

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

PRINTED: 01/23/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/10/2013
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NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS An abbreviated survey was completed on 01/08/13 through 01/10/13 for KY19595. The Division of Health Care unsubstantiated the allegation; however, related regulatory violations were identified at 42 CFR 483.10 Resident Rights F157, 42 CFR 483.20 Resident Assessment F282, 42 CFR 483.25 Quality of Care F323, and 42 CFR 483.75 Administration F514 at a scope and severity of a "G". The facility's noncompliance resulted in actual harm to one resident with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000	F-157 1. Physician and family for Resident #1 were made aware of the 12/27/2012 incident on 12/30/2012. The notification was made by the staff nurse. Resident returned to the facility after recent hospitalization. 2. All reports of any incident and the 24-hour communication report sheets for the past 30 days will be reviewed to ensure the Physician and Family of the resident were notified of any incidents with or without injury and any change in condition for the resident. This will be completed by 02/08/2013 by DON, ADON, and MDS staff. 3. Licensed nurses were re-educated on the facility policy for notification of change, initiation and completion of the incident reporting process and investigation system, completion of the 24 hour report, and nursing documentation guidelines. This includes notification to families and physicians when an incident occurs or a change in condition occurs. This education was presented by the corporate consultant and Director of Nursing on	
F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; 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). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* 01/28/2013. Completion by: *[Signature]* (X6) DATE 02/13/2013

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.

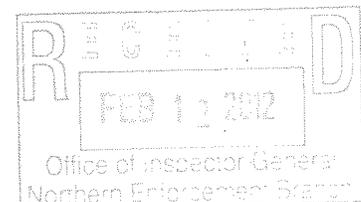
FEB 12 2013
If continuation sheet Page 1 of 31
Northern Enforcement Branch

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F 157	<p>Continued From page 1</p> <p>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 observation, interview, record review, and review of the facility policy and procedures and investigation, it was determined the facility failed to notify the physician and family for one (1) of four (4) sampled residents (Resident #1) after an incorrect transfer in the Maxi-Lift was completed, resulting in a Right Comminuted Fractured Femur. The Shift Supervisor was notified by Certified Medication Technician (CMT) #2, and an initial assessment was completed for Resident #1; however, neither the Physician nor the Power of Attorney were notified of the incident. This facility failure delayed treatment and resulted in Actual Harm for Resident #1.</p> <p>Refer to F323 and F282</p> <p>The findings include:</p> <p>Review of the facility's policy "Notification of Changes", dated 07/01/08, revealed this facility would immediately inform the resident; consult with the resident's physician; and notify the designated family member or resident's legal representative when there was an accident</p>	F 157	<p>Education will continue from 02/03/2013-02/08/2013. Nurses will complete a post test after the education to evaluate understanding. Tests were reviewed by the Corporate Consultant and Director of Nursing. This education will be repeated monthly for 3 months then annually. All newly hired Licensed staff will be educated, during orientation on notification of change, incident reporting & investigation, 24 hour reports, & Nursing Documentation guidelines we will utilize a post-test to evaluate understanding. This education will be presented by the Staff Development Coordinator.</p> <p>4. The DON, ADON, and MDS staff will audit all incidents reported, using the incident reporting procedure and the 24-hour communication tool, to ensure notification was made to the Physician and Family and was documented in the clinical record, weekly for the next 3 months. DON, ADON, and MDS staff will audit 25% of the incident reports monthly thereafter to ensure continued compliance. Findings will be reported to the QA committee quarterly for at least one year.</p>	

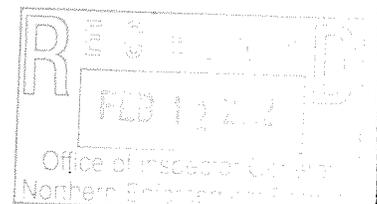
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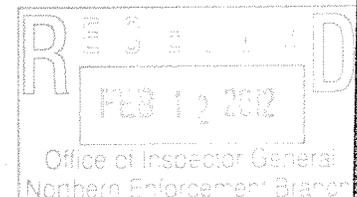
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F 157	<p>Continued From page 2</p> <p>involving the resident which results in injury and had the potential for requiring physician intervention. Even when a resident was mentally competent, a designated family member should be notified of significant changes in the resident's health status, because the resident may not be able to notify them personally, especially in case of sudden illness or accident. Conditions that should be communicated to the physician: any accidents or incidents with or without injury.</p> <p>Review of the facility's investigation by the Director of Nursing, initiated on 12/30/12, revealed CMT #2 reported to the Unit Manager and 2nd Shift Supervisor #2 that she had walked into Resident #1's room where Certified Nurse Aide (CNA) #1 was transferring the resident in the Maxi-Lift alone. The CMT stated it appeared the resident was not positioned properly in the lift and she assisted CNA #1 in getting Resident #1 back to the bed. As the resident was being lowered in the bed, CMT #2 stated she heard a "snap". The investigation revealed the resident did not complain of pain at that time, and the 2nd Shift Supervisor #2 went to the room and assessed Resident #1. The report stated the resident was not in distress, and physically appeared fine.</p> <p>Review of the clinical record for Resident #1 revealed the facility admitted the resident on 12/03/10, with diagnoses of Atrial Fibrillation, Heart Disease, Knee Joint Replacement, History of Falls, Mental Disorder, Hypertension, and Diabetes Mellitus. Review of the 12/01/12 quarterly Minimum Data Set (MDS) assessment revealed the facility assessed Resident #1 with a decline since the 08/31/12 re-admission comprehensive MDS assessment, and had been</p>	F 157			



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F 157	<p>Continued From page 3</p> <p>placed on palliative care, on 10/28/12. Resident #1's 08/31/12 re-admission comprehensive MDS assessment and 12/01/12 quarterly MDS assessment revealed the facility assessed the resident as non-ambulatory and required maximum assistance with bathing, dressing and grooming, and was not interviewable.</p> <p>Interview with Resident #1, on 01/08/13 at 10:00 AM, revealed while being transferred with a lift, they dropped him/her and his/her leg went under him/her. Resident #1 stated he/she hit the floor. The resident stated they did check him/her, and he/she kept complaining for days before anyone did anything. He/she stated, "I broke my knee". After the resident pulled the sheet off his/her leg, observation of the knee revealed multiple staples noted vertically along the center of the patella or knee cap, with three to four staples on each side of the patella, also vertically. The resident stated he/she had pain, but was receiving pain medication when requested.</p> <p>Interview with Shift Supervisor #2, on 01/09/13 at 3:30 PM, revealed CMT #2 had reported to her, on 12/27/12 around 6:00 PM, that she had observed CNA #1 using the Maxi-Lift without assist of two people, as per facility policy, and observed Resident #1 suspended in the lift off the bed. The Shift Supervisor stated she was told by the CMT upon returning the resident to the bed, there was a popping sound, and said something might have happened with Resident #1. The Shift Supervisor stated she assessed the resident and looked for bruising, swelling, pain, and deformity, and at the time did not see any evidence of injury. The Shift Supervisor asked the resident if she was having pain, and the resident stated "no".</p>	F 157		



