

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

2nd SCD

PRINTED: 10/05/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185434	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/26/2015
NAME OF PROVIDER OR SUPPLIER THE HERITAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 191 BACON CREEK ROAD CORBIN, KY 40702		
(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	INITIAL COMMENTS An abbreviated survey (KY23729) was initiated on 08/25/15 and concluded on 08/26/15. The complaint was substantiated with deficient practice identified at "D" level.	F 000	The Heritage Nursing Facility does not believe and does not admit any deficiencies existed, either before, during or after the survey. The Heritage Nursing facility reserves the right to contest the survey findings through informal dispute resolution, formal legal appeal proceedings or any administrative or legal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds, nor is meant to establish any standard of care, contract obligation or position and The Heritage Nursing Facility reserves the right to raise all possible contentions and defenses in any type of civil or criminal claims, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self-critical examination privileges which The Heritage Nursing Facility does not waive, and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Heritage Nursing Facility offers the responses, credible allegations of compliance and plan of correction as part of its ongoing effort to provide quality care to its residents. It is and always has been the policy of The Heritage to notify the physician of	
F 157 SS=D	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 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. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		

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

Cathy Wells

TITLE

Administrator

(X6) DATE

10-8-16

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 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview, record review, facility policy review, and review of the facility investigation it was determined the facility failed to notify the physician of the need to alter treatment and the presence of acute pain for one (1) of three (3) sampled residents (Resident #1). On 08/14/15, Resident #1 had a physician order to obtain x-rays of the resident's right hip and right knee; however, the x-rays were not obtained until 08/15/15 and the facility failed to notify the physician of the delay. The resident was observed by staff to be experiencing pain from 08/14/15 until 08/16/15; however, the facility failed to notify the physician of the episodes of acute pain. The findings include: Review of the facility policy titled "Change in a Resident's Condition," dated 08/01/13, revealed the Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been a significant change in the resident's physical/emotional/mental condition; a need to alter the resident's medical treatment significantly; or a need to transfer the resident to a hospital/treatment center. Review of the facility's "Pain Protocol," date unknown, revealed communication to the physician, when pain was not controlled, would occur to collaborate for the resident to find the best way to change treatments and plan of care.	F 157	the need to alter treatment and of the presence of acute pain. 1. Resident #1 has returned from a brief hospital stay. Geriatric pain scale has been implemented and she is assessed for pain every shift and prn. Her physician and her responsible party have been notified when an alteration in treatment is warranted. 2. All residents are assigned an appropriate method for communicating and/or assessing pain. When a resident's pain is not controlled, the attending physician is notified and new interventions put into place. The responsible party is notified and the care plan is updated accordingly. Mobile diagnostic services for x-ray are obtained in a reasonable amount of time, 4-6 hours. If unavailable within that time, the physician will be notified and new order to obtain the x-ray at the hospital will be requested. The responsible party will be notified of any change. Residents have been assessed to ensure that each diagnostic test ordered has been completed in a timely manner and that all symptoms of pain		

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F 157	<p>Continued From page 2</p> <p>Review of the facility policy titled "Diagnostic Services: Availability," dated 08/01/13, revealed radiologic services were available twenty-four (24) hours a day, seven (7) days a week, including holidays.</p> <p>Review of a facility investigation revealed Resident #1's right knee appeared swollen on 08/14/15, the physician was notified, and the facility received an order for x-rays of the resident's right knee and right hip. Further review revealed the initial x-rays did not indicate a fracture. The resident's family member requested the resident be sent to the Emergency Room for further evaluation on 08/16/15. A second x-ray of the resident's right knee was obtained at the hospital and revealed a distal femur (bone in the upper leg) fracture.</p> <p>Medical record review for Resident #1 revealed the facility originally admitted the resident on 05/08/12 with diagnoses that include Cerebrovascular Accident (Stroke), Expressive Aphasia, and Right Hemiplegia. Review of the quarterly Minimum Data Set (MDS) assessment, dated 06/17/15, revealed the facility assessed the resident to have modified independent cognition, indicating the resident may experience difficulty in new situations. The facility further assessed the resident to be able to normally recall the location of his/her room, staff names and faces, as well as being in a nursing home. Further review revealed the resident was assessed to require extensive assistance with bed mobility and experience impairment on one side of his/her upper and lower extremities. The MDS assessment of pain indicated no signs were observed of the resident experiencing pain during the assessment</p>	F 157	<p>has been appropriately addressed.</p> <ol style="list-style-type: none"> 3. Nursing staff has received inservice, on 09/04/15 training by the Director of Nursing concerning identifying pain and responding appropriately, obtaining diagnostic services timely and physician and responsible party notification. 4. As part of the facility Quality Assurance, for the next 6 months the Director of Nursing will monitor all orders for diagnostic services to ensure timeliness. Additionally, we will review 5% of pain assessments each month to ensure that the physician of a resident who is assessed as having acute pain, has been contacted, new order received for alteration of treatment and notification of Responsible Party. 5. Completion date: 09/27/15 		

