

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

PRINTED: 10/16/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  D. WING _____		(X3) DATE SURVEY COMPLETED  10/02/2014
NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40299		
(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  A Recertification/Abbreviated/Extended Survey initiated on 09/23/14 and concluded on 10/02/14 found the facility not meeting the minimum requirements for recertification with deficiencies cited. Complaint KY22256 was substantiated with Immediate Jeopardy identified on 09/25/14. The Immediate Jeopardy was determined to exist on 09/16/14 at a scope and severity of a "J", at 42 CFR 483.10 Resident Rights (F157), 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.25 Quality of Care (F309 and F323), and 42 CFR 483.75 Administration (F514), with Substandard Quality of Care at 42 CFR 483.25 Quality of Care. The facility was notified of the Immediate Jeopardy on 09/25/14.  On 09/16/14 at 11:30 AM, Resident #14 sustained a 1.5 centimeter laceration above the right eye with profuse bleeding during a transfer with a mechanical lift. There was no documented evidence the resident's physician was notified of the injury. The Director of Nursing (DON) was not notified of the injury until approximately 2:00 PM and she instructed the staff to apply a dressing to the wound. Interviews revealed between 3:30 PM and 4:00 PM, Registered Nurse (RN) #1 and Minimum Data Set (MDS) Nurse #1 found Resident #14 with bruising around the right eye with significant swelling and increased bleeding that had soaked through the initial dressing. However, interviews and record review revealed no documented evidence of assessment and/or monitoring of Resident #14. At 4:00 PM the DON was again notified of the change of condition and gave direction to RN #1 to prepare the resident for transfer to the hospital for evaluation. However, interviews revealed neither	F 000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.		

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 listed 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 required for program participation.

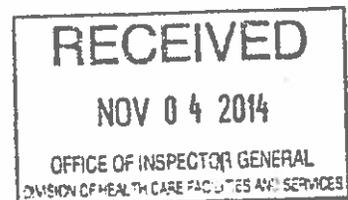
OFFICE OF INSPECTION GENERAL  
WISCONSIN DEPARTMENT OF HEALTH SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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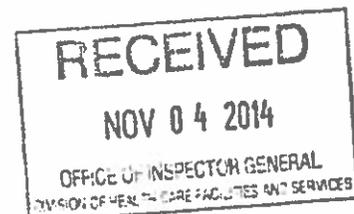
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185208	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  10/02/2014
NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40299	
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F 000	Continued From page 1 the physician nor the ambulance service was notified as instructed. At 5:00 PM, the resident was found unresponsive and in respiratory distress. The facility made an urgent call to the ambulance company at 5:08 PM with arrival at 5:18 PM. The resident was found with no pulse or spontaneous respirations and was pronounced dead at 5:20 PM.  The facility provided an acceptable Allegation of Compliance on 10/01/14 that alleged removal of Immediate Jeopardy on 09/30/14. The State Survey Agency verified Immediate Jeopardy was removed on 09/30/14 as alleged, at 42 CFR 483.10 Resident Rights (F157), 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.25 Quality of Care (F309 and F323) and 42 CFR 483.75 Administration (F514) with the scope and severity lowered to a "D" while the facility monitors the effectiveness of the implemented plan of correction.  Additional deficiencies cited were F431 at a scope and severity of a "D", and F497 at a scope and severity of an "E".	F 000	Continued From page 1	
F 157 SS=J	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	F 157	An Allegation of Compliance was provided on 09/29/14 alleging removal of the Immediate Jeopardy on 09/30/14. The following steps were taken:  1. The resident affected by this incident is deceased. The C.N.A. involved in the incident was suspended pending investigation of the incident.	10/31/14



