the Incident Report revealed Resident #1 was transported to the hospital where he/she was diagnosed with a right femoral head fracture also.

Review of the facility's Re-admission Data Set documentation dated 03/21/14 at 5:00 PM, which included a fall risk assessment revealed a Fall Risk Assessment score of fifteen (15) and indicated a fall care plan with appropriate interventions was to be initiated based upon the assessment.

Interview with the Assistant Director of Nursing (ADON) on 04/16/14 at 1:35 PM, revealed the facility did not have a legend or system that guided nurses on the fall risk scores.

Interview with the DON, on 04/16/14 at 7:20 PM, revealed Resident #1 was readmitted to the facility on 03/21/14 and on 03/24/14, the care plan was updated with an intervention to place fall mats on the floor beside the bed. The DON stated on 03/25/14, Resident #1 experienced a fall from the bed and the fall mats were not in place on the floor beside the bed. However, she stated the fall mats should have been in place.

Interview with Registered Nurse (RN) #3 on 04/16/14 at 3:58 PM, revealed assistive devices were placed on residents' Treatment Administration Records (TARs), and nurses were to sign the appropriate block, to indicate the device had been checked for placement and

N 194

as needed to ensure that they had a current and appropriate intervention in place to prevent any further falls.

Criteria:3  
All licensed nurses were re-educated on 5/8/14 by Trena Lee, Education Director that when a resident falls or incurs any type of accident that they are to be assessed immediately and the incident should be investigated to determine how or why the resident accident occurred and what can be done immediately to prevent any further accidents for the resident. The intervention should then be placed in handwritten form and dated on the resident's care plan under the fall care plan interventions. The incident should be documented on the 24 hour shift report so that they next business day, it can be reviewed in the daily clinical morning meeting to ensure that the care plan was

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N 194	<p>Continued From page 7</p> <p>functionality. She stated she had informed State Registered Nursing Assistant (SRNA) #1, at the beginning of her 3:00 PM to 11:00 PM shift on 03/24/14, Resident #1 needed bilateral fall mats on the floor beside the bed. RN #3 stated SRNA #1 told her the fall mats were locked up and she told the SRNA she needed to get the fall mats in place by Resident #1's bed. She stated however, she did not ensure the fall mats were placed on the evening of 03/24/14, but did pass the information regarding the intervention along to the oncoming shift. Continued interview revealed she was the nurse caring for Resident #1 on the evening of 03/25/14, when he/she fell at 5:15 PM. She stated she had not ensured the fall mats were in place as care planned, when she came to work that morning.</p> <p>Interview with SRNA #1 on 04/16/14 at 6:43 PM, revealed she was unable to remember RN #3 asking her to put fall mats down on the evening of 03/24/14. Continued interview revealed she did not know where the locked up fall mats were kept. SRNA #1 stated nurses could get a key for any locked area from the key box in the conference room to obtain necessary items.</p> <p>Continued interview with the DON on 04/16/14 at 7:20 PM, revealed the fall mats should have been initiated on 03/24/14 on the 3:00 PM to 11:00 PM shift. She stated the charge nurse was responsible for making sure care plan interventions were implemented, and indicated Resident #1's fall mats should have been in place at the time of the fall on 03/25/14.</p>	N 194	<p>updated with an intervention and if a device was initiated, that the device had an order and placed on the treatment record and accunurse for placement and function monitoring. Also included in the education was re-educating nurses and nursing assistants to check accunurse, the treatment record and where the devices are located and the keys to get to the devices.</p> <p>Criteria #4 The Director of Nursing or designee will monitor daily Mon through Friday and the weekend Nurse manager will review all new orders to ensure any falls or new orders are updated on the residents' care plan as appropriate. Any trends noted that the orders are not getting updated immediately when necessary on the residents' care plan will be brought to the Quality Assurance Committee for review and further recommendations monthly x 3 months then</p>	
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NAME OF PROVIDER OR SUPPLIER  SPRINGFIELD NURSING & REHABILITATION C	STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069
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(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) COMPLETE DATE
N 194	<p>Continued From page 7</p> <p>functionality. She stated she had informed State Registered Nursing Assistant (SRNA) #1, at the beginning of her 3:00 PM to 11:00 PM shift on 03/24/14, Resident #1 needed bilateral fall mats on the floor beside the bed. RN #3 stated SRNA #1 told her the fall mats were locked up and she told the SRNA she needed to get the fall mats in place by Resident #1's bed. She stated however, she did not ensure the fall mats were placed on the evening of 03/24/14, but did pass the information regarding the intervention along to the oncoming shift. Continued interview revealed she was the nurse caring for Resident #1 on the evening of 03/25/14, when he/she fell at 5:15 PM. She stated she had not ensured the fall mats were in place as care planned, when she came to work that morning.</p> <p>Interview with SRNA #1 on 04/16/14 at 6:43 PM, revealed she was unable to remember RN #3 asking her to put fall mats down on the evening of 03/24/14. Continued interview revealed she did not know where the locked up fall mats were kept. SRNA #1 stated nurses could get a key for any locked area from the key box in the conference room to obtain necessary items.</p> <p>Continued interview with the DON on 04/16/14 at 7:20 PM, revealed the fall mats should have been initiated on 03/24/14 on the 3:00 PM to 11:00 PM shift. She stated the charge nurse was responsible for making sure care plan interventions were implemented, and indicated Resident #1's fall mats should have been in place at the time of the fall on 03/25/14.</p>	N 194	<p>quarterly for 6 months for further recommendations. The nurse who executes the order will immediately assure that the order is carried out, report to the Director of Nursing that the order was implemented. The Director of Nursing will personally check 10 % of all orders each day and will report to the QA Committee each week for 3 weeks and monthly thereafter that the order was implemented.</p>	5/11/2014