

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/16/2014
NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>An Abbreviated/Partial Extended Survey investigating complaint #KY21607 was conducted on 05/01/14 through 05/16/14 to determine the facility's compliance with Federal requirements. Complaint #KY21607 was substantiated with deficiencies cited. Immediate Jeopardy was identified on 05/09/14 and determined to exist on 03/26/14, at 42 CFR 483.10 Resident Rights, F-157; 42 CFR 483.20 Resident Assessment, F-279; 42 CFR 483.25 Quality of Care, F-309 and F-323; and 42 CFR 483.75 Administration, F-490 and F-520 at a Scope and Severity of a "J". Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care. The facility was notified of the Immediate Jeopardy on 05/09/14.</p> <p>On 03/26/14, at approximately 3:30 AM, Resident #1 had an unwitnessed fall from his/her bed and was unable to explain what happened. Resident #1 was found on the floor beside the bed. When the resident was assessed by Licensed Practical Nurse (LPN) #1 he/she was found to have bruising to the right cheekbone. An ice pack was applied to Resident #1's cheek and Tylenol (pain medication) was administered for complaints of pain. The physician was notified on 03/26/14 at approximately 8:25 AM that the resident's nose was bleeding and there was dark discoloration to the resident's right cheek and bridge of nose. Orders were received to send the resident to the Emergency Room (ER). Resident #1 returned to the facility on 03/26/14 at 2:00 PM with new diagnoses of Facial Bone Fracture, Cervical Sprain, Head Injury, Closed Head Injury without Cranial wound, and Unspecified State Level of Consciousness and a new order for Norco (narcotic pain medication) 7.5/325 milligrams</p>	F 000		

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

TITLE

(X6) DATE

Executive Director

7/16/14

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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F 000	<p>Continued From page 1</p> <p>(mg) as needed (PRN) for pain. In addition, the resident returned with discharge orders to "follow up with primary care physician in one (1) to two (2) days to recheck today's complaints if not improving". However, further record review revealed the facility failed to conduct ongoing assessments of the resident and failed to make the resident's attending physician aware of the resident's facial fractures. On 04/03/14, approximately eight (8) days after the resident's fall, which resulted in facial fractures, the Primary Care Physician visited the facility to make routine rounds and found the resident with facial fractures and complaints of pain when he/she attempted to open his/her mouth. The Physician immediately ordered a consultation with an Ear, Nose, and Throat (ENT) Specialist. The resident required surgery to repair the fractures.</p> <p>An Acceptable Allegation of Compliance (AOC) was received on 05/14/14 alleging removal of Immediate Jeopardy on 05/14/14. The State Survey Agency validated, on 05/16/14, the Immediate Jeopardy was removed on 05/14/14, as alleged. The Scope and Severity was lowered to a "D" at 42 CFR 483.10 Resident Rights, F-157; 42 CFR 483.20 Resident Assessment, F-279; 42 CFR 483.25 Quality of Care, F-309 and F-323; and 42 CFR 483.75 Administration, F-490 and F-520; while the facility develops and implements the Plan of Correction (PoC) and the facility's Performance Improvement Committee monitors the effectiveness of the systemic changes.</p>	F 000		
F 157 SS-J	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident;</p>	F 157		

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F 157	<p>Continued From page 2</p> <p>consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policies and procedures, it was determined the facility failed to consult with the physician for one (1) of six (6) sampled residents (Resident #1), when the resident had a significant change in condition.</p>	F 157	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F 157</p> <p>I. Corrective Action for Identified Resident(s)</p> <p>Resident #1 was discharged to home from the center on 5/12/14. Resident # 1 Physician was notified of the change of condition on 3/26/14 on the day of the fall and again on 4/3/14 of the pain related to injury and the CAT scan results by the licensed nurse.</p> <p>II. Identification of Other Residents having potential to be affected</p> <p>On May 12th and 13th 2014 a team of licensed nurses including Unit Managers, Case Managers, Medical Records Nurses, Directors of Nursing (DNS), and Assistant Directors of Nursing, reviewed all current residents' progress notes for the previous 30 days to identify any changes of condition and verify MD and family notification and care plans updated to reflect the change in condition. Any identified concerns were corrected at that time.</p> <p>As of 5/13/14 The DNS leading the Interdisciplinary Team (IDT) conduct Clinical Rounds.</p>	7/16/14

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F 157	Continued From page 3 On 03/26/14, at approximately 3:30 AM, Resident #1 had an unwitnessed fall from his/her bed. Resident #1 was assessed by Licensed Practical Nurse (LPN) #1 and was found to have bruising to the right cheekbone. The resident was given an ice pack and Tylenol, as needed (PRN) for complaints of pain. The physician was called at approximately 8:25 AM, when the resident was identified to have a nose bleed, dark discoloration to the right cheek area and bridge of nose and complaints of pain. An order was received to send the resident to the Emergency Room (ER) at that time. Resident #1 returned to the facility on 03/26/14 at 2:00 PM with diagnoses which included Facial Bone Fractures, Cervical Sprain, Head Injury, Closed Head Injury without Cranial Wound, and Unspecified State Level of Consciousness and a new order for Norco (narcotic pain medication) 7.5/325 milligrams (mg) PRN for pain. In addition, the resident had discharge orders to follow up with his/her primary care physician "in one (1) to two (2) days to recheck today's complaints if no improvement". Resident #1 continued to have complaints of pain when he/she opened his/her mouth; however, the physician was not notified. There was no follow-up with the resident's primary care physician until 04/03/14, (eight days later) when he visited the facility to make routine rounds, and found the resident to have complaints of pain when he/she attempted to open his/her mouth. The physician ordered a consultation with an Ear, Nose, and Throat (ENT) Specialist. The resident required surgery for repair of the fractures and was hospitalized overnight.	F 157	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> This process includes reviewing the Change in Condition Report to identify residents with a change in condition and validate that the physician and family have been notified. As of 5-17-14 the daily clinical rounds form is utilized as an audit tool (Daily Clinical Rounds Form/Audit Tool) by the Director of Nursing (DNS), RN Weekend Supervisor, RN Case Manager, and/or Unit Manager (UM) to assist in identifying findings from the clinical rounds that require additional follow up by the IDT. This process is on-going to identify any resident with the potential for a change in condition to validate notification of change to MD and family. (Refer to the 2567 of 5/16/14 for the definition of Clinical Rounds). IDT members are: DNS, UMs, Staff Development Coordinator (SDC), Case Manager, Social Service Director, Activities Director, Rehabilitation Manager III. Systemic Changes On May 13 th 2014 the Director of Nursing implemented Interdisciplinary Clinical Rounds daily (Monday- Friday) on each unit. These rounds include the Director of Nursing, Unit Managers, MDS nurse or Case Manager, Social Services Director, and Therapy Program	

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F 157	<p>Continued From page 4</p> <p>The facility's failure to notify and consult with the physician when the resident had a fall with injury and a significant change in condition has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 05/09/14 and was determined to exist on 03/26/14.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedures titled, "Notifications" dated 04/28/14, revealed its policy was to notify the resident's attending physician when the resident had an accident involving an injury that may require physician intervention, and when a significant change occurred in the patient's physical, mental or psychosocial status.</p> <p>Review of the facility's policy and procedure titled, "Condition Change of a Resident", dated 10/31/06, revealed the resident's change of condition should be identified to ensure proper treatment implementation. Additionally, it revealed the physician would be informed of resident events and/or changes in residents' conditions.</p> <p>Record review revealed the facility admitted Resident #1 on 03/12/14 with diagnoses which included Diabetes Mellitus, Chronic Obstructive Pulmonary Disease (COPD), Hypertension, Convulsions, Depression, Anxiety and History of Falls.</p> <p>Review of the Initial Minimum Data Set (MDS) assessment, dated 03/19/14, revealed the facility assessed Resident #1's cognition as intact with a Brief Interview of Mental Status (BIMS) score of</p>	F 157	<p><i>This Plan of Correction is the center's verifiable allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Director. The Weekend Supervisor Nurse will be responsible to conduct this review on Sat-Sun.</p> <p>The Clinical Rounds will verify physicians and families have been notified as needed with changes in resident condition and will verify follow up completed as needed for resident appointments outside the center from the previous day.</p> <p>As of 5-17-14 the daily clinical round audit tool will be completed by the Director of Nursing, RN Weekend Supervisor, RN Case Manager, and/or Unit Manager with the findings from the clinical rounds and is ongoing to identify potential change in resident condition. The Regional Quality Specialist (RQS) validated the Clinical Rounds Process through observation and audit 6/30/14 through 7/2/14.</p> <p>On May 10th 2014 the Staff Development Coordinator, Director of Nursing, and/or Unit Managers initiated education with all Licensed Nurses related to a reference tool titled: Reporting Change of Condition to the Physician. The education continued on May 11th, 12th, and 13th, 2014 until all Licensed</p>	

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F 157	<p>Continued From page 5</p> <p>nine (9) which indicated the resident was interviewable. Resident #1 required extensive assistance with bed mobility, transfer, and ambulation.</p> <p>Review of a Post Fall Assessment, dated 03/26/14 at 3:30 AM, revealed Resident #1 was found on the floor. The resident stated he/she just woke up and was on the floor. The resident was assessed and bruising was noted to the right cheek bone. An ice pack was applied, Tylenol (pain reliever) was given for pain and neurological checks were initiated.</p> <p>Review of a Situation, Background, Assessment Request (SBAR- health status change note) revealed on 03/26/14 at 8:25 AM, (approximately five hours after the fall) Resident #1 complained of pain to the face, his/her nose was bleeding and there was dark discoloration to the resident's right cheek area and bridge of nose. The physician was notified and an order was received to send the resident to the hospital.</p> <p>Review of a Computerized Tomography (CT) scan, completed on 03/26/14, indicated the resident had displaced facial fractures of the anterior and lateral walls of the right maxillary sinus and buckling of the lateral wall of the right orbit suggesting a fracture.</p> <p>Review of the hospital discharge instructions, dated 03/26/14, revealed Resident #1 was diagnosed to have a Facial Bone Fracture, Cervical Sprain, Head Injury, Closed Head Injury without Cranial Wound, and Unspecified State Level of Consciousness. Additional review revealed discharge instructions to follow-up with the family physician in one (1) to two (2) days, if no improvement. Further review of the discharge</p>	F 157	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Nurses received it and will be ongoing for any newly hired nurses by SDC.</p> <p>On June 16th, 2014 the Staff Development Coordinator, Director of Nursing, and/or District Director of Clinical Operations initiated education with all Licensed Nurses related to the requirements of this regulation and the procedures: Condition Change of a Resident, Documenting change of condition in the Medical Record, Documenting Resident Health Status, and Documenting in the Medical Record. The education continued on June 17th, 18th, 19th 2014; until all Licensed Nurses received it and will be ongoing for any newly hired nurses by the SDC.</p> <p>On an ongoing basis, The Director of Nursing, Unit Manager, RN Weekend Supervisor and/or The Registered Nurse Staff Development Coordinator will conduct clinical education as needed based on findings/trends of the daily clinical rounds form/audit tool and the recommendations of the Performance Improvement Committee.</p> <p>IV. Monitoring</p> <p>The clinical rounds daily audit tool will be completed by the Director of Nursing (or Unit</p>	

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F 157	<p>Continued From page 6</p> <p>instructions revealed a new order for a narcotic pain medication, Norco 7.5/32 milligrams (mg) PRN (as needed) for pain control.</p> <p>Review of a Nurse's Note, dated 03/26/14 at 12:50 PM, revealed report was received from the nurse at the hospital. Further review revealed documentation revealed the hospital nurse stated Resident #1 had oral and maxillary fractures, the resident would need to follow-up with his/her attending physician and the nurse expressed concerns regarding fall precautions.</p> <p>Interview with Resident #1, on 05/05/14 at 12:30 PM, revealed he/she had reported for several days to various staff members that he/she continued to be in pain and had difficulty eating. Resident #1 stated, "I thought I was going to starve." The resident stated he/she did not recall the exact staff, times, or dates he/she reported this to staff.</p> <p>Review of Resident #1's Narcotic Count Record for Norco 7.5 mg/325 mg PRN for facial/jaw pain revealed the resident received nineteen (19) doses of the medication between 03/27/14 through 04/03/14.</p> <p>Review of Resident #1's medical record revealed there was no documented evidence the facility notified the resident's physician about the resident's facial fractures; and, no documented evidence the physician was notified of the resident's use of PRN narcotic medication due to the pain in his/her face and jaw.</p> <p>Review of a Nurse's Note, dated 04/03/14 at 4:19 PM, revealed Resident #1's physician made</p>	F 157	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Manager, Staff Development Coordinator, Case Manager, or Weekend Supervisor when the Director of Nursing is not available). This audit tool will identify any concerns with notification of physician or family.</p> <p>Findings from the audit tool will be tracked and trended weekly by the Director of Nursing and forwarded to the Performance Improvement Committee weekly with further education or actions taken as determined by the Committee.</p> <p>By reviewing the findings of the tracking and trending, the Performance Improvement Committee will monitor the effectiveness and compliance with the plan weekly to validate solutions is sustained.</p> <p>The Performance Improvement Committee consists of the Executive Director, Director of Nursing, Unit Managers, Staff Development Coordinator, Case Manager, MDS nurse, Social Services Director, Activity director, and Therapy Services Director. The Performance Improvement Committee is meeting weekly at this time, but will resume monthly meetings once substantial compliance is achieved.</p>		

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F 157	<p>Continued From page 7</p> <p>routine rounds at the facility and examined the resident. Resident #1 complained of pain when he/she attempted to open his/her mouth. The physician ordered a consultation with an ENT Specialist (Ear, Nose and Throat).</p> <p>Review of a Physician's Note, dated 04/08/14, revealed Physician #2 (ENT Specialist) assessed Resident #1 to have a Right Malar Complex Fracture (right cheek) and scheduled Resident #1 for surgery for an open reduction and internal fixation (ORIF) the next day, on 04/09/14.</p> <p>Interview with Certified Nurse Aide (CNA) #1, on 05/09/14 at 9:50 AM, revealed Resident #1 complained of pain to the right side of his/her face for several days after the fall. The CNA stated she reported this to the Charge Nurse.</p> <p>Interview with LPN #1 (Charge Nurse), on 05/06/14 at 8:20 AM, revealed they were conducting neurological checks and seventy-two (72) hour observations. LPN #1 stated Resident #1 continued to complain of pain for several days after the fall; however, she did not notify the physician. LPN #1 revealed she did not feel they needed to notify the physician because the pain was expected due to the broken bones and they expected the resident to heal.</p> <p>Interview with LPN #3 (Charge Nurse), on 05/05/14 at 1:45 PM, revealed she did not notify the Primary Care Physician per the discharge order and stated she just thought it was minor fractures.</p> <p>Interview with Resident #1's Physician, on 05/06/14 at 1:17 PM, revealed he was not notified by the facility about the resident's facial fractures.</p>	F 157			

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F 157	<p>Continued From page 8</p> <p>The physician stated he visited the facility on 04/03/14 and found the resident had orbital fractures. He stated he referred him/her to an ENT for an evaluation. Further interview revealed he would have expected the facility to notify him of the fractures and increased pain. Additionally, the physician stated if he had been made aware of the fractures at the time of the diagnosis, he would have consulted a specialist immediately.</p> <p>Interview with the Administrator, on 05/06/14 at 3:25 PM, revealed her expectations for residents with a change in condition included notification of the physician of the change in condition.</p> <p>**The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>On 05/10/14, the facility's Nursing Management Team which consisted of the Director of Nursing (DON), Unit Manager, Case Manager, and MDS Nurse, met and reviewed all current residents with falls in the previous thirty (30) days to validate the root cause identified, and care plans were updated with appropriate interventions to prevent reoccurrence.</p> <p>On 05/10/14, the DON revised the falls packet for the licensed staff to use to investigate a fall at the time of occurrence. This revision included a Fall's Scene Investigation Report from the Kentucky Quality Improvement Organization which will be used by the licensed nurses as a guide to determine the root cause with any falls that occur.</p> <p>On 05/10/14, the Registered Nurse Staff Development Coordinator (RN SDC) and/or designee to consist of the DON, and/or Unit</p>	F 157			

