

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

PRINTED: 10/07/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185402	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 09/30/2015
NAME OF PROVIDER OR SUPPLIER HENDERSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	<p>INITIAL COMMENTS</p> <p>An On-site Revisit Survey was conducted on 09/29/15 through 09/30/15 for the Abbreviated Surveys (KY #23461 & #23503) conducted on 08/10/15 with the facility determined to be in compliance on 09/11/15, as alleged.</p>	{F 000}			

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

TITLE

(X6) DATE

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

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185402	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 9/30/2015
Name of Facility HENDERSON NURSING AND REHABILITATION CENTER		Street Address, City, State, Zip Code 2500 NORTH ELM ST. HENDERSON, KY 42420

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0280</u> Reg. # <u>483.20(d)(3), 483.10(k)(2)</u> LSC _____	Correction Completed 09/11/2015	ID Prefix <u>F0282</u> Reg. # <u>483.20(k)(3)(II)</u> LSC _____	Correction Completed 09/11/2015	ID Prefix <u>F0309</u> Reg. # <u>483.25</u> LSC _____	Correction Completed 09/11/2015
ID Prefix <u>F0314</u> Reg. # <u>483.25(c)</u> LSC _____	Correction Completed 09/11/2015	ID Prefix <u>F0323</u> Reg. # <u>483.25(h)</u> LSC _____	Correction Completed 09/11/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By <u>LOH</u>	Date: <u>10/07/15</u>	Signature of Surveyor: <u>Deborah A. Henderson, MPE, DR</u>	Date: <u>10/07/15</u>
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 8/10/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185402	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ RECEIVED SEP 2015	(X3) DATE SURVEY COMPLETED C 08/10/2015
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NAME OF PROVIDER OR SUPPLIER HENDERSON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420
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F 000	<p>INITIAL COMMENTS</p> <p>An Abbreviated Survey Investigating Complaints #KY23461 and KY23503 was conducted on 07/07/15 through 07/13/15. Complaint KY23503 was reopened on 08/03/15 and concluded on 08/10/15. Complaints KY23461 and KY23503 were substantiated with deficient practice identified at the highest Scope and Severity of a "G".</p> <p>On 08/25/15, staff failed to revise the care plan to ensure interventions for the use of a Low Air Loss Mattress (alternating pressure) were in place to address the specific mattress setting and the need to position the resident in the center of the bed. In addition, staff failed to ensure a bed alarm was in place per the resident's care plan. On 07/03/15, Resident #6 slid off a specialty Low Air Loss Mattress sustaining an injury to the left side of the face and head which caused swelling and bruising, a large skin tear to the left arm, and a fracture of the left humerus (upper arm). The facility determined the resident was not positioned in the center of the bed.</p>	F 000	<p>F 000</p> <p>Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by this facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18, and Title 19</p>	
F 280 SS=G	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility</p>	F 280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Cathy Allen* TITLE: *Administrator* (X6) DATE: *9/2/15* R