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F 157	<p>Continued From page 3</p> <p>look-back period. Review of the comprehensive care plan, dated 03/30/15, revealed the resident was at risk for alteration in comfort with interventions to anticipate the resident's need for pain relief and respond immediately, notify the physician if interventions were unsuccessful, observe and report changes or resistance of care, and observe for nonverbal signs and symptoms of pain.</p> <p>Review of Resident #1's Medication Administration Record (MAR) for August 2015 revealed per the Geriatric Pain Scale the resident was assessed to not experience pain from 08/13/15 through 08/16/15. Further review of the August 2015 MAR revealed the resident received a dose of Tylenol (pain reliever) 500 milligrams (mg) by mouth on 08/14/15 at 9:30 AM and a second dose at 8:00 PM. Further review of the MAR revealed the resident received Ativan (anti-anxiety medication) 0.5 mg by mouth on 08/13/15 at 8:00 PM and on 08/14/15 at 9:30 AM and 8:00 PM. The resident also received Ativan 1 mg by injection on 08/13/15 at 9:20 PM.</p> <p>Review of the nurse's notes dated 08/14/15 at 9:30 AM, revealed Licensed Practical Nurse (LPN) #2 was called to Resident #1's room, the resident had complaints of right knee pain, and the right knee was found to be swollen. The resident's nurse practitioner was notified and an order was obtained for x-rays of the resident's right hip and knee. Nurse's notes dated 08/14/15 at 10:00 AM, revealed the x-ray order was called to the mobile x-ray company utilized by the facility. Further review of the nurse's notes revealed the x-rays were not completed until 08/15/15 at 12:00 PM; however, there was no documentation that the physician was notified of</p>	F 157		

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F 157	<p>Continued From page 4</p> <p>the delay. Further review of the nurse's notes revealed the results of the x-rays were not received until 08/15/15 at 6:00 PM, at which time the physician was notified of the results. A late entry nurse's note for 08/15/15 at 10:00 PM revealed the resident had no signs or symptoms of pain at that time. No further documentation was noted in the nurse's notes until 08/16/15 at 6:00 PM. At the time, the nurse's note stated the resident's family requested the resident be sent to the Emergency Room for further evaluation of his/her right hip and knee. The note also stated the resident appeared to be in pain at that time.</p> <p>Review of the hospital History and Physical, dated 08/17/15, revealed the resident's family had expressed the resident was experiencing severe right hip pain on 08/14/15 and due to continued pain the resident was sent to the Emergency Room on 08/16/15. The resident was evaluated in the Emergency Room and noted to have a right distal femoral fracture. The History and Physical stated that the family expressed the resident had significant pain during most of the day on 08/15/15 and 08/16/15.</p> <p>Interview with the mobile x-ray Technician on 08/25/15 at 5:02 PM revealed Resident #1's x-rays were not completed on 08/14/15 as ordered due to the technician being "swamped." The Technician stated she did not notify the facility the x-rays would not be obtained on 08/14/15.</p> <p>Interview with the resident's Family Member on 08/25/15 at 3:13 PM revealed the resident's right knee was swollen and the resident had complaints of pain on 08/14/15 in the morning. The Family Member stated when the resident's</p>	F 157			