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F 157	<p>Continued From page 9</p> <p>Managers, initiated education with all licensed nurses related to policy and procedures on the following topics: Pain Management, Reporting Change of Condition to the Physician, Accidents and Supervision to Prevent Accidents, Patient Assessment, Seizure, Root Cause Analysis, and Fall Response and Management. The education continued on 05/11/14, 05/12/14, and 05/13/14 and is ongoing until all licensed nurses have attended. No licensed nurse may work until the education has been received.</p> <p>The Performance Improvement (PI) committee met on 05/12/14 and discussed the root cause of the adverse event on 03/26/14. In addition, all cited deficient practice was discussed. The Medical Director was notified via telephone conference and approved the plan developed by the PI committee. Members of the PI committee in attendance included the Executive Director (ED), DON, Case Manager, Unit Managers, the District Director of Clinical Operations (DDCO), MDS Nurse, the Regional Vice President of Clinical Operations (RVPCO), and the Divisional Vice President (VP). The PI committee reviewed and approved the plan and will meet weekly until substantial compliance is achieved. During the weekly PI committee meetings, the committee will review the results of the Daily Clinical Rounds and monthly pain audit, and track and trend the audit tool findings to identify need for further actions and/or education.</p> <p>On 05/12/14 and 05/13/14, the facility identified residents who had the potential to be affected by the alleged deficient practice and all concerns were corrected.</p> <p>On 05/12/14 and 05/13/14, the facility's Unit</p>	F 157			

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F 157	<p>Continued From page 10</p> <p>Managers, Case Managers, Medical Record Nurses, DON, and Assistant Director of Nursing (ADON) reviewed all current residents Progress Notes for the previous thirty (30) days to identify any changes of condition, verified physician and family notification, and care plans were updated to reflect the change in condition.</p> <p>On 05/12/14 and 05/13/14, the facility's Unit Managers, Case Managers, Medical Record Nurses, DON, and ADON assessed every current resident using the "Patient Nursing Evaluation" and updated care plans as needed to reflect current status of the residents. This assessment included a pain assessment and a Morse Fall's Risk Assessment for every current resident.</p> <p>On 05/12/14 and 05/13/14, the facility's Unit Managers, Case Managers, Medical Record Nurses, DON, and ADON reviewed every current resident for a diagnosis of seizure disorder and validated the care plan to reflect the diagnosis and appropriate interventions.</p> <p>On 05/13/14, the DON implemented Interdisciplinary Clinical Rounds daily (Monday-Friday) on each unit. These rounds included the DON, Unit Managers, MDS Nurse, Social Services Director (SSD), and Therapy Program Director. An audit tool will be completed daily with the findings from the clinical rounds.</p> <p>The DDCO and/or Divisional VP will provide weekly oversight by validating action plans are implemented and attend facility PI committee meetings until substantial compliance has been determined.</p> <p>The State Survey Agency validated the corrective</p>	F 157			

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F 157	<p>Continued From page 11 actions taken by the facility as follows:</p> <p>Record review revealed Resident #1 was discharged home to Home Health services. On 05/12/14 and 05/13/14, the facility completed an investigation which included interviews with staff who provided care for Resident #1 on the date of the fall (03/26/14). In addition, the facility completed a medical record review to attempt to identify the root cause.</p> <p>On 05/16/14, review of Residents #7, #8 and #9's record revealed current care plans, pain assessments, and Morse Falls Risk Assessments had been completed. Progress Notes were reviewed and no concerns were noted with physician notification or change of condition.</p> <p>Review of the inservice logs, on 05/16/14, revealed all staff working had been inserviced on Pain Management, Reporting Change of Condition to the Physician, Accidents and Supervision to Prevent Accidents, Patient Assessment, Seizure, Root Cause Analysis, and Fall Response and Management. The inservice was completed by facility staff which included the RN SDC, DON, and Unit Managers.</p> <p>On 05/16/14 at 10:03 AM, the DON verified through interview he provided inservice to all staff working, performed pain assessments, fall assessments, reviewed every patient for diagnosis of seizure disorder, and validated care plans. In addition, he reviewed all the falls for the past ninety (90) days to ensure the root cause was identified. Further interview revealed, that he, along with the Unit Managers, SDC, MDS Nurse, Social Services and Rehab initiated the daily (Monday-Friday) Clinical Rounds.</p>	F 157			

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F 157	<p>Continued From page 12</p> <p>On 05/16/14 at 11:16 AM, Registered Nurse (RN) #2 (Unit Manager) and LPN #2 (Unit Manager) verified through interview they assisted with review of all falls for the last ninety (90) days at the facility. In addition, they reviewed every current resident for diagnosis of seizures and validated the care plans. Further interview revealed they assisted with daily (Monday-Friday) clinical rounds. Each of them stated they received the education provided by the facility related to falls, root cause, seizures, physician notification, change of condition, and pain assessment.</p> <p>On 05/16/14 at 2:30 PM, LPN #4 verified through interview he received education from the facility related to the new falls packet, change in condition, physician notification, seizures, and care plan interventions.</p> <p>On 05/16/14 at 2:50 PM, RN #3 verified through interview she received education from the facility related to falls, physician notification, and pain monitoring.</p> <p>On 05/16/14 at 3:02 PM, LPN #5 verified through interview she received education from the facility related to physician notification, the new falls packet, pain assessment, seizures, and determining the root cause of the falls.</p> <p>On 05/16/14 at 3:03 PM, LPN #7 verified through interview she received education from the facility related to physician notification, new falls packet, seizures, condition changes, and pain.</p> <p>On 05/16/14 at 3:30 PM, RN #4 verified through interview she received education from the facility</p>	F 157		

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F 167	Continued From page 13 related to physician notification, status changes in residents, seizures, falls, and pain assessment. On 05/16/14 at 3:30 PM, RN #1 (MDS Coordinator) verified through interview she received education from the facility related to notification in change of condition, pain management, seizures, and falls packet. Further interview revealed she assisted with daily clinical rounds and assisted with review of falls for the past 90 days to validate the root causes. On 05/16/14 at 3:54 PM, LPN #6 verified through interview she received education from the facility related to falls, pain monitoring, condition changes, seizures, patient assessments, and physician notification. On 05/16/14 at 4:00 PM, LPN #8 verified through interview she received education from the facility related to the new falls packet, physician notification, updating care plans, seizures, condition changes, and pain assessment. On 05/16/14 at 4:23 PM, the Physical Therapy Program Director verified through interview she was educated on the new process for clinical rounds, falls, and the new falls packet. On 05/16/14 at 4:25 PM, the SSD verified through interview she assisted with the clinical rounds daily (Monday-Friday). She stated she did not receive the other education because she was not clinical.	F 167			
F 279 SS=J	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment	F 279			

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F 279	<p>Continued From page 14</p> <p>to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's policy and procedures and review of the hospital's History and Physical and Consultation Report it was determined the facility failed to revise the care plan for one (1) of six (6) sampled residents (Resident #1) related to the resident's increased risk of seizures.</p> <p>Resident #1 was admitted to the facility on 03/12/14 after hospitalization for a seizure at home. A Comprehensive Care Plan was developed on 03/13/14, for Risk for Injury due to seizure activity with interventions to administer seizure medications/draw blood levels per physician orders and seizure precautions. On 03/20/14, Resident #1 was found in bed having</p>	F 279	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F279</p> <p>I. Corrective Action for Identified Resident(s)</p> <p>Resident #1 was discharged to home from the center on 5/12/14. Resident #1's care plan was reviewed and revised to reflect current level of care on 5/10/14 by Interdisciplinary Team (IDT).</p> <p>II. Identification of Other Residents having potential to be affected</p> <p>On May 12th and 13th 2014 a team of Licensed nurses including Unit Managers, Case Managers, Medical Records Nurses, Directors of Nursing, and Assistant Directors of Nursing completed a review of all current residents. This review included- assessing the resident using the Patient Nursing Evaluation, Pain Assessments, Morse Falls Risk Assessments, review for any seizure diagnosis, review of the previous 30 days of progress notes, and verifying the care plan was updated</p>	7/16/14	

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F 279	<p>Continued From page 15</p> <p>seizure activity and the resident was sent to the hospital. The resident's seizure medication was adjusted and the resident returned to the facility on 03/22/14; however, review of the Comprehensive Care Plan, revealed there were no revisions made to the care plan related to the resident's seizures and safety.</p> <p>On 03/26/14, at approximately 3:30 AM, Resident #1 had an unwitnessed fall from his/her bed and was unable to voice what happened. Resident #1 was found sitting on the floor beside his/her bed and when asked by the staff what happened, the resident stated, "I don't know, I just woke up and I was on the floor." Resident #1 was assessed and found to have bruising to the right cheekbone. At 8:25 AM, Resident #1 was identified with a nose bleed and the physician was notified with an order received to send the resident to the Emergency Room (ER).</p> <p>Resident #1 returned to the facility on 03/26/14 at 2:00 PM with diagnoses which included Facial Bone Fracture, Cervical Sprain, Head Injury, Closed Head Injury without Cranial wound, and Unspecified State Level of Consciousness. On 04/03/14, the physician visited the facility to make routine rounds and found the resident to have facial fractures and complaints of pain when he/she attempted to open his/her mouth. The physician ordered a consultation with an Ear, Nose, and Throat (ENT) Specialist. Resident #1 was seen by the ENT Specialist on 04/08/14 and was scheduled for surgery on 04/09/14 for an Open Reduction Internal Fixation (ORIF) of the right malar complex. The procedure required surgical plates and screws for repair. Resident #1 returned to the facility on 04/10/14.</p>	F 279	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>accordingly. Any concerns identified were corrected at that time.</p> <p>As of 5/13/14 The DNS leading the Interdisciplinary Team (IDT) conduct Clinical Rounds. This process includes reviewing the Change in Condition Report to identify residents with a change in condition and validate that care plan updates/revisions have been identified and or completed by the IDT and or licensed nurse.</p> <p>As of 5-17-14 the daily clinical rounds form is utilized as an audit tool (Daily Clinical Rounds Form/Audit Tool) by the Director of Nursing (DNS), RN Weekend Supervisor, RN Case Manager, and/or Unit Manager (UM) to assist in identifying findings (i.e. care plans that need to be initiated and or revised) from the clinical rounds that require additional follow up by the IDT. This process is on-going to identify any resident with the potential to be affected which will allow for immediate corrective action by the IDT (Refer to the 2567 of 5/16/14 for the definition of Clinical Rounds).</p> <p>IDT members are: DNS, UMs, Staff Development Coordinator (SDC), Case Manager, Social Service Director, Activities Director, Rehabilitation Manager</p>	

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F 279	<p>Continued From page 16</p> <p>The facility's failure to revise the care plan related to seizures has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 05/09/14 and was determined to exist on 03/26/14.</p> <p>The findings include:</p> <p>Review of the facility's "Care Plans" policy and procedures, dated 01/07/13, revealed a comprehensive care plan would be developed for residents consistent with the patient's specific conditions, risks, needs, behaviors, preferences and with standards of practice including measurable objectives, interventions/services, and timetables to meet the resident's needs as identified in the patient's assessment or as identified in relation to the patient's response to the interventions or changes in the patient's condition. In addition, the plan of care is developed based on the resident's individual needs as identified by assessments. Further review revealed the care plan will be reviewed and revised quarterly, annually, and with significant change in condition, or more frequently as needed. The care plan addresses risk factors that might lead to avoidable decline in function and reflect current professional standards of practice.</p> <p>1. Record review revealed the facility admitted Resident #1 on 03/12/14, with diagnoses which included Diabetes Mellitus, Chronic Obstructive Pulmonary Disease (COPD), Hypertension, Convulsions, Depression, and Anxiety.</p> <p>Review of the Hospital History and Physical, dated 03/02/14, revealed Resident #1 was</p>	F 279	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>III. Systemic Changes</p> <p>On June 16th, 2014 the Staff Development Coordinator, Director of Nursing, and/or District Director of Clinical Operations initiated education with all Licensed Nurses related to the requirements of this regulation and the procedure Comprehensive Plan of Care. The Licensed Nurses were educated on their responsibility to update a resident's plan of care with new problems, modified interventions, improvements and declines, and or goals attained for any resident as needed. The education continued on June 17th, 18th, 19th 2014, until all Licensed Nurses received it and will be ongoing for any newly hired nurses by the SDC.</p> <p>On May 13th 2014 the Director of Nursing implemented Interdisciplinary Clinical Rounds daily (Monday- Friday) on each unit. These rounds include the Director of Nursing, Unit Managers, MDS nurse or Case Manager, Social Services Director, and Therapy Program Director. The Weekend Supervisor Nurse will be responsible to conduct this review on Sat-Sun. The Clinical Rounds will verify resident care plans updated as needed with changes in</p>	
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F 279	<p>Continued From page 17</p> <p>admitted to the hospital from home due to the resident having a seizure.</p> <p>Review of the Initial Minimum Data Set (MDS) assessment, dated 03/19/14, revealed the facility assessed Resident #1's cognition as cognitively intact with a Brief Interview for Mental Status (BIMS) score of nine (9), which indicated the resident was interviewable. Additionally, the facility assessed Resident #1 to require extensive assistance with bed mobility, transfer, and ambulation.</p> <p>Review of Resident #1's Comprehensive Care Plan, dated 03/13/14, revealed he/she was at risk for injury related to falls and seizure activity with interventions initiated on 03/13/14 to participate in the Falling Stars Program, remind to call for assistance, seizure precautions and to administer anticonvulsant medications and draw blood for levels per physician orders. However, there was no guidance to staff in the Plan of Care to define what seizure precautions they were to implement to ensure the care plan met the resident's individualized needs.</p> <p>Review of a Nurse's Note, dated 03/20/14 at 5:35 PM, revealed when staff entered Resident #1's room, the resident was in bed and showing signs of seizure activity. The resident was turned on his/her right side, vital signs were obtained and the physician was called with orders received to send the resident to the Emergency Room.</p> <p>Review of the Hospital Consultation Report, dated 03/20/14, revealed the resident was admitted to the hospital and the resident's anticonvulsant medication was adjusted. Review of a Nurse's Note, dated 03/22/14 at 1:45 PM, revealed the resident returned to the facility</p>	F 279	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>resident condition and will verify newly admitted residents care plans initiated.</p> <p>As of 5-17-14 the daily clinical rounds form is utilized as an audit tool (Daily Clinical Rounds Form/Audit Tool) by the Director of Nursing (DNS), RN Weekend Supervisor, RN Case Manager, and/or Unit Manager (UM) to assist in identifying findings (i.e. care plans that need to be initiated and or revised) from the clinical rounds that require additional follow up by the IDT. This process is on-going to identify any resident with the potential to be affected which will allow for immediate corrective action by the IDT (Refer to the 2567 of 5/16/14 for the definition of Clinical Rounds).</p> <p>On an ongoing basis, The Director of Nursing, Unit Manager, RN Weekend Supervisor and/or The Registered Nurse Staff Development Coordinator will conduct clinical education as needed based on findings/trends of the Daily Clinical Rounds Form/Audit Tool and the recommendations of the Performance Improvement Committee.</p> <p>IV. Monitoring</p> <p>The clinical rounds daily audit tool was implemented will be completed by the</p>		