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F 157	<p>Continued From page 4</p> <p>Interview revealed there was no notification to the physician or family regarding the incident at that time.</p> <p>Continued interview with the Shift Supervisor revealed that later in the shift on 12/27/12, CMT #2 came to her again and reported upon turning Resident #1, the resident said "Oh!". The Shift Supervisor went back to re-assess the resident and still didn't see anything. Shift Supervisor #2 stated she was responsible for assessing, reporting, and initiating any investigations. She also stated she was responsible for completing a night report which was turned in to the Director of Nursing at the end of each shift. The Shift Supervisor stated she did not put the incident on the night report, because she didn't associate the resident's pain on turning with anything, just maybe arthritis. The Shift Supervisor also revealed the assessment was not documented in the nurse's notes, nor was there an incident report completed for the incident, or family and physician notified. Shift Supervisor #2 revealed she did not ask the resident what happened, only if she was in pain. Looking back, the Shift Supervisor stated the physician and family should have been notified.</p> <p>Interview with Licensed Practical Nurse (LPN) #4, on 01/09/13 at 2:00 PM, who took care of Resident #1, on 12/28/12 on the day shift, revealed CNA #5 called her to the resident's room around 2:00 PM to look at the resident's leg. She assessed the right leg, it looked tight and swollen, and the resident said he/she had fallen out of the lift when they weighed him/her, and that the girl came in and dropped him/her. LPN #4 stated the resident could not identify any specific staff, and</p>	F 157			



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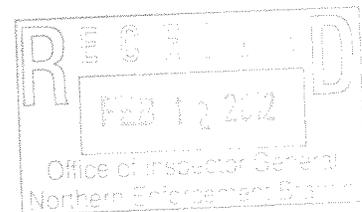
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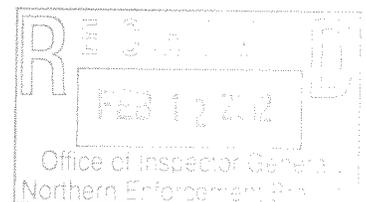
F 157	<p>Continued From page 5</p> <p>she called the Assistant Director Of Nursing (ADON) to come and assess the resident also. LPN #4 stated she did not document the assessment or the resident's pain in the clinical record that day, but should have done so, since the nurses are primarily responsible for documenting, nor did she notify the resident's physician or family.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 01/08/12 at 4:45 PM, revealed she was asked by CNA #5 and LPN #4 to assess Resident #1's leg, because the resident said "Ouch!" and said his/her leg hurt when moved. Upon assessment, the ADON stated there were no abnormalities, but the leg looked tight or cramped, like a muscle spasm. The ADON stated the resident's son was visiting, and he was informed the resident's leg was hurting like a muscle spasm, and a nursing intervention of warm compresses had been applied. However, there was no evidence the assessment completed by the ADON had been documented in the nurse's notes, nor physician notified of the resident's pain on movement. Further interview with the ADON revealed she was not aware of the 12/27/12 incident at that time, since it had not been documented or passed on during shift report.</p> <p>Interview, on 01/09/13 at 2:45 PM, with the evening shift LPN #3, revealed she had worked on 12/28/12 and received report that Resident #1 had been complaining of leg pain, and was stating he/she had been dropped with the lift during being weighed. However, review of the facility investigation regarding CNAs #3 and #4, who had weighed Resident #1 the previous day,</p>	F 157		
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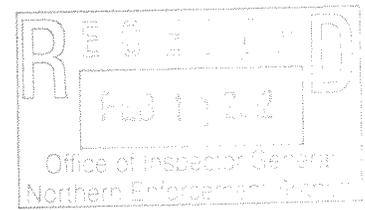
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F 157	<p>Continued From page 6</p> <p>revealed there had been no incident with the Maxi-Lift with Resident #1. Interview with LPN #3 also revealed she had passed this information to the next shift; however, there was no evidence LPN #3 had documented her assessment of the resident's pain, completed an incident report, or notified the physician or family.</p> <p>Continued interview with LPN #3, who worked from 3:00 PM-7:00 PM on 12/29/12, revealed she received no reports of pain from Resident #1 in the previous shift report; however, stated when she and LPN #5 tried to turn and reposition him/her at 6:00 PM, the resident said "Ouch!". LPN #3 stated when they assessed the resident's leg, it looked swollen above the knee, and when they lifted the leg, the resident did not complain of pain; the appearance of the leg had not changed from 12/28/12. Although interview revealed LPN #3 reported the resident's pain upon movement to the night shift nurse LPN #6, LPN #3 failed to document the assessment, notify the physician, or the resident's family. The LPN stated she was unaware of the incident which had occurred with the lift on 12/27/12 at that time; however, should have documented the assessment and notified the physician and family of her findings.</p> <p>Attempted interview with LPN #6, on 12/29/12 at 3:00 PM, was unsuccessful with no return call as of 01/10/13.</p> <p>Review of the nurse's notes, on 12/30/12 at 1:00 AM, revealed the night shift nurse LPN #6 documented the resident's complaints of pain to the right upper thigh, and the physician was initially notified and orders received to obtain an X-ray to rule out a fracture. Review of the nurses'</p>	F 157			



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F 157	<p>Continued From page 7</p> <p>note also revealed the resident stated he/she "fell yesterday when being weighed in the lift, and his/her leg bent back". The portable X-ray service was notified at 1:00 AM; however, even after multiple calls from the facility, did not arrive at the facility until 4:00 PM that day to obtain the X-ray. Pain medication (Tylenol 500 mg 2 tablets) was given at 1:00 AM for right leg pain with relief. The pain medication was offered again at 7:30 AM to the resident; however, the resident refused the medication.</p> <p>Interview with LPN #5, on 01/09/13 at 2:30 PM, revealed she cared for Resident #1 on 12/30/12 during the day shift, and revealed throughout the day the resident complained of pain on turning, and around 2:00 PM-2:30 PM, she noted a movement in his/her leg with rotation and notified the weekend supervisor Registered Nurse (RN) #1. LPN #5 stated they obtained an order at that time to go ahead and send the resident to the hospital; however, the family refused to allow transfer until the X-ray had been obtained. The LPN revealed she had not noted the incident on the 24 hour report, or documentation in the nurse's note until 12/30/12 at 1:00 AM.</p> <p>Interview with Resident #1's Power of Attorney (POA), on 01/09/13 at 1:10 PM, revealed he was not called about the incident with the lift until 12/30/12. He did not want him/her to be transferred until the X-ray results were obtained. The facility told him on Saturday 12/29/12 they were putting hot compresses on his/her leg for pain, but did not inform him of anything else. He had not seen or heard about an incident report. The POA stated the resident required surgery with rods and a number of screws in his/her</p>	F 157	



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F 157	Continued From page 8 fractured leg, "pretty serious stuff". Interview with the Director of Nursing (DON), on 01/08/13 at 10:20 AM, revealed she had not been notified of the 12/27/12 incident until 1:00 AM on 12/30/12, when the night shift LPN #6 called her. The DON stated she investigated the incident on Monday when she returned to work and found there was no documentation in the clinical record until 12/30/12, after LPN #6 called her. The DON stated that during the investigation they found there had been no incident report completed initially, nor family or physician notified of the incident until 12/30/12. In addition, there was no documentation on the facility's 24 hour shift report, or assessment documentation by each nurse in the resident's record of the incident. The Director of Nursing stated this did not meet the facility's expectation. Interview with the Administrator, on 01/10/12 at 1:30 PM, revealed the incident could have been prevented with better communication with the staff, notification of the physician and family, and the incident passed on during the shift reports. The Administrator revealed the facility expectation would have been to call the physician and family initially, on 12/27/12, and to have assessments documented and communicated to the next shifts. The Administrator stated the lack of assessment documentation and notifications were unacceptable.	F 157	F-282 1. Upon Return from the hospital, facility did change Resident #1 transfer status to a 4 person sheet lift for a short period of time. Once Therapy was done working with resident #1, Resident #1 returned to a maxi Lift per their recommendation. On 01/08/2013, a review of the care plan was completed to ensure the correct transfer status was noted. This was completed by the DON. Transfer status was also noted on a quick reference in front of each MAR for nurses access for on-going monitoring of transfer activities being observed. DON checked that the transfer status for resident #1 was correctly noted. This was completed on 01/08/2013. 2. DON, ADON, and Unit Managers reviewed transfer status for all residents to ensure the current transfer status was accurate. This was completed on 01/09/2013. An Audit of transfer documentation was completed for a 7 day look-back period for all residents to identify anyone that is not being transferred as per the care plan.		
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of	F 282			