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F 157	<p>Continued From page 5</p> <p>bed was bumped, the resident would "panic." The Family Member stated he felt he should have been notified that the x-rays were not completed on 08/14/15 as ordered. He further stated he would have expected other arrangements to be made when the x-rays were not completed as ordered. Further interview with the Family Member revealed the resident continued to experience pain on 08/15/15 and was in "visible pain" on 08/16/15. The Family Member stated the resident would "scream" if facility staff came in the resident's room to provide care. Further interview with the Family Member on 08/26/15 at 12:43 PM revealed the facility did not offer to send the resident to the Emergency Room during the time of 08/14/15 through 08/16/15 until the Family Member requested the resident be sent to the hospital. The Family Member also stated the facility did not approach him or the resident about obtaining an order for pain medication and "only gave Tylenol they had on hand."</p> <p>Interviews with Licensed Practical Nurse (LPN) #1 on 08/25/15 at 3:31 PM, and Certified Nurse Assistant (CNA) #2 on 08/25/15 at 6:28 PM revealed both staff members were aware the resident appeared to be in pain and was resistant of care on the night of 08/13/15. The resident was observed by CNA #2 to "pull the covers up and wouldn't let you get close."</p> <p>Interview with LPN #2 on 08/25/15 at 4:16 PM revealed the resident was crying and right knee swelling was noted on the morning of 08/14/15. Further interview with the LPN revealed she notified the physician and an order for the right knee and hip x-ray was received and the mobile x-ray company was notified. The LPN stated the x-ray was not completed during her shift but it</p>	F 157			

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F 157	<p>Continued From page 6</p> <p>was common for the mobile x-rays to be done during the late evening or night.</p> <p>Interviews with CNA #2 on 08/25/15 at 6:28 PM and LPN #4 on 08/26/15 at 3:00 PM revealed they were responsible for the resident's care on the night of 08/14/15 from 7:00 PM to 7:00 AM. CNA #2 stated the resident was observed to refuse care and would "yell and scream" when care was provided. The LPN stated she was aware the resident had x-ray orders from the previous shift and that the resident had been assessed to have a swollen right knee. The LPN stated she was aware the resident was refusing care and crying; however, she "could not say" the resident was in pain. Further interview with LPN #4 revealed the physician was not notified of the delayed x-ray or resident's behaviors, or to address pain medication, because she was not sure the resident was actually having pain.</p> <p>Interview with CNA #8 on 08/26/15 at 2:49 PM revealed the resident was resistant to care and guarding his/her right leg on the night of 08/15/15. Further interview revealed the CNA was told in shift change report the resident had been experiencing pain. The CNA stated the nurse was aware of the resident's behaviors and that the resident appeared to be in pain.</p> <p>Interviews with CNA #1 on 08/25/15 at 2:57 PM and LPN #3 on 08/25/15 at 4:47 PM revealed the resident appeared to be in pain during the days of 08/15/15 and 08/16/15. LPN #3 stated he asked the resident if he/she wanted the physician called regarding pain but the resident stated "no." Further interview with the LPN revealed the resident "seemed" to be in pain and the resident would "yell out" during care; however, he did not</p>	F 157			

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F 157	Continued From page 7 feel the resident's pain was worsening and therefore did not notify the physician. The LPN stated he did not notify the physician on 08/15/15 of the resident's pain nor the delay in the x-ray. The LPN notified the physician on 08/16/15 per the resident's family request that the resident be sent to the Emergency Room for further evaluation. Interview with Resident #1's Physician on 08/26/15 at 11:13 AM revealed he was not made aware the resident had experienced pain from 08/14/15 thru 08/16/15. Further interview revealed if the Physician had been made aware the resident did not have the x-ray completed on 08/14/15 and was experiencing continued pain he would have instructed the facility to send the resident to the hospital. Interview with the Director of Nursing (DON) on 08/26/15 at 3:46 PM revealed Resident #1's physician should have been notified of the resident's pain and the delayed x-ray. Interview with the Administrator on 08/26/15 at 4:20 PM revealed facility staff should have called the mobile x-ray company when the x-rays were not completed on 08/14/15 as ordered and determined the cause for delay or obtained a physician order to send the resident to the hospital. Further interview revealed if facility staff was aware the resident appeared to be in pain, they should have notified the physician.	F 157		
F 282 SS=D	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	F 282	It is and always has been the policy of The Heritage to ensure that residents are provided required assistance	