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F 279	<p>Continued From page 18</p> <p>Further review of the Comprehensive Care Plan, dated 03/13/14; revealed there were no revisions made to the care plan related to the resident's seizures.</p> <p>Review of a Post Fall Evaluation, dated 03/26/14, revealed Resident #1 sustained an unwitnessed fall from his/her bed at approximately 3:30 AM, and when asked what had happened by staff the resident stated "I don't know I just woke up and was on the floor". Further review revealed Licensed Practical Nurse (LPN) #1 assessed the resident to have a bruise to the right cheek bone, so she applied an ice pack and administered Tylenol for pain. Review of the Nurse's Note, dated 03/26/14 at 8:25 AM, revealed Resident #1 complained of pain to his/her face and his/her nose was bleeding. The Physician was notified at the time, and an order was received to send Resident #1 to the Emergency Room. Review of Hospital Discharge Instructions, dated 03/26/14, revealed Resident #1 was diagnosed with Facial Bone Fractures, Cervical Sprain, Head Injury, Closed Head Injury without Cranial Wound, and Unspecified State Level of Consciousness. Review of an Inpatient Operative Report, dated 04/09/14, revealed the resident had an Open Reduction and Internal Fixation a right Malar Complex Fracture (Cheek bone) and returned to the facility on 04/10/14.</p> <p>Interview with Resident #1, on 05/01/14 at 6:00 PM, revealed he/she had fallen from his/her bed on 03/26/14 at approximately 3:30 AM and he/she did not know how he/she had fallen to the floor out of the bed.</p> <p>Interview with Certified Nurse Aide (CNA) #1, on</p>	F 279	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Director of Nursing (or Unit Manager, Staff Development Coordinator, Case Manager, or Weekend Supervisor when the Director of Nursing is not available). This audit tool will identify any concerns with updating resident notification of physician or family.</p> <p>Findings from the audit tool will be tracked and trended by the Director of Nursing weekly and forwarded to the Performance Improvement Committee with further education or actions taken as determined by the Committee.</p> <p>By reviewing the findings of the tracking and trending, the Performance Improvement Committee will monitor the effectiveness and compliance with the plan weekly to validate solutions is sustained.</p> <p>The Performance Improvement Committee consists of the Executive Director, Director of Nursing, Unit Managers, Staff Development Coordinator, Case Manager, MDS nurse, Social Services Director, Activity director, and Therapy Services Director. The Performance Improvement Committee is meeting weekly at this time, but will resume monthly meetings once substantial compliance is achieved.</p>	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066	
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F 279	<p>Continued From page 19</p> <p>05/09/14 at 9:50 AM, revealed she found Resident #1 on the floor by the bed when she was walking by Resident #1's room around 3:00 AM on 03/26/14. The CNA stated she was not sure how long the resident had been on the floor but when she found the resident, he/she was incontinent of stool.</p> <p>Interview with the Registered Nurse (RN) #5/Minimum Data Set (MDS) Coordinator, on 06/02/14 at 1:50 PM (post survey interview), revealed if a resident had a change in condition it was the Charge Nurse's responsibility to update the care plans.</p> <p>Post survey interviews conducted with RN #2, on 06/04/14 at 3:00 PM, and LPN #2/Unit Manager at 3:10 PM revealed the resident's care plan should have been updated if there were any changes with the resident. RN #2 stated that the care plan should have been more individualized for Resident #1 to include bed safety if she had a seizure in the bed. LPN #2 stated she would have expected the care plan to be revised after a hospitalization due to a seizure.</p> <p>Interview with the Director of Nursing (DON), on 05/19/14 at 3:25 PM, revealed seizure precautions were not specific interventions and were individualized according to the resident's individual needs. A Post Survey Interview was conducted with the DON, on 06/04/14 at 3:15 PM, and revealed he expected the staff to look at the care but not necessarily revise it. The DON stated the licensed staff should have addressed the care plan with possibly having identified specific interventions.</p> <p>A Post Survey Interview with the Administrator, on</p>	F 279		

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F 279	<p>Continued From page 20</p> <p>06/04/14 at 3:18 PM, revealed if the resident had a care plan for seizures she would have expected the staff to review and revise the care plan as needed.</p> <p>**The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>On 05/10/14, the facility's Nursing Management Team which consisted of the Director of Nursing (DON), Unit Manager, Case Manager, and MDS Nurse, met and reviewed all current residents with falls in the previous thirty (30) days to validate the root cause identified, and care plans were updated with appropriate interventions to prevent reoccurrence.</p> <p>On 05/10/14, the DON revised the falls packet for the licensed staff to use to investigate a fall at the time of occurrence. This revision included a Fall's Scene Investigation Report from the Kentucky Quality Improvement Organization which will be used by the licensed nurses as a guide to determine the root cause with any falls that occur.</p> <p>On 05/10/14, the Registered Nurse Staff Development Coordinator (RN SDC) and/or designee to consist of the DON, and/or Unit Managers, initiated education with all licensed nurses related to policy and procedures on the following topics: Pain Management, Reporting Change of Condition to the Physician, Accidents and Supervision to Prevent Accidents, Patient Assessment, Seizure, Root Cause Analysis, and Fall Response and Management. The education continued on 05/11/14, 05/12/14, and 05/13/14 and is ongoing until all licensed nurses have attended. No licensed nurse may work until the</p>	F 279		

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F 279	<p>Continued From page 21 education has been received.</p> <p>The Performance Improvement (PI) committee met on 05/12/14 and discussed the root cause of the adverse event on 03/26/14. In addition, all cited deficient practice was discussed. The Medical Director was notified via telephone conference and approved the plan developed by the PI committee. Members of the PI committee in attendance included the Executive Director (ED), DON, Case Manager, Unit Managers, the District Director of Clinical Operations (DDCO), MDS Nurse, the Regional Vice President of Clinical Operations (RVPCO), and the Divisional Vice President (VP). The PI committee reviewed and approved the plan and will meet weekly until substantial compliance is achieved. During the weekly PI committee meetings, the committee will review the results of the Daily Clinical Rounds and monthly pain audit, and track and trend the audit tool findings to identify need for further actions and/or education.</p> <p>On 05/12/14 and 05/13/14, the facility identified residents who had the potential to be affected by the alleged deficient practice and all concerns were corrected.</p> <p>On 05/12/14 and 05/13/14, the facility's Unit Managers, Case Managers, Medical Record Nurses, DON, and Assistant Director of Nursing (ADON) reviewed all current residents Progress Notes for the previous thirty (30) days to identify any changes of condition, verified physician and family notification, and care plans were updated to reflect the change in condition.</p> <p>On 05/12/14 and 05/13/14, the facility's Unit Managers, Case Managers, Medical Record</p>	F 279		
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F 279	<p>Continued From page 22</p> <p>Nurses, DON, and ADON assessed every current resident using the "Patient Nursing Evaluation" and updated care plans as needed to reflect current status of the residents. This assessment included a pain assessment and a Morse Fall's Risk Assessment for every current resident.</p> <p>On 05/12/14 and 05/13/14, the facility's Unit Managers, Case Managers, Medical Record Nurses, DON, and ADON reviewed every current resident for a diagnosis of seizure disorder and validated the care plan to reflect the diagnosis and appropriate interventions.</p> <p>On 05/13/14, the DON implemented Interdisciplinary Clinical Rounds daily (Monday-Friday) on each unit. These rounds included the DON, Unit Managers, MDS Nurse, Social Services Director (SSD), and Therapy Program Director. An audit tool will be completed daily with the findings from the clinical rounds.</p> <p>The DDCO and/or Divisional VP will provide weekly oversight by validating action plans are implemented and attend facility PI committee meetings until substantial compliance has been determined.</p> <p>The State Survey Agency validated the corrective actions taken by the facility as follows:</p> <p>Record review revealed Resident #1 was discharged home to Home Health services. On 05/12/14 and 05/13/14, the facility completed an investigation which included interviews with staff who provided care for Resident #1 on the date of the fall (03/26/14). In addition, the facility completed a medical record review to attempt to identify the root cause.</p>	F 279		
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F 279	<p>Continued From page 23</p> <p>On 05/16/14, review of Residents #7, #8 and #9's record revealed current care plans, pain assessments, and Morse Falls Risk Assessments had been completed. Progress Notes were reviewed and no concerns were noted with physician notification or change of condition.</p> <p>Review of the inservice logs, on 05/16/14, revealed all staff working had been inserviced on Pain Management, Reporting Change of Condition to the Physician, Accidents and Supervision to Prevent Accidents, Patient Assessment, Seizure, Root Cause Analysis, and Fall Response and Management. The inservice was completed by facility staff which included the RN SDC, DON, and Unit Managers.</p> <p>On 05/16/14 at 10:03 AM, the DON verified through interview he provided inservice to all staff working, performed pain assessments, fall assessments, reviewed every patient for diagnosis of seizure disorder, and validated care plans. In addition, he reviewed all the falls for the past ninety (90) days to ensure the root cause was identified. Further interview revealed, that he, along with the Unit Managers, SDC, MDS Nurse, Social Services and Rehab initiated the daily (Monday-Friday) Clinical Rounds.</p> <p>On 05/16/14 at 11:16 AM, Registered Nurse (RN) #2 (Unit Manager) and LPN #2 (Unit Manager) verified through interview they assisted with review of all falls for the last ninety (90) days at the facility. In addition, they reviewed every current resident for diagnosis of seizures and validated the care plans. Further interview revealed they assisted with daily (Monday-Friday) clinical rounds. Each of them stated they</p>	F 279		
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F 279	<p>Continued From page 24</p> <p>received the education provided by the facility related to falls, root cause, seizures, physician notification, change of condition, and pain assessment.</p> <p>On 05/16/14 at 2:30 PM, LPN #4 verified through interview he received education from the facility related to the new falls packet, change in condition, physician notification, seizures, and care plan interventions.</p> <p>On 05/16/14 at 2:50 PM, RN #3 verified through interview she received education from the facility related to falls, physician notification, and pain monitoring.</p> <p>On 05/16/14 at 3:02 PM, LPN #5 verified through interview she received education from the facility related to physician notification, the new falls packet, pain assessment, seizures, and determining the root cause of the falls.</p> <p>On 05/16/14 at 3:03 PM, LPN #7 verified through interview she received education from the facility related to physician notification, new falls packet, seizures, condition changes, and pain.</p> <p>On 05/16/14 at 3:30 PM, RN #4 verified through interview she received education from the facility related to physician notification, status changes in residents, seizures, falls, and pain assessment.</p> <p>On 05/16/14 at 3:30 PM, RN #1 (MDS Coordinator) verified through interview she received education from the facility related to notification in change of condition, pain management, seizures, and falls packet. Further interview revealed she assisted with daily clinical rounds and assisted with review of falls for the</p>	F 279		

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F 279	Continued From page 25 past 90 days to validate the root causes. On 05/16/14 at 3:54 PM, LPN #8 verified through interview she received education from the facility related to falls, pain monitoring, condition changes, seizures, patient assessments, and physician notification. On 05/16/14 at 4:00 PM, LPN #8 verified through interview she received education from the facility related to the new falls packet, physician notification, updating care plans, seizures, condition changes, and pain assessment. On 05/16/14 at 4:23 PM, the Physical Therapy Program Director verified through interview she was educated on the new process for clinical rounds, falls, and the new falls packet. On 05/16/14 at 4:26 PM, the SSD verified through interview she assisted with the clinical rounds daily (Monday-Friday). She stated she did not receive the other education because she was not clinical.	F 279		
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced	F 309		

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F 309	<p>Continued From page 26</p> <p>by: Based on interview, record review, and review of the facility's policies and procedures, it was determined the facility failed to ensure each resident was provided the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the plan of care for one (1) of six (6) sampled residents (Resident #1). The facility failed to provide ongoing assessments for Resident #1 after an unexplained and unwitnessed fall from the bed which resulted in facial fractures and other injuries.</p> <p>On 03/26/14, at approximately 3:30 AM, Resident #1 had an unwitnessed fall from his/her bed and was found to have bruising to the right cheekbone. The resident was given an ice pack and was administered Tylenol (pain medication), as needed (PRN) for complaints of pain and placed on neurological assessments for seventy-two (72) hours. At 8:25 AM, Resident #1 was identified to have a nose bleed, continued complaints of pain to the face and a dark discoloration to the right cheek and bridge of his/her nose. The physician was contacted and an order was received to send the resident to the Emergency Room (ER) at that time. Resident #1 returned to the facility on 03/26/14 at 2:00 PM and was diagnosed with Facial Bone Fractures, Cervical Sprain, Head Injury, Closed Head Injury without cranial wound, and Unspecified State Level of Consciousness. In addition, the resident had discharge orders for Norco (narcotic pain medication) 7.5/325 milligrams as needed (PRN) for pain and to follow up with Resident #1's Primary Care Physician in one (1) to two (2) days to recheck today's complaints if the resident was</p>	F 309	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F 309</p> <p>I. Corrective Action for Identified Resident(s)</p> <p>Resident #1 was discharged to home from the center on 5/12/14. Resident # 1 physician was notified of the change of condition on 3/26/14 on the day of the fall and again on 4/3/14 of the pain related to the injury and the CAT scan results. The physician on 4/3/14 ordered no further revisions to the resident's pain regime. Resident #1 care plan was reviewed and revised to reflect current level of care on 5/10/14 Interdisciplinary Team (IDT).</p> <p>II. Identification of Other Residents having potential to be affected</p> <p>On May 12th and 13th 2014 a team of Licensed nurses including Unit Managers, Case Managers, Medical Records Nurses, Directors of Nursing, and Assistant Directors of Nursing completed a review of all current residents. This review included- assessing the resident using the Patient Nursing Evaluation, Pain Assessments, Morse Falls Risk Assessments,</p>	7/16/14
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F 309	Continued From page 27 not improving". The facility care planned Resident #1 for facial fractures with an intervention to observe the resident and report any changes to usual routine, sleep pattern, decrease in functional abilities, decrease range of motion, withdrawal or resistance to care. However, there was no documented evidence Licensed Staff assessed Resident #1 every shift after the change in condition related to the facial fractures. In addition, the facility failed to complete routine full neurological assessments and pain assessments per the facility's policy and procedures. Resident #1 complained of pain to his/her face and received narcotic pain medication nineteen (19) times between 03/27/14-04/03/14. However, there was no documented evidence the facility assessed the resident's pain to include the pain scale rating, duration, intensity and character per facility policy. Further review revealed there was no documented evidence the care plan was followed related to addressing the resident's lack of improvement and making the physician aware of the resident's change in condition. On 04/03/14, approximately eight (8) days after the fall with facial fractures, the Primary Care Physician visited the facility to make routine rounds and found the resident with facial fractures and complaints of pain when he/she opened his/her mouth. The Primary Care Physician ordered a consultation with an Ears, Nose, and Throat Specialist (ENT). Resident #1 required surgery for repair of the Facial Bone Fractures and overnight hospitalization. The facility's failure to ensure each resident received necessary care and services and failure to provide an on-going assessment of Resident	F 309	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> review for any seizure diagnosis, review of the previous 30 days of progress notes, and verifying the care plan was updated accordingly. Any concerns identified were corrected at that time. As of 5/13/14 The DNS leading the Interdisciplinary Team (IDT) conduct Clinical Rounds. This process includes reviewing the Change in Condition Report to identify residents with a change in condition and validate that the physician and family have been notified, and reviewing necessary supplemental assessments (supplemental assessment is defined as any assessment or evaluation performed to obtain information to further determine resident's condition to enhance resident's individualized plan of care). As of 5-17-14 the daily clinical rounds form is utilized as an audit tool (Daily Clinical Rounds Form/Audit Tool) by the Director of Nursing (DNS), RN Weekend Supervisor, RN Case Manager, and/or Unit Manager (UM) to assist in identifying findings from the clinical rounds that require additional follow up by the IDT. This process is on-going to identify any resident with the potential to be affected which will allow for immediate corrective action by	