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F 157	<p>Continued From page 2</p> <p>clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, closed record review and review of the facility's policy and procedures, it was determined the facility failed to have an effective system in place to ensure a resident's physician was notified immediately of any resident who sustained an injury and potentially required physician intervention for one (1) of sixteen (16) sampled residents (Resident #14). The facility also failed to notify the family of the resident's injury timely. (Refer to F309)</p> <p>On 09/16/14 at 11:30 AM, Resident #14 sustained an open wound to the face above the right eye with profuse bleeding when State Registered Nursing Assistant (SRNA) #3 attempted a</p>	F 157	<p>Continued From page 2</p> <p>On 09/25/2014 at 2 pm EST, a meeting was held to discuss the investigation, root cause of the IJ, GSS policy &amp; procedures, and action plan. Attendees included Administrator, Director of Nursing Services, Staff Development / Quality Assurance Coordinator, Human Resources Director, GSS Rehabilitation / Skilled Consultants, GSS Quality Improvement Consultant, and GSS Workforce Consultant. GSS policy and procedure review included Safe Resident Handling, Incident Reporting and Notification of Change of Condition. All policies &amp; procedures were found to be appropriate; no revisions were required and a lesson plan was developed for re-education related to F282, F309, F323, and F514. On 09/25/2014 at 4 pm EST, a meeting was held to communicate IJ situation, assign tasks and communicate mandatory adjusted schedules. Attendees included Director of Nursing Services, Staff Development / Quality Assurance Coordinator, and Nurse Case Managers.</p>		



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F 157	<p>Continued From page 3</p> <p>transfer using a lift without staff assistance. However, there was no documented evidence the resident's physician was notified of the injury. Interviews revealed between 3:30 PM and 4:00 PM, Registered Nurse (RN) #1 and Minimum Data Set (MDS) Nurse #1 found Resident #14 with bruising around the right eye with significant swelling and increased bleeding that had soaked through the initial dressing. At 4:00 PM the Director of Nursing (DON) gave direction to RN #1 to prepare the resident for transfer to the hospital for evaluation. However, interviews revealed neither the physician nor the ambulance service was notified as instructed. At 5:00 PM, the resident was found unresponsive and in respiratory distress. The facility made an urgent call to the ambulance company at 5:08 PM with arrival at 5:18 PM. The resident was found with no pulse or spontaneous respirations and was pronounced dead at 5:20 PM.</p> <p>The facility's failure to have an effective system in place to ensure the resident's physician was notified immediately in case of an injury that required a physician's intervention, placed Resident #14 and other at risk residents in a situation that could cause or was likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 09/24/14 and determined to exist 09/16/14. The facility was notified of the Immediate Jeopardy on 09/25/14.</p> <p>The facility provided an acceptable Allegation of Compliance on 10/01/14 that alleged removal of Immediate Jeopardy on 09/30/14, the State Survey Agency verified Immediate Jeopardy was removed on 09/30/14 as alleged at 42 CFR 483.10 Resident Rights (F157) with the scope</p>	F 157	<p>Continued From page 3</p> <p>On 09/26/2014, an inventory of facility mechanical lift slings was reviewed by Administrator and Environmental Services Director and it was identified that sufficient number of slings were present. For a total of 19 residents requiring the use of a mechanical lift, there are 88 available slings. Soiled slings are placed in the soiled utility rooms by nursing staff to be laundered. Laundry staff cleans and inspect slings before slings are returned to the floor for use. Once slings are sent to laundry, they are returned to the floor clean the very next day. Clean slings are stored on unit AB in room B12 and on unit CD in the clean utility room. On 09/26/2014 at 5:00 am EST, a meeting was held to provide re-education in response to IJ and to discuss re-education to follow for the entire active nursing staff. Attendees included Administrator, Director of Nursing Services, Staff Development / Quality Assurance Coordinator, and Nurse Case Managers with re-education provided by GSS Rehabilitation / Skilled Consultant.</p>		