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F 282	<p>Continued From page 8</p> <p>accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review it was determined the facility failed to ensure one (1) of three (3) sampled residents (Resident #1) was provided required assistance during transfers in accordance with the resident's written plan of care. Interviews with facility staff revealed Resident #1 was routinely transferred with the assistance of one (1) staff person; however, the resident's written plan of care directed staff to assist Resident #1 with two people during transfers.</p> <p>The findings include:</p> <p>Review of facility procedure titled "Transferring the Non-Ambulatory Resident from Wheelchair to Bed," date unknown, revealed the first step was to ask another staff member for help with the transfer. The procedure directed staff to "lock arms" with the resident prior to the transfer.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator on 08/25/15 at 3:52 PM revealed the facility had no policy related to care plan development; however, she stated she utilized the MDS manual for completing comprehensive care plans for residents.</p> <p>Review of the MDS 3.0 manual revealed when selecting interventions and planning care for residents the individual resident's response to interventions and treatments should be evaluated and adjustments made as needed.</p>	F 282	<p>during transfers in accordance with the resident's written plan of care.</p> <ol style="list-style-type: none"> 1. Resident #1 has been re-assessed and determined to continue to require 2 person assist for transfers. Staff is aware that there are to always be 2 persons conducting the transfers of Resident #1. The resident and Responsible Party have been informed that, for the resident's safety, there will always be 2 persons transferring the resident. The care plan has been reviewed and verified that 2 person transfer is the required transfer for Resident #1. 2. All residents are assessed quarterly for safest method of performing transfers. Once determined, the method is documented on the care plan, which is reviewed by the attending physician and developed in cooperation with the resident and responsible party. Residents have been assessed to ensure that the individualized plan of care has addressed the level of assistance needed and that 		

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F 282	<p>Continued From page 9</p> <p>Review of the facility policy titled "Nurse Aide Care Plan Kardex Protocol," date unknown, revealed the Nurse Aide Care Plan Kardex will contain information on the level of assistance required by staff to provide the resident's Activities of Daily Living (ADL), mobility, feeding, toileting, and general care. The protocol stated the Nurse Aide Care Plan Kardex would be updated to reflect the resident's current status as the resident experienced changes in status. The protocol further stated that Nurse Aides were responsible to view and utilize the Care Plan Kardex.</p> <p>Medical record review for Resident #1 revealed the facility originally admitted the resident on 05/08/12 with diagnoses that include Cerebrovascular Accident (Stroke), Expressive Aphasia, and Right Hemiplegia. Review of the quarterly Minimum Data Set (MDS) assessment, dated 06/17/15, revealed the facility assessed the resident to have modified independent cognition, indicating the resident may experience difficulty in new situations. The facility further assessed the resident to be able to normally recall the location of his/her room, staff names and faces, as well as being in a nursing home. Further review revealed the resident was assessed to require extensive assistance with bed mobility and experience impairment on one side of his/her upper and lower extremities. The assessment did not reveal the amount of assistance the resident required during transfer as the assessment stated the activity of transferring did not occur during the assessment period. Review of the comprehensive care plan, dated 03/30/15 with a goal date of 09/17/15, revealed the resident should be assisted with transfers per staff.</p>	F 282	<p>staff are providing the assistance that is indicated as being required on the care plan.</p> <ol style="list-style-type: none"> 3. Nursing staff has received inservice education, on 09/04/15, by the Director of Nursing regarding referring to care plan for the method to be used for transferring a resident. They also received instruction on the reporting process for changes, when needed, in interventions and/or resident's response to interventions. 4. Through Quality Assurance, transfers will be monitored by the Director of Nursing, or her designee, on 5% of residents who require assistance with transfers monthly for 6 months to ensure proper method is utilized as indicated in the care plan. The Director of Nursing, or her designee, will review the care plan to determine the amount of assistance required and observe transfers to ensure compliance. 5. Completion date: 09/27/15 		

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F 282	<p>Continued From page 10</p> <p>Review of the Nursing Clinical Flow sheet (Nurse Aide Care Plan Kardex), dated August 2015, revealed the resident was to be assisted by two (2) people for transfers.</p> <p>Interviews with Certified Nurse Assistant (CNA) #1 on 08/25/15 at 2:57 PM, the Certified Medication Technician (CMT) on 08/25/15 at 3:56 PM, Licensed Practical Nurse (LPN) #2 on 08/25/15 at 4:16 PM, CNA #2 on 08/25/15 at 6:28 PM, CNA #3 on 08/26/15 at 11:28 AM, CNA #5 on 08/26/15 at 2:23 PM, and CNA #6 on 08/26/15 at 2:34 PM revealed they were aware Resident #1 required two people during assistance with transfers and the information was found on the Nursing Clinical Flow Sheet (Nurse Aide Care Plan Kardex). Further interviews with CNA #2 on 08/25/15 at 6:28 PM, CNA #3 on 08/26/15 at 11:28 PM, CNA #5 on 08/26/15 at 2:23 PM, and CNA #6 on 08/26/15 at 2:34 PM revealed the resident was transferred with one (1) person and another staff person standing by for assistance if needed. The staff stated they transferred the resident that way because it was the resident's preference.</p> <p>Interview with the Director of Nursing (DON) on 08/26/15 at 3:46 PM revealed facility staff should follow resident care plans.</p> <p>Interview with the Administrator on 08/26/15 at 4:20 PM revealed Resident #1 required assistance of two (2) people during transfers; however, she was aware that facility staff had been transferring the resident with one (1) person and having another staff person to stand by. The Administrator stated a two (2) person assist should consist of two (2) staff members assisting the resident at the same time.</p>	F 282		