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F 280	<p>Continued From page 1 for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the hospital Emergency Room Report; Hospice Registered Nurse documentation, the Resident Assessment Instrument (RAI) User Manual version 3.0; and, the Low Air Loss Mattress Manufacturers Guidelines, it was determined the facility failed to revise the care plan for one (1) of six (6) sampled residents (Resident #6).</p> <p>On 06/25/15, Resident #6's Comprehensive Care Plan was updated to include the use of a Low Air Loss Mattress with low pressure settings and bolsters. However, further review revealed the facility failed to revise the care plan to include what mattress setting was needed for Resident #6; and, failed to address the proper positioning of the resident on the mattress. On 07/03/15, Resident #6 slid off the specialty Low Air Loss Mattress sustaining an injury to the left side of his/her face and head which caused swelling and bruising. The resident also suffered a large skin tear to the left arm, and a fracture of the humerus. The facility determined the resident was not positioned correctly in the bed.</p>	F 280	<p>programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p> <p>1. Resident # 6 is no longer a resident in the facility as of 7/7/15 when she was discharged to the hospital. No changes were made to the care plan as the resident had discharged from the facility.</p>	
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F 280	<p>Continued From page 2 The findings include:</p> <p>Review of the facility's "RAI version 3.0 Manual", dated 10/2011, section 4.7, revealed the comprehensive care plan must be reviewed and revised periodically and services provided or arranged must be consistent with each written plan of care. The care plan should be revised on an ongoing basis to reflect changes in the resident and the care of the resident.</p> <p>Review of the Low Air Loss Mattress manufacturer's guidelines revealed settings were determined by the resident's weight and clinical assessment for need. Further review revealed the mattress did not have a firm perimeter that keeps the resident centered. The mattress has Anatomic Zones, Integrated Bolsters and Alternating Pressure.</p> <p>Closed record review revealed the facility admitted Resident #6 on 11/29/14 with diagnoses which included Leukocytopenia, Mental Disorder, Depressive Disorder, Hypotension, and Vertebral Fractures. Review of a Quarterly Minimum Data Set (MDS) Assessment, dated 06/10/15, revealed the facility assessed Resident #6's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of ninety-nine (99) indicating the resident was not interviewable. The resident required extensive assistance with two (2) or more persons for Activities of Daily Living (ADL) and weighed one-hundred (100) pounds.</p> <p>Review of Resident #6's Comprehensive Care Plan for Terminal/End Stage Diagnoses with Hospice Involvement, dated 12/06/14, revealed a low air loss mattress (alternating pressure) with bolsters for pressure relief was put in place on</p>	F 280	<p>2. All current facility residents are being reviewed to be certain that; a) their care plans are accurate and being carried out, b) the appropriate information is carried over to the Treatment Administration Record (TAR), c) the pressure settings are correct on the care plan and are accurate on the alternating air mattress and the TAR, and d) the proper positioning of the resident on the alternating air mattress is being followed. This review will be conducted by the Interdisciplinary Team (IDT) consisting of the Director of Nurses (DON), Assistant Director of Nurses (ADON), Unit Managers (UM), Minimum Data Set Coordinators (MDS), Activity Director (AD), Social Services Director (SSD), and/or Food Services Supervisor (FSS). Any identified concerns will be corrected. Audits will be completed by 9/10/15.</p> <p>3. All licensed nursing staff and nursing assistants are being re-educated to ensure that they are knowledgeable</p>	
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F 280	<p>Continued From page 3</p> <p>12/10/14 . Further review revealed on 06/25/15, the care plan was updated with an intervention for a low air loss mattress with bolsters with low pressure settings. However, there were no specific details for the settings of the mattress and no interventions related to the resident's positioning.</p> <p>Review of the July 2015 Treatment Administration Record (TAR) revealed to have a "low air loss mattress with bolsters, monitor functioning and settings every shift"; however, the TAR did not specify what the setting should be.</p> <p>Review of Nursing Note, dated 07/04/15 at 4:49 AM, and interview with Licensed Practical Nurse (LPN) #1 on 07/10/15 at 10:47 AM, revealed Resident #6 was heard yelling from his/her room and was found on the floor on 07/03/15 at approximately 10:45 PM, between the two (2) beds in the room, laying on his/her left side. Staff assessed the resident and identified a large skin tear on his/her left arm below his/her elbow and a "knot" and bruising to the left side of his/her head above the temple.</p> <p>Review of Nursing Notes, dated 07/06/15 at 8:40 AM and 07/07/15 at 1:45 PM; an Emergency Room (ER) Patient Record, dated 07/07/15 at 1:55 PM, and the Hospitalist Discharge Summary, dated 07/09/15, revealed the resident was complaining of pain anytime staff moved his/her left arm. The Physician was called and an order was received for an x-ray. Resident #6 was identified with a fracture of the left upper arm. Resident #6 told the Hospitalist he/she just wanted his/her pain controlled and if the pain could not be controlled they should "just let (him/her) die". The resident was admitted to the</p>	F 280	<p>regarding the appropriate use of the specialty low air loss mattresses, the specific resident care plans, the appropriate settings, and proper positioning. This re-education is being conducted by the Don, ADON, and/or UM and will be completed by 9/10/15. This re-education is being conducted by the DON, ADON, and/or UM and will be completed by 9/10/15. The IDT consisting of the DON, ADON, UM, MDS, AD, SSD, and FSS will be re-educated by the Regional Reimbursement Nurse on the development of the plan of care to meet the needs of the resident by 9/10/15. No IDT member nor nursing staff will work after 9/10/15 without having received this re-education.</p>	
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F 280	<p>Continued From page 4 inpatient Hospice for comfort measures on 07/09/15, and expired on 07/24/15.</p> <p>Interview with Certified Nurse Aide (CNA) #3, on 07/09/15 at 2:45 PM, revealed she had provided incontinent care for Resident #8 and turned him/her to the left side. She stated she completed her care and left the room to go across the hall to another resident when not five (5) minutes later she heard Resident #8 calling out for help. CNA #3 said she re-entered the room to find Resident #8 on the floor in the position she had left him/her. She stated, "I don't know how it happened, the way I had positioned him/her way over towards the left side of the bed, it's like he/she slid off backwards". She stated the resident was on a specialty "constant air flow mattress", but she was not aware of any settings for the mattress. Further interview revealed CNA #3 stated she had no inservice prior to 07/06/15, on the air mattresses that she could recall to ensure she was aware to make sure the resident was centered in the bed.</p> <p>Interview, on 08/06/15 at 10:05 AM with Hospice Nurse Aide State Registered (NASR), revealed she visited Resident #8 three (3) days a week for his/her bath. She stated when she asked the resident about his/her fall the resident stated, "I must have fell out of bed, I told them I was too close to the edge, they think I'm stupid or something, the bed was slick and oops the next thing I know they were picking me up off the floor".</p> <p>Interview with Licensed Practical Nurse (LPN) #4, on 08/06/15 at 3:00 PM, revealed she wrote the intervention on the Impaired Skin Integrity Care Plan for the Low Air Loss Mattress with Bolsters</p>	F 280	<p>4. The DON, ADON, MDS and/or UM will audit five care plans weekly for three months to ensure that appropriate care plans were developed including positioning and settings of low air loss mattresses. The results of the audits will be reviewed by the Quality Assurance Performance Improvement (QAPI) Committee monthly for three months. The QAPI Committee will consist of at least five of the following QAPI members; the Administrator (ADM), DON, ADON, UM, MDS, FSS, SSD, Maintenance Service Director (MSD), Environmental Services Supervisor (ESS), Director of Rehab (DOR), Business Office Manager (BOM), or Medical Director (MD).</p> <p>5. Date of Completion:</p>	9/11/15
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F 280	<p>Continued From page 5</p> <p>and low pressure settings on 06/25/15 after an inservice conducted by the Director of Nursing (DON). She stated she was not aware of what specific setting the mattress needed to be set LPN #4 stated Resident #5 was about the same size and weight as another resident (Resident #5) so she would think their mattresses would have been at the same setting. She stated all staff should try to position any resident centered on the bed for safety. Observation of Resident #5, on 08/03/15 at 11:00 AM, revealed Resident #5's mattress was set on eighty-five (85) pounds.</p> <p>Interview with the Director of Nursing (DON), on 07/30/15 at 12:45 PM, revealed she expected the licensed staff to update and revise a resident's care plan per the facility's policy, on admission, re-admission, when there were any changes in treatment and, at least quarterly. The DON further revealed she expected the licensed nurses to be specific when care planning for any piece of equipment. She stated the Low Air Loss Mattresses may be different with a different pressure controller so the settings should be included on the care plan. She stated Physician Orders, Medication Administration Records and TARs should reflect that specificity, and for residents' safety, they should be positioned centered in the bed no matter what type mattress was being used.</p>	F 280		
F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p>	F 282	<ol style="list-style-type: none"> 1. Resident # 6 is no longer a resident in the facility as of 7/7/15 when she was discharged to the hospital. No changes were made to the care plan as the resident had discharged from the facility. 2. All current facility residents' care plans will be reviewed by the DON, ADON, UM, and/or MDS by 9/10/15 to determine if all care plan interventions are in place including bed alarms and a review of the medical record and observation of the resident. Any identified as not in place will be immediately implemented. A review of all current residents with wounds was completed to determine if the dressings were changed per care plan with no concerns identified. 	

