

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

PRINTED: 03/14/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185353	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/11/2014
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NAME OF PROVIDER OR SUPPLIER BRANDENBURG NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 814 OLD EKRON RD BRANDENBURG, KY 40108
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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) COMPLETION DATE
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F 000	INITIAL COMMENTS	F 000		
F 282 SS=D	<p>An Abbreviated Survey was initiated on 03/10/14 and concluded on 03/11/14 to investigate KY 21419. The Division of Health Care substantiated the allegation with deficiencies cited.</p> <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 observation, interview, record review and policy review, it was determined the facility failed to ensure staff followed the care plan for one (1) of four (4) sampled residents, (Resident #1) The staff failed to utilize two (2) person assist with the transfer of Resident #1 in a Hoyer lift as careplanned.</p> <p>The findings include:</p> <p>Review of the Resident Comprehensive Care Plan Guidelines, dated 09/08, revealed the resident comprehensive care plan should be viewed as an interdisciplinary approach to managing the acute and chronic needs of the resident living in the facility.</p> <p>Review of Resident #1's clinical record revealed the facility admitted the resident on 07/01/12 with diagnoses of Alzheimer's Disease, Senile Dementia, Lack of Coordination, Difficulty Walking and General Osteoarthritis. Review of</p>	F 282	<ol style="list-style-type: none"> 1. An observation of C N A #4 using the lift to transfer a resident was made by RN Charge Nurse on 3/13/14. The C N A used a two person assist and followed the care plan during the transfer. 2. On 3/20/14 the RN Charge Nurse observed 5 different C N As providing transfers operating the mechanical lift. The C N As used a two person lift in all transfers and followed the care plan during the transfer. 3. All Nursing personnel are being re-educated on using a two person lift and following the care plan when using the Mechanical lift by the Director of Nursing or RN charge nurse with no Nursing staff working past 3/28/14 without the training. They have also been instructed to report to the charge nurse anytime they are not able to follow the plan of care. A post test is being given following the training. 	3-29-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Beth Appleby* TITLE: *Administrator* (X6) DATE: *3-24-14*

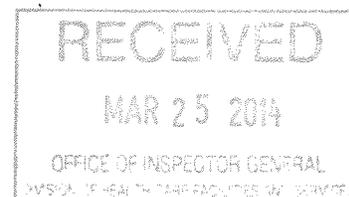
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 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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If continuation sheet Page 1 of 11
MAR 25 2014
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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F 282	<p>Continued From page 1</p> <p>the Minimum Data Set (MDS) Quarterly Assessment, dated 12/30/13, revealed Resident #1 had no BIM score recorded which meant Resident #1 was not interviewable.</p> <p>Observation of Resident #1, on 03/10/14 at 2:58 PM, revealed Resident #1 had a green and yellow bruise at the base of his/her right eye and cheek bone.</p> <p>Review of Resident #1's Nurses Notes, written by Registered Nurse (RN) #2, dated 02/22/14 at 12:26 PM, revealed Certified Nursing Assistant (CNA) #4 reported a knot above Resident #1's right eye. The knot had a pin point bruise in the center and appeared to look like a cyst or edema. RN #2 documented that after breakfast, she and another nurse looked at Resident #1's eye to obtain a second opinion. Upon entering the room Resident #1's eye had a hematoma (blood outside the blood vessels, usually in liquid form within the tissue) noted and bruising on the corner of the eye. Further review of the nursing notes revealed that the staff currently in the building denied any knowledge of an incident that would have caused injury.</p> <p>Interview with RN #2, on 03/11/14 at 11:26 AM, revealed at approximately 7:15 AM on 02/22/14, CNA #4 informed her that Resident #1 had a pin point mark on his/her eye. RN #2 stated at first the mark looked like a cyst, but later looked swollen and bruised. RN #2 stated she attempted to put ice on it, but Resident #1 would not allow that to occur. RN #2 stated the wound appeared to have just happened because the wound had gotten bigger. RN #2 stated she interviewed CNA #4 and the aid had denied anything had happened with the resident. Through interviews</p>	F 282	<p>4. The Director of Nursing, Assistant Director of Nursing, RN Charge Nurse or Unit Manager will do five(5) observations per week for twelve(12) weeks to ensure that a two person assist is being used when operating a mechanical lift and that the care plan is being followed. Additional training will be provided as necessary. The results of these observations will be reviewed by the Quality Assurance Committee consisting of the Administrator, Director of Nursing or Assistant Director of Nursing on a monthly basis until the team concludes the issue is resolved. The Medical Director will attend these meetings at least quarterly. If at any time concerns are identified, the Quality Assurance Committee will convene to analyze and implement further measures dependent upon the root cause to ensure ongoing compliance.</p>		