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F 309	<p>Continued From page 28</p> <p>#1 after a change in condition has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 05/09/14 and determined to exist on 03/26/14.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled, "Pain Management", dated 08/31/13, revealed its policy recognized a resident's right to be free of pain and will promote pain relief through the use of the pain management plan during the patient's duration of stay at the facility. Further review revealed the licensed nurse will communicate the adequacy of pain management and/or changes in pain significance to the physician at admission and as needed based on assessment and reassessment data throughout the resident's stay. Pain is assessed at least every shift, when a resident complained of pain and after an analgesic is given to determine the effectiveness of the analgesic. When pain is identified, assessment and documentation will include pain scale rating, location, duration, intensity, and character. The plan of care is developed for residents, documented and updated as needed.</p> <p>Review of the facility's Neurological Assessments policy and procedures, last revised 10/31/10, revealed Neurological Assessment would be conducted every fifteen (15) minutes for the first hour, every thirty (30) minutes for the next hour, every hour for two (2) hours, then every four (4) hours until the physician says it is no longer necessary or in seventy-two (72) hours if patient's condition is stable and showing no signs and symptoms of neurological injury.</p>	F 309	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>the IDT (Refer to the 2567 of 5/16/14 for the definition of Clinical Rounds).</p> <p>IDT members are: DNS, UMs, Staff Development Coordinator (SDC), Case Manager, Social Service Director, Activities Director, Rehabilitation Manager</p> <p>III. Systemic Changes</p> <p>On May 13th 2014 the Director of Nursing implemented Interdisciplinary Clinical Rounds daily (Monday-Friday) on each unit. These rounds include the Director of Nursing, Unit Managers, MDS nurse or Case Manager, Social Services Director, and Therapy Program Director. The Weekend Supervisor Nurse will be responsible to conduct this review on Sat-Sun. The Clinical Rounds will verify ongoing assessments and documentation in the medical record for residents experiencing a change in condition, physician and family have been notified, and the care plans updated as needed.</p> <p>As of 5-17-14 the daily clinical rounds form is utilized as an audit tool (Daily Clinical Rounds Form/Audit Tool) by the Director of Nursing (DNS), RN Weekend Supervisor, RN Case Manager, and/or Unit Manager (UM) to assist</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066
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F 309	<p>Continued From page 29</p> <p>Post Interview with the Administrator, on 06/03/14 at 3:00, revealed the facility did not have a policy that addressed resident assessments after the resident had a change in condition.</p> <p>Record review revealed the facility admitted Resident #1 on 03/12/14 with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), Diabetes, Hypertension, Convulsions, Depression, and Anxiety.</p> <p>Review of the Initial Minimum Data Set (MDS) assessment, dated 03/19/14, revealed the facility assessed Resident #1 as cognitively intact with a Brief Interview for Mental Status (BIMS) score of nine (9), which indicated the resident was interviewable. Additionally, the facility assessed Resident #1 to require extensive assistance with bed mobility, transfer, and ambulation.</p> <p>Interview with Resident #1, on 05/01/14 at 6:00 PM, revealed he/she was sent to the hospital on 03/26/14 after a fall, and was diagnosed with facial fractures. The resident stated she could feel the bones moving in his/her face when he/she opened his/her mouth. He/she stated the facility did not get him/her to the physician for two (2) weeks and he/she required surgery. Further interview, on 05/05/14 at 12:30 PM, revealed Resident #1 reported to various staff members (resident doesn't recall staffs' names or dates) for several days as he/she continued to be in pain and had difficulty eating.</p> <p>Review of a Post Fall Assessment, dated 03/26/14 at 3:30 AM, revealed Resident #1 had a fall and was identified with bruising to the right cheek bone and neurological assessments were initiated.</p>	F 309	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>in identifying findings from the clinical rounds that require additional follow up by the IDT. This process is on-going to identify any resident with the potential to be affected which will allow for immediate corrective action by the IDT (Refer to the 2567 of 5/16/14 for the definition of Clinical Rounds).</p> <p>On May 10th 2014 the Staff Development Coordinator, Director of Nursing, and/or Unit Managers initiated education with all Licensed Nurses on following policies and procedures: Pain Management, Resident Assessment, and Seizures. The education continued on May 11th, 12th, and 13th, 2014 until all Licensed Nurses received it and will be ongoing for any newly hired nurses by the SDC.</p> <p>On June 16th, 2014 the Staff Development Coordinator, Director of Nursing, and/or District Director of Clinical Operations initiated education with all Licensed Nurses on additional policies and procedures: Condition Change of a Resident, Documenting Change of Condition in the Medical Record, Documenting Resident Health Status, and Documenting in the Medical Record. The education continued on June 17th, 18th, 19th 2014, until all Licensed Nurses received it and</p>	
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F 309	<p>Continued From page 30</p> <p>Review of a Nurse's Note, dated 03/26/14 at 8:25 AM, revealed Resident #1 complained of pain to his/her face and his/her nose was bleeding after a fall during the night. Further review revealed a dark discoloration was noted to the resident's right cheek area and bridge of his/her nose. The Physician was notified and an order was received to send Resident #1 to the Emergency Room. Review of a Computerized Tomography (CT) scan, completed on 03/26/14, revealed the resident had displaced facial fractures of the anterior and lateral walls of the right maxillary sinus and buckling of the lateral wall of the right orbit suggesting a fracture.</p> <p>Review of Hospital Discharge Instructions, dated 03/26/14, revealed Resident #1 suffered injuries with diagnoses which included Facial Bone Fracture, Cervical Sprain, Head Injury, Closed Head Injury without Cranial Wound, and Unspecified State Level of Consciousness. Additional review revealed discharge instructions to follow-up with the Primary Care Physician in one (1) to two (2) days, if no improvement. Further review of the discharge instructions revealed a new order for a narcotic pain medication; Norco 7.5/325 milligrams (mg) PRN for pain control.</p> <p>Review of Resident #1's Comprehensive Care Plan for, "I have Acute Pain because I have facial fractures", dated 03/26/14, revealed an intervention to observe the resident and report changes in his/her usual routine, sleep patterns, decrease in functional abilities, decrease range of motion and withdrawal or resistance to care. However, there were no interventions to address assessing the resident for pain.</p>	F 309	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>will be ongoing for any newly hired nurses by the SDC.</p> <p>On an ongoing basis, The Director of Nursing, Unit Manager, RN Weekend Supervisor and/or The Registered Nurse Staff Development Coordinator will conduct clinical education as needed based on findings/trends of the daily clinical rounds form/audit tool and the recommendations of the Performance Improvement Committee.</p> <p>The District Director of Clinical Operations, Director of Nursing, and/or Unit Managers will conduct a monthly pain audit reviewing all residents most recent pain assessment score and pain scales for residents with orders for routine or prn pain medications. The physician will be notified of any needed pain medication recommendations. The frequency of this audit will be monthly yet may be adjusted as directed by the Performance Improvement Committee once substantial compliance is achieved.</p> <p>IV. Monitoring</p> <p>The clinical rounds daily audit tool is</p>	
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* * * Error Report (Jul. 23. 2014 8:21AM) * * *

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 : Memory
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 : RX Notice Req.
 : Folder

C : Confidential
L : Send later
D : Detail
H : Stored/D. Server
A : RX Notice

\$: Transfer
@ : Forwarding
F : Fine
* : LAN-Fax
 : Mail

P : SEP Code
E : ECM
U : Super Fine
+ : Delivery
<> : IP-FAX

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F 309	<p>Continued From page 31</p> <p>Review of Resident #1's Neurological Record form revealed staff should conduct neurological assessments every fifteen (15) minutes for the first hour, every thirty (30) minutes for the next hour, every hour for two (2) hours, then every four (4) hour for the remainder of the seventy-two (72) hours. Review of Resident #1's Neurological Assessments, dated 03/26/14-03/29/14 revealed one of the every thirty (30) minute assessments; two (2) of the every four (4) hour assessments were not conducted; and, seven (7) of the assessments were incomplete.</p> <p>Review of the Nurse's Notes, dated 03/25/14-04/03/14 revealed there was no documented evidence the Licensed Nurses conducted assessments of Resident #1 consistently every shift related to the resident's change in condition due to the facial fractures.</p> <p>Review of Resident #1's Narcotic Count Record for Norco 7.5 mg/325 mg PRN for facial/jaw pain revealed the resident received nineteen (19) doses of the medication between 03/27/14 through 04/03/14. However, review of the March and April 2014 Medication Administration Records (MAR) and Nurse's Notes from 03/27/14 to 04/03/14 revealed there was no documented evidence the staff assessed the resident's pain for the rating, duration, character and intensity prior to or after the administration of the pain medication. In addition, there was no evidence the resident had a PRN medication sheet.</p> <p>Post survey interviews conducted on 06/04/14 at 3:00 PM with Registered Nurse (RN) #2/Unit Manager, and at 3:10 PM with LPN #2 revealed pain assessments were conducted before and</p>	F 309	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>completed by the Director of Nursing (or Unit Manager, Staff Development Coordinator, Case Manager, or Weekend Supervisor when the Director of Nursing is not available). This audit tool will identify any concerns with ongoing assessments needed related to resident change in condition.</p> <p>Findings from the audit tool will be tracked and trended by the Director of Nursing weekly and forwarded to the Performance Improvement Committee with further education or actions taken as determined by the Committee.</p> <p>Additionally, the findings from the Monthly Pain Audit will be tracked and trended by the Director of Nursing and forwarded to the Performance Improvement Committee with further education and/ or follow up actions taken as determined by the Committee. The frequency of this audit may be adjusted according to the Performance Improvement Committee.</p> <p>By reviewing the findings of the tracking and trending weekly, the Performance</p>		

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F 309	<p>Continued From page 32</p> <p>after pain medication was administered and should include the level of pain on a scale of one to ten (1-10), duration, intensity, and character. The assessments were documented on the Nurse's Notes and the back of the MAR and on a PRN (as needed) medication sheet. RN #2 stated the PRN medication sheets were not used for Resident #1.</p> <p>Interview with Certified Nurse Aide (CNA) #1, on 05/09/14 at 9:50 AM, revealed Resident #1 continued to complain of pain to his/her face and jaw for several days after the fall and he/she reported the complaints of pain to the nurse.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 (Charge Nurse), on 05/06/14 at 8:20 AM, revealed Resident #1 continued to complain of pain for several days after the fall and she did not notify the physician. LPN #1 stated she expected the resident to have pain and she thought Resident #1 would heal.</p> <p>Review of a Nurse's Note, dated 04/03/14 at 4:19 PM, revealed Resident #1's physician completed routine rounds at the facility and examined the resident. Resident #1 complained of pain when he/she attempted to open his/her mouth and the physician ordered a consultation with an Ears, Nose Throat (ENT) Specialist.</p> <p>Interview with Resident #1's Physician, on 05/06/14 at 1:17 PM, revealed the facility had not made him aware Resident #1 had sustained facial fractures. The physician stated he found out the resident had facial fractures on 04/03/14 when he conducted his routine visit to the facility and made rounds. He revealed he referred the resident to an ENT for evaluation. Further</p>	F 309	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Improvement Committee will monitor the effectiveness and compliance with the plan weekly to validate solutions are sustained.</p> <p>The Performance Improvement Committee consists of the Executive Director, Director of Nursing, Unit Managers, Staff Development Coordinator, Case Manager, MDS nurse, Social Services Director, Activity director, and Therapy Services Director.</p> <p>The Performance Improvement Committee is meeting weekly at this time, but will resume monthly meetings once substantial compliance is achieved.</p>	

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F-309	<p>Continued From page 33</p> <p>interview revealed, he would have expected the facility to have made him aware of the fractures and increased pain. He revealed the resident should have been seen by a Specialist immediately due to the resident's facial fractures.</p> <p>Review of a Physician's Note, dated 04/08/14, revealed Physician #2 (ENT Specialist) determined Resident #1 had a Right Malar Complex Fracture and he scheduled Resident #1 for surgery for an open reduction and internal fixation (ORIF) the next day, on 04/09/14.</p> <p>Review of an Inpatient Operative Record, dated 04/09/14, revealed Resident #1 was diagnosed with a severely impacted right malar complex with a step off at the orbital rim of approximately one (1) centimeter (cm), one (1) cm of depression and rotation of malar complex into the right maxillary sinus. The procedure completed was an Open Reduction and Internal Fixation of the right malar complex (tripod)-fracture through various approaches.</p> <p>Interview with LPN #3, on 05/05/14 at 1:45 PM, revealed Resident #1 reported on several occasions he/she felt pain in his/her face/jaw from the injury. LPN #3 stated it usually was around medication time. Further interview revealed she did not notify the primary care physician per the discharge order and stated she thought it was minor fractures.</p> <p>Interview with Registered Nurse (RN) #2 (Unit Manager), on 05/06/14 at 10:37 AM, revealed because Resident #1 reported his/her pain was controlled with the narcotic pain medication, they felt they did not need to follow-up with the resident's family physician. In addition, she</p>	F 309			

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F 309	<p>Continued From page 34</p> <p>stated she felt the hospital Emergency Room (ER) physician should have let them know the resident's fractures were displaced.</p> <p>Interview with the ENT Specialist (Physician #2), on 05/08/14 at 12:30 PM, revealed the resident was at greater risk for complications due to an existing diagnosis of Diabetes and would potentially have a slower healing time and be at increased risk for infection. Physician #2 revealed, on examination, he could feel a "significant step off" at the site of the broken bone. The physician stated the location and type of fractures could interfere with various activities and chewing would be painful due to the large muscles attached to the fractured bones required for chewing. In addition, Physician #2 stated he had to use plates and screws to repair the fractures due to the extent of the injury. Further interview revealed Physician #2 stated it would have been optimal for the resident to have been seen sooner after the fractures were diagnosed rather than two (2) weeks later.</p> <p>Post Interviews with the Director of Nursing (DON), on 06/04/14 at 3:15 PM, revealed he was mainly concerned with the pain rating before and after the pain medication was administered and not as concerned with the intensity and duration. He stated he expected the pain assessments to be documented in the Nurse's Notes and/or back of MAR. When asked about the facility's policy for pain assessments he revealed it was the facility's policy to assess and document pain scale rating, location, duration, intensity and character.</p> <p>Interview with the Administrator, on 05/08/14 at 9:07 AM, revealed she felt like the facility acted</p>	F 309		
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F 309	<p>Continued From page 35</p> <p>appropriately, assessed the resident and did nothing wrong. Post Interview with the Administrator, on 06/04/14 at 3:18 PM, revealed she expected staff to look for signs of pain; verbal or non verbal, and determine if the PRN medication was effective. The Administrator stated she also expected the licensed staff to use their nursing judgment related to pain assessments and documentation. When asked about the facility's policy related to pain assessments the Administrator stated, "The staff should follow the policy if in fact it is the policy". However, interview with the DON, on 06/04/14 at 3:15 PM, revealed this was the facility's policy.</p> <p>**The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>On 05/10/14, the facility's Nursing Management Team which consisted of the Director of Nursing (DON), Unit Manager, Case Manager, and MDS Nurse, met and reviewed all current residents... with falls in the previous thirty (30) days to validate the root cause identified, and care plans were updated with appropriate interventions to prevent reoccurrence.</p> <p>On 05/10/14, the DON revised the falls packet for the licensed staff to use to investigate a fall at the time of occurrence. This revision included a Fall's Scene Investigation Report from the Kentucky Quality Improvement Organization which will be used by the licensed nurses as a guide to determine the root cause with any falls that occur.</p> <p>On 05/10/14, the Registered Nurse Staff Development Coordinator (RN SDC) and/or designee to consist of the DON, and/or Unit</p>	F 309			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/16/2014
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NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066
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F 309	<p>Continued From page 36</p> <p>Managers, initiated education with all licensed nurses related to policy and procedures on the following topics; Pain Management, Reporting Change of Condition to the Physician, Accidents and Supervision to Prevent Accidents, Patient Assessment, Seizure, Root Cause Analysis, and Fall Response and Management. The education continued on 05/11/14, 05/12/14, and 05/13/14 and is ongoing until all licensed nurses have attended. No licensed nurse may work until the education has been received.</p> <p>The Performance Improvement (PI) committee met on 05/12/14 and discussed the root cause of the adverse event on 03/26/14. In addition, all cited deficient practice was discussed. The Medical Director was notified via telephone conference and approved the plan developed by the PI committee. Members of the PI committee in attendance included the Executive Director (ED), DON, Case Manager, Unit Managers, the District Director of Clinical Operations (DDCO), MDS Nurse, the Regional Vice President of Clinical Operations (RVPCO), and the Divisional Vice President (VP). The PI committee reviewed and approved the plan and will meet weekly until substantial compliance is achieved. During the weekly PI committee meetings, the committee will review the results of the Daily Clinical Rounds and monthly pain audit, and track and trend the audit tool findings to identify need for further actions and/or education.</p> <p>On 05/12/14 and 05/13/14, the facility identified residents who had the potential to be affected by the alleged deficient practice and all concerns were corrected.</p> <p>On 05/12/14 and 05/13/14, the facility's Unit</p>	F 309		
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F 309	<p>Continued From page 37</p> <p>Managers, Case Managers, Medical Record Nurses, DON, and Assistant Director of Nursing (ADON) reviewed all current residents Progress Notes for the previous thirty (30) days to identify any changes of condition, verified physician and family notification, and care plans were updated to reflect the change in condition.</p> <p>On 05/12/14 and 05/13/14, the facility's Unit Managers, Case Managers, Medical Record Nurses, DON, and ADON assessed every current resident using the "Patient Nursing Evaluation" and updated care plans as needed to reflect current status of the residents. This assessment included a pain assessment and a Morse Fall's Risk Assessment for every current resident.</p> <p>On 05/12/14 and 05/13/14, the facility's Unit Managers, Case Managers, Medical Record Nurses, DON, and ADON reviewed every current resident for a diagnosis of seizure disorder and validated the care plan to reflect the diagnosis and appropriate interventions.</p> <p>On 05/13/14, the DON implemented Interdisciplinary Clinical Rounds daily (Monday-Friday) on each unit. These rounds included the DON, Unit Managers, MDS Nurse, Social Services Director (SSD), and Therapy Program Director. An audit tool will be completed daily with the findings from the clinical rounds.</p> <p>The DDCO and/or Divisional VP will provide weekly oversight by validating action plans are implemented and attend facility PI committee meetings until substantial compliance has been determined.</p> <p>The State Survey Agency validated the corrective</p>	F 309			