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F 282	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of a hospital Emergency Room Photograph, and review of the facility's Resident Assessment Instrument (RAI) version 3.0 Manual, it was determined the facility failed to implement the care plan for one (1) of six (6) sampled residents (Resident #6).</p> <p>Resident #6 was care planned for a bed alarm and to treat and change dressing to a Stage III pressure sore to the left outer ankle. On 07/03/15, Resident #6 sustained a fall from the bed and it was identified there was no bed alarm in place. In addition, Resident #6 was supposed to have a treatment and dressing change every day; however, the licensed staff failed to provide the treatment and dressing change to the left ankle for three (3) days. When the dressing was removed at the hospital on 07/07/15, the dressing was dated 07/03/15.</p> <p>The findings include:</p> <p>Review of the facility's "CMS's (Center's for Medicare and Medication Services) RAI version 3.0 Manual", dated 10/2011, section 4.7, revealed the comprehensive care plan must be reviewed and revised periodically and services provided or arranged must be consistent with each written plan of care.</p> <p>Closed record review revealed the facility admitted Resident #6 on 11/29/14 with diagnoses which included Leukocytopenia, Mental Disorder, Depressive Disorder, Hypertension, and Vertebral Fractures. Review of the Quarterly Minimum</p>	F 282	<p>3. All licensed nursing staff and nursing assistants are being re-educated to ensure that they are knowledgeable regarding the following of the care plan to include bed alarms and dressing treatment changes. The fall committee will also be re-educated on reviewing all care plans again at the weekly QAPI fall committee meeting to ensure all orders and care plans are correct. This re-education is being conducted by the DON, ADON, and/or UM and will be completed by 9/10/15 with no nursing staff working after 9/10/15 without having received this re-education.</p>	
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F 282	<p>Continued From page 7</p> <p>Data Set (MDS) Assessment, dated 06/10/15, revealed the facility assessed Resident #6's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of 99 which indicated the resident was not interviewable. Further review of the MDS revealed the resident required extensive assistance of two (2) or more for Activities of Daily Living (ADLs).</p> <p>Review of the Comprehensive Care Plan for risk of injury from falls, dated 12/10/14, revealed an intervention, dated 05/14/15, for a chair and bed alarm to alert staff of need of assistance. However, review of a form titled, Fall Investigation Worksheet, dated 07/04/15, revealed Resident #6 had a fall from the bed and there was no bed alarm in place.</p> <p>Interview with Licensed Practical Nurse (LPN) #2/MDS Assistant, on 08/03/15 at 3:00 PM, revealed she recalled talking about Resident #6's fall on 05/12/15 in morning meeting. She stated they care planned the resident to have alarms to the bed and chair to alert staff for need of assistance. LPN #2 stated the Unit Manager was in the morning meeting and should have contacted the physician for the order and placed the notation for the alarms on the Treatment Administration Record (TAR) and initiated the alarms.</p> <p>Interview with Registered Nurse (RN) #1 (Unit Manager), on 08/04/15 at 1:09 PM, revealed she was not the Unit Manager on 05/14/15. However, she was responsible for checking the residents' care plans, but she was not aware that Resident #6 was care planned, on 05/14/15, by LPN #2 for alarms to alert staff the resident needed</p>	F 282	<p>4. The DON, ADON, and/or UM will audit for compliance three care plans per week for twelve weeks to ensure interventions are in place, dressings have been changed per physician's order, and plan of care are correct. The results of the audits will be reviewed by the QAPI Committee monthly for three months. The QAPI Committee will consist of at least five of the following QAPI members; the ADM, DON, ADON, UM, FSS, SSD, MSD, ESS, DOR, BOM, MDS, or MD.</p> <p>5. Date of Completion</p>	9/11/15
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185402	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/10/2015
NAME OF PROVIDER OR SUPPLIER HENDERSON NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420		
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F 282	<p>Continued From page 8 assistance.</p> <p>Further review of the Comprehensive Care Plan revealed a care plan for Alteration in comfort, dated 11/29/14, with an intervention to provide treatments per Physician's Orders. Review of a Physician's Order, dated 06/30/15, revealed to clean wound to right outer ankle with saline (NaCl), apply Aquacel ag (cut to fit), and cover with Blatin adhesive foam. Change daily and as needed (prn). However; review of the July 2015 Treatment Administration Record revealed Resident #6's treatment was last documented as being completed on 07/03/15 and review of a photograph taken at the Emergency Room (ER), dated 07/07/15, revealed a picture of a dressing to Resident #6's right ankle that was dated 07/03/15.</p> <p>Interview with RN #2, on 07/09/15 at 10:07 AM, revealed he worked the day shift on 07/04/15 and 07/05/15; and, Interview with LPN #1, on 07/10/15 at 10:47 AM, revealed she worked the day shift on 07/06/15. Both licensed nurses did not recall changing Resident #6's right ankle dressing. Further interview revealed if they could not get to a treatment they would make the next shift aware. Neither of them recalled making the oncoming shift aware. RN #2 also stated he was usually Resident #6's nurse and he did not recall the resident having any alarms.</p> <p>Interview with the Director of Nursing (DON), on 07/07/15 at 9:12 AM, revealed Resident #6 was care planned for licensed staff to change the right ankle dressing daily according to the Physician's Order and to maintain comfort level at end of life. Further interview revealed she could not find there was ever an order for alarms for Resident</p>	F 282		