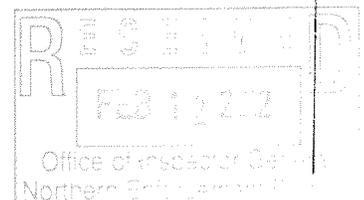
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F 282	Continued From page 9 care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility policy and procedure and investigation, it was determined the facility failed to follow the care plan relating to Maxi-Lift transfers for one (1) of four (4) sampled residents. Certified Nursing Assistant (CNA) #1 failed to follow care plan interventions for two person assist with the Maxi-Lift for Resident #1 on 12/27/12. The resident was observed by Certified Medication Technician (CMT) #2 to be positioned incorrectly in the lift during transfer, and in assisting with transferring the resident back to the bed, a popping sound was heard. Resident #1 sustained a Comminuted Fractured Right Femur. The facility's failure to follow the care plan for two assist resulted in Actual Harm to Resident #1. Refer to F323 The findings include: Review of the facility's policy "Resident Care Plan Policy", no date given, revealed approaches were to be stated in terms related to the staff, while problem/needs were related to the resident. Each discipline would follow up on the problems and achievement or non-achievement of the goals through communication with the appropriate staff. Review of the facility's policy "Clinical Record	F 282	This was completed by DON, ADON, MDS Director and Unit Manager on 01/10/2013. DON & ADON interviewed all interviewable residents that require transfer by mechanical lift to determine if they are being transferred appropriately. If resident was not interviewable, direct observation of a transfer was conducted to ensure use of a lift was utilized for transfer. This was completed on 01/12/2013. Staff were also interviewed by DON & ADON regarding identification of all residents utilizing a lift for transfer to ensure staff knowledge of resident transfer status & where to find the transfer status for each resident. This was completed on 01/12/2013. 3. Non-licensed nursing staff are being re-educated on the facility practice for using 2 people with all residents requiring a maxi lift transfer. They are also educated on the proper use of the lift and will perform a return demonstration to ensure competency on using the lift appropriately. This started on 01/07/2013 and will be completed by 02/07/2013.	Completion by: 02/13/2013	