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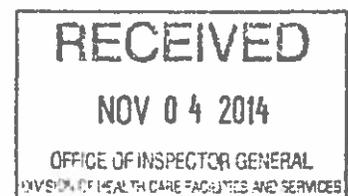
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F 157	<p>Continued From page 4</p> <p>and severely lowered to a "D" while the facility monitors the effectiveness of the implemented plan of correction.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure regarding A Fallen or Injured Resident, revised June 2014, revealed the purpose was to give prompt treatment and prevent further injury. The policy directed staff, in case of complications; notify the physician and follow orders; for residents with suspected head injury notify the physician by phone, not fax.</p> <p>Review of facility's incident report for Resident #14's injury, dated 09/16/14, revealed the wound nurse (Minimum Data Set Nurse #1) measured the wound at 0.1 centimeter (cm) x 1.5 cm. The area was cleaned and pressure applied to the wound with some decrease in bleeding. The report indicated the injury type as a laceration located on the face. The injury report noted the family and resident's physician were notified at 1:00 PM on 09/16/14. However, interview with staff and the resident's physician and family revealed this notification was not conducted.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 09/23/14 at 3:21 PM, revealed she did not notify the resident's family or tell the resident's physician of her concerns at the time of the incident because she was busy with other tasks. LPN #1 stated she did not actually notify the family or the physician until the next shift.</p> <p>Interview with Minimum Data Set (MDS) Nurse #1, on 09/23/14 at 5:07 PM, revealed she told Registered Nurse (RN) #1 around 3:20 PM to go</p>	F 157	<p>Continued From page 4</p> <p>2. All residents dependent on staff for assistance with bed mobility and transfer had the potential to be affected by this deficiency. 100% of the 79 current residents' Mobilization User Defined Assessments (UDA) were reviewed for accuracy, by the Director of Nursing Services, in determining type of assistance required for bed mobility and transfers; this review was initiated on 09/25/2014 and was completed on 09/28/2014. 10 of the 79 residents were re-assessed by completing the Mobilization UDA for 3 consecutive shifts on 09/27/2014 and 09/28/2014; Case Managers and floor nurses completed the re-assessments. 100% of 79 current residents care plans were reviewed by the Director of Nursing Services to ensure care plan and kardex included level of assist for bed mobility and transfer, including number of staff members, type of lift and sling size if indicated; this review was initiated on 09/25/2014 and was completed on 09/28/2014.</p>		

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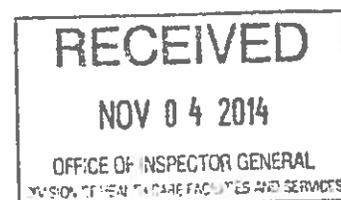
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F 157	<p>Continued From page 5</p> <p>ahead and prepare the paperwork for the resident to be transferred, notify the resident's physician, and call the ambulance service.</p> <p>Review of the Facsimile (fax) Transmission Verification Report, not signed, dated or timed revealed there was no confirmation of the physician notification ever being sent. Further review of the fax revealed the resident obtained a split/gash measuring 0.1 x 1.5 cm above the right eye during a transfer and had a moderate amount of bleeding and steri-strips were applied.</p> <p>Interview with the DON, on 09/25/14 at 11:50 AM, revealed she went back to the room around 4:00 PM to assess the resident and told RN #1 the resident needed to go immediately for sutures and evaluation at the hospital.</p> <p>Review of the second Facsimile (fax) Transmission Verification Report, dated 09/16/14, revealed a confirmation time of 4:34 PM. The fax specified the resident sustained a gash above the right eye, it was cleaned with normal saline and steri-strips were applied. The gash continued to moderately bleed and was it okay to send the resident out to be sutured.</p> <p>Further interview with LPN #1, on 09/24/14 at 12:01 PM, revealed on 09/16/14 at 4:00 PM, she sent a fax to the resident's physician requesting an order to send the resident to the emergency room and called the family for the first time to let them know the resident was injured and required stitches. The LPN further stated the resident's physician preferred notifications through fax; however, if something was emergent it was the policy to page the physician. LPN #1 stated she did not know why she did not page the doctor per</p>	F 157	<p>Continued From page 5</p> <p>3. Re-education for compliance of F282, F309, F323 and F514 was provided to C.N.A staff and licensed nursing staff by GSS Rehabilitation / Skilled Care Consultation, Nurse Case Manager / Safe Resident Handling Coordinator and Staff Development / Quality Assurance Coordinator began at 5:00 am EST on 09/26/2014 with multiple meetings scheduled throughout the day on all shifts through 09/27/2014. Beginning on 1<sup>st</sup> shift of 09/26/2014, no nursing staff member was permitted to provide resident care until re-education was completed. As of 09/29/2014 70 employees, which represents all current full and part time nursing staff, have received the re-education which included passing post-test and return mechanical lift use demonstration. 2 PRN / on call employees who are currently not scheduled to work will receive the re-education prior to working. Re-education included:</p> <p>1. Care Delivered as Per Care Plan</p> <p>A) The plan of care is written to meet the resident's individualized needs based on data collection and assessment UDAs. The care plan needs to be updated with resident's change of condition.</p>		