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

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NAME OF PROVIDER OR SUPPLIER HENDERSON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420
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F 282	Continued From page 9 #6's bed or chair as a device to alert staff of needs; however the intervention was written in the resident's Comprehensive Care Plan on 05/14/15. She stated she expected the staff to follow the Comprehensive Care Plan for the residents.	F 282		
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, and review of the facility Hospice Contract, Resident Hospice Agreement; Hospice Nurse's Clinical Records; Neurological Assessment Flowsheet; Emergency Room (ER) Patient Record; and Hospitalist Discharge Summary; it was determined the facility failed to 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 for one (1) of six (6) sampled residents (Resident #6).</p> <p>Resident #6 sustained a fall from the bed on 07/03/15 and was assessed as having a bruise to the left side of his/her head (a goose egg) above</p>	F 309	<ol style="list-style-type: none"> 1. Resident #6 is no longer a resident in the facility as of 7/7/15 when she was discharged to the hospital. 2. The DON, ADON, MDS and/or Um will review all current facility residents current medical condition including any recent falls to determine the need to conduct neurological assessments. Any identified will have neurological assessments implemented. Pain assessments of all current residents will be done to determine that all pain is controlled. Any identified concerns will be corrected immediately. 	

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

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F 309	<p>Continued From page 10</p> <p>the temple and a large skin tear to the left elbow and a blood pressure of 234/90 mm/Hg (normal:120/70 mm/Hg). The Hospice Nurse was made aware and the Hospice Nurse instructed Licensed Practical Nurse (LPN) #1 to conduct neurochecks, and administer Morphine for pain and to decrease blood pressure. However, LPN #1 failed to provide this care and services.</p> <p>The findings include:</p> <p>Review of the facility's Hospice Contract, dated 03/29/13, revealed Hospice and the facility will each notify the other of any change in condition of a Hospice Patient that requires a change in the patient's plan of care. Changes in the plan of care must be authorized by Hospice.</p> <p>Review of the Hospice Agreement signed by Resident #6 on admission, on 11/29/14, revealed the services of the Hospice Agency were provided at wherever the individual calls home, whether it be in their own home, in a family member's home or in a Nursing Home. The members of the Hospice team help persons be as free of pain as possible. At the same time, the team provides support, education, and counseling to family members, nursing home staff, and other nursing home residents who know the person.</p> <p>Review of the the facility's Neurological Assessment Flowsheet revealed to perform an assessment every fifteen (15) minutes times four (4), every thirty (30) minutes times four (4), every hour times four (4) until stable, and then every four (4) hours times four (4) until stable, and every eight (8) hours.</p>	F 309	<p>3. All licensed nursing staff is being re-educated to ensure that they are knowledgeable regarding the appropriate protocols for neurological checks and the administration of pain medication, pain needs and end of life care as it relates to pain control and use of narcotics. This re-education is being conducted by the DON, ADON, and/or UM and will be completed by 9/10/15 with no licensed nursing staff working after 9/10/15 without having received this re-education.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	<p>Continued From page 11</p> <p>Closed record review revealed the facility admitted Resident #8 on 11/29/14 with diagnoses which included Leukocytopenia, Mental Disorder, Depressive Disorder, Hypertension, and Vertebral Fractures.</p> <p>Review of an Admission Minimum Data Set (MDS) Assessment, dated 06/10/15, revealed the facility assessed Resident #8's cognition as severely impaired with a Brief Interview Mental Status (BIMS) score of ninety-nine (99) indicating the resident was not interviewable. The resident required extensive assistance with two (2) or more persons for Activities of Daily Living (ADLs); and the resident's pain was assessed to be present seven (7) of 7 days of the look back period. The resident received routine pain medication by mouth.</p> <p>Review of a Resident Incident Report, dated 07/03/15 at 10:00 PM, revealed staff found Resident #8 on the floor in his/her room. The facility assessed the resident to have a bruise and knot (goose egg) to the left side of his/her head above the temple and a large skin tear to the left elbow. In addition, the resident's blood pressure was 234/90 mm/Hg (millimeter of Mercury).</p> <p>Review of Resident #8's Comprehensive Care Plan for Alteration in Comfort, dated 11/29/14, revealed an intervention for medication and treatments per Physician's Orders. Review of Physician's Order, dated 11/29/14, revealed to administer Norco (opioid pain medication) 7.5/325 tablet one (1) orally four (4) times daily as needed (PRN) for pain, Morphine (opioid pain medication) 20 mg/ml give 0.25 ml sublingually (sl) every hour as needed for mild pain, and Morphine 20 mg/ml</p>	F 309	<p>4. The DON, ADON, MDS, and/or UM will audit five residents for pain control and documentation of neurological checks when appropriate weekly for three months to ensure compliance. The results of the audits will be reviewed by the QAPI Committee monthly for three months. The QAPI Committee will consist of at least five of the following QAPI members; the ADM, DON, ADON, UM, FSS, MDS, SSD, MSD, ESS, DOR, BOM, or MD.</p> <p>5. Date of Completion:</p>	9/11/15	