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F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, facility policy review, and review of the facility investigation it was determined the facility failed to provide necessary care and services to maintain the highest practicable physical, mental, and psychosocial well-being for one (1) of three (3) sampled residents (Resident #1) related to pain. On 08/14/15, Resident #1 was assessed to have a swollen right knee and have complaints of knee pain. The resident was observed by facility staff to have increased behaviors during care from 08/14/15 thru 08/16/15; however, the facility failed to address the resident's pain. The resident was sent to the emergency room on 08/16/15, per family request, and was found to have a right femur (bone in the upper leg) fracture.</p> <p>The findings include:</p> <p>Review of facility policy titled "Pain Protocol," date unknown, revealed communication to the physician, when pain was not controlled, would occur to collaborate for the resident to find the best way to change treatments and the plan of care.</p>	F 309	<p>It is and always has been the policy of The Heritage to provide necessary care and services to maintain the highest practicable physical, mental and psychosocial well- being for our residents.</p> <ol style="list-style-type: none"> 1. Resident #1 is having her pain assessed through the use of the Geriatric pain scale. Medications are administered in a timely manner. Her physician is notified whenever an alteration in treatment is warranted. Her responsible party is kept informed of changes. Her care plan has been updated to accurately reflect interventions in place to manage her pain. 2. All residents are assessed each shift and prn for pain using the method deemed appropriate for them individually and documented in their care plan. Residents have been assessed to ensure that they are receiving assistance as required by the plan of care and that their pain has been identified and addressed using the method indicated on the care plan. If pain was identified, the 		

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F 309	Continued From page 12 Medical record review for Resident #1 revealed the facility originally admitted the resident on 05/08/12 with diagnoses that include Cerebrovascular Accident (Stroke), Expressive Aphasia, and Right Hemiplegia. Review of the quarterly Minimum Data Set (MDS) assessment, dated 06/17/15, revealed the facility assessed the resident to have modified independent cognition, indicating the resident may experience difficulty in new situations. The facility further assessed the resident to be able to normally recall the location of his/her room, staff names and faces, as well as that he/she was in a nursing home. Further review revealed the resident was assessed to require extensive assistance with bed mobility and experience impairment on one side of his/her upper and lower extremities. The MDS assessment of pain indicated no signs were observed of the resident experiencing pain during the assessment look-back period. Review of the comprehensive care plan, dated 03/30/15, revealed the resident was at risk for alteration in comfort with interventions to include anticipating the resident's need for pain relief and responding immediately, notifying the physician if interventions were unsuccessful, observing and reporting changes or resistance of care, and observing for nonverbal signs and symptoms of pain. Further review of the comprehensive care plan revealed the resident had alteration in thought process and communication related to aphasia and rarely made himself/herself understood, and rarely understood others. The interventions included anticipating and meeting the resident's needs promptly. The resident also had care plan interventions to address alterations in behavior and mood related to episodes of crying, cursing, meal and medication refusal,	F 309	appropriate intervention was verified as ordered by the physician. 3. Nursing staff has received inservice education by the Director of Nursing on 09/04/15 regarding assessing pain and ensuring that interventions are implemented per the residents' plan of care. A resident who is identified as having pain is to have the pain treated as prescribed by the physician. 4. The Director of Nursing or her designee, through our Quality Assurance program, will monitor 5% of our residents monthly for 6 months to ensure that pain assessments are timely and appropriate interventions are implemented. This monitoring will include ensuring that physicians are notified when an alteration in treatment is necessary and that the resident's responsible party is notified. 5. Completion date: 09/27/15		