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F 282	<p>Continued From page 2</p> <p>with other CNA's RN #2 had learned that CNA #4 was not as forth coming in how she had utilized the Hoyer lift. RN #2 stated she then interviewed CNA #4 again and learned CNA #4 got Resident #1 up by herself with the Hoyer lift. CNA #4 was then asked to write a statement.</p> <p>Interview with CNA #4, on 03/11/14 at 1:41 PM, revealed on 02/22/14 at 7:15 AM, she saw a knot on Resident #1's head and showed the resident to the nurse, RN #2, who thought the knot was a cyst. CNA #4 stated she had written a statement in which she informed the Administrator that she had gotten Resident #1 up in the Hoyer lift all by herself. CNA #4 stated she did not ask anyone to help her with the transfer, because CNA #2 was giving a shower and the other option was the aid on the next hall and she was in a hurry. CNA #4 stated she did not always get residents up without assistance. CNA #4 stated Resident #1 was in bed when she transferred him/her to the wheelchair and she did not recall the bar of the Hoyer lift hitting Resident #1 in the head or the resident's head hitting the bar. CNA #4 stated she was not really looking at Resident #1's face when placing the strap on the Hoyer bar, but as she did notice the pin point mark on Resident #1's face during the transfer. CNA #4 stated as soon as she saw the mark, she immediately took Resident #1 to the nurse to inform her of the mark. CNA #4 stated she did not hear Resident #1 cry out in pain. CNA #4 stated if she had caused an accident she would have informed someone.</p> <p>Review of the written statement made by CNA #4, dated 02/26/14, revealed on Saturday around 7:00 AM, she was getting Resident #1 up using a Hoyer lift. While doing this CNA #4 stated she had no one to help assist with the transfer due to</p>	F 282		
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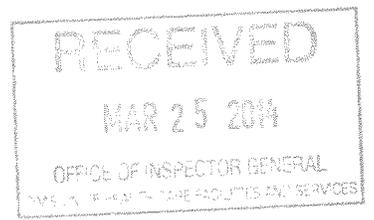
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F 282	Continued From page 3 both CNA's being busy. CNA #4 stated she knew this was not acceptable and very dangerous, but she was sure Resident #1 did not acquire any injuries during the transfer. Review of Resident #1's Activity of Daily Living (ADL) Care plan for the month of February, revealed Resident #1 was to be transferred with a level of support of two (2) or more person physical assist. Review of Resident #1's Falls Nursing Care plan, onset 01/05/14, revealed the approach with transfers was a two (2) person physical assist. Interview with CNA #4, on 03/11/14 at 1:41 PM, revealed she knew Resident #1 was a two (2) person assist with the Hoyer lift and that she was expected to follow the plan of care for each resident. She stated when there are two people assisting with the lift, one person was to help with the sling and one person was to monitor the Hoyer lift. Interview with RN #2, on 03/11/14 at 11:26 AM, revealed nursing staff was expected to follow the plan of care for each resident to ensure each resident's safety. Interview with the Assistant Minimum Data Set (MDS) Coordinator, on 03/11/14 at 2:36 PM, revealed that as an assistant she ensured everything was transferred over to the hard copy of the care plan and the CNA care plans were updated in the Accu nurse computer system. The Assistant MDS stated she would expect the CNA and nursing staff to follow the care plan. Interview with the Director of Nursing (DON), on	F 282		
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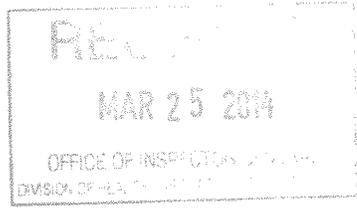
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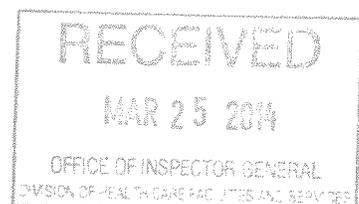
F 282	Continued From page 4 03/11/14 at 2:07 PM, revealed the nursing staff and the MDS Coordinator could initiate and update the care plans. The DON stated the CNA care plans had to be manually put into the Accu Nurse System. The DON further stated there should have been two (2) staff members when using the Hoyer lift, because of safety and she thought the hook part of the Hoyer lift had the potential to hit the resident, but there was no witness. Thus it could not be determined that the Hoyer lift was the cause of the injury to Resident #1's face.	F 282		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure each resident had adequate supervision and assistive devices to prevent accidents for one (1) of four (4) residents, (Resident #1). A staff member transferred Resident #1 using the Hoyer lift when it was meant to be a two (2) person assist. Subsequently Resident #1 sustained an injury to the face and the cause could not be determined. The findings include:	F 323	<ol style="list-style-type: none"> 1. An observation of C N A #4 using the lift to transfer a resident was made by RN Charge Nurse on 3/13/14. The C N A used a two person assist and followed the care plan during the transfer. 2. On 3/20/14 the RN Charge Nurse observed 5 different C N As providing transfers operating the mechanical lift. The C N As used a two person lift in all transfers and followed the care plan during the transfer. 3. All Nursing personnel are being re-educated on using a two person lift and following the care plan when using the Mechanical lift by the Director of Nursing or RN charge nurse with no Nursing staff working past 3/28/14 without the training. They have also been instructed to report to the charge nurse anytime they are not able to follow the plan of care. A post test is being given following the training. 	3-29-14