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

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F 309	<p>Continued From page 12 give 0.5 ml sl every hour prn for moderate to severe pain.</p> <p>Review of the Hospice Nurse's Clinical Records, dated 07/03/15 at 10:45 PM, revealed Licensed Practical Nurse (LPN) #1 called and made her aware of Resident's #6's fall which resulted in a head injury. She instructed the nurse to administer the resident's "as needed" pain medication and to perform neurological checks according to the facility's Neurological Assessment Flowsheet. However, review of the July 2015 Medication Administration Record (MAR) revealed there was no documented evidence the resident's as needed pain medication was administered at that time.</p> <p>Review of the Hospice Nurse's Clinical Records, dated 07/04/15 at 11:05 PM, revealed LPN #1 called her back and stated the resident's blood pressure was elevated. She explained to the nurse the blood pressure could be elevated due to the resident's increased pain and the fall; and, instructed the nurse to administer the PRN Morphine, as ordered for increased pain and the medication would also help decrease the resident's blood pressure. However, further review of the July 2015 MAR revealed LPN #1 did not administered the as needed Morphine until 07/03/15 at 11:45 PM.</p> <p>Review of a Nursing Note, dated 07/04/15 at 4:49 AM, revealed LPN #1 again called Hospice and made the Hospice Nurse aware the resident was complaining of left arm pain when moved or touched. The Hospice Nurse again instructed LPN #1 to administered the as needed Morphine for pain. However, further review of the July 2015 MAR revealed LPN #1 did not administered the</p>	F 309		

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

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FORM APPROVED
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F 309	<p>Continued From page 13 as needed Morphine after 07/03/15 at 11:45 PM.</p> <p>In addition, review of Resident #6's Neurological Assessment Flowsheet revealed there was no documented evidence the neurological checks were completed per facility protocol until 07/04/15 at 8:15 AM which was nine and one-half (9 1/2) hours after the fall.</p> <p>Interview with the Hospice Nurse (RN), on 07/10/15 at 3:20 PM, revealed she spoke with LPN #1 and made recommendations for neurochecks per protocol and to medicate the resident with the sublingual Morphine to help decrease the resident's pain and elevated blood pressure of 235/90 mm/Hg, and she would be in the that day (07/04/15) to assess the resident. She stated she thought LPN #1 was reluctant to administer sublingual (sl) Morphine and documented this in her case communications, dated 07/04/15 at 4:00 AM. She stated she also educated LPN #1 and RN #2 on managing Resident #6's pain, as a priority.</p> <p>Interview with LPN #1, on 07/08/15 at 11:25 AM, revealed she was Resident #6's nurse, on the evening of 07/03/15, when the resident was found on the floor beside his/her bed. She stated the resident had a "goose egg type knot" to the left side of his/her head and a skin tear on his/her left elbow. She stated she called Hospice to inform them about the fall and the Hospice Nurse gave instructions to conduct "neuro-checks" as standard practice since there was no apparent loss of consciousness and medicate the resident for pain and to contact the family and physician. LPN #1 stated, "I could not find the neuro-check sheets so I wrote the vital signs on post-it notes". LPN #1 stated she did not administer the</p>	F 309			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 309	<p>Continued From page 14</p> <p>Morphine immediately and did not administer the resident anymore Morphine because she was uncomfortable giving Morphine after a head injury. She stated if a resident receives Hospice, they typically call them first after a fall with injury.</p> <p>Review of the Hospice Nurse's Clinical Records, dated 07/04/15 at 11:45 AM, revealed the Hospice Nurse assessed the resident and identified a large dark purple bruise and "knot" to the resident's left forehead and bruising was also noted to the left arm. The resident was guarding and unable to straighten his/her left arm. She instructed Registered Nurse #2 to administer the "as needed" SL Morphine due to the resident's increased pain and to use the Morphine due to the resident's severe pain. Further review of the Hospice Nurse's Clinical Records revealed on 07/05/15 at 12:00 PM, the Hospice Nurse received a call from RN #2 and he stated the resident still continued to have severe pain to the left arm when moved or touched. Review of a Nursing Note, dated 07/06/15 at 6:40 AM, revealed the Hospice Nurse was called again related to the resident's severe pain anytime staff moved his/her left arm. The Hospice Nurse told the nurse to obtain an x-ray to see if there was a break/fracture so they could better assess the resident's pain scale and increase the pain medication.</p> <p>Further review of the July 2015 MAR revealed the resident received Morphine SL 25 ml on 07/04/15 at 11:40 AM when the Hospice Nurse was present and routine Norco (pain med) at 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. However, there was no documented evidence the resident received any Morphine from 07/04/15 at 11:40 AM until sent he/she was sent to the hospital on</p>	F 309		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	<p>Continued From page 15 07/07/15 per the Hospice Nurse's instructions.</p> <p>Further interview with LPN #1 on 07/08/15 at 11:25 AM, revealed she worked on 07/05/15 and 07/06/15 and she was not comfortable with administering the Morphine with the resident having a head injury.</p> <p>Interview with RN #2, on 07/09/15 at 10:07 AM, revealed he worked the day shift of 07/04/15 and 07/05/15 and when asked about administering the Morphine per Hospice instructions he stated the resident only had pain if his/her arm was moved.</p> <p>Review of the Emergency Room (ER) Patient Record of Resident #6, revealed he/she arrived on 07/07/15 at 1:55 PM and was assessed to have ecchymosis (bruising) and tenderness to the left arm and a skin tear and tenderness and ecchymosis to the left forehead. Further review of the ER Physician's Note revealed the resident had a fracture of the proximal humerus (upper arm).</p> <p>Review of the Hospitalist Discharge Summary, dated 07/09/15, revealed Resident #6 stated that he/she just wanted his/her pain controlled and if the pain could not be controlled they "... should just let (him/her) die." The resident was admitted to the Inpatient Hospice for comfort measures on 07/09/15 and expired on 07/24/15.</p> <p>Interview with the Director of Nursing (DON), on 07/07/15 at 9:12 AM, revealed staff was expected to follow the Physician's Orders, Comprehensive Care Plan, and the recommendations of the Hospice Nurses; if the resident was under the care of Hospice. She stated if routine pain</p>	F 309		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	Continued From page 16 medication was not controlling the resident's pain then the "as needed" (prn) pain medication should have been given as the Hospice Nurse had recommended. She stated the resident sustained a bruise to his/her side of the head in the fall; therefore, the LPN should have monitored the resident more closely and followed the Hospice Nurse's recommendation to perform neurological assessments.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interview, record review, facility policy review, and review of a Hospital Photograph; and Hospital Wound Assessment, it was determined the facility failed to ensure a resident who has a pressure sore receives the necessary care and services to promote healing and prevent infection for one (1) of six (6) sampled residents (Resident #6). Licensed staff failed to conduct daily treatments and dressing changes for Resident #6's Stage III pressure sore on the right outer ankle for three (3) consecutive days (07/04/15, 07/05/15 and	F 314	1. Resident # 6 is no longer a resident in the facility as of 7/7/15 when she was discharged to the hospital. 2. All current facility residents who have pressure wounds are being reviewed to be certain that they are receiving care and treatment per their physician's orders. This review will be conducted by the DON, ADON, MDS and/or UM by 9/10/15. Any identified concerns will be corrected and the physician will be notified.	