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F 309	<p>Continued From page 38</p> <p>actions taken by the facility as follows:</p> <p>Record review revealed Resident #1 was discharged home to Home Health services. On 05/12/14 and 05/13/14, the facility completed an investigation which included interviews with staff who provided care for Resident #1 on the date of the fall (03/26/14). In addition, the facility completed a medical record review to attempt to identify the root cause.</p> <p>On 05/16/14, review of Residents #7, #8 and #9's record revealed current care plans, pain assessments, and Morse Falls Risk Assessments had been completed. Progress Notes were reviewed and no concerns were noted with physician notification or change of condition.</p> <p>Review of the inservice logs, on 05/16/14, revealed all staff working had been inserviced on Pain Management, Reporting Change of Condition to the Physician, Accidents and Supervision to Prevent Accidents, Patient Assessment, Seizure, Root Cause Analysis, and Fall Response and Management. The inservice was completed by facility staff which included the RN SDC, DON, and Unit Managers.</p> <p>On 05/16/14 at 10:03 AM, the DON verified through interview he provided inservice to all staff working, performed pain assessments, fall assessments, reviewed every patient for diagnosis of seizure disorder, and validated care plans. In addition, he reviewed all the falls for the past ninety (90) days to ensure the root cause was identified. Further interview revealed, that he, along with the Unit Managers, SDC, MDS Nurse, Social Services and Rehab initiated the daily (Monday-Friday) Clinical Rounds.</p>	F 309		

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F 309	Continued From page 39 On 05/16/14 at 11:16 AM, Registered Nurse (RN) #2 (Unit Manager) and LPN #2 (Unit Manager) verified through interview they assisted with review of all falls for the last ninety (90) days at the facility. In addition, they reviewed every current resident for diagnosis of seizures and validated the care plans. Further interview revealed they assisted with daily (Monday-Friday) clinical rounds. Each of them stated they received the education provided by the facility related to falls, root cause, seizures, physician notification, change of condition, and pain assessment. On 05/16/14 at 2:30 PM, LPN #4 verified through interview he received education from the facility related to the new falls packet, change in condition, physician notification, seizures, and care plan interventions. On 05/16/14 at 2:50 PM, RN #3 verified through interview she received education from the facility related to falls, physician notification, and pain monitoring. On 05/16/14 at 3:02 PM, LPN #5 verified through interview she received education from the facility related to physician notification, the new falls packet, pain assessment, seizures, and determining the root cause of the falls. On 05/16/14 at 3:03 PM, LPN #7 verified through interview she received education from the facility related to physician notification, new falls packet, seizures, condition changes, and pain. On 05/16/14 at 3:30 PM, RN #4 verified through interview she received education from the facility	F 309			

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F 309	Continued From page 40 related to physician notification, status changes in residents, seizures, falls, and pain assessment. On 05/16/14 at 3:30 PM, RN #1 (MDS Coordinator) verified through interview she received education from the facility related to notification in change of condition, pain management, seizures, and falls packet. Further interview revealed she assisted with daily clinical rounds and assisted with review of falls for the past 90 days to validate the root causes. On 05/18/14 at 3:54 PM, LPN #6 verified through interview she received education from the facility related to falls, pain monitoring, condition changes, seizures, patient assessments, and physician notification. On 05/16/14 at 4:00 PM, LPN #8 verified through interview she received education from the facility related to the new falls packet, physician notification, updating care plans, seizures, condition changes, and pain assessment. On 05/16/14 at 4:23 PM, the Physical Therapy Program Director verified through interview she was educated on the new process for clinical rounds, falls, and the new falls packet. On 05/16/14 at 4:25 PM, the SSD verified through interview she assisted with the clinical rounds daily (Monday-Friday). She stated she did not receive the other education because she was not clinical.	F 309			
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323			

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F 323	<p>Continued From page 41</p> <p>environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and procedures, it was determined the facility failed to ensure each resident was free of accident hazards for three (3) of six (6) sampled residents (Residents #1, #2 and #3).</p> <p>Resident #1 was admitted to the facility on 03/12/14 after hospitalization due to having a seizure at home. On 03/20/14, Resident #1 was found having seizure activity in his/her room in bed and the resident was sent to the hospital. The resident's seizure medication was adjusted and the resident returned to the facility on 03/22/14. However, review of the Comprehensive Care Plan, revealed there were no revisions made to the care plan related to the resident's seizure activity in bed and the resident's safety.</p> <p>On 03/26/14, at approximately 3:30 AM, Resident #1 had an unwitnessed fall from his/her bed and was unable to voice what happened. Resident #1 was found sitting on the floor beside his/her bed and when asked by the staff what happened, the resident stated, "I don't know, I just woke up and I was on the floor." Resident #1 was assessed by Licensed Practical Nurse (LPN) #1 and was found to have bruising to the right cheekbone. At</p>	F 323	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F323</p> <p>I. Corrective Action for Identified Resident(s)</p> <p>Resident #1 was discharged to home from the center on 5/12/14. On 5/12/14 and 5/13/14 the facility Executive Director and Director of Nursing completed an additional investigation to include interviews with staff who cared for resident #1 on 3/26/14, as well as medical record review to attempt to identify root causes for the fall. The care plan was reviewed and revised as needed as part of that investigation. By May 13, 2014, all current residents were reassessed Unit Managers, Case Managers, Medical Records Nurses, Director of Nursing, and Assistant Director of Nursing including resident #1 using the Patient Nursing Evaluation, and Morse Falls Risk assessment and updated the care plan as needed to reflect current status of the resident.</p> <p>Resident #2 care plan was reviewed by the Interdisciplinary Team (IDT) and updated on 3/20/14. By May 13, 2014, all current residents were reassessed Unit Managers, Case</p>	7/16/14

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F 323	<p>Continued From page 42</p> <p>8:25 AM, Resident #1 was identified with a nose bleed and the physician was notified with an order received to send the resident to the Emergency Room (ER). Resident #1 returned to the facility on 03/26/14 at 2:00 PM with diagnoses which included Facial Bone Fracture, Cervical Sprain, Head Injury, Closed Head Injury without Cranial wound, and Unspecified State Level of Consciousness. On 04/03/14, the physician visited the facility to make routine rounds and found the resident to have facial fractures and complaints of pain when he/she attempted to open his/her mouth. The physician ordered a consultation with an Ear, Nose, and Throat (ENT) Specialist. Resident #1 was seen by the ENT Specialist on 04/08/14 and was scheduled for surgery on 04/09/14 for an Open Reduction Internal Fixation (ORIF) with the diagnosis of a severely impacted right malar complex with step-off at the orbital rim and rotation of malar complex into the right maxillary sinus. The procedure required surgical plates and screws for repair. There was no documented evidence the facility investigated the resident's fall to determine the causal factor of this fall to implement interventions to prevent further falls and injury.</p> <p>Additionally, the facility failed to provide adequate supervision to Resident #2. On 03/20/14, Resident #2 was in his/her room unsupervised and fell out of a "Broda" chair and sustained a skin tear to the left elbow and a "knot" to the left side of the forehead. However, review of Resident #2's care plan revealed the resident should be in the hallway or other visible area when in his/her chair. In addition, there was no documented evidence the facility investigated this fall to identify the causal factor of this fall.</p>	F 323	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Managers, Medical Records Nurses, Director of Nursing, and Assistant Director of Nursing including resident #2 using the Patient Nursing Evaluation, and Morse Falls Risk assessment and updated the care plan as needed to reflect current status of the resident. A root cause analysis was conducted on 7-15-14 by the Regional Quality Specialist for Resident #2 to determine causative factors related to the resident fall. The care plan was reviewed at that time.</p> <p>Resident #3 was alert and oriented and transferred self. Resident #3 was sent to hospital and upon return on 2/26/14 the IDT reviewed the care plan and updated accordingly. By May 13, 2014, all current residents were reassessed by Unit Managers, Case Managers, Medical Records Nurses, Director of Nursing, and Assistant Director of Nursing including resident #3 using the Patient Nursing Evaluation, and Morse Falls Risk assessment and updated the care plan as needed to reflect current status of the resident. A root cause analysis was conducted on 7-15-14 by the Regional Quality Specialist (RQS) for Resident #3 to determine causative factors</p>	
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F 323	<p>Continued From page 43</p> <p>On 02/20/14, Resident #3 was found sitting on the floor, screaming in pain. He/she had fallen and his/her leg went back underneath him/her. Resident #3 was sent to the Emergency Room on 02/20/14 and was admitted at that time and diagnosed with a femur fracture, which required surgery. However, there was no documented evidence the facility investigated this fall to identify the causal factor of the fall.</p> <p>The facility's failure to ensure each resident was provided adequate supervision to prevent accidents has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 05/09/14 and was determined to exist on 03/26/14.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled, "Accidents and Supervision to Prevent Accidents"; dated 04/28/11, revealed the facility will provide an environment free from accident hazards over which it has control and will provide supervision and assistive devices to each resident to prevent avoidable accidents. In addition, the policy stated the processes were designed to identify hazards and risks, evaluate and analyze hazards and risks, implement interventions to reduce hazards and risk, and monitor for effectiveness, and modify approaches when necessary. Further review revealed the facility will evaluate the causal factors which lead to a resident's fall to help support relevant and consistent interventions to try to prevent future occurrences. Proper actions following a fall include to ascertain if there were injuries, provide treatment as necessary, determine what may have caused or contributed to the fall, address</p>	F 323	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>related to the resident fall. The care plan was reviewed at that time.</p> <p>II. Identification of Other Residents having potential to be affected</p> <p>On May 10th 2014 the Director of Nursing, Unit Managers, Case Manager, and MDS nurse met and reviewed all current residents with falls in the previous 30 days to validate root cause identified and care plan updated with appropriate interventions to prevent reoccurrence. Any concerns were corrected at that time.</p> <p>As of 5/13/14 The DNS leading the Interdisciplinary Team (IDT) conduct Clinical Rounds. This process includes reviewing the Change in Condition Report to identify residents with a change in condition and validate notification of MD/family, careplan updates and assessments and subsequent findings have been reviewed and resolved by the IDT and or licensed nurse.</p> <p>As of 5-17-14 the daily clinical rounds form is utilized as an audit tool (Daily Clinical Rounds Form/Audit Tool) by the Director of Nursing (DNS), RN Weekend Supervisor, RN Case</p>	

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F 323	<p>Continued From page 44</p> <p>the factors for the fall, and revise the resident's care plan and or facility practices, as needed to reduce the likelihood of another fall. Additionally, the policy revealed all accidents, including falls, will be investigated and a plan of action developed to prevent the accident from recurring.</p> <p>1. Record review revealed the facility admitted Resident #1 on 03/12/14, with diagnoses which included Diabetes Mellitus, Chronic Obstructive Pulmonary Disease (COPD), Hypertension, Convulsions, Depression, and Anxiety.</p> <p>Review of the Initial Minimum Data Set (MDS) assessment, dated 03/19/14, revealed the facility assessed Resident #1's cognition as cognitively intact with a Brief Interview for Mental Status (BIMS) score of nine (9), which indicated the resident was interviewable. Additionally, the facility assessed Resident #1 to require extensive assistance with bed mobility, transfer, and ambulation.</p> <p>Review of Resident #1's Comprehensive Care Plan, dated 03/13/14, revealed he/she was at risk for injury related to falls and seizure activity. Interventions dated 03/13/14 included the Falling Stars Program and remind to call for assistance. Review of a Nurse's Note, dated 03/20/14 at 5:35 PM, revealed Resident #1 was found in the bed having seizure activity; however, review of the care plan revealed it was not revised to include any interventions to address the resident's safety in bed if he/she should have a seizure.</p> <p>Review of a Post Fall Evaluation, dated 03/26/14, revealed Resident #1 sustained an unwitnessed fall from his/her bed at approximately 3:30 AM. The resident stated, "I just woke up and was on</p>	F 323	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Manager, and/or Unit Manager (UM) to assist in identifying findings from the clinical rounds that require additional follow up by the IDT. This process is on-going to identify any resident with the potential to be affected which will allow for immediate corrective action by the IDT (Refer to the 2567 of 5/16/14 for the definition of Clinical Rounds).</p> <p>III. Systemic Changes</p> <p>On May 10th, 2014 the Director of Nursing revised the falls packet for the Licensed Nurses to use to investigate a fall at the time of occurrence. This revision includes using a new Falls Scene Investigation Report form the Kentucky Quality Improvement Organization and guides a licensed nurse to determine root cause with any fall that occurs.</p> <p>On May 10th 2014 the Staff Development Coordinator, Director of Nursing, and/or Unit Managers initiated education with all Licensed Nurses on the following policies and procedures: Accidents and Supervision to Prevent Accidents, Root Cause Analysis, and Fall Response and Management. The education continued on May 11th, 12th, and 13th, 2014</p>	
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F 323	Continued From page 45 the floor". Further review revealed LPN #1 assessed the resident to have a bruise to the right cheek bone. In addition, the resident received an ice pack for swelling and Tylenol (pain medication) for complaints of pain. Review of a Nurse's Note, dated 03/26/14 at 8:25 AM, revealed Resident #1 complained of pain to his/her face and his/her nose was bleeding. The Physician was notified at the time, and an order was received to send Resident #1 to the Emergency Room. Review of Hospital Discharge Instructions, dated 03/26/14, revealed Resident #1 was diagnosed with Facial Bone Fractures, Cervical Sprain, Head Injury, Closed Head Injury without Cranial Wound, and Unspecified State Level of Consciousness. Review of the Nurse's Notes, dated 04/03/14, revealed approximately eight (8) days after the resident's fall with facial fractures, the Primary Care Physician visited the facility to make routine rounds and found the resident with facial fractures and complaints of pain when he/she opened his/her mouth. The Primary Care Physician ordered a consultation with an Ears, Nose, and Throat Specialist (ENT). Record review revealed Resident #1 required surgery for repair of the Facial Bone Fractures and overnight hospitalization. Interview with Resident #1, on 05/01/14 at 6:00 PM, revealed he/she had fallen from his/her bed on 03/26/14 prior to 3:30 AM and did not know how he/she had fallen. The resident stated; he/she just woke up and was on the floor. Interview with Certified Nurse Aide (CNA) #1, on 05/09/14 at 9:50 AM, revealed she walked by Resident #1's room and saw him/her on the floor prior to 3:00 AM. CNA #1 stated the resident was unsure how long he/she had been on the floor,	F 323	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> until all Licensed Nurses received it and will be ongoing for any newly hired nurses SDC. On an ongoing basis, The Director of Nursing, Unit Manager, RN Weekend Supervisor and/or The Registered Nurse Staff Development Coordinator will conduct clinical education as needed based on findings/trends of the daily clinical rounds form/audit tool and the recommendations of the Performance Improvement Committee. On May 13 th 2014 the Director of Nursing implemented Interdisciplinary Clinical Rounds daily (Monday- Friday) on each unit. These rounds include the Director of Nursing, Unit Managers, MDS nurse or Case Manager, Social Services Director, and Therapy Program Director. The Weekend Supervisor Nurse will be responsible to conduct this review on Sat-Sun. The Clinical Rounds will verify investigations are complete for any falls that occurred, and care plans updated with interventions to prevent reoccurrence. As of <u>7/15/14</u> the IDT Falls Review Form will be utilized and completed in daily Clinical Rounds to assure interventions and applicable		

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F-323	<p>Continued From page 46 and the resident was incontinent of stool.</p> <p>Review of Resident #1's Medical Record revealed no documented evidence an investigation was conducted to determine the causal factors of the fall.</p> <p>Interview with the previous Director of Nursing (DON)/current MDS Coordinator, (RN #1), on 05/06/14 at 1:35 PM, revealed she was responsible for completing the investigations related to falls and incident reports. She stated the root cause of the fall was not determined, a thorough investigation was not completed, and she was not sure why. In addition, she stated she was not notified about the fall until later that morning when she arrived at the facility. She stated it would have been her expectation for the LPN to notify her about the fall at the time it was discovered, and she would have advised them to send the resident to the ER.</p> <p>Interview with the Administrator, on 05/05/14 at 2:45 PM, revealed it was the facility's policy to investigate all falls to determine the root cause, what interventions were in place, and what appropriate interventions should be added to prevent future falls. This was her expectation for any resident who had a fall with or without injury.</p> <p>2. Record review revealed Resident #2 was admitted to the facility on 10/23/08 and re-admitted on 04/25/14 with diagnoses which included Chronic Airway Obstruction, Hypertension, Atrial Fibrillation, Osteoarthritis, Senile Dementia, Congestive Heart Failure, Depression, Psychosis, Delusional Disorder, and Anxiety.</p>	F 323	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>measures have been implemented to reduce and prevent future falls from occurring.</p> <p>As of 5-17-14 the daily clinical rounds form is utilized as an audit tool (Daily Clinical Rounds Form/Audit Tool) by the Director of Nursing (DNS), RN Weekend Supervisor, RN Case Manager, and/or Unit Manager (UM) to assist in identifying findings from the clinical rounds that require additional follow up by the IDT. This process is on-going to identify any resident with the potential to be affected which will allow for immediate corrective action by the IDT (Refer to the 2567 of 5/16/14 for the definition of Clinical Rounds).</p> <p>IV. Monitoring</p> <p>The clinical rounds daily audit tool and or the IDT Falls Review Form is completed by the Director of Nursing (or Unit Manager, Staff Development Coordinator, Case Manager, or Weekend Supervisor when the Director of Nursing is not available). These audit tools will identify any concerns with falls investigations and revision of interventions to prevent reoccurrence of falls.</p>		