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F 309	<p>Continued From page 13 being easily annoyed, and refusal of care.</p> <p>Review of the nurse's notes, dated 08/14/15 at 9:30 AM, revealed Licensed Practical Nurse (LPN) #2 was called to the resident's room and assessed the resident to have a swollen right knee with complaints of right knee pain. The resident's nurse practitioner was notified of the findings and an order was obtained for x-rays of the resident's right knee and hip. Review of the nurse's note, dated 08/14/15 at 10:00 AM, revealed the facility notified the mobile x-ray company utilized by the facility. Further review revealed the x-rays were not completed until 08/15/15 at 12:00 PM and the results were not received until 08/15/15 at 6:00 PM. The resident's physician was notified of the results at that time. A late entry nurse's note for 08/15/15 at 10:00 PM revealed the resident showed no signs or symptoms of pain at that time. Further review of the nurse's notes revealed on 08/16/15 at 6:00 PM the family requested the resident to be sent to the Emergency Room for further evaluation of the resident's right hip and knee. The nurse's note indicated the resident appeared to be in pain at that time. Review of the "Nursing Clinical Flow Sheet" revealed documentation stating on 08/15/15 Resident #1 "refused all personal care after 11 PM" and "screams, cries, and cusses when you try to do anything." CNA #8 and the nurse signed the documentation.</p> <p>Review of Resident #1's Medication Administration Record (MAR) for August 2015 revealed per the Geriatric Pain Scale the resident was assessed to not experience pain from 08/13/15 through 08/16/15. Further review of the August 2015 MAR revealed the resident received a dose of Tylenol (pain reliever) 500 milligrams</p>	F 309		

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F 309	<p>Continued From page 14</p> <p>(mg) by mouth on 08/14/15 at 9:30 AM and a second dose at 8:00 PM. Further review of the MAR revealed the resident received Ativan (anti-anxiety medication) 0.5 mg by mouth on 08/13/15 at 8:00 PM and on 08/14/15 at 9:30 AM and 8:00 PM. The resident also received Ativan 1 mg by injection on 08/13/15 at 9:20 PM.</p> <p>Review of the hospital History and Physical, dated 08/17/15, revealed per the resident's family the resident began experiencing severe right hip pain on the night of 08/13/15 and continued to have severe right hip pain on 08/14/15. Due to the continued pain, the resident was sent to the Emergency Room on 08/16/15. The resident was evaluated in the Emergency Room on 08/16/15 and was found to have a right distal femoral fracture. Further review revealed the resident's physician assessed the resident to experience severe right hip pain and right leg pain with any palpation or attempts at range of motion.</p> <p>Interview with the resident's Family Member on 08/25/15 at 3:13 PM revealed on 08/14/15 the resident was noted to have a swollen right knee and had complaints of right knee pain. The Family Member stated the resident continued to have pain on 08/15/15 thru 08/16/15, and was in "visible pain" on 08/16/15. On 08/16/15, the Family Member requested the resident be sent to the Emergency Room for further evaluation related to the resident's continued pain. The Family Member stated the resident would "scream" if facility staff attempted care. Further interview with the Family Member on 08/26/15 at 12:43 PM revealed the facility did not approach the resident or him regarding sending the resident to the hospital from 08/14/15 thru 08/16/15 until requested by him on 08/16/15. The Family</p>	F 309			

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F 309	<p>Continued From page 15</p> <p>Member also stated the facility did not discuss calling the physician to obtain pain medication and that the facility just gave the resident "Tylenol that they had on hand." The Family Member stated the facility gave the resident Ativan a "couple" of times to "calm" the resident down but did not address the resident's pain.</p> <p>Interviews with Licensed Practical Nurse (LPN) #1 on 08/25/15 at 3:31 PM and Certified Nurse Assistant (CNA) #2 on 08/25/15 at 6:28 PM revealed the resident was extremely agitated and appeared to be in pain on the night of 08/13/15 at 8:00 PM. The LPN stated the resident pointed above his/her perineal area when asked to identify the location of the pain. The LPN stated she administered Ativan 0.5 mg by mouth at 8:00 PM due to the resident's agitation. The LPN stated the resident appeared to calm down for a short time; however, when staff attempted to provide care approximately an hour later the resident became "very agitated and was yelling and screaming." The LPN stated she administered Ativan 1 mg by injection at that time and Resident #1 was "fine" after that. Further interview revealed the LPN asked the resident if he/she was in pain, after the Ativan injection, and the resident stated "no." The LPN stated she had cared for the resident the night before (08/12/15) and the resident "did not act that way." Interview with CNA #2 revealed on the night of 08/13/15 the resident was observed to pull the covers up and not allow staff near.</p> <p>Interview with LPN #2 on 08/25/15 at 4:16 PM revealed she was responsible for the care of Resident #1 during the day shifts on 08/13/15 and 08/14/15. The LPN stated the resident did not appear to be in pain during the day on 08/13/15.</p>	F 309			