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F 157	<p>Continued From page 6 the facility's policy and procedure.</p> <p>Interview with RN #1, on 09/23/14 at 2:45 PM, revealed he answered a call from the resident's physician who was upset and said if there was an emergency the facility should call and not send a fax. The RN #1 further stated he received an order to transfer the resident to the hospital; however, failed to write the order. RN #1 stated he did not call the ambulance service as was instructed because he thought someone else was taking care of it.</p> <p>Interview with the resident's family member, on 09/24/14 at 11:47 AM, revealed he was not told until late afternoon of the injury and was told at that time the resident required stitches. The family member then stated that a short while later the facility called to say the resident had passed away.</p> <p>Further interview with LPN #1, on 09/25/14 at 11:29 AM, revealed if there was any type of accident they were supposed to notify the family and the physician. Continued review of the closed record did not reveal any evidence the physician or family were notified as documented in the incident report dated 09/16/14.</p> <p>Interview with Resident #14's physician, on 09/24/14 at 4:42 PM, revealed she was not notified until late afternoon that the resident had been hit in the head. The physician stated she was told the resident needed to go out for stitches but was not aware of when the incident actually occurred. The physician stated she was called later by the facility and told she needed to sign the death certificate. The physician stated she was very confused by this because she had given</p>	F 157	<p>Continued From page 6</p> <p>B) Facility staff must review the care plan / kardex and provide care as documented in the care plan.</p> <p>C) GSS Safe Resident Handling Policy and Procedure</p> <p>D) Mobilization UDA completion.</p> <p>E) Bod Mobility, Transfers, Use of Mechanical Lifts and Proper Lift Sling Utilization with return demonstration. Clean slings are stored on unit AB in room B12 and on unit CD in the clean utility room. If a needed sling cannot be located, report to the nurse, Case Manager or Director of Nursing Services.</p> <p>II. Quality of Care</p> <p>A) Resident care is provided based on resident's data collection and assessment UDAs and the written care plan. This is done to meet the resident's standard of care without injury or decline in resident's condition.</p> <p>B) The licensed nurses are responsible for working with C.N.As and supervising resident care – this is done by observation of care and communication with C.N.As to ensure care is delivered as per care plan.</p>		



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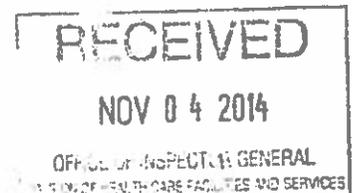
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F 157	<p>Continued From page 7</p> <p>an order for the resident to be transferred to the hospital and did not understand why that was not done.</p> <p>The facility provided an Allegation of Compliance (AOC) on 09/29/14 alleging the Immediate Jeopardy was removed on 09/30/14; the facility took the following steps to remove the Immediate Jeopardy.</p> <ol style="list-style-type: none"> <li>1. The SRNA (SRNA #3) involved in the incident was suspended after the incident on 09/16/14 pending investigation of the incident.</li> <li>2. A meeting was held to discuss the investigation, root cause of the Immediate Jeopardy, Good Samaritan Society policies and procedures (review included safe resident handling, incident reporting and notification of change of condition and action plan), on 09/25/14 at 2:00 PM. Attendees of the meeting on 09/25/14 were the Administrator, Director of Nursing, Staff Development/Quality Assurance Coordinator, Human Resources Director, Good Samaritan Society (GASS) Rehabilitation/Skilled Consultants, Good Samaritan Society Quality Improvement Consultant and a Good Samaritan Society Workforce Consultant.</li> <li>3. All policies and procedures reviewed at the 2:00 PM meeting on 09/25/14 were found to be appropriate with no revisions required. A lesson plan was developed by the attendees for re-education.</li> <li>4. A meeting was held, on 09/25/14 at 4:00 PM, to communicate the Immediate Jeopardy situation, assign tasks and communicate mandatory adjusted schedules. Attendees included the</li> </ol>	F 157	<p>Continued From page 7</p> <p>III. Accidents</p> <p>A) GSS Incident Report Policy and Procedure – incident report completion, vital signs, neuro check UDA if resident hit head or unknown if resident hit head in a fall, pain data collection and assessment UDAs if resident has “new” area of pain related to the incident, fall risk UDA if resident fell. Progress note follow up to the incident each shift for 72 hours or longer until stable. Progress note related to physician notification and family notification.</p> <p>B) GSS Notification of Change of Condition Policy and Procedure – assessing resident, notifying physician, documenting the communication with physician – follow doctor’s orders for sending resident to the hospital / calling EMS – if the resident is in an emergent situation, physician and EMS are both called immediately.</p> <p>IV. Clinical Records</p> <p>A) Documentation must be clear, concise, objective findings using medical terminology and approved GSS abbreviations. Information stated by residents should be documented exactly as heard</p>		