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

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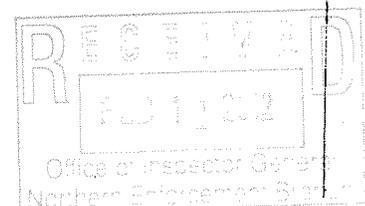
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F 282	<p>Continued From page 10</p> <p>Documentation Guidelines", dated 02/20/12, revealed a procedure on how to document implementation of the care plan. Documentation should include practicing the plan of care that had been developed which included specific actions that the nurse needed to take to activate and implement that plan.</p> <p>Interview with the Director of Nursing (DON), on 01/09/13 at 2:00 PM, revealed there was no specific policy for following the care plan; however, she stated the shift supervisors and the floor managers have a daily round check list for monitoring completed tasks or care plan interventions that should have been done. The DON stated they also complete spot checks with staff still on probation.</p> <p>Review of the facility's investigation revealed that on 12/27/12, CMT #2 approached the Unit Manager and the 2nd Shift Supervisor #2, to inform them that she had walked into Resident #1's room where CNA #1 was transferring the resident in the Maxi-Lift alone. The CMT stated it appeared the resident was not positioned properly in the lift, she told CNA #1 she would assist in getting Resident #1 back in the bed. As the resident was being lowered in the bed, CMT #2 stated she heard a "snap". The investigation revealed the resident did not complain of pain at that time, and 2nd Shift Supervisor #2 entered the room and assessed the resident. The investigative report revealed the resident was not in distress at that time, and had no complaints of pain and physically appeared fine.</p> <p>A review of the comprehensive care plan and the CNA care plan for Resident #1, dated 09/03/12,</p>	F 282	<p>The Staff Development Coordinator was responsible for this process. Non-Licensed nursing staff will be checked off with their annual review process as well to ensure continued competency. All newly hired Non-Licensed staff will be educated during orientation by The Staff Development Coordinator and will complete the skills check off within 60 days of employment and annually. Nursing staff are being re-educated on following the care plan and C.N.A plans of care. This was started on 01/28/2013 and will be complete on 02/08/2013 by DON, ADON and Staff Development. A post-test is being administered by the Corporate Consultant to nurses and by the DON, ADON or Staff Development Coordinator to the non-licensed nursing staff to ensure understanding of the care plan process and following the care plan.</p> <p>4. The DON, ADON, or Unit Managers will observe a minimum of 5 transfers a day for 2 weeks, then 10 a week x4 weeks and then at least 10 per month x6 months and then will continue audits of a minimum of 10 transfers each quarter for 2 quarters to ensure staff are following the resident plan of care regarding transfer status, including using the lift and following the practice of using 2 staff assist with a lift.</p>	Completion by: 02/13/2013	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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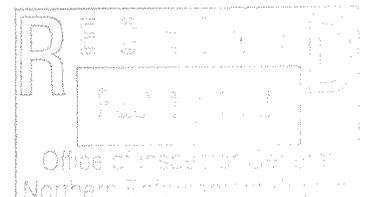
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F 282	<p>Continued From page 11</p> <p>revealed the resident required assist with Activities of Daily Living related to recent hospitalization for pacemaker insertion and general weakness, with an approach to transfer the resident per Maxi-Lift with the assist of two (2).</p> <p>Interview with Resident #1, on 01/08/13 at 10:00 AM, revealed the resident stated, while being transferred with a lift, they dropped him/her and his/her leg went under him/her. Resident #1 stated he/she hit the floor. The resident stated they did check him/her, and he/she kept complaining for days before anyone did anything. He/she stated, "I broke my knee". During the interview, Resident #1 pulled the sheet off his/her leg, observation of the knee revealed multiple staples noted vertically along the center of the patella or knee cap, with three to four staples on each side of the patella, also vertically. The resident stated he/she had pain, but was receiving pain medication when requested.</p> <p>Interview with CMT #2, on 01/09/13 at 10:00 AM, revealed that on 12/27/12 around 4:45 PM, she observed CNA #1 transferring Resident #1 from the bed to the chair in the Maxi-Lift. The CMT stated Resident #1 was suspended in the air and positioned incorrectly on the resident's left side. The CMT stated she was afraid the resident was going to fall out of the lift. CMT #2 assist CNA #1 in transferring Resident #1 back to bed, and upon transfer back to the bed, CMT #2 heard a popping sound. CMT #2 stated she reported the incident to Shift Supervisor #2 and Unit Manager #1 because she was not sure if the pop sound came from the resident or the lift, and the resident should be checked out. CMT #2 stated</p>	F 282	DON will also review transfer documentation weekly for 4 weeks then one unit per week for 3 months then will include a transfer audit as part of the quarterly QA audit program. Quarterly DON will audit no less than two weeks of transfer documentation for each unit. This audit will check to see that documentation of resident transfers matched the resident Care Plan & will identify staff who may require re-education. These audit findings will be reported to the QA Committee no less than quarterly for one year.	Completion by: 02/13/2013	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 282	<p>Continued From page 12</p> <p>all residents who use the Maxi-Lift were to be transferred with 2 staff. The CMT stated the resident did not complain of pain at the time of the incident.</p> <p>Interview with CNA #1, on 01/09/13 at 3:00 PM, revealed he had worked at the facility for one month and had received lift training during his orientation to the facility. CNA#1 stated the son of Resident #1 had asked him to get the resident up into the chair on 12/27/12. CNA #1 stated he had placed Resident #1 on the lift pad, and attached the hooks to the lift; however, stated he was waiting for CMT #2 to come into the room to assist him with transferring the resident, because he knew the resident required two people to transfer and should not be lifted until the second person was there to assist. CNA #1 denied the allegation that Resident #1 was suspended in the air when the CMT came into the room. CNA #1 stated CMT #2 told him he did not have the resident positioned correctly in the lift, then she grabbed the resident's leg, trying to reposition the resident and caused the leg to snap. CNA #1 stated the policy was for two people to use the lift, and his CNA care plan sheet stated that the resident required two people for lift transfers.</p> <p>Interview with the Director of Nursing (DON), on 01/08/13 at 10:20 AM, revealed she had not been notified of the 12/27/12 incident until 1:00 AM on 12/30/12, when the night shift LPN #6 called her. The DON stated she investigated the incident on Monday when she returned to work, and revealed the expectation for following the plan of care lies with following the CNA care sheets that are carried with each CNA.</p>	F 282			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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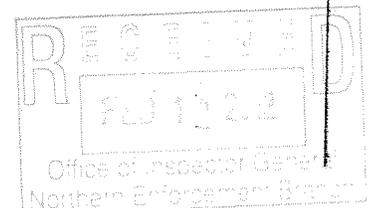
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F 282	Continued From page 13 Interview with the Staff Development Coordinator (SDC), on 01/10/13 at 12:00 PM, revealed CNA #1 was still on probation and had received lift training with return demonstration as well as completed all 29 skills competencies that are required for new staff within the first 60 days. The SDC stated that the nurses were responsible for supervising new staff, as well as spot checks and rounds check lists that were completed by unit managers and shift supervisors for all new staff.	F 282			
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility policy and procedures	F 323	F-323 1. Upon return from the hospital, facility did change Resident #1 transfer status to a 4 person sheet lift for a short period of time. Once therapy was done working with resident #1, resident #1 returned to a maxi lift per their recommendation. On 01/08/2013, a review of the care plan was completed to ensure the correct transfer status was noted. This was completed by the DON. Transfer status was also noted on a quick reference in front of each MAR for nurses access for ongoing monitoring of transfer activities being observed. DON checked that the transfer status for resident #1 was correctly noted. This was completed on	Completion by: 02/13/2013	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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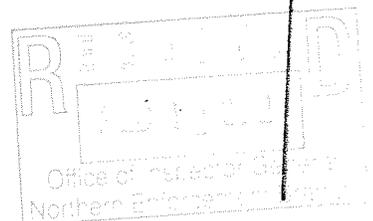
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F 323	Continued From page 14 and investigation, it was determined the facility failed to provide adequate supervision and assistive devices to prevent accidents for one (1) of four (4) sampled residents. Certified Nurse Assistant (CNA) #1 failed to follow care plan interventions regarding use of the Maxi-Lift with two person assist for Resident #1. The resident was observed by Certified Medication Technician (CMT) #2, on 12/27/12, to be positioned incorrectly in the lift during transfer. CMT #2 was assisting CNA #1 with transferring the resident back to the bed and heard a loud popping sound. The incident was reported to the Shift Supervisor. However, there was no documented evidence of the initial assessment of the resident by Shift Supervisor #2 in the resident's clinical record. The record revealed continued complaints of pain by Resident #1 was reported by the CNAs on 12/28/12 through 12/29/12 to Licensed Practical Nurse #3, #4, and #5 and the Assistant Director of Nursing; however, no assessments had been documented in the clinical record, or the initial report of the incident. In addition, neither the physician or family were notified until 12/30/12 at 1:00 AM, or four (4) days after the 12/27/12 incident. On 12/30/12 Resident #1 was transferred to the hospital and diagnosed with a Comminuted Fractured Right Femur. This delay in reporting the incident, delay of notification of physician and family, and lack of assessment documentation caused the delay in the resident receiving emergency treatment for the Fractured Femur, that required surgical intervention. The facility's failure caused Actual Harm to Resident #1. Refer to F157, F282, and F514.	F 323	2. DON and ADON reviews transfer status for all residents to ensure the current transfer status is appropriate and then reviewed all care plans and NA care sheets to ensure the transfer status was accurate. This was completed on 01/09/2013. An audit of transfer documentation was completed for a 7 day look-back for all residents to identify anyone that is not being transferred as per the care plan. This was completed by DON, ADON and MDS Director on 01/10/2013. All reports of any incident and the 24-hour communication report sheets for the past 30 days have been reviewed to ensure Physician and Family of the resident were notified of any incidents with or without injury and any change in condition for the resident. This will be completed by 02/08/2013 by DON, ADON, and MDS staff. 3. Non-Licensed nursing staff were re-educated on the facility practice for using 2 people with all residents requiring a maxi lift transfer. They were also educated on the proper use of the lift and will perform a return demonstration to ensure competency on using the lift appropriately.	Completion by: 02/13/2013	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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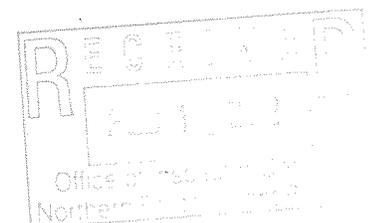
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F 323	<p>Continued From page 15</p> <p>The findings include:</p> <p>Review of the facility's "Policy on Lifting", not dated, revealed residents were to be transferred by the Maxi mechanical lifts only. The resident would be assessed for their transfer ability and it would be documented how they were to be transferred on the care plan and the nurse aide care plan. All staff would be in-serviced upon employment regarding the correct use of the lifts.</p> <p>Review of the facility's policy "Clinical Record Documentation Guidelines", dated 02/20/12, revealed a complete clinical record contains an accurate and functional representation of the experience of the resident and contains evidence of the effects of the care provided. Documentation should include response to treatment, change in condition and changes in treatment. The record should contain individual assessments, plan of care and services provided. In addition, the guidelines specified how to document assessments through observations of the resident related to signs and symptoms that may indicate an actual or a potential problem. It further specified what to document in relation to incidents, MD notifications, communication with the MD, family notification and any communication, any injuries, and any unusual occurrences.</p> <p>Review of the hospital's 12/30/12 admission History and Physical, revealed Resident #1, at the nursing facility, allegedly fell from a lift injuring his/her right leg approximately four days ago and had been complaining of pain when the resident was repositioned. The History and Physical also revealed Resident #1 had been bedfast for</p>	F 323	<p>This started on 01/07/2013 and will be completed on 02/07/2013. The Staff Development Coordinator is responsible for this process. Non-licensed nursing staff will be checked off with their annual review process as well to ensure continued competency. All newly hired non-licensed staff will be educated during orientation by the Staff Development Coordinator and will complete the skills check off within 60 days of employment and annually.</p> <p>Nursing staff are being re-educated on following the care plan and C.N.A plans of care. This will be completed by 02/08/2013 by Corporate Consultant, DON, ADON, and staff development. A post test was administered by the Corporate Consultant to nurses and by the DON, ADON, or Staff Development Coordinator to the non-licensed nursing staff to ensure understanding of the care plan process and following care plan.</p> <p>Licensed Nurses are being re-educated on the facility policy for notification of change, initiation and completion of the incident reporting process and investigative system, completion of the 24 hour report, and nursing documentation guidelines.</p>	Completion by: 02/13/2013	