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

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F 314	<p>Continued From page 17 07/08/15).</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Skin System Policy and Procedure, not dated, revealed a resident having a pressure sore receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. Further review revealed a skin/wound assessment would be completed on admission/readmission, with any fall and weekly thereafter. Upon identification of skin/wound impairment the nurse would update the Treatment Administration Record (TAR).</p> <p>Closed record review revealed the facility admitted Resident #8 on 11/29/14 with diagnoses which included Leukocytopenia, Mental Disorder, Depressive Disorder, Hypertension, and Vertebral Fractures. Review of a Quarterly Minimum Data Set (MDS) assessment, dated 06/10/15, revealed the facility assessed Resident #8's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of ninety-nine (99) indicating the resident was not interviewable. The resident required extensive assistance with two (2) or more persons for Activities of Daily Living (ADLs) and was at risk for pressure sores; and, had a pressure sore to the right outer ankle on admission.</p> <p>Review of Resident #6's Comprehensive Care Plan for Alteration in Comfort, dated 11/29/14, revealed to provide medication and treatments per Physician's Orders. Review of a Physician's Order, dated 06/30/15, revealed to clean the wound to the right outer ankle with saline (NaCl), apply Aquacel ag (cut to fit), and cover with Biatin</p>	F 314	<p>3. All licensed nursing staff is being re-educated to ensure that they are knowledgeable regarding the protocols of dressing changes per the physician's order. This re-education is being conducted by the DON, ADON, and/or UM and will be completed by 9/10/15 with no licensed nurse working after 9/10/15 without having received the re-education.</p> <p>4. The DON, ADON, MDS and/or UM will audit five residents and their medical records weekly for three months to ensure compliance including an observation of dressings to ensure dressings are changed per physician</p>	