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F 323	<p>Continued From page 5</p> <p>Review of the Fall Assessment/Intervention Process Policy, revised 09/13, revealed the facility must ensure that the resident environment remains as free from accident hazards as possible and each resident receive adequate supervision and assistance devices to prevent accidents.</p> <p>Review of the Safe Patient Handling and Movement Policy, revised 10/31/13, revealed Mechanical Lifting Devices: all patient transfers with mechanical lifts will be done with a minimum of two (2) persons or as specified in the patient's plan of care. Based on the resident's ability to assist or self perform, this requirement may be adjusted to reflect one person or independent use of certain lifts such as the Sit to Stand type lift.</p> <p>Review of Resident #1's clinical record revealed the facility admitted the resident on 07/01/12 with diagnoses of Alzheimer's Disease, Senile Dementia, Lack of Coordination, Difficulty Walking and General Osteoarthritis. Review of the Minimum Data Set (MDS) Quarterly Assessment, dated 12/30/13, revealed Resident #1 had no BIM score assigned which meant Resident #1 was not interviewable.</p> <p>Observation of Resident #1, on 03/10/14 at 2:58 PM, revealed Resident #1 had a green and yellow bruise at the base of his/her right eye and cheek bone.</p> <p>Observation of Resident #1, on 03/10/14 at 3:46 PM, revealed Resident #1 coming out of his/her room in a wheelchair. Two (2) staff members were observed exiting Resident #1's room and a Hoyer lift was observed to be in Resident #1's</p>	F 323	<p>4. The Director of Nursing, Assistant Director of Nursing, RN Charge Nurse or Unit Manager will do five(5) observations per week for twelve(12) weeks to ensure that a two person assist is being used when operating a mechanical lift and that the care plan is being followed. Additional training will be provided as necessary. The results of these observations will be reviewed by the Quality Assurance Committee consisting of the Administrator, Director of Nursing or Assistant Director of Nursing on a monthly basis until the team concludes the issue is resolved. The Medical Director will attend these meetings at least quarterly. If at any time concerns are identified, the Quality Assurance Committee will convene to analyze and implement further measures dependent upon the root cause to ensure ongoing compliance.</p>	