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F 323	<p>Continued From page 47</p> <p>Review of a Significant Change (SC) MDS assessment, dated 04/22/14, revealed the facility assessed Resident #2's cognition as cognitively impaired with a Brief Interview for Mental Status score of ninety-nine (99), which indicated the resident was not interviewable. Additionally, the facility assessed Resident #2 to require extensive assistance with bed mobility and ambulation, and total assistance with transfers.</p> <p>Review of Resident #2's Care Plan revealed he/she was at risk for injury related to falls due to psychotropic medications, decreased safety awareness, and a history of falls. Further review revealed an intervention, initiated on 08/07/13 for Resident #2 to remain in the hallway or other visible area when in his/her chair.</p> <p>Review of a Nurse's Note, dated 03/20/14, revealed Resident #2 fell out of a "Broda" chair and sustained a skin tear to the left elbow and a "knot" to the left side of the forehead. The resident was assessed by LPN #3, and the physician was notified. Resident #2 was sent to the Emergency Room (ER) for an evaluation. Further review revealed Resident #2 returned to the facility, on 03/20/14 at approximately 5:55 PM, with a new diagnosis of a head contusion.</p> <p>Interview with CNA #2, on 05/05/14 at 3:35 PM, revealed she was on duty at the time Resident #2 fell from the broda chair. She stated she was completing her two (2) hour checks and when she entered Resident #2's room, she found him/her flipped out of the broda chair and calling for help. Additionally, she stated, "Now we have started keeping [him/her] in the hallway where we can see [him/her], and it has not happened again." Further interview revealed she was</p>	F 323	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Findings from the audit tool and or IDT Falls Review Form will be tracked and trended by the Director of Nursing weekly and forwarded to the Performance Improvement Committee with further education or actions taken as determined by the Committee.</p> <p>By reviewing the findings of the tracking and trending, the Performance Improvement Committee will monitor the effectiveness and compliance with the plan weekly to validate solutions is sustained.</p> <p>The Performance Improvement Committee consists of the Executive Director, Director of Nursing, Unit Managers, Staff Development Coordinator, Case Manager, MDS nurse, Social Services Director, Activity director, and Therapy Services Director.</p> <p>The Performance Improvement Committee is meeting weekly at this time, but will resume monthly meetings once substantial compliance is achieved.</p>		

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F 323	<p>Continued From page 48</p> <p>unaware the resident should have been in the hallway when in the chair prior to this incident, as care planned.</p> <p>Interview with LPN #3, on 05/05/14 at 1:48 PM, revealed she was the nurse on duty at the time of Resident #2's fall. She stated she was called to Resident # 2's room by CNA #2 and found the resident on the floor beside his/her broda chair. She stated Resident #2 was sent to the ER. Further interview revealed she should have completed a post fall evaluation. LPN #2 stated, " Now we keep [Resident #2] in the hallway at all times when [he/she] is in the broda chair." Further interview revealed she was unaware the resident was supposed to be in the hallway or other visible are prior to this fall.</p> <p>Further review of Resident #2's Medical Record revealed no documented evidence the fall was investigated to try to determine the causal factors of the fall to prevent further falls with injury.</p> <p>An attempt to interview Resident #2 was unsuccessful.</p> <p>3. Record review revealed Resident #3 was admitted to the facility on 03/16/13 and re-admitted on 03/13/14 with diagnoses which included Coronary Atherosclerosis, Hypertension, Anxiety, Depression, Chronic Pain, and Chronic Kidney Disease Stage III (Moderate).</p> <p>Review of a Significant Change Minimum Data Set (MDS) assessment, dated 03/20/14, revealed the facility assessed Resident #3's cognition as intact with a BIMS score of nine (9), which indicated the resident was interviewable. Additionally, the facility assessed Resident #3 to</p>	F 323			

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F 323	<p>Continued From page 49</p> <p>require extensive assistance with bed mobility and transfers.</p> <p>Review of Resident #3's Care Plan, dated 03/18/13, revealed he/she was at risk for falls related to a history of falls and medications. An intervention included the Falling Stars Program, and if a fall occurred, determine the root cause so it would not happen again.</p> <p>Review of a Nurse's Note, dated 02/20/14, revealed Resident #3 was found sitting on the floor and screaming in pain. The resident stated he/she had fallen and his/her leg went back underneath him/her. Further review revealed the resident was sent to the Emergency Room for evaluation/treatment. Review of a Nurse's Note, dated 02/26/14, revealed the resident was re-admitted to the facility from the hospital with a new diagnosis of femur fracture, which required surgery.</p> <p>Interview with CNA #3 revealed she was on duty at the time of Resident #3's fall. She stated she entered Resident #3's room and found him/her on the floor on the left side of his/her bed.</p> <p>Interview with LPN #3, on 05/05/14 at 1:48 PM, revealed she was the nurse on duty at the time of Resident #3's fall and she was called to his/her room by CNA #3. She stated Resident #3 was sent out to the hospital via ambulance due to complaints of pain in the left leg. She stated the resident was admitted to the hospital with a fractured left leg. Further interview revealed a post fall evaluation should have been completed; however, she was uncertain if she completed the post fall evaluation.</p>	F 323			

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F 323	<p>Continued From page 50</p> <p>Further review of the Resident #3's Medical Record revealed no documented evidence the fall was investigated to determine causal factors to prevent further falls with injury.</p> <p>Interview with the current DON, on 05/02/14 at 2:00 PM, revealed there were no Post Falls Evaluation Reports completed for Resident #2 or Resident #3 per the facility's policy and procedure. He stated the facility failed to investigate the falls to determine the root cause and implement appropriate interventions.</p> <p>Interview with the Administrator, on 05/05/14 at 2:45 PM, revealed it was her expectation and the facility's policy and procedures for all staff to complete a Post Falls Evaluation Report after any resident fall occurred, with or without injury, and should be completed before the end of the shift. Further interview revealed the facility identified, on 05/05/14, the Post Falls Evaluations were not completed for Resident #2 or Resident #3, and the facility failed to thoroughly investigate to determine the root cause of the falls.</p> <p>**The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>On 05/10/14, the facility's Nursing Management Team which consisted of the Director of Nursing (DON), Unit Manager, Case Manager, and MDS Nurse, met and reviewed all current residents with falls in the previous thirty (30) days to validate the root cause identified, and care plans were updated with appropriate interventions to prevent reoccurrence.</p> <p>On 05/10/14, the DON revised the falls packet for the licensed staff to use to investigate a fall at the</p>	F 323		

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F 323	<p>Continued From page 51</p> <p>time of occurrence. This revision included a Fall's Scene Investigation Report from the Kentucky Quality Improvement Organization which will be used by the licensed nurses as a guide to determine the root cause with any falls that occur.</p> <p>On 05/10/14, the Registered Nurse Staff Development Coordinator (RN SDC) and/or designee to consist of the DON, and/or Unit Managers, initiated education with all licensed nurses related to policy and procedures on the following topics: Pain Management, Reporting Change of Condition to the Physician, Accidents and Supervision to Prevent Accidents, Patient Assessment, Seizure, Root Cause Analysis, and Fall Response and Management. The education continued on 05/11/14, 05/12/14, and 05/13/14 and is ongoing until all licensed nurses have attended. No licensed nurse may work until the education has been received.</p> <p>The Performance Improvement (PI) committee met on 05/12/14 and discussed the root cause of the adverse event on 03/26/14. In addition, all cited deficient practice was discussed. The Medical Director was notified via telephone conference and approved the plan developed by the PI committee. Members of the PI committee in attendance included the Executive Director (ED), DON, Case Manager, Unit Managers, the District Director of Clinical Operations (DDCO), MDS Nurse, the Regional Vice President of Clinical Operations (RVPCO), and the Divisional Vice President (VP). The PI committee reviewed and approved the plan and will meet weekly until substantial compliance is achieved. During the weekly PI committee meetings, the committee will review the results of the Daily Clinical Rounds</p>	F 323		

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F 323	<p>Continued From page 52</p> <p>and monthly pain audit, and track and trend the audit tool findings to identify need for further actions and/or education.</p> <p>On 05/12/14 and 05/13/14, the facility identified residents who had the potential to be affected by the alleged deficient practice and all concerns were corrected.</p> <p>On 05/12/14 and 05/13/14, the facility's Unit Managers, Case Managers, Medical Record Nurses, DON, and Assistant Director of Nursing (ADON) reviewed all current residents Progress Notes for the previous thirty (30) days to identify any changes of condition, verified physician and family notification, and care plans were updated to reflect the change in condition.</p> <p>On 05/12/14 and 05/13/14, the facility's Unit Managers, Case Managers, Medical Record Nurses, DON, and ADON assessed every current resident using the "Patient Nursing Evaluation" and updated care plans as needed to reflect current status of the residents. This assessment included a pain assessment and a Morse Fall's Risk Assessment for every current resident.</p> <p>On 05/12/14, and 05/13/14, the facility's Unit Managers, Case Managers, Medical Record Nurses, DON, and ADON reviewed every current resident for a diagnosis of seizure disorder and validated the care plan to reflect the diagnosis and appropriate interventions.</p> <p>On 05/13/14, the DON implemented Interdisciplinary Clinical Rounds daily (Monday-Friday) on each unit. These rounds included the DON, Unit Managers, MDS Nurse, Social Services Director (SSD), and Therapy</p>	F 323		

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F 323	<p>Continued From page 53</p> <p>Program Director. An audit tool will be completed daily with the findings from the clinical rounds.</p> <p>The DDCO and/or Divisional VP will provide weekly oversight by validating action plans are implemented and attend facility PI committee meetings until substantial compliance has been determined.</p> <p>The State Survey Agency validated the corrective actions taken by the facility as follows:</p> <p>Record review revealed Resident #1 was discharged home to Home Health services. On 05/12/14 and 05/13/14, the facility completed an investigation which included interviews with staff who provided care for Resident #1 on the date of the fall (03/26/14). In addition, the facility completed a medical record review to attempt to identify the root cause.</p> <p>On 05/16/14, review of Residents #7, #8 and #9's record revealed current care plans, pain assessments, and Morse Falls Risk Assessments had been completed. Progress Notes were reviewed and no concerns were noted with physician notification or change of condition.</p> <p>Review of the inservice logs, on 05/16/14, revealed all staff working had been inserviced on Pain Management, Reporting Change of Condition to the Physician, Accidents and Supervision to Prevent Accidents, Patient Assessment, Seizure, Root Cause Analysis, and Fall Response and Management. The inservice was completed by facility staff which included the RN SDC, DON, and Unit Managers.</p> <p>On 05/16/14 at 10:03 AM, the DON verified</p>	F 323		
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F 323	<p>Continued From page 54</p> <p>through interview he provided inservice to all staff working, performed pain assessments, fall assessments, reviewed every patient for diagnosis of seizure disorder, and validated care plans. In addition, he reviewed all the falls for the past ninety (90) days to ensure the root cause was identified. Further interview revealed, that he, along with the Unit Managers, SDC, MDS Nurse, Social Services and Rehab initiated the daily (Monday-Friday) Clinical Rounds.</p> <p>On 05/16/14 at 11:16 AM, Registered Nurse (RN) #2 (Unit Manager) and LPN #2 (Unit Manager) verified through interview they assisted with review of all falls for the last ninety (90) days at the facility. In addition, they reviewed every current resident for diagnosis of seizures and validated the care plans. Further interview revealed they assisted with daily (Monday-Friday) clinical rounds. Each of them stated they received the education provided by the facility related to falls, root cause, seizures, physician notification, change of condition, and pain assessment.</p> <p>On 05/16/14 at 2:30 PM, LPN #4 verified through interview he received education from the facility related to the new falls packet, change in condition, physician notification, seizures, and care plan interventions.</p> <p>On 05/16/14 at 2:50 PM, RN #3 verified through interview she received education from the facility related to falls, physician notification, and pain monitoring.</p> <p>On 05/16/14 at 3:02 PM, LPN #5 verified through interview she received education from the facility related to physician notification, the new falls</p>	F 323		

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F 323	<p>Continued From page 55</p> <p>packet, pain assessment, seizures, and determining the root cause of the falls.</p> <p>On 05/16/14 at 3:03 PM, LPN #7 verified through interview she received education from the facility related to physician notification, new falls packet, seizures, condition changes, and pain.</p> <p>On 05/16/14 at 3:30 PM, RN #4 verified through interview she received education from the facility related to physician notification, status changes in residents, seizures, falls, and pain assessment.</p> <p>On 05/16/14 at 3:30 PM, RN #1 (MDS Coordinator) verified through interview she received education from the facility related to notification in change of condition, pain management, seizures, and falls packet. Further interview revealed she assisted with daily clinical rounds and assisted with review of falls for the past 90 days to validate the root causes.</p> <p>On 05/16/14 at 3:54 PM, LPN #6 verified through interview she received education from the facility related to falls, pain monitoring, condition changes, seizures, patient assessments, and physician notification.</p> <p>On 05/16/14 at 4:00 PM, LPN #8 verified through interview she received education from the facility related to the new falls packet, physician notification, updating care plans, seizures, condition changes, and pain assessment.</p> <p>On 05/16/14 at 4:23 PM, the Physical Therapy Program Director verified through interview she was educated on the new process for clinical rounds, falls, and the new falls packet.</p>	F 323		
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NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066	
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F 323	Continued From page 56 On 05/16/14 at 4:25 PM, the SSD verified through interview she assisted with the clinical rounds daily (Monday-Friday). She stated she did not receive the other education because she was not clinical.	F 323	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
F 490 SS=J	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 and review of the facility's Administrator's Job Duties and Plan of Correction for the 02/19/14 Abbreviated Survey, it was determined the facility failed to ensure the facility was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for one (1) of six (8) sampled residents (Resident #1). During an Abbreviated Survey concluded on 02/19/14, Immediate Jeopardy was identified at 42 CFR 483.25 Quality of Care, F309. The facility submitted a Plan of Correction for the 02/19/14 survey; however, additional investigation during an Abbreviated Survey concluded on 05/16/14, revealed the residents continued to be at risk as licensed staff were not conducting ongoing assessments of residents when there	F 490	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> F 490 I. Corrective Action for Identified Resident(s) Resident #1 was discharged to home from the center on 5/12/14. Resident # 1 physician was notified of the change of condition on 3/26/14 on the day of the fall and again on 4/3/14 of the pain related to the injury and the CAT scan results. The physician on 4/3/14 ordered no further revisions to the resident's pain regime. Resident #1's care plan was reviewed and revised to reflect current level of care on 5/10/14 by Interdisciplinary Team (IDT). II. Identification of Other Residents having potential to be affected On May 10 th 2014 the Director of Nursing, Unit Managers, Case Manager, and MDS nurse met and reviewed all current residents with falls in the previous 30 days to validate root cause identified and care plan updated with appropriate interventions to prevent reoccurrence. Any concerns were corrected at that time.	7/16/14