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

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F 314	<p>Continued From page 18</p> <p>adhesive foam. Change daily and as needed (pm) and Weekly Skin Assessments on Wednesdays.</p> <p>Review of a Wound Log, dated 06/19/15, revealed Resident #6's right outer ankle had a Stage III pressure sore which measured 0.3 centimeters (cm) width, by 0.3 cm length and 0.1 cm depth. The facility could not produce wound assessments for 08/24/15 and/or 07/01/15.</p> <p>Review of the July 2015 Treatment Administration Record (TAR) revealed the last wound treatment and dressing change was completed on 07/03/15 by LPN #8.</p> <p>Review of a photograph taken at the hospital, dated 07/07/15, revealed Resident #6's had a dressing on his/her right ankle that was dated 07/03/15 which meant the resident's daily treatment and dressing change had not been conducted for three (3) consecutive days.</p> <p>Review of the Hospital's Assessment of the resident's right outer ankle pressure sore, dated 07/07/15, revealed a dressing was removed from the right ankle on 07/07/15 on admission and the dressing was dated 07/03/15. Further documentation revealed the wound measured 1.5 centimeters (cm) length by 0.5 cm width and the periwound skin was red. The wound had dried blood and two (2) small black places.</p> <p>Interview with Licensed Practical Nurse (LPN) #6, on 07/11/15 at 3:15 PM, revealed she recalled changing the resident's right ankle dressing on 07/03/15 and the Stage III area was had no drainage, odor or bleeding and was small.</p>	F 314	<p>order. The results of the audits will be reviewed by the QAPI Committee monthly for three months. The QAPI Committee will consist of at least five of the following QAPI members; ADM, DON, ADON, UM, FSS, SSD, MSD, ESS, MDS, DOR, BOM, or MD.</p> <p>5. Date of Compliance:</p>	9/11/15
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F 314	Continued From page 19 Interview with Registered Nurse (RN) #2, on 07/09/15 at 10:07 AM, revealed he worked the day shift on 07/04/15 and 07/05/15. He stated he did not recall changing the resident's right ankle dressing and he did not recall making the oncoming staff aware that he had not completed the treatment. Interview with LPN #1, on 07/10/15 at 10:47 AM, revealed she worked the day shift on 07/06/15 and did not recall changing the dressing to Resident #6's right ankle or notifying the oncoming shift she had not completed the treatment. Interview with the Director of Nursing (DON), on 07/07/15 at 9:12 AM, revealed staff was expected to follow the Physician's Orders and the Comprehensive Care Plan in regards to dressing changes and if it says daily, the dressing should be changed daily. The DON stated if the day shift got busy and did not get it done, then they should relay this information in shift report so the next shift could change the dressing. Further interview with the DON revealed the Wound Nurse was responsible for completing the weekly wound assessments and she was on vacation at the time of the assessments that were missing.	F 314	1. Resident # 6 is no longer a resident in the facility as of 7/7/15 when she was discharged to the hospital. No changes were made to the care plan as the resident had discharged from the facility. 2. All current facility residents are being reviewed to be certain that; a) their care plans are accurate and being carried out, b) the appropriate information is carried over to the TAR, c) the pressure settings are correct on the care plan and are accurate on the alternating air mattress and the TAR, and c) the proper positioning of the resident on the alternating air mattress is being followed. This review will be conducted by the IDT, consisting of the DON, ADON, MDS, AD, SSD, FSS, and/or UM. Any identified concerns will be corrected. Audits will be completed by 9/10/15.		
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.	F 323			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	<p>Continued From page 20</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, facility policy review, and review of the Low Air Loss Mattress Manufacturer Instructions; a hospital Emergency Room Report; and, review of the Hospice Registered Nurse documentation, it was determined the facility failed to ensure the resident's environment remained free of accident hazards as possible; and adequate supervision and assistive devices were provided to prevent accidents for (1) of six (6) sampled residents (Resident #6).</p> <p>On 06/25/15, Resident #6's Comprehensive Care Plan was updated to include the use of a Low Air Loss Mattress (alternating pressure) with low pressure settings and bolsters, and the need to position the resident in the center of the bed. However, the facility failed to revise the care plan to include what mattress setting was needed for Resident #6 and to position the resident on the center of the mattress. On 07/03/15, Resident #6 slid off a specialty Low Air Loss Mattress sustaining an injury to the left side of the face and head which caused swelling and bruising, a large skin tear to the left arm, and a fracture of the humerus. The facility determined the resident was not positioned correctly in the bed. In addition, the facility had care planned Resident #6 for a bed alarm after a fall on 05/15/15; however, there was no bed alarm in place at the time of the 07/03/15 fall to notify staff if the resident needed assistance.</p> <p>The findings include:</p>	F 323	<p>3. All licensed nursing staff and nursing assistants are being re-educated to ensure that they are knowledgeable regarding the appropriate use of the specialty low air loss mattresses, the specific resident care plans, the appropriate settings, and proper positioning. This re-education is being conducted by the DON, ADON, and/or UM and will be completed by 9/10/15. This re-education is being conducted by the DON, ADON, and/or UM and will be completed by 9/10/15. The IDT consisting of the DON, ADON, UM, MDS, AD, SSD, and FSS will be re-educated by the Regional Reimbursement Nurse on the development of the plan of care to meet the needs of the residents by 9/10/15. No IDT member nor nursing staff working after 9/10/15 without having received this re-education.</p>	

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F 323	<p>Continued From page 21</p> <p>Review of the facility's policy titled, "Fall Assessment/Intervention Process" not dated, revealed all residents on any admission and re-admission and at least quarterly will be assessed for fall risk and appropriate interventions initiated immediately to reduce the risk of injuries with falls. Further review revealed at the time of a fall after assessing and caring for the resident the "Resident Incident Report and Incident Investigation" should be initiated to determine appropriate intervention.</p> <p>Review of the Low Air Loss Mattress manufacturer's guideline revealed this was the type mattress used by Resident #8. The mattress had Anatomic Zones, Integrated Bolsters and Alternating Pressure; however it did not have a firm perimeter which was a standard feature on other mattresses to keep residents centered.</p> <p>Closed record review revealed the facility admitted Resident #8 on 11/29/14 with diagnoses which included Leukocytopenia, Mental Disorder, Depressive Disorder, Hypotension, and Vertebral Fractures. Review of an Quarterly Minimum Data Set (MDS) Assessment, dated 06/10/15, revealed the facility assessed Resident #8's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of ninety-nine (99) indicating the resident was not interviewable. The resident required extensive assistance with two (2) or more persons for Activities of Daily Living; was at risk for falls; and, weighed one-hundred (100) pounds.</p> <p>Review of the Comprehensive Care Plan, dated 12/10/14 revealed an intervention for a low air loss mattress with bolsters for pressure relief; and, an intervention dated 05/14/15, for staff to</p>	F 323	<p>4. The DON, ADON, MDS, and/or UM will audit five care plans weekly for three months to ensure that appropriate care plans were developed including positioning and settings of low air loss mattresses. They will also audit the air loss mattress itself to be certain it is on the correct settings and auditing the residents for correct placement on the mattress. The results of the audits will be reviewed by the QAPI Committee monthly For three months. The QAPI Committee will consist of at least five of the following QAPI members, the ADM, DON, ADON, UM, FSS, SSD, MSD, MDS, ESS, DOR, BOM, or MD.</p> <p>5. Date of Completion:</p>	9/11/15
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F 323	<p>Continued From page 22</p> <p>apply a chair alarm and bed alarm. Further review revealed on 08/25/15, an intervention was added for a low air loss mattress with bolsters with low pressure settings. However, the care plan did not address the specific mattress setting for Resident #8 and did not state to ensure the resident was positioned in the center of the bed.</p> <p>Review of Resident #8's July Treatment Administration Record (TAR) revealed there was a treatment to have "low air loss mattress with bolsters, monitor functioning and settings every shift". However, it did not specify the mattress setting and there were no initials in the boxes dated 07/01/15-07/07/15 to indicate the mattress and mattress settings were checked every shift.</p> <p>Interview with LPN #4, on 08/06/15 at 3:00 PM, revealed she wrote the intervention on the Impaired Skin Integrity Care Plan for the Low Air Loss Mattress with Bolsters and low pressure settings on 06/25/15 after an inservice conducted by the Director of Nursing (DON). She stated she was not aware of what specific setting the mattress needed to be set, but Resident #5 was about the same size and weight of Resident #8 so she would think their mattresses would have been at the same setting. She stated, "We should always try to position any resident centered on the bed for safety." Observation of Resident #5, on 08/03/15 at 11:00 AM, revealed Resident #5's mattress was set on eighty-five (85) pounds.</p> <p>Review of Nursing Note, dated 07/04/15 at 4:49 AM, revealed Resident #8 was heard yelling from his/her room and was found on the floor between the two (2) beds in the room, laying on his/her left side. Resident #8 was assessed and placed back into bed, and he/she was noted to have bruising</p>	F 323		
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F 323	<p>Continued From page 23</p> <p>and a knot on the left side of the head just above the temple and a large skin tear on his/her left arm below the elbow. Review of the Fall Investigation Work Sheet, dated 07/04/15, revealed there was no alarm in place at the time of the fall. Further review revealed the facility determined the Certified Nurse Aide (CNA) had failed to ensure the resident was positioned in the center of the bed.</p> <p>Review of a Nursing Note, dated 07/06/15 at 6:40 AM, revealed the resident was complaining of pain anytime the resident's left arm was moved. The Physician was notified and an order was received to obtain an x-ray.</p> <p>Review of a Nursing Note, dated 07/07/15 at 1:45 PM, revealed the the resident had a fracture to the upper left arm, and the resident's family wanted him/her sent to the hospital.</p> <p>Review of the Emergency Room (ER) Patient Record of Resident #6, revealed he/she arrived on 07/07/15 at 1:55 PM and was assessed as having ecchymosis (bruising) and tenderness to the left arm and a skin tear and tenderness and ecchymosis to the left forehead. Review of the ER Physician's Note revealed he ordered an x-ray of the left arm which revealed a fracture of the proximal humerus (upper arm).</p> <p>Review of the Hospitalist Discharge Summary, dated 07/09/15, revealed Resident #6 just wanted his/her pain controlled and if the pain could not be controlled they should just let him/her die. The resident was then admitted to Inpatient Hospice for comfort measures on 07/09/15 and, expired on 07/24/15.</p>	F 323		