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F 157	<p>Continued From page 8</p> <p>Director of Nursing, Staff Development/Quality Assurance Coordinator and Nurse Case Managers.</p> <p>5. On 09/26/14 at 5:00 AM, a meeting was held to provide re-education in response to the immediate Jeopardy and to discuss re-education to follow for the entire active nursing staff. Attendees included the Administrator, Director of Nursing, Staff Development/Quality Assurance Coordinator, and Nurse Case Managers with re-education provided by a Good Samaritan Society Rehabilitation/Skilled Consultant.</p> <p>6. On 09/26/14 an inventory of mechanical lift slings was reviewed by the Administrator and the Environmental Services Director and it was identified that a sufficient number of slings were present. There were eighty-eight (88) available slings for a total of nineteen (19) residents requiring the use of a mechanical lift. Soiled slings were placed in the soiled utility rooms by nursing staff to be laundered. Laundry staff cleaned and inspected slings and returned them to the floor the very next day.</p> <p>7. A one-hundred (100)% review was initiated on 09/25/14 and concluded on 09/28/14 to ensure accuracy (determination of type of assistance required for bed mobility and transfers) of seventy-nine (79) current residents' Mobilization User Defined Assessments (UDA) by the Director of Nursing. Ten (10) of the seventy-nine (79) residents were re-assessed by completing the Mobilization UDA for three (3) consecutive shifts on 09/27/14 and 09/28/14 by Nurse Case Managers and floor nurses.</p> <p>8. One-hundred (100)% review of seventy-nine</p>	F 157	<p>Continued From page 8</p> <p>B) Documentation must be timely – at the time of data collection, UDA completion – take the PCC tablet / laptop into resident's room for immediate documentation. In emergency situations, documentation must be completed as a late entry as soon as possible, no later than the end of the shift. Nursing staff are not to leave the building until documentation is complete. PCC will date and time stamp when the entry is made, so when documenting event that occurred at an earlier time, the time of occurrence will be entered in the text of the note.</p> <p>C) Utilize the proper progress note type to document follow up assessment, physician notification and family notification.</p> <p>4. Audits will be completed by licensed nurse for completion of Mobilization UDA on each shift in the first 24 hours of admission/readmission and with change of condition, for accurate care planning / kardex for level of assist for bed mobility and transfer including number of staff, type of lift and sling size if indicated. Audits will be completed by licensed nurse observing 1 C.N.A. on each unit on each shift in assisting resident with bed mobility and transfer to ensure safe care as per resident's care plan.</p>		



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  10/02/2014
NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40208		
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F 157	Continued From page 9 (79) current residents' care plans was initiated on 09/25/14 and completed on 09/28/14 by the Director of Nursing to ensure care plans and Kardexs included the level of assist for bed mobility and transfer, included the number of staff members required for use of the lift, the type of lift to be used, and the sling size, if indicated.  9. Re-education was provided to SRNA staff and licensed nursing staff beginning at 5:00 AM on 09/26/14 on all shifts and continued through 09/27/14 for compliance by Good Samaritan Society Rehabilitation/Skilled Consultant, Nurse Case Manager/Safe Resident Handling Coordinator and Staff Development/Quality Assurance Coordinator. Beginning on first (1st) shift of 09/26/14 no nursing staff member was permitted to provide resident care until re-education was completed. As of 09/29/14 seventy (70) employees (all current full and part-time nursing staff) had received the re-education which included passing a post-test and return demonstration for use of the mechanical lift. Two (2) prn/on-call nursing employees who were not scheduled to work will receive the re-education prior to working. The re-education included 1) care delivered per care plan, 2) quality of care, 3) accidents and 4) clinical records.  10. Audits will be completed daily times seven (7) days by licensed nurses for completion of mobilization (UDA) on each shift in the first twenty-four (24) hours of admission/readmission and with change of condition for accurate care planning/Kardexs for level of assistance for bed mobility and transfer including number of staff, type of lift, and sling size if indicated.	F 157	Continued From page 9 Medical Record Audits will be completed by licensed nurse to ensure with each incident an incident report has been completed, GSS #415 (facility investigation) is initiated, physician and resident's responsible party have been notified with appropriate documentation, resident monitoring and assessment is completed and documented in appropriate UDAs and progress notes. All audits will be completed daily X 7 days.  The facility has developed a Compliance Ad Hoc Committee which is chaired by the facility Administrator to manage the development of the POC for ongoing compliance of F282, F309, F323 and F514 and oversee the implementation of the POC with GSS Consultant support and assistance. Committee members include Director of Nursing Service, Staff Development / Quality Assurance Coordinator, Nurse Case Managers, Human Resource Director, Health Information Manager, and Medical Director. All audit results will be submitted to the Ad Hoc Committee for review and follow up action as indicated. The Ad Hoc Committee minutes will be reported to the Quality Committee monthly.		