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F 323	<p>Continued From page 16</p> <p>several months and the family had requested primarily palliative care over the past several months, with the resident's appetite poor and refusing food. Review of the X-ray report, dated 12/30/12, revealed a Comminuted Fracture of the Distal Right Femur.</p> <p>Review of the clinical record for Resident #1 revealed an admission date of 12/03/10, with diagnoses of Atrial Fibrillation, Heart Disease, Knee Joint Replacement, History of Falls, Mental Disorder, Hypertension, and Diabetes Mellitus. Review of the resident's 08/31/12 re-admission comprehensive Minimum Data Set (MDS) assessment and 12/01/12 quarterly MDS assessment revealed the resident was non-ambulatory and required maximum assist with activities of daily living, such as bathing, dressing and grooming. Resident #1's cognition status had been assessed on the 08/31/12 re-admission comprehensive MDS assessment with the Brief Interview for Mental Status (BIMS) cognitive score of 11 which was considered interviewable; however, review of the 12/01/12 quarterly MDS assessment revealed the resident's cognition BIMS score had declined to 4, which now classified the resident as not interviewable.</p> <p>Review of Resident #1's comprehensive plan of care and the CNA care plan, dated 09/03/12, revealed the resident required assist with Activities of Daily Living related to a recent hospitalization (Pacemaker Insertion) and general weakness, with an approach to transfer per Maxi-Lift with two assist.</p> <p>Interview with Resident #1, on 01/08/13 at 10:00</p>	F 323	<p>This includes notification to families and physicians when an incident occurs or a change in condition occurs. This education was presented by the Corporate Consultant and Director of Nursing on 01/28/2013. Education will continue 02/03-02/08/2013. Nurses will complete a post-test after the education to evaluate understanding. Tests will be reviewed by the Corporate Consultant and DON. This education will be repeated monthly for 3 months then annually. All newly hired licensed staff will be educated during orientation by the Staff Development Coordinator.</p> <p>The ADON attached signage to the maxi lift equipment reminding staff that the equipment requires 2 people to use it properly. This was completed on 01/31/2013.</p> <p>Licensed nursing staff will be re-educated by DON and ADON on how to complete a head to toe assessment and documenting in the medical record. Each nurse will be given a sample scenario and will be required to demonstrate appropriate documentation, to evaluate proficient knowledge. The DON and Corporate Consultant will review all sample documentation to determine areas that may require focused review and re-education. This will be completed by 02/08/2013.</p>	Completion by: 02/13/2013



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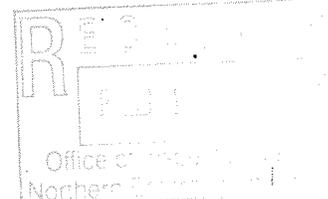
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F 323	<p>Continued From page 17</p> <p>AM, revealed the resident while being transferred with a lift, was dropped and his/her leg went under him/her. Resident #1 stated he/she hit the floor. The resident stated they did check him/her, and he/she kept complaining for days before anyone did anything. He/she stated, "I broke my knee". During the interview, Resident #1 pulled the sheet off his/her leg. Observation of the right knee revealed multiple staples positioned vertically along the center of the patella or knee cap, with three to four staples on each side of the patella, also vertically. The resident stated he/she had pain, but was receiving pain medication when requested.</p> <p>Review of the facility's investigation revealed that on 12/27/12, CMT #2 approached the Unit Manager and the 2nd Shift Supervisor #2, to inform them that she had walked into Resident #1's room where CNA #1 was transferring the resident in the Maxi-Lift alone. The CMT stated it appeared the resident was not positioned properly in the lift, she told CNA #1 she would assist in getting Resident #1 back in the bed. As the resident was being lowered in the bed, CMT #2 stated she heard a "snap". The investigation revealed the resident did not complain of pain at that time, and 2nd Shift Supervisor #2 entered the room and assessed the resident. The investigative report revealed the resident was not in distress at that time, and had no complaints of pain and physically appeared fine.</p> <p>Interview with the CMT #2, on 01/09/13 at 10:00 AM, revealed she had walked into the resident's room, on 12/27/12 around 4:45 PM, and observed CNA #1 transferring Resident #1 from the bed to the chair in the Maxi-Lift. The CMT</p>	F 323	<p>DON or Falls Management Team will review all reports of incidents & Appropriate investigation to ensure a root cause of the incident is identified & that appropriate intervention were/are put in place to aide in preventing the incident from occurring or re-occurring. Care Plans & C.N.A care plans will be reviewed following any incident to ensure communication of new interventions occurs. All incidents will be tracked & Trended for QA to ensure identification of trends related to day, time, unit, staff, equipment involved, ect. Each Resident is assessed for risk of falls, elopement & smoking on admission & no less than quarterly to identify risk areas & establish care plans related to ensuring the safety of each resident.</p> <p>4. The DON, ADON, or Unit Manager will observe a minimum of 5 transfers a day for 2 weeks, then 10 a week x4 weeks and then at least 10 per month x6 months and then will continue audits of a minimum of 10 transfers each quarter for 2 quarters to ensure staff are following the resident plan of care regarding transfer status, including using lift and following the practice for using 2 staff assist with a lift</p>	Completion by: 02/13/2013



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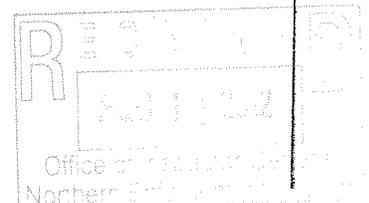
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F 323	<p>Continued From page 18</p> <p>stated Resident #1 was suspended in the air and positioned incorrectly on the resident's left side. The CMT stated she was afraid the resident was going to fall out of the lift, and told CNA #1 she would assist him in getting Resident #1 back to bed, so they could position the resident correctly in the lift. However, upon transfer back to the bed, CMT #2 heard a popping sound.</p> <p>Continued interview with CMT #2 revealed they returned Resident #1 to the bed, and did not get the resident up at that time, because they were not sure if the pop sound came from the resident or the lift. The CMT stated the resident's son was standing outside the door, but was not told about the incident at that time. CMT #2 stated she reported to the Shift Supervisor #2 and the Unit Manager #1 that something had happened during the transfer with Resident #1, they had heard a popping sound, and thought the resident should be checked out. In addition, CMT #2 stated the resident had sustained a skin tear during the transfer from the resident's watch and the watch had been pushed up under the skin. The CMT stated the resident did not complain of pain at the time of the incident.</p> <p>Interview with CNA #1, on 01/09/13 at 3:00 PM, revealed he had worked at the facility for one month and had received lift training during his orientation to the facility. CNA#1 stated the son of Resident #1 had asked him to get the resident up into the chair. CNA #1 stated he had placed Resident #1 on the lift pad, and attached the hooks to the lift; however, stated he was waiting for CMT #2 to come into the room to assist him with transferring the resident. CNA #1 denied the allegation that Resident #1 was suspended in the</p>	F 323	<p>DON will also review transfer documentation weekly for 4 weeks then one unit per week for 3 months then will include a transfer audit as part of the quarterly QA audit program. Quarterly DON will audit no less than two weeks of transfer documentation for each unit. This audit will check to see that documentation of resident transfers matches the resident care plan & identify staff who may require re-education. The ADON or DON will audit assessment documentation using the 24 hour report and incident reports to identify residents. They will review 5 records a week x4 weeks, then 10 records a month x9months.</p> <p>ADON and DON will review documentation of all resident assessments (identified by reviewing the reports of incidents, and the 24 hours report) weekly for 4 weeks, then minimum of 5 per week for 4 weeks then 10 per month for 6 months then no less than 10 per quarter. Results of these reviews will be used to determine need for re-education.</p>	Completion by: 02/13/2013	