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F 323	<p>Continued From page 24</p> <p>Interview with CNA #3, on 07/09/15 at 2:45 PM, revealed she had provided incontinent care for Resident #6 and turned him/her to the left side, noting the resident was on a specialty "constant air flow mattress", but she was not aware of any settings for the mattress. She stated she completed her care and left the room to go across the hall to another resident when not five (5) minutes later, she heard Resident #6 calling for help. CNA #3 re-entered the room to find Resident #6 on the floor, in the position she had left him/her. She stated "I don't know how it happened, the way I had positioned him/her way over towards the left side of the bed, it's like he/she slid off backwards". CNA #3 stated RN #2 had CNA #7 pick up the resident off the floor and put him/her back in the bed and LPN #1 assessed the resident. CNA #3 stated the resident was not complaining of any pain, but he/she did have a "goose egg" on his/her left side of head. CNA #3 stated she had not been inserviced on the use of the mattress.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 07/08/15 at 11:25 AM, revealed she was Resident #6's nurse on 07/03/15 when he/she was found on the floor beside his/her bed. She stated she didn't know what happened, we just found him/her on the floor. LPN #1 noted the resident had a "goose egg" to the left side of his/her head and a skin tear on his/her left elbow.</p> <p>Interview, on 08/06/15 at 10:05 AM with the Hospice Nurse Aide State Registered (NASR), revealed she visited Resident #6 three (3) days a week for his/her bath. She stated she talked with him/her at length about how he/her injured his/her head and arm. She stated Resident #6's exact words to her were, "I fell out of bed, I told them I was too close to the edge, they think I'm stupid or</p>	F 323			

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F 323	<p>Continued From page 25</p> <p>something, the bed was slick and oops the next thing I know they were picking me up off the floor".</p> <p>Interview with LPN #2/MDS Assistant, on 08/03/15 at 3:00 PM, revealed she recalled talking about Resident #6's fall on 05/15/15 in morning meeting and they care planned the resident to have alarms to the bed and chair to alert staff for need of assistance. She stated the Unit Manager was in the morning meeting and should have contacted the physician for the order and placed the notation for the alarms on the Treatment Administration Record and initiated the alarms.</p> <p>Interview with Registered Nurse (RN) #1 (Unit Manager), on 08/04/15 at 1:09 PM, revealed she was not the Unit Manager on 05/14/15. However, she was responsible for checking the residents' care plans. She stated she was not Resident #6 had been care planned by LPN #2 for alarms to alert staff that resident needed assistance.</p> <p>Interview on 07/30/15 at 12:45 PM with the Director of Nursing (DON) revealed she would expect the licensed staff to update a resident's care plan per the facility's policy; on admission, re-admission, with any changes in treatment and at least quarterly. The DON stated she expected the licensed nurses to be specific when care planning for any piece of equipment. She stated the Low Air Loss Mattresses may be different with a different pressure controller so the settings should be included on the care plan. The DON stated Physician Orders, MARs and TARs should reflect that specifically, and for residents' safety they should be positioned centered in the bed no matter what type mattress was being used. She</p>	F 323		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	Continued From page 26 further stated she was not aware of Resident #6 ever having an alarm on his/her bed or chair. The DON stated she expected staff to follow the care plans to ensure residents received adequate supervision and assistive devices to prevent accidents.	F 323			