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F 309	<p>Continued From page 16</p> <p>Further interview revealed on the morning of 08/14/15 the resident was crying, appeared to be in pain, and was assessed to have a swollen right knee. The LPN stated she notified the physician and received an order for x-rays of the resident's right hip and knee. The LPN stated she administered Tylenol 500 mg by mouth and Ativan 0.5 mg by mouth at that time. LPN #2 stated the resident was observed to "rest" during the remainder of the shift.</p> <p>Interview with CNA #2 on 08/25/15 at 6:28 PM and LPN #4 on 08/26/15 at 2:49 PM revealed they were responsible for Resident #1's care on the night of 08/14/15. Interview with the CNA revealed the resident was resistant to care and would "yell and scream" when care was provided. Interview with LPN #4 revealed she was aware the resident was refusing care and was observed to be crying. The LPN stated she was aware the resident had x-ray orders and was assessed to have a swollen right knee. The LPN stated the resident frequently had those types of behaviors and she "couldn't say" the resident was in pain. Further interview revealed the LPN did not notify Resident #1's physician regarding his/her behaviors or to address pain medication.</p> <p>Interviews with CNA #1 on 08/25/15 at 2:57 PM and LPN #3 on 08/25/15 at 4:47 PM revealed they were responsible for Resident #1's care during the days of 08/15/15 and 08/16/15, and the resident appeared to be in pain on both days. The CNA stated she had been instructed to "protect" the resident's knee during care. The LPN stated the resident was "ok" during rest but was "worse" when care was provided. The LPN stated he offered to call the physician for pain</p>	F 309			

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F 309	<p>Continued From page 17</p> <p>medications but the resident declined. Further interview with the LPN revealed although the resident "seemed" to be in pain and would "yell out" during care the LPN did not feel the resident's pain was worsening. The LPN stated the resident's physician was not notified of the resident's behavior or symptoms of pain.</p> <p>Interview with CNA #8 on 08/26/15 at 2:49 PM revealed she was responsible for Resident #1's care on the night of 08/15/15. The CNA stated, "You could tell something was wrong and the resident was in pain." Further interview revealed the resident was observed to pull the covers up, refuse care, and guard his/her right leg. The CNA stated the nurse was aware of the resident's behaviors and pain.</p> <p>Interview with Resident #1's Physician on 08/26/15 at 11:13 AM revealed he was aware the resident had complaints of right knee pain and was assessed to have a swollen right knee on 08/14/15. The Physician stated a resident with hemiplegia that is experiencing pain and swelling on the affected side is "alarming and needs looked at." Further interview revealed the Physician had not been made aware by the facility that the resident was experiencing episodes of acute pain until 08/16/15 when the Physician was notified the resident's family had requested to send the resident to the Emergency Room for further evaluation. The Physician stated the resident would have been sent to the hospital if the facility had made him aware the resident had continued pain. The Physician stated "turning and changing the resident would have been excruciating pain" and the facility should have made him aware. Further interview revealed no attempts were made by the facility to</p>	F 309			

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F 309	Continued From page 18 obtain an order for pain medication during 08/14/15 thru 08/16/15. The Physician stated he was made aware by the family that the resident only received Ativan, for agitation, during that period. Further interview revealed the Physician believed the resident was agitated due to pain and administering pain medication would have been the "better choice." Interview with the Director of Nursing on 08/26/15 at 3:00 PM revealed facility staff should have addressed the resident's pain. Interview with the Administrator on 08/26/15 at 4:20 PM revealed Resident #1 had known behaviors of resisting care and refusing medications. The Administrator stated "it is hard to differentiate the resident's behaviors" and it was the "interpretation of the family" that the resident was in pain. Further interview revealed if facility staff was aware the resident was in pain the physician should have been notified.	F 309			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review it was determined the facility failed	F 323	It is and has always been the policy of The Heritage to ensure that residents receive adequate supervision to prevent accidents. 1. Resident #1 has been assessed to require 2 person assist with transfers. This information has been verified on her care plan and nurse aides have been made aware.		