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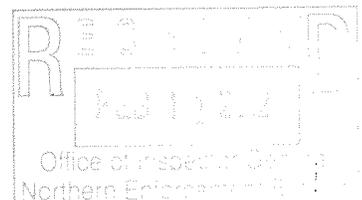
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F 323	<p>Continued From page 19</p> <p>air when the CMT came into the room. CNA #1 stated CMT #2 told him when she came into the room the resident was not positioned in the sling correctly, then grabbed the residents leg, trying to reposition the resident and caused the leg to snap. CNA #1 stated the policy was for two people to use the lift, and his CNA care plan sheet stated that the resident required two people for lift transfers.</p> <p>Interview with Unit Manager #1, on 01/09/13 at 1:05 PM; revealed that between 5:30-6:30 PM on 12/27/12, CMT #2 reported to her and Shift Supervisor #2 that she observed CNA #1 transferring Resident #1 incorrectly with one person and the resident was lying "crooked" in the lift. The Unit Manager stated CMT #2 stated she thought she heard a pop sound when transferring Resident #1 per lift back to the bed. She also stated CMT #2 was very upset because she had walked into the room to check on CNA #1. CMT #2 stated Resident #1's son, who was standing outside the door, had requested her to check on the resident because CNA #1 had been in the room for a long time. The Unit Manager stated the Shift Supervisor went to assess the resident because she already had her coat on and was leaving for the day.</p> <p>Interview with Shift Supervisor #2, on 01/09/13 at 3:30 PM, revealed CMT #2 had reported to her, on 12/27/12 around 6:00 PM, that she had observed CNA #1 using the Maxi-Lift without the assist of two people, and observed Resident #1 suspended in the lift off the bed. The shift supervisor stated she was told by the CMT upon returning the resident to the bed, there was a popping sound, and said something might have</p>	F 323	<p>The DON or ADON will audit all incidents reported, using the incident reporting procedure and the 24 hours communication tool, to ensure notification was made to the physician and family was documented in the clinical record weekly for the next 3 months. DON or ADON will audit 25% of the incident reports monthly thereafter to ensure continued compliance.</p> <p>All Audits, reviews and observations will be reported to the QA committee no less than quarterly for one year. Based on review of all audits, reviews & observations presented, the facility QA Committee may recommend additional education, audits, or changes in policy to ensure POC is implemented & effective in ensuring continued compliance. All QA actions will be recorded in the QA minutes.</p>	Completion by: 02/13/2013



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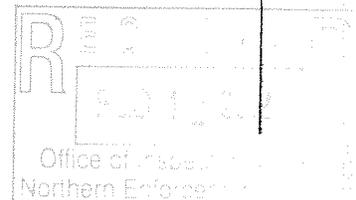
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F 323	<p>Continued From page 20</p> <p>happened with Resident #1. The Shift Supervisor stated she assessed the resident and looked for bruising, swelling, pain, and deformity, and at the time did not see any evidence of injury. The Shift Supervisor asked the resident if he/she was having pain, and the resident stated "no".</p> <p>Continued interview with the Shift Supervisor, on 01/09/13 at 3:30 PM, revealed CMT #2 reported to her later in the shift that when turning Resident #1, the resident said "oh". The Shift Supervisor went back to the re-assess the resident and still didn't see anything. Shift Supervisor #2 stated she was responsible for assessing, reporting, and initiating any investigations. She also stated she was responsible for completing a night report which was turned in to the Director of Nursing at the end of each shift. The Shift Supervisor stated she did not put the incident on the night report, because she didn't associate the resident's pain on turning with anything, just maybe arthritis. The Shift Supervisor also revealed the assessment was not documented in the nurse's notes, nor was there an incident report completed for the incident, or family and physician notified. Looking back, the shift supervisor stated the incident and assessment should have been documented.</p> <p>Interview with CNA #5, on 01/09/13 at 9:30 AM, revealed she was responsible for the care of Resident #1, on 12/28/12, from 7:00 AM-2:30 PM, and had noted that when turning the resident toward the window at 1:30 PM, the resident said "Oh!". The CNA stated the resident's leg was very tight and she reported this to LPN #4.</p> <p>Interview with LPN #4, on 01/09/13 at 2:00 PM, who took care of Resident #1, on 12/28/12 on the</p>	F 323			



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

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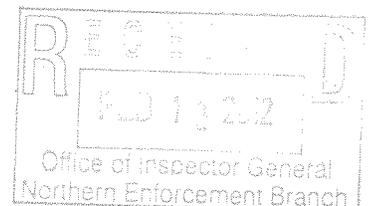
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F 323	<p>Continued From page 21</p> <p>day shift, revealed CNA #5 called her to the resident's room around 2:00 PM to look at his/her leg. LPN #4 stated her assessment revealed the right leg looked tight and swollen, and the resident said he/she had fallen out of the lift when they weighed him/her, and the girl came in and dropped him/her. LPN #4 stated the resident could not identify any specific staff, so she called the ADON to come and assess the resident also. LPN #4 stated she did not document the assessment or the resident's pain in the clinical record that day, but should have done so, since the nurses were primarily responsible for documenting.</p> <p>Interview with the ADON, on 01/08/12 at 4:45 PM, revealed she was asked by CNA #5 and LPN #4 to assess Resident #1's leg, because the resident said "Ouch!" and his/her leg hurt when moved. Upon assessment, the ADON stated there were no abnormalities, but the leg looked tight or cramped, like a muscle spasm. The ADON stated the resident's son was visiting, and he was informed the resident's leg was hurting, like a muscle spasm, and a nursing intervention of warm compresses had been applied.</p> <p>However, record review revealed there was no documented evidence of the assessment by the ADON of the resident's pain nor physician notification of the resident's pain on movement. In addition, there was no evidence the resident's pain had been reported to the resident's POA (son). Further interview with the ADON revealed she was not aware of the 12/27/12 incident at that time, since it had not been documented or passed on during shift report.</p>	F 323			



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

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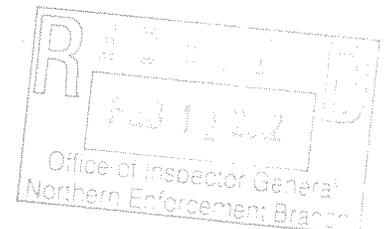
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F 323	<p>Continued From page 22</p> <p>Interview, on 01/09/13 at 2:45 PM, with LPN #3 who worked the evening shift on 12/28/12, revealed she received the shift report that Resident #1 had been complaining of leg pain, and was stating he/she had been dropped from the Maxi-Lift while being weighed the day before. However, the LPN stated after speaking with the two CNAs who had weighed him/her, CNAs #3 and #4, it was determined there had been no incident with Resident #1 during the 12/27/12 day shift weight with the Maxi-Lift. Interview with LPN #3 revealed she reported this to the next shift; however, there was no evidence the LPN had documented her assessment of the resident's pain, completed an incident report, or notified the physician or family.</p> <p>Continued interview with LPN #3, who worked from 3:00-7:00 PM on 12/29/12, revealed she received no reports of pain from Resident #1 in the previous shift report; however, stated when she and LPN #5 tried to turn and reposition him/her at 6:00 PM, the resident said "Ouch!". LPN #3 stated when they assessed the resident's leg, it looked swollen above the knee, and when they lifted the leg, the resident did not complain of pain; however, the appearance had not changed from 12/28/12. Although interview revealed that LPN #3 reported the resident's pain upon movement to the night shift nurse LPN #6, LPN #3 failed to document the assessment, notify the physician, or the resident's family. The LPN stated she was unaware of the incident which had occurred with the lift on 12/27/12 at that time.</p> <p>Attempted interview with LPN #6, on 12/29/12 at 3:00 PM, was unsuccessful with no return call as of 01/10/13.</p>	F 323		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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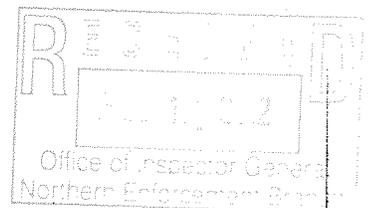
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F 323	Continued From page 23 Review of the nurse's notes, on 12/30/12 at 1:00 AM, revealed the night shift nurse LPN #6 documented the resident complaints of pain to the right upper thigh, and the physician was notified with an X-ray ordered to rule out a fracture. The nurse's note revealed the resident stated he/she "fell yesterday when being weighed in the lift, and his/her leg bent back". The record also revealed the resident was unable to verify any staff caring for him/her, and the portable X-ray service was notified at 1:00 AM. Pain medication (Tylenol 500 mg 2 tablets) was given at 1:00 AM for right leg pain with relief. The pain medication was offered again at 7:30 AM to the resident; however, the resident refused the medication. Review of the nurses notes, at 6:30 AM on 12/30/12, revealed the X-ray service had not arrived, so the facility paged them again. The nurses notes stated the service was called several times throughout the day, and was told they were on their way. A late entry in the nurse's note, on 12/30/12 at 2:45 PM, revealed the nurse noticed a deformity to the right thigh with the right leg turned in. The supervisor and physician was notified with new physician orders to transfer the resident to the hospital at that time. However, when the family was notified, they did not want the resident sent to the hospital until the results of the x-ray had been obtained, due to the resident being on comfort measures only. Review of the 4:00 PM nurses notes revealed the X-ray service arrived and completed the x-ray. Review of the 4:45 PM nurses notes revealed the results of the X-ray confirmed a Comminuted Fracture of the Distal Right Femur. The power of attorney (POA)	F 323			