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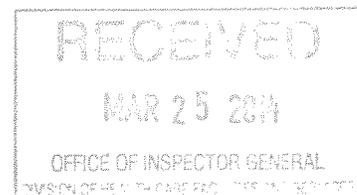
F 323	<p>Continued From page 6 room as the staff members were exiting.</p> <p>Review of Resident #1's Nurses Notes, written by Registered Nurse (RN) #2, dated 02/22/14 at 12:26 PM, revealed Certified Nursing Assistant (CNA) #4 reported a knot above Resident #1's right eye. The knot had a pin point bruise in the center and appeared to look like a cyst or edema. RN #2 documented that after breakfast she and another nurse looked at Resident #1's eye to obtain a second opinion. Upon entering the room Resident #1's eye had a hematoma (blood outside the blood vessels, usually in liquid form within the tissue) noted and bruising on the corner of the eye. Further review of the nursing notes revealed that the staff currently in the building denied any knowledge of an incident that caused an injury. The RN then notified the family, Director of Nursing (DON) and the Medical Doctor's office. Statements were taken from the staff and nursing was to continue monitoring for any changes.</p> <p>Interview with CNA #4, on 03/11/14 at 1:41 PM, revealed Resident #1 was in bed when she transferred him/her to the wheelchair and she did not recall the bar of the Hoyer lift hitting Resident #1 in the head or the resident's head hitting the bar. CNA #4 stated she was not really looking at Resident #1's face when placing the strap on the Hoyer bar, but she did notice the pin point mark on Resident #1's face during the transfer. CNA #4 stated at 7:15 AM, she showed the resident to RN #2, who thought the knot was a cyst.</p> <p>Interview with RN #2, on 03/11/14 at 11:26 AM, revealed it was normally first shift's responsibility to get Resident #1 up for breakfast in the morning, which was approximately 7:15 AM. At</p>	F 323		
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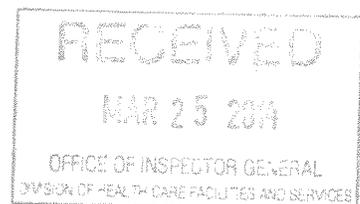
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F 323	<p>Continued From page 7</p> <p>7:15 AM, CNA #4 informed her that Resident #1 had a pin point mark on his/her eye. RN #2 stated that at first the mark looked like a cyst and she sent Resident #1 to breakfast. But later around 9:30 AM to 10:00 AM, she and another nurse went to Resident #1's room to help RN #2 distinguish if the mark was a cyst or not and found that the wound looked swollen and bruised. RN #2 stated she attempted to put ice on it, but Resident #1 would not allow that to occur. RN #2 stated the wound appeared to have just happened because the wound had gotten bigger. RN #2 stated she then called the MD, DON and family and was informed by the DON to interview staff. RN #2 stated she interviewed CNA #4 and she had denied anything had happened with the resident. Through interviews with other CNA's, RN #2 had learned that CNA #4 was not as forth coming in how she had utilized the Hoyer lift. RN #2 stated she then interviewed CNA #4 again and learned CNA #4 got Resident #1 up by herself with the Hoyer lift. CNA #4 was then asked to write a statement.</p> <p>Interview with the CNA #4, on 03/11/14 at 1:41 PM, revealed she informed RN #2 that when she was getting Resident #1 up with the Hoyer lift that CNA #2 had walked into the room and did not offer to help with the transfer. CNA #4 stated CNA #2 was giving a shower and the other option was to ask the aid on the other hall, but CNA #4 was in a hurry. CNA #4 stated she did not always transfer a resident without help.</p> <p>Interview with CNA #2, on 03/10/14 at 2:04 PM, revealed she was not made aware of the bruise to Resident #1's face until RN #2 had showed her. CNA #2 stated the nurses had asked her what had happened to Resident #1's eye,</p>	F 323		