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F 490	<p>Continued From page 57</p> <p>was a change in condition. Immediate Jeopardy was identified at 42 CFR 483.10 Resident Rights, F-157; 42 CFR 483.20 Resident Assessment, F-279; 42 CFR 483.25 Quality of Care, F-309 and F-323; and, 42 CFR 483.75 Administration, F-490 and F-520; at a Scope and Severity of a "J".</p> <p>The facility failed to have an effective system in place to ensure ongoing assessments were conducted when the resident was identified as having a significant change in condition for one (1) of six (6) sampled residents (Resident #1). In addition, the facility failed to ensure education provided to the staff was effective. Per the facility's plan of correction, for the survey dated 02/19/14, the Director of Nursing (DON) implemented a seventy-two (72) hour Alert Charting tool as a guide to document evidence of resident assessment and following of the care plan. All Licensed Staff was educated to initiate one of these assessment tools for any resident noted with a change in condition. The tool cues every shift to assess and document on the residents noted with a change in condition for seventy-two (72) hours or until the condition change is resolved. However, Licensed Staff failed to conduct ongoing assessments of Resident #1 when he/she had a fall and sustained facial fractures.</p> <p>On 03/26/14, at approximately 3:30 AM, Resident #1 had an unwitnessed fall from his/her bed. Resident #1 was found to have bruising to the right cheekbone; an ice pack was applied and Tylenol (pain reliever) was administered for pain. At 8:25 AM, Resident #1 was identified to have a nose bleed and dark discoloration to the right cheek and bridge of nose. The Physician was notified and the resident was sent to the</p>	F 490	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>On May 12th and 13th 2014 a team of Licensed nurses including Unit Managers, Case Managers, Medical Records Nurses, Directors of Nursing, and Assistant Directors of Nursing completed a review of all current residents. This review included- assessing the resident using the Patient Nursing Evaluation, Pain Assessments, Morse Falls Risk Assessments, review for any seizure diagnosis, review of the previous 30 days of progress notes, and verifying the care plan was updated accordingly. Any concerns identified were corrected at that time.</p> <p>As of 5/13/14 The DNS leading the Interdisciplinary Team (IDT) conduct Clinical Rounds. This process includes reviewing the Change in Condition Report to identify residents with a change in condition and validate that the physician and family have been notified, and reviewing necessary supplemental assessments (supplemental assessment is defined as any assessment or evaluation performed to obtain information to further determine resident's condition to enhance resident's individualized plan of care).</p>	

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F 490	Continued From page 58 Emergency Room. Resident #1 returned to the facility on 03/26/14 at 2:00 PM diagnoses of Facial Bone Fracture, Cervical Sprain, Head Injury, Closed Head Injury without Cranial wound, and Unspecified State Level of Consciousness. In addition, the resident had discharge orders to follow up with the Primary Care Physician in one (1) to two (2) days to recheck today's complaints if not improving and the nurse received report from the hospital to report the fractures to the Primary Care Physician. The facility failed to notify the resident's physician of the facial fractures and failed to conduct ongoing assessments of the resident due to the facial fractures. Resident #1 complained of pain to his/her face and received Norco (narcotic pain medication) nineteen (19) times between 03/27/14-04/03/14; however, there was no evidence the pain was assessed per the facility's policy and the physician was not notified of the continued pain. On 04/03/14, approximately eight (8) days after the fall with facial fractures, the primary care physician visited the facility to make routine rounds and found the resident with facial fractures and complaints of pain with attempts to open his/her mouth and he ordered a consultation with an Ears, Nose, and Throat Specialist. Resident #1 required surgery for repair and an overnight hospitalization. The facility's failure to ensure the facility was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 05/09/14 and determined to exist on 03/26/14. Refer to F157	F 490	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> As of 5-17-14 the daily clinical rounds form is utilized as an audit tool (Daily Clinical Rounds Form/Audit Tool) by the Director of Nursing (DNS), RN Weekend Supervisor, RN Case Manager, and/or Unit Manager (UM) to assist in identifying findings from the clinical rounds that require additional follow up by the IDT. This process is on-going to identify any resident with the potential to be affected which will allow for immediate corrective action by the IDT (Refer to the 2567 of 5/16/14 for the definition of Clinical Rounds). IDT members are: DNS, UMs, Staff Development Coordinator (SDC), Case Manager, Social Service Director, Activities Director, Rehabilitation Manager III. Systemic Changes On May 13 th 2014 the Director of Nursing implemented Interdisciplinary Clinical Rounds daily (Monday- Friday) on each unit. These rounds include the Director of Nursing, Unit Managers, MDS nurse or Case Manager, Social Services Director, and Therapy Program Director. The Weekend Supervisor Nurse will		

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F 490	Continued From page 59 and F309. The findings include: Review of the Administrator's job description, no date, revealed the Administrator was responsible for the efficient and profitable operation of the facility, facility compliance with (facility) policies and State and Federal rules and regulations, and providing the highest quality of care possible. In addition, essential functions of the Administrator will include leading the planning process to develop goals for quality care, implementing control systems to ensure accountability of all departments, and ensuring all employees receive ongoing training to meet the quality goals of the facility. Review of the facility's Plan of Correction for the Abbreviated Survey conducted on 02/19/14, revealed on 02/12/14 the Director of Nursing (DON) implemented a seventy-two (72)-hour Alert Charting tool as a guide to document evidence of resident assessment and following of the care plan. All Licensed Staff was educated to initiate one of these assessment tools for any resident noted with a change in condition. The tool cues every shift to assess and document on the residents noted with a change in condition for seventy-two (72) hours, or until the condition change is resolved. Interview and record review revealed Resident #1 had a fall and sustained facial fractures on 03/25/14; however, there was no documented evidence the Licensed Staff conducted ongoing assessments of Resident #1 to determine if the resident was improving; and, no documented evidence the facility notified the physician of the	F 490	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> be responsible to conduct this review on Sat-Sun. The Clinical Rounds will verify physicians and families have been notified as needed with changes in resident condition, ongoing assessments and documentation in the medical record for residents, resident care plans updated as needed with changes in resident condition, newly admitted residents care plans initiated, investigations complete for any falls that occurred, care plans updated with interventions to prevent reoccurrence, and will verify follow up completed as needed for resident appointments outside the center from the previous day. As of 5-17-14 the daily clinical rounds form is utilized as an audit tool (Daily Clinical Rounds Form/Audit Tool) by the Director of Nursing (DNS), RN Weekend Supervisor, RN Case Manager, and/or Unit Manager (UM) to assist in identifying findings from the clinical rounds that require additional follow up by the IDT. This process is on-going to identify any resident with the potential to be affected which will allow for immediate corrective action by the IDT (Refer to the 2567 of 5/16/14 for the definition of Clinical Rounds).	

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F 490	<p>Continued From page 60</p> <p>resident's facial fractures. On 04/03/14 at 4:19 PM, eight (8) day after the fall with fractures, Resident #1's physician made routine rounds at the facility and examined the resident. The resident complained of pain when he/she attempted to open his/her mouth and the physician ordered a consultation with an Ear/Nose/Throat (ENT) Specialist (Physician #2). On 04/08/14, the ENT Specialist determined Resident #1 had a Right Malar Complex Fracture and scheduled Resident #1 for surgery for an open reduction and internal fixation (ORIF) the next day, on 04/09/14.</p> <p>Interview with the Administrator, on 05/16/14 at 3:25 PM, revealed her expectations for residents with a change in condition were for staff to conduct accurate and thorough assessments of the residents. In addition, a Post Interview with the Administrator conducted on 06/03/14 at 3:00 PM, revealed there was an alert in Point Click Care (PCC-computer) that triggers staff to conduct resident assessments every shift when a resident is identified to have a significant change. These assessments should have been documented in the Progress Notes.</p> <p>**The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>On 05/10/14, the facility's Nursing Management Team which consisted of the Director of Nursing (DON), Unit Manager, Case Manager, and MDS Nurse, met and reviewed all current residents with falls in the previous thirty (30) days to validate the root cause identified, and care plans were updated with appropriate interventions to prevent reoccurrence.</p>	F 490	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>On May 10th 2014 the Staff Development Coordinator, Director of Nursing, and/or Unit Managers initiated education with all Licensed Nurses related to a reference tool labeled (TL 6103-09) Reporting Change of Condition to the Physician. The education continued on May 11th, 12th, and 13th, 2014 until all Licensed Nurses received it and will be ongoing for any newly hired nurses by the SDC.</p> <p>On June 16th, 2014 the Staff Development Coordinator, Director of Nursing, and/or District Director of Clinical Operations initiated education with all Licensed Nurses on the following policies and procedures: Condition Change of a Resident and the Procedures for Documenting Change of Condition in the Medical Record, Documenting Resident Health Status, Documenting in the Medical Record. The education continued on June 17th, 18th, 19th 2014, until all Licensed Nurses received it and will be ongoing for any newly hired nurses by the SDC.</p> <p>On May 10th 2014 the Staff Development Coordinator, Director of Nursing, and/or Unit Managers initiated education with all Licensed</p>	
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F 490	<p>Continued From page 61</p> <p>On 05/10/14, the DON revised the falls packet for the licensed staff to use to investigate a fall at the time of occurrence. This revision included a Fall's Scene Investigation Report from the Kentucky Quality Improvement Organization which will be used by the licensed nurses as a guide to determine the root cause with any falls that occur.</p> <p>On 05/10/14, the Registered Nurse Staff Development Coordinator (RN SDC) and/or designee to consist of the DON, and/or Unit Managers, initiated education with all licensed nurses related to policy and procedures on the following topics: Pain Management, Reporting Change of Condition to the Physician, Accidents and Supervision to Prevent Accidents, Patient Assessment, Seizure, Root Cause Analysis, and Fall Response and Management. The education continued on 05/11/14, 05/12/14, and 05/13/14 and is ongoing until all licensed nurses have attended. No licensed nurse may work until the education has been received.</p> <p>The Performance Improvement (PI) committee met on 05/12/14 and discussed the root cause of the adverse event on 03/26/14. In addition, all cited deficient practice was discussed. The Medical Director was notified via telephone conference and approved the plan developed by the PI committee. Members of the PI committee in attendance included the Executive Director (ED), DON, Case Manager, Unit Managers, the District Director of Clinical Operations (DDCO), MDS Nurse, the Regional Vice President of Clinical Operations (RVPCO), and the Divisional Vice President (VP). The PI committee reviewed and approved the plan and will meet weekly until substantial compliance is achieved. During the</p>	F 490	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Nurses on the following policies and procedures: Pain Management, Resident Assessment, and Seizures. The education continued on May 11th, 12th, and 13th, 2014 until all Licensed Nurses received it and will be ongoing for any newly hired nurses by the SDC.</p> <p>On June 16th, 2014 the Staff Development Coordinator, Director of Nursing, and/or District Director of Clinical Operations initiated education with all Licensed Nurses on the following policies and procedures: Condition Change of a Resident and the Procedures for Documenting Change of Condition in the Medical Record, Documenting Resident Health Status, and Documenting in the Medical Record. The education continued on June 17th, 18th, 19th 2014, until all Licensed Nurses received it and will be ongoing for any newly hired nurses.</p> <p>On an ongoing basis, The Director of Nursing, Unit Manager, RN Weekend Supervisor and/or The Registered Nurse Staff Development Coordinator will conduct clinical education as needed based on findings/trends of the daily clinical rounds form/audit tool and the</p>	
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F 490	<p>Continued From page 62</p> <p>weekly PI committee meetings, the committee will review the results of the Daily Clinical Rounds and monthly pain audit, and track and trend the audit tool findings to identify need for further actions and/or education.</p> <p>On 05/12/14 and 05/13/14, the facility identified residents who had the potential to be affected by the alleged deficient practice and all concerns were corrected.</p> <p>On 05/12/14 and 05/13/14, the facility's Unit Managers, Case Managers, Medical Record Nurses, DON, and Assistant Director of Nursing (ADON) reviewed all current residents Progress Notes for the previous thirty (30) days to identify any changes of condition, verified physician and family notification, and care plans were updated to reflect the change in condition.</p> <p>On 05/12/14 and 05/13/14, the facility's Unit Managers, Case Managers, Medical Record Nurses, DON, and ADON assessed every current resident using the "Patient Nursing Evaluation" and updated care plans as needed to reflect current status of the residents. This assessment included a pain assessment and a Morse Fall's Risk Assessment for every current resident.</p> <p>On 05/12/14 and 05/13/14, the facility's Unit Managers, Case Managers, Medical Record Nurses, DON, and ADON reviewed every current resident for a diagnosis of seizure disorder and validated the care plan to reflect the diagnosis and appropriate interventions.</p> <p>On 05/13/14, the DON implemented Interdisciplinary Clinical Rounds daily (Monday-Friday) on each unit. These rounds</p>	F 490	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>recommendations of the Performance Improvement Committee.</p> <p>IV. Monitoring</p> <p>The clinical rounds daily audit tool is completed by the Director of Nursing (or Unit Manager, Staff Development Coordinator, Case Manager, or Weekend Supervisor when the Director of Nursing is not available). This audit tool will identify any concerns with physician/family notification, changes in resident condition, ongoing assessments, and documentation in the medical record for residents, resident care plans updated as needed with changes in resident condition, newly admitted residents care plans initiated, investigations for any falls that occurred, care plans updated with interventions to prevent reoccurrence, and follow up completed as needed for resident appointments outside the center from the previous day.</p> <p>Findings from the audit tool will be tracked and trended by the Director of Nursing weekly and forwarded to the Performance Improvement Committee with further education or actions taken as determined by the Committee.</p>		

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F 490	<p>Continued From page 63</p> <p>included the DON, Unit Managers, MDS Nurse, Social Services Director (SSD), and Therapy Program Director. An audit tool will be completed daily with the findings from the clinical rounds.</p> <p>The DDCO and/or Divisional VP will provide weekly oversight by validating action plans are implemented and attend facility PI committee meetings until substantial compliance has been determined.</p> <p>The State Survey Agency validated the corrective actions taken by the facility as follows:</p> <p>Record review revealed Resident #1 was discharged home to Home Health services. On 05/12/14 and 05/13/14, the facility completed an investigation which included interviews with staff who provided care for Resident #1 on the date of the fall (03/26/14). In addition, the facility completed a medical record review to attempt to identify the root cause.</p> <p>On 05/16/14, review of Residents #7, #8 and #9's record revealed current care plans, pain assessments, and Morse Falls Risk Assessments had been completed. Progress Notes were reviewed and no concerns were noted with physician notification or change of condition.</p> <p>Review of the Inservice logs, on 05/16/14, revealed all staff working had been inserviced on Pain Management, Reporting Change of Condition to the Physician, Accidents and Supervision to Prevent Accidents, Patient Assessment, Seizure, Root Cause Analysis, and Fall Response and Management. The inservice was completed by facility staff which included the RN SDC, DON, and Unit Managers.</p>	F 490	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>By reviewing the findings of the tracking and trending, the Performance Improvement Committee will monitor the effectiveness and compliance with the plan weekly to validate solutions is sustained.</p> <p>The Executive Director is to assume overall responsibility for the actions of the Performance Improvement Committee.</p> <p>The Performance Improvement Committee consists of the Executive Director, Director of Nursing, Unit Managers, Staff Development Coordinator, Case Manager, MDS nurse, Social Services Director, Activity director, and Therapy Services Director.</p> <p>The Performance Improvement Committee is meeting weekly at this time, but will resume monthly meetings once substantial compliance is achieved.</p>	

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F 490	<p>Continued From page 64</p> <p>On 05/16/14 at 10:03 AM, the DON verified through interview he provided inservice to all staff working, performed pain assessments, fall assessments, reviewed every patient for diagnosis of seizure disorder, and validated care plans. In addition, he reviewed all the falls for the past ninety (90) days to ensure the root cause was identified. Further interview revealed, that he, along with the Unit Managers, SDC, MDS Nurse, Social Services and Rehab initiated the daily (Monday-Friday) Clinical Rounds.</p> <p>On 05/16/14 at 11:16 AM, Registered Nurse (RN) #2 (Unit Manager) and LPN #2 (Unit Manager) verified through interview they assisted with review of all falls for the last ninety (90) days at the facility. In addition, they reviewed every current resident for diagnosis of seizures and validated the care plans. Further interview revealed they assisted with daily (Monday-Friday) clinical rounds. Each of them stated they received the education provided by the facility related to falls, root cause, seizures, physician notification, change of condition, and pain assessment.</p> <p>On 05/16/14 at 2:30 PM, LPN #4 verified through interview he received education from the facility related to the new falls packet, change in condition, physician notification, seizures, and care plan interventions.</p> <p>On 05/16/14 at 2:50 PM, RN #3 verified through interview she received education from the facility related to falls, physician notification, and pain monitoring.</p> <p>On 05/16/14 at 3:02 PM, LPN #5 verified through</p>	F 490		
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F 490	<p>Continued From page 65</p> <p>interview she received education from the facility related to physician notification, the new falls packet, pain assessment, seizures, and determining the root cause of the falls.</p> <p>On 05/16/14 at 3:03 PM, LPN #7 verified through interview she received education from the facility related to physician notification, new falls packet, seizures, condition changes, and pain.</p> <p>On 05/16/14 at 3:30 PM, RN #4 verified through interview she received education from the facility related to physician notification, status changes in residents, seizures, falls, and pain assessment.</p> <p>On 05/16/14 at 3:30 PM, RN #1 (MDS Coordinator) verified through interview she received education from the facility related to notification in change of condition, pain management, seizures, and falls packet. Further interview revealed she assisted with daily clinical rounds and assisted with review of falls for the past 90 days to validate the root causes.</p> <p>On 05/16/14 at 3:54 PM, LPN #6 verified through interview she received education from the facility related to falls, pain monitoring, condition changes, seizures, patient assessments, and physician notification.</p> <p>On 05/16/14 at 4:00 PM, LPN #8 verified through interview she received education from the facility related to the new falls packet, physician notification, updating care plans, seizures, condition changes, and pain assessment.</p> <p>On 05/16/14 at 4:23 PM, the Physical Therapy Program Director verified through interview she was educated on the new process for clinical</p>	F 490		