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

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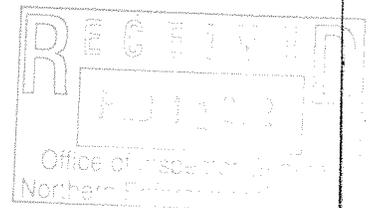
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F 323	<p>Continued From page 24</p> <p>was notified, and the resident was transferred to the hospital. The resident required surgical intervention for the Fractured Femur.</p> <p>Interview with LPN #5, on 01/09/13 at 2:30 PM, revealed she cared for Resident #1 on 12/30/12 during the day shift, and revealed throughout the day the resident complained of pain on turning, The LPN revealed around 2:00-2:30 PM, she noted a movement in his/her leg with rotation and notified the weekend supervisor Registered Nurse (RN) #1. LPN #5 stated they obtained an order at that time to go ahead and send the resident to the hospital; however, the family refused to allow transfer until the X-ray had been obtained. The LPN revealed the incident on 12/27/12 had not been noted on the 24 hour report, nor documented in the nurse's note until 12/30/12 at 1:00 AM.</p> <p>Interview with Resident #1's Power of Attorney (POA), on 01/09/13 at 1:10 PM, revealed he was not called about the incident with the lift until 12/30/12, and did not want the resident to be transferred until the x-ray results were obtained. The POA stated the facility told him on 12/29/12, they were putting hot compresses on the resident's leg for pain, but did not inform him of anything else. He had not seen or heard about an incident report. The POA stated the resident required rods and a number of screws in the fractured leg, "pretty serious stuff".</p> <p>Interview with the Director of Nursing (DON), on 01/08/13 at 10:20 AM, revealed she had not been notified of the 12/27/12 incident until, 1:00 AM on 12/30/12, when the night shift LPN #6 called her. Interview with the DON revealed all the</p>	F 323			



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

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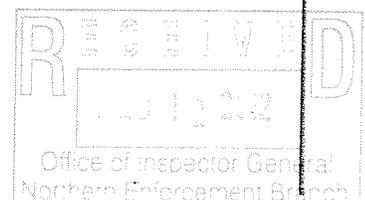
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F 323	Continued From page 25 mechanical lifts had been checked by the maintenance department on 12/31/12 with no mechanical problems found with Resident #1's lift. The DON stated she investigated the incident on Monday 12/31/12 when she returned to work and was sure there was going to be documentation of each assessment in the clinical record and there was not. Interview with the DON, on 01/10/13 at 1:30 PM, revealed during the investigation they found there had been no incident report completed initially, nor family or physician notified of the incident until 12/30/12. In addition, there was no documentation on the facility 24 hour shift report, or assessment documentation by LPN # 3, #4, #5 and the Assistant Director of Nursing. The Director of Nursing stated that although assessments had been completed for Resident #1 by the nurses, this did not meet the facility expectation. Interview with the Administrator, on 01/10/12 at 1:30 PM, revealed the incident could have been prevented with better communication with the staff and incident reporting passed on during the shift reports. The Administrator revealed the facility expectation would have been to call the physician and family initially, on 12/27/12, and to have all assessments documented and communicated to the next shifts. The Administrator also stated he would have expected an incident report completed at the time of the incident. The Administrator stated the lack of assessment documentation and reporting was unacceptable.	F 323			
F 514 SS=G	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB	F 514			



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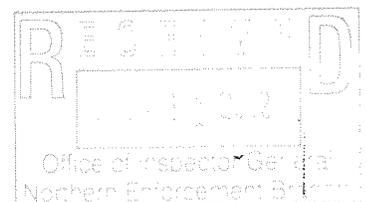
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F 514	Continued From page 26 LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility policy and procedures and investigation, it was determined the facility failed to document multiple assessments completed by licensed nurses for one (1) of four (4) sampled residents (Resident #1). After Resident #1 sustained a Right Comminuted Femur Fracture during an incorrect transfer with the Maxi-Lift, on 12/27/12, the resident was assessed by the Shift Supervisor #2; however, the Supervisor failed to document the assessment in the clinical record or complete necessary documentation related to the incident. Further nursing assessments by Licensed Practical Nurse (LPN) #4, #3, #6, and the Assistant Director of Nursing for Resident #1, completed 12/28 through 12/29/12, revealed no evidence the assessments had been documented in the resident's record. The facility's failure to record and document the resident's condition	F 514	F-514 1. As part of the investigation into the incident involving Resident #1 on 12/27/2012 a report of the incident was completed on 12/30/2012. Shift Supervisor #2 has provided a written report including the assessment of the resident following the incident. LPN #4 has provided her statement related to her care of the resident on 01/28/2013. The ADON also provided documentation of her assessment of the resident on 01/28/2013. LPN #3 provided documentation of her observations and assessment of the resident from 12/29/2012. These statements and documentation have been incorporated into the investigation, and were completed on 01/31/2013. 2. All reports of any incident and the 24 hour communication report sheets for the past 30 days have been reviewed to ensure the Physician and family of the resident were notified of any incidents with or without injury and any change in condition for the resident. This will be completed by 02/08/2013 by DON, ADON and MDS Staff.	Completion by: 02/13/2013	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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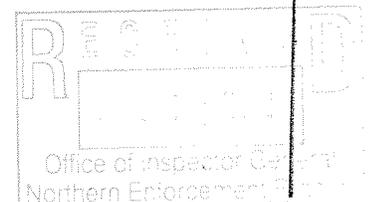
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F 514	<p>Continued From page 27</p> <p>delayed emergency treatment, causing Actual Harm to the resident.</p> <p>Refer to F323, F157, F282.</p> <p>The findings include:</p> <p>Review of the facility's policy "Clinical Record Documentation Guidelines", dated 02/20/12, revealed a complete clinical record contains an accurate and functional representation of the experience of the resident in the facility and contains evidence of the effects of the care provided. Documentation should provide a picture of the resident's progress, including response to treatment, change in condition and changes in treatment. The record should contain sufficient information to identify the resident, individual assessments, plan of care and services provided. How to Document: Assessment, observations of the resident for signs and symptoms that may indicate actual or potential problems. What to Document: Incidents, MD notifications, Communication with MD, Family Notification and Communication, Injuries, and Unusual occurrences.</p> <p>Review of the facility's investigation by the Director of Nursing, initiated on 12/30/12, revealed CMT #2 approached Unit Manager #1 and 2nd Shift Supervisor #2 to inform them she had walked into Resident #1's room where CNAs #1 was transferring the resident in the Maxi-Lift alone. The CMT stated it appeared the resident was not positioned properly in the lift and she assisted CNAs #1 in getting Resident #1 in the bed. As the resident was being lowered in the bed, CMT #2 stated she heard a "snap". The</p>	F 514	<p>DON. ADON and MDS staff will review clinical documentation related to each reported incident to ensure appropriate assessment of the resident was completed. This will be completed by 02/08/2013.</p> <p>3. Education was provided by the Corporate Consultant or DON to licensed nursing staff (LPN's and RN's). Education included the facility policy on clinical record documentation. A post test was given to nurses. They were reviewed by Corporate Consultant and DON to determine understanding. This was started on 01/28/2013 and will be complete by 02/08/2013.</p> <p>Licensed nurses will be re-educated on the facility policy for notification of change, initiation and completion of the incident reporting process and investigation system, completion of 24 hour report, and nursing documentation guidelines. This includes notification to families and physicians when and incident occurs or a change in condition occurs. This education was presented by the Corporate Consultant and Director of Nursing on 01/28/2013 and will also be conducted 02/03-02/07/2013. All nurses will complete a post-test after the</p>	Completion by: 02/13/2013	