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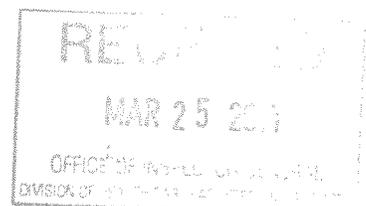
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F 323	<p>Continued From page 8</p> <p>because CNA #4 had informed them that she had helped her transfer Resident #1 with the Hoyer lift. CNA #2 stated she told the nurse that she did not transfer the resident and never walked into the room while Resident #1 was being transferred. CNA #2 stated that CNA #4 had walked up to her at that time and she informed CNA #4 that she did not watch her transfer Resident #1. CNA #2 stated the whole situation made her feel uncomfortable. CNA #2 stated that when she used the Hoyer lift that she was to have two people, just in case something was to happen. CNA #2 stated she could ask staff to help when she needed the help.</p> <p>Interview with the Restorative Aid, on 03/11/14 at 1:17 PM, revealed she remembered RN #2 talking with her. RN #2 asked if she had seen a bruise on the residents's face and if CNA #4 was assisted with the Hoyer transfer that morning and she responded with a "no". The Restorative Aid stated lifts were usually a two (2) person assist, because someone needed to monitor the resident and someone needed to monitor the lift. The Restorative Aid stated it was very easy to hit someone with the bar of the lift, because the bar was loose and there was no way to lock the bar.</p> <p>Further interview with RN #2, on 03/11/14 at 11:26 AM, revealed she then interviewed CNA #4 again and learned CNA #4 got Resident #1 up by herself with the Hoyer lift. CNA #4 was then asked to write a statement.</p> <p>Interview with CNA #4, on 03/11/14 at 1:41 PM, revealed she had written a statement in which she informed the Administrator that she had gotten Resident #1 up in the Hoyer lift all by herself. CNA #4 stated she did not ask anyone to</p>	F 323			



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185353	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/11/2014
NAME OF PROVIDER OR SUPPLIER BRANDENBURG NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 814 OLD EKRON RD BRANDENBURG, KY 40108		
(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 323	<p>Continued From page 9</p> <p>help her with the transfer because CNA #2 was giving a shower and the other option was the aid on the next hall and CNA #4 was in a hurry. CNA #4 stated she did not always get residents up without assistance. CNA #4 stated she did not hear Resident #1 cry out in pain. CNA #4 stated if she had caused an accident she would have informed someone.</p> <p>Review of the written statement made by CNA #4, dated 02/26/14, revealed on Saturday, 02/22/14 around 7:00 AM, she was getting Resident #1 up using a Hoyer lift. While doing this CNA #4 stated she had no one to help assist with the transfer due to both CNA's being busy. CNA #4 stated she new this was not acceptable and very dangerous, but she was sure Resident #1 did not acquire any injuries during the transfer.</p> <p>Interview with RN #1, on 03/10/14 at 2:32 PM, revealed he saw Resident #1 face to face between the hours of 5:30 AM and 6:00 AM, while he provided him/her with medications and did not see any bruising on Resident #1's face. RN #1 stated no CNA came up to him to inform him of any bruising that morning.</p> <p>Interview with the Director of Nursing (DON), on 03/11/14 at 2:07 PM, revealed RN #2 had called her to inform her about Resident #1's face. RN #2 informed her that CNA #4 had communicated that Resident #1 had a bruise to his/her eye and then RN #2 looked at it again and it had gotten bigger. RN #2 stated that the place on the residents eye was a small place, but then it grew as if the wound had just happened. RN #2 informed the DON that CNA #4 had utilized the Hoyer lift by herself and she informed RN #2 to call the Administrator. The DON stated that she expected</p>	F 323			



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

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F 323	<p>Continued From page 10</p> <p>the CNA's to use two (2) staff members when using the Hoyer lift for safety. The DON stated it was possible that the hook, which was the part that swung, could have hit the resident in the face, but there was no witnesses to this event.</p> <p>Interview with Administrator, on 03/11/14 at 2:59 PM, revealed RN #2 had notified her of the incident that Saturday (02/22/14). The Administrator stated that she spoke with CNA #4 and asked that the nurses interview everyone who was currently working and get statements from everyone. The Administrator stated that she was back and forth all day with the RN #2, CNA #2 and CNA #4. The Administrator stated she did not find out that CNA #4 transferred the resident by herself until Monday (02/24/14). The Administrator stated CNA #4 did not come to work that Sunday, Monday or Tuesday, but when she came back to work the Administrator counseled her about the lift situation and at that time CNA #4 confessed to transferring Resident #1 by herself. The Administrator stated she expected staff to use two (2) people when using the Hoyer lift to prevent injuries.</p>	F 323		
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