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F 323	<p>Continued From page 19</p> <p>to ensure one (1) of three (3) sampled residents (Resident #1) received adequate supervision to prevent accidents. Review of Resident #1's Nursing Clinical Flow Sheet revealed the resident required two (2) persons for assistance when transferred. Interview with facility staff revealed one (1) person with another staff person standing by for assistance if necessary routinely transferred the resident.</p> <p>The findings include:</p> <p>Review of facility procedure titled "Transferring the Non-Ambulatory Resident from Wheelchair to Bed," date unknown, revealed the first step was to ask another assistant for help with the transfer. The procedure directed staff members to "lock arms" with the resident prior to the transfer.</p> <p>Medical record review for Resident #1 revealed the facility originally admitted the resident on 05/08/12 with diagnoses that include Cerebrovascular Accident (Stroke), Expressive Aphasia, and Right Hemiplegia. Review of the quarterly Minimum Data Set (MDS) assessment, dated 06/17/15, revealed the facility assessed the resident to have modified independent cognition, indicating the resident may experience difficulty in new situations. The facility further assessed the resident to be able to normally recall the location of his/her room, staff names and faces, as well as being in a nursing home. Further review revealed the resident was assessed to require extensive assistance with bed mobility and experience impairment on one side of his/her upper and lower extremities. The assessment did not reveal the amount of assistance the resident required during transfer as the assessment stated the activity of transferring did not occur during the</p>	F 323	<p>Resident and responsible party have been informed that all transfers must be accomplished with 2 person assist to assure the resident's safety.</p> <ol style="list-style-type: none"> 2. All residents are assessed quarterly for proper method for conducting safe transfers. This method has been identified on the care plan and relayed to nursing staff. Residents have been assessed to ensure that each individualized plan of care addresses the level of assistance required and that the appropriate level of assistance is being provided. 3. Resident care plans are reviewed at least quarterly and updated to reflect current care needs. Nursing staff has received education by the Director of Nursing, on 9/04/15, to reinforce their knowledge of care plan 	
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F 323	<p>Continued From page 20</p> <p>assessment period. Review of the comprehensive care plan, dated 03/30/15 with a goal date of 09/17/15, revealed the resident should be assisted with transfers per staff. Review of the Nursing Clinical Flow sheet, dated August 2015, revealed the resident was to be assisted by two (2) people for transfers.</p> <p>Interviews with Certified Nursing Assistant (CNA) #2 on 08/25/15 at 6:28 PM, CNA #3 on 08/26/15 at 11:28 AM, CNA #5 on 08/26/15 at 2:23 PM, and CNA #6 on 08/26/15 at 2:34 PM revealed Resident #1 required two (2) people for assistance during transfers; however, the resident was transferred by one (1) staff person assist and the other staff person standing by to assist if necessary. CNA #3 and CNA #6 stated Resident #1 did not like two (2) people touching him/her at the same time when being assisted with transfers.</p> <p>Interview with the Physical Therapist (PT) on 08/26/15 at 4:10 PM revealed if a resident was assessed to require two (2) people for assistance with transfers, it would be expected that two (2) staff members would physically assist the resident at the same time.</p> <p>Interview with the Administrator on 08/26/15 at 4:20 PM revealed Resident #1 required two (2) persons for assistance during transfers. The Administrator stated staff would be expected to have two (2) people physically assist during a transfer, if a resident was assessed to require a two (2) person assist. Further interview revealed the Administrator was aware Resident #1 preferred that only one staff person assist during transfers. The Administrator stated she had heard Resident #1 "scream" when staff attempted</p>	F 323	<p>interventions and safe care of all residents.</p> <p>4. Through our Quality Assurance program, the Director of Nursing or her designee will monitor monthly for 6 months 5% of residents who require assistance with transfer to ensure that proper transfer methods are used. The monitoring will include reviewing the care plan for the level of assistance required and observation of transfers to ensure compliance.</p> <p>5. Completion date: 09/27/15</p>	

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

PRINTED: 10/05/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185434	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/26/2015
NAME OF PROVIDER OR SUPPLIER THE HERITAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 192 BACON CREEK ROAD CORBIN, KY 40702		
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F 323	Continued From page 21 to transfer the resident with two (2) staff members touching the resident at the same time. Further interview revealed the resident's care plan should have addressed the resident's preference during transfers.	F 323			