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PRINTED: 01/23/2013
FORM APPROVED
OMB NO. 0938-0391

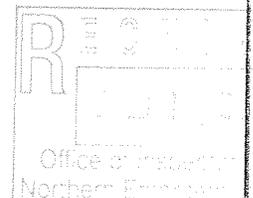
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/10/2013
NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160		
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F 514	<p>Continued From page 28</p> <p>investigation revealed the resident did not complain of pain at that time, and 2nd Shift Supervisor #2 entered the room and assessed the resident. The report stated at that time, the resident was not in distress, and had no complaints of pain and physically appeared fine.</p> <p>Interview with Resident #1, on 01/08/13 at 10:00 AM, revealed while being transferred with a lift, they dropped him/her and his/her leg went under him/her. Resident #1 stated he/she hit the floor. The resident stated they did check him/her, and he/she kept complaining for days before anyone did anything. He/she stated, "I broke my knee".</p> <p>Interview with Shift Supervisor #2, on 01/09/13 at 3:30 PM, revealed she was responsible for assessing, reporting, and initiating any investigations. She also stated she was responsible for completing a night report which was turned in to the Director of Nursing at the end of each shift. The Shift Supervisor stated she did not put the incident on the night report, because she didn't associate the resident's pain on turning with anything, just maybe arthritis. The Shift Supervisor also revealed the assessment was not documented in the nurse's notes, nor was there an incident report completed for the incident, or family and physician notified. Shift Supervisor #2 revealed she did not ask the resident what happened, only if he/she was in pain. The Supervisor stated she did not document her assessment of the resident, complete an incident report, or put the incident on the 24 hour report, because she did not see any evidence of injury.</p> <p>Interview with LPN #4, on 01/09/13 at 2:00 PM, who took care of Resident #1, on 12/28/12 on the</p>	F 514	<p>Education to evaluate understanding. Tests reviewed by the Corporate Consultant and DON. This education will be repeated monthly for 3 months then annually. All newly hired licensed staff will be educated during orientation by the Staff Development Coordinator.</p> <p>Licensed nursing staff are being re-educated by DON, ADON and Staff Development on how to complete a head to toe assessment and documenting in the medical record. Each nurse will be given a sample scenario and will be required to demonstrate how to document to evaluate proficient knowledge. The DON and Corporate Consultant will review all sample documentation to determine areas that may require focused review and re-education. This will be completed by 02/08/2013.</p> <p>4. The DON and ADON will audit all incidents reported, using the incident reporting procedure and the 24-hour communication tool, to ensure notification was made to the physician and family and was documented in the clinical record, and that a clinical assessment of the resident is completed and documented. This will be audited</p>	Completion by: 02/13/2013	



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F 514	<p>Continued From page 29</p> <p>day shift, revealed she did not document the assessment or the resident's pain in the clinical record that day, but should have done so, since the nurses were primarily responsible for documenting, nor did she complete an incident report.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 01/08/12 at 4:45 PM, revealed upon assessment, the ADON stated there were no abnormalities, but the leg looked tight or cramped, like a muscle spasm. However, there was no evidence the assessment completed by the ADON had been documented in the nurse's notes, nor physician notified of the resident's pain on movement. Further interview with the ADON revealed she was not aware of the 12/27/12 incident at that time, since it had not been documented or passed on during shift report and would have looked at the issue differently if known.</p> <p>Interview, on 01/09/13 at 2:45 PM, with the evening shift LPN #3, revealed she had passed this information to the next shift; however, there was no evidence LPN #3 had documented her assessment of the resident's pain, completed an incident report, or notified the physician or family.</p> <p>Continued interview with LPN #3, who worked from 3:00 PM-7:00 PM, on 12/29/12 revealed she received no reports of pain from Resident #1 in the previous shift report. Although interview revealed LPN #3 reported the resident's pain upon movement to the night shift nurse LPN #6, LPN #3 failed to document the assessment, notify the physician, or the resident's family. LPN #3 stated she was unaware of the incident which had</p>	F 514	<p>Don or ADON will audit 25% of the incident reports monthly thereafter to ensure continued compliance.</p> <p>ADON and DON will review documentation of all resident assessments (identified by reviewing the reports of incidents, and the 24-hour report) weekly for 4 weeks, then a minimum of 5 per week for 4 weeks then 10 per month. Results of these reviews will be used to determine need for re-education.</p> <p>Corporate Consultant will review audits of clinical documentation, and review all reported incidents for 3 months. She will continue audits/reviews of 25% quarterly to ensure the incident is documented sufficiently in the clinical record and meets policy guidelines.</p> <p>All reviews, audits, observations will be reported to the facility QA Committee no less than quarterly for one year. Based on review of all audits, reviews & observations presented, the facility QA Committee may recommend additional education, audits or changes in policy to ensure the POC is implemented & effective in ensuring</p>		

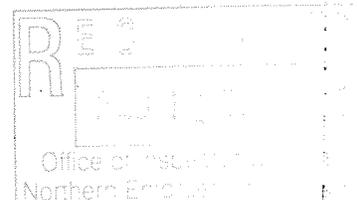


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NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160		
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F 514	<p>Continued From page 30</p> <p>occurred with the lift on 12/27/12 at that time; however, should have documented the assessment and notified the physician and family.</p> <p>Interview with LPN #5, on 01/09/13 at 2:30 PM, revealed the incident had not been noted on the 24 hour report, nor documented in the nurse's note until 12/30/12 at 1:00 AM.</p> <p>Interview with the Director of Nursing (DON), on 01/08/13 at 10:20 AM, revealed she believed the assessment documentation would be present in the clinical record; however, it was not. The DON stated that during the investigation they found that there had been no incident report completed initially, nor family or physician notification of the incident until 12/30/12. In addition, there was no documentation on the facility 24 hour shift report, or assessment documentation by each nurse's assessment in Resident #1's record. The Director of Nursing stated this did not meet the facility expectation.</p> <p>Interview with the Administrator, on 01/10/12 at 1:30 PM, revealed the incident should have been documented and passed on during the shift reports. The Administrator stated the lack of assessment documentation was unacceptable.</p>	F 514	<p>Accurate documentation. All QA actions will be recorded in the QA Minutes.</p>		

Completion by:
02/13/2013



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NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160
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{F 000}	<p>INITIAL COMMENTS</p> <p>A follow-up/revisit survey was conducted on 02/19/13 and found the facility had met all the requirements in the Plan of Correction to bring the facility back in compliance.</p>	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.