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F 490	Continued From page 66 rounds, falls, and the new falls packet.	F 490	<i>This Plan of Correction is the center's credible allegation of compliance.</i>		
F 520 SS=J	483.76(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 and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced	F 520	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> F 520 I. Corrective Action for Identified Resident(s) Resident #1 was discharged to home from the center on 5/12/14. Resident # 1's physician was notified of the change of condition on 3/26/14 on the day of the fall and again on 4/3/14 of the pain related to the injury and the CAT scan results. The physician on 4/3/14 ordered no further revisions to the resident's pain regime. Resident #1's care plan was reviewed and revised to reflect current level of care on 5/10/14 by Interdisciplinary Team (IDT). II. Identification of Other Residents having potential to be affected On May 10 th 2014 the Director of Nursing, Unit Managers, Case Manager, and MDS nurse met and reviewed all current residents with falls in the previous 30 days to validate root cause identified and care plan updated with	7/16/14	

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F 520	<p>Continued From page 67</p> <p>by: Based on interview and review of the facility's policy and procedure and Plan of Correction for the 02/19/14 Abbreviated Survey, it was determined the facility's Quality Assessment and Assurance Committee (QACC) failed to monitor, track and trend the education provided to licensed staff on ongoing assessments after a significant change in condition was effective. The facility failed to ensure staff conducted resident assessments every shift for one (1) of six (6) sampled residents (Resident #1), after the resident sustained facial fractures, as per the Plan of Correction.</p> <p>During an Abbreviated Survey concluded on 02/19/14, Immediate Jeopardy was identified at 42 CFR 483.25 Quality of Care, F309. The facility submitted a Plan of Correction for the 02/19/14 survey; however, additional investigation during an Abbreviated Survey concluded on 05/16/14, revealed the residents continued to be at risk as licensed staff was not conducting ongoing assessments of residents when there was a change in condition. Immediate Jeopardy was identified at 42 CFR 483.10 Resident Rights, F-157; 42 CFR 483.25 Quality of Care, F-309 and F-323; and 42 CFR 483.75 Administration, F-490 and F-520; at a Scope and Severity of a "J".</p> <p>On 03/26/14, at approximately 3:30 AM, Resident #1 had a fall from his/her bed and was assessed to have bruising to the right cheekbone. At approximately 8:25 AM, Resident #1 was identified with a nosebleed and an order was received to send the resident to the Emergency Room. Resident #1 returned to the facility on 03/26/14 at 2:00 PM and was diagnosed with Facial Bone Fracture, Cervical Sprain, Head</p>	F 520	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>III. Systemic Changes</p> <p>The District Director of Clinical Operations (DDCO) and DND (Director of Nursing Division) reviewed and revised the Clinical Rounds Audit Tool on 6/18/14. On May 13th 2014 the Director of Nursing implemented Interdisciplinary Clinical Rounds daily (Monday- Friday) on each unit. These rounds include the Director of Nursing, Unit Managers, MDS nurse or Case Manager, Social Services Director, and Therapy Program Director. The Weekend Supervisor Nurse will be responsible to conduct this review on Sat-Sun. The Clinical Rounds will verify physicians and families have been notified as needed with changes in resident condition, ongoing assessments and documentation in the medical record for residents, resident care plans updated as needed with changes in resident condition, newly admitted residents care plans initiated, investigations complete for any falls that occurred, care plans updated with interventions to prevent reoccurrence, and will verify follow up completed as needed for resident appointments outside the center from the previous day.</p>	
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F 520	<p>Continued From page 68</p> <p>Injury, Closed Head Injury without Cranial wound, and Unspecified State Level of Consciousness. In addition, the resident had discharge orders for Norco 7.5/325 milligrams as needed (PRN) for pain and to follow up with Resident #1's Primary Care Physician in one (1) to two (2) days "to recheck today's complaints if the resident was not improving". However, there was no documented evidence the licensed staff was conducting resident assessments for Resident #1 related to the resident facial fracture. On 04/03/14, approximately eight (8) days after the fall with facial fractures, the Primary Care Physician visited the facility to make routine rounds and found the resident with facial fractures and complaints of pain when he/she opened his/her mouth. He ordered a consultation with an Ears, Nose, and Throat Specialist (ENT). Resident #1 required surgery for repair of the Facial Bone Fractures and an overnight hospitalization.</p> <p>The facility's failure to ensure an effective system was in place to monitor and assess the residents, has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 05/09/14 and determined to exist on 03/26/14. Refer to F279, F309 and F323.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure, "Performance Improvement" dated 03/05/08, revealed its policy was to identify and respond to negative outcomes and deficiencies. In addition, the actions taken are directed toward enhancing quality of care and quality of life for residents and also serves as a preventative function by reviewing and improving functions. Further</p>	F 520	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>As of 5-17-14 the daily clinical round audit tool will be completed by the Director of Nursing, RN Weekend Supervisor, RN Case Manager, and/or Unit Manager with the findings from the clinical rounds and is ongoing to identify any resident with the potential to be affected which will allow for immediate corrective action.</p> <p>On 7-15-14 the Performance Improvement Committee was educated by the Regional Quality Specialist on the Performance Improvement Process to include the PI Policy and supplemental PI forms.</p> <p>The Director of Nursing, Unit Manager, RN Weekend Supervisor and/or The Registered Nurse Staff Development Coordinator will conduct clinical education with facility staff on an ongoing basis as indicated based on the findings of daily clinical rounds and the recommendations of the Performance Improvement Committee.</p> <p>IV. Monitoring</p>	

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F 520	<p>Continued From page 69</p> <p>review revealed the committee meets at least monthly to identify issues that necessitates quality assessment and assurance activities and develop and implement appropriate plans of action to correct identified quality deficiencies.</p> <p>Interview with the Administrator, on 05/16/14 at 3:45 PM, revealed the QACC meets monthly or as needed and its purpose is to track and trend clinical outcomes with an overall goal to improve the residents' quality of life. Additionally, she revealed she was responsible for the QACC. Post Interview with the Administrator, dated 06/03/14 at 3:50 PM, revealed the audits to ensure the assessments were completed every shift were stopped around 04/16/14 or 04/17/14 when the revisit was conducted to determine the facility was back in compliance.</p> <p>Interview with the Medical Director, on 05/16/14 at 10:00 AM, revealed that he attends QACC meetings monthly and when he was unable to attend, he was available by phone. The Medical Director stated he was not made aware of the resident's fall with facial fractures until 05/09/14, after the Jeopardy was identified. The Medical Director stated the QACC had not addressed any new concerns with monitoring and assessment of a resident until he was made aware on 05/09/14 and they were addressed in the next QACC meeting. During further interview, the Medical Director stated it would be his expectation for the facility to have notified the primary care physician of the resident's significant change of condition.</p> <p>**The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>On 05/10/14, the facility's Nursing Management</p>	F 520	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>The Performance Improvement Committee met on May 12, 2014 to discuss root cause of adverse event. A fishbone diagram along with brainstorming was the basis of the root cause analysis. In addition each deficient practice cited by the survey team was discussed. The Medical Director was notified via telephone of the plan developed by the Performance Improvement Committee on that date.</p> <p>The Daily Clinical Rounds Form/Audit Tool is completed by the Director of Nursing (or Unit Manager, Staff Development Coordinator, Case Manager, or Weekend Supervisor when the Director of Nursing is not available). This audit tool will identify any concerns with physician/family notification, changes in resident condition, ongoing assessments and documentation in the medical record for residents, resident care plans updated as needed with changes in resident condition, newly admitted residents care plans initiated, investigations for any falls that occurred, care plans updated with interventions to prevent reoccurrence, and follow up completed as needed for resident appointments outside the center from the previous day.</p>	

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F 520	<p>Continued From page 70</p> <p>Team which consisted of the Director of Nursing (DON), Unit Manager, Case Manager, and MDS Nurse, met and reviewed all current residents with falls in the previous thirty (30) days to validate the root cause identified, and care plans were updated with appropriate interventions to prevent reoccurrence.</p> <p>On 05/10/14, the DON revised the falls packet for the licensed staff to use to investigate a fall at the time of occurrence. This revision included a Fall's Scene Investigation Report from the Kentucky Quality Improvement Organization which will be used by the licensed nurses as a guide to determine the root cause with any falls that occur.</p> <p>On 05/10/14, the Registered Nurse Staff Development Coordinator (RN SDC) and/or designee to consist of the DON, and/or Unit Managers, initiated education with all licensed nurses related to policy and procedures on the following topics: Pain Management, Reporting Change of Condition to the Physician, Accidents and Supervision to Prevent Accidents, Patient Assessment, Seizure, Root Cause Analysis, and Fall Response and Management. The education continued on 05/11/14, 05/12/14, and 05/13/14 and is ongoing until all licensed nurses have attended. No licensed nurse may work until the education has been received.</p> <p>The Performance Improvement (PI) committee met on 05/12/14 and discussed the root cause of the adverse event on 03/26/14. In addition, all cited deficient practice was discussed. The Medical Director was notified via telephone conference and approved the plan developed by the PI committee. Members of the PI committee</p>	F 520	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Findings from the audit tool will be tracked and trended by the Director of Nursing weekly and forwarded to the Performance Improvement Committee with further education or actions taken as determined by the Committee.</p> <p>Findings from the Monthly Pain Audit will be tracked and trended and forwarded to the Performance Improvement Committee for weekly and or monthly review with further education and/ or follow up actions taken as determined by the Committee. The frequency of this audit may be adjusted according to the Performance Improvement Committee.</p> <p>By reviewing the findings of the tracking and trending, the Performance Improvement Committee will monitor the effectiveness and compliance with the plan weekly to validate solutions are sustained.</p> <p>The Executive Director is to assume overall responsibility for the actions of the Performance Improvement Committee.</p>	
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F 520	<p>Continued From page 71</p> <p>in attendance included the Executive Director (ED), DON, Case Manager, Unit Managers, the District Director of Clinical Operations (DDCO), MDS Nurse, the Regional Vice President of Clinical Operations (RVPCO), and the Divisional Vice President (VP). The PI committee reviewed and approved the plan and will meet weekly until substantial compliance is achieved. During the weekly PI committee meetings, the committee will review the results of the Daily Clinical Rounds and monthly pain audit, and track and trend the audit tool findings to identify need for further actions and/or education.</p> <p>On 05/12/14 and 05/13/14, the facility identified residents who had the potential to be affected by the alleged deficient practice and all concerns were corrected.</p> <p>On 05/12/14 and 05/13/14, the facility's Unit Managers, Case Managers, Medical Record Nurses, DON, and Assistant Director of Nursing (ADON) reviewed all current residents Progress Notes for the previous thirty (30) days to identify any changes of condition, verified physician and family notification, and care plans were updated to reflect the change in condition.</p> <p>On 05/12/14 and 05/13/14, the facility's Unit Managers, Case Managers, Medical Record Nurses, DON, and ADON assessed every current resident using the "Patient Nursing Evaluation" and updated care plans as needed to reflect current status of the residents. This assessment included a pain assessment and a Morse Fall's Risk Assessment for every current resident.</p> <p>On 05/12/14 and 05/13/14, the facility's Unit Managers, Case Managers, Medical Record</p>	F 520	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>The Performance Improvement Committee consists of the Executive Director, Director of Nursing, Unit Managers, Staff Development Coordinator, Case Manager, MDS nurse, Social Services Director, Activity director, and Therapy Services Director.</p> <p>The Performance Improvement Committee is meeting weekly at this time, but will resume monthly meetings once substantial compliance is achieved.</p>	
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F 520	<p>Continued From page 72</p> <p>Nurses, DON, and ADON reviewed every current resident for a diagnosis of seizure disorder and validated the care plan to reflect the diagnosis and appropriate interventions.</p> <p>On 05/13/14, the DON implemented Interdisciplinary Clinical Rounds daily (Monday-Friday) on each unit. These rounds included the DON, Unit Managers, MDS Nurse, Social Services Director (SSD), and Therapy Program Director. An audit tool will be completed daily with the findings from the clinical rounds.</p> <p>The DDCO and/or Divisional VP will provide weekly oversight by validating action plans are implemented and attend facility PI committee meetings until substantial compliance has been determined.</p> <p>The State Survey Agency validated the corrective actions taken by the facility as follows:</p> <p>Record review revealed Resident #1 was discharged home to Home Health services. On 05/12/14 and 05/13/14, the facility completed an investigation which included interviews with staff who provided care for Resident #1 on the date of the fall (03/26/14). In addition, the facility completed a medical record review to attempt to identify the root cause.</p> <p>On 05/16/14, review of Residents #7, #8 and #9's record revealed current care plans, pain assessments, and Morse Falls Risk Assessments had been completed. Progress Notes were reviewed and no concerns were noted with physician notification or change of condition.</p> <p>Review of the inservice logs, on 05/16/14,</p>	F 520		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/16/2014
NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066		
(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 520	<p>Continued From page 73</p> <p>revealed all staff working had been inserviced on Pain Management, Reporting Change of Condition to the Physician, Accidents and Supervision to Prevent Accidents, Patient Assessment, Seizure, Root Cause Analysis, and Fall Response and Management. The inservice was completed by facility staff which included the RN SDC, DON, and Unit Managers.</p> <p>On 05/16/14 at 10:03 AM, the DON verified through interview he provided inservice to all staff working, performed pain assessments, fall assessments, reviewed every patient for diagnosis of seizure disorder, and validated care plans. In addition, he reviewed all the falls for the past ninety (90) days to ensure the root cause was identified. Further interview revealed, that he, along with the Unit Managers, SDC, MDS Nurse, Social Services and Rehab initiated the daily (Monday-Friday) Clinical Rounds.</p> <p>On 05/16/14 at 11:16 AM, Registered Nurse (RN) #2 (Unit Manager) and LPN #2 (Unit Manager) verified through interview they assisted with review of all falls for the last ninety (90) days at the facility. In addition, they reviewed every current resident for diagnosis of seizures and validated the care plans. Further interview revealed they assisted with daily (Monday-Friday) clinical rounds. Each of them stated they received the education provided by the facility related to falls, root cause, seizures, physician notification, change of condition, and pain assessment.</p> <p>On 05/16/14 at 2:30 PM, LPN #4 verified through interview he received education from the facility related to the new falls packet, change in condition, physician notification, seizures, and</p>	F 520		

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NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066		
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F 520	Continued From page 74 care plan interventions. On 05/16/14 at 2:50 PM, RN #3 verified through interview she received education from the facility related to falls, physician notification, and pain monitoring. On 05/16/14 at 3:02 PM, LPN #5 verified through interview she received education from the facility related to physician notification, the new falls packet, pain assessment, seizures, and determining the root cause of the falls. On 05/16/14 at 3:03 PM, LPN #7 verified through interview she received education from the facility related to physician notification, new falls packet, seizures, condition changes, and pain. On 05/16/14 at 3:30 PM, RN #4 verified through interview she received education from the facility related to physician notification, status changes in residents, seizures, falls, and pain assessment. On 05/16/14 at 3:30 PM, RN #1 (MDS Coordinator) verified through interview she received education from the facility related to notification in change of condition, pain management, seizures, and falls packet. Further interview revealed she assisted with daily clinical rounds and assisted with review of falls for the past 90 days to validate the root causes. On 05/16/14 at 3:54 PM, LPN #6 verified through interview she received education from the facility related to falls, pain monitoring, condition changes, seizures, patient assessments, and physician notification. On 05/16/14 at 4:00 PM, LPN #8 verified through	F 520			

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F 520	<p>Continued From page 75</p> <p>interview she received education from the facility related to the new falls packet, physician notification, updating care plans, seizures, condition changes, and pain assessment.</p> <p>On 05/16/14 at 4:23 PM, the Physical Therapy Program Director verified through interview she was educated on the new process for clinical rounds, falls, and the new falls packet.</p> <p>On 05/16/14 at 4:25 PM, the SSD verified through interview she assisted with the clinical rounds daily (Monday-Friday). She stated she did not receive the other education because she was not clinical.</p>	F 520		