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F 157	<p>Continued From page 10</p> <p>11. Audits will be completed daily times seven (7) days by licensed nurses observing one (1) SRNA on each unit on each shift in assisting residents with bed mobility and transfer to ensure safe care per the resident's care plan.</p> <p>12. Medical record audits will be completed daily times seven (7) days by licensed nurses to ensure an incident report has been completed with each incident. Good Samaritan Society facility investigation policy was initiated, physician and resident's responsible party were notified with appropriate documentation, resident monitoring and assessment was completed and documented in appropriate UDA's and progress notes.</p> <p>13. The facility developed a compliance Ad-Hoc Committee chaired by the facility Administrator to manage the development of the Plan of Correction for ongoing compliance and to oversee the implementation of the Plan of Correction with Good Samaritan Society Consultant support and assistance. Committee members include the Director of Nursing, the Staff Development/Quality Assurance Coordinator, Nurse Case Managers, Human Resource Director, Health Information Manager, and the Medical Director. All audit results will be submitted to the Ad-Hoc Committee for review and follow-up action as indicated. The Ad-Hoc Committee minutes will be reported to the Continuing Quality Improvement Committee Monthly.</p> <p>Through observation, interview and record review the State Survey Agency validated the Allegation of Compliance with removal of Immediate Jeopardy on 09/30/14 as alleged prior to exit on 10/02/14 as follows:</p>	F 157	<p>Continued From page 10</p> <p>POC Start</p> <p>The resident found to have been affected by the deficient practice (Resident #14) is now deceased.</p> <p>In identifying other residents having the potential to be affected by the same deficient practice, it was determined that all residents could experience a change of condition and could be affected.</p> <p>Re-education was initiated on 09/26/2014 to all licensed nurses by GSS Rehabilitation / Skilled Consultant. These staff members were instructed on the importance of following GSS Notification of Change of Condition policy and procedures in order to maintain safety for our residents. Specific focus was placed on physician and family notifications when a change of condition occurs to facilitate physician intervention. It was required all staff members complete and pass a post test for all training received prior to working on the floor to ensure the deficient practice does not recur.</p>		

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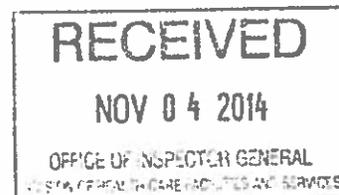
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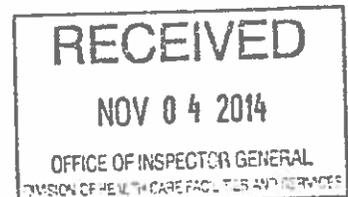
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F 157	Continued From page 11  1. Review of the personnel file for SRNA #3 revealed she was suspended from work after the incident on 09/16/14 pending the facility investigation and remained suspended throughout the survey including date of exit of 10/02/14.  2. A group interview including the Administrator, the Director of Nursing, the Staff Development Coordinator, the Human Resource Director, two (2) Good Samaritan Society Rehabilitation/Skilled Consultants (per telephone conference call), a Good Samaritan Society Quality Improvement (QI) Coordinator (per telephone conference call), and the Good Samaritan Society Workforce Consultant (per telephone conference call), on 10/02/14 at 2:00 PM, revealed the Administrator, the Director of Nursing, the Staff Development Coordinator and the Human Resource Director were present in person at the meeting held, on 09/25/14 at 2:00 PM, and the two (2) GSS Consultants, the GSS QI Coordinator and the GSS Workforce Consultant were at the meeting via telephone conference call to discuss the investigation regarding Resident #14, the root cause of the Immediate Jeopardy, GSS policies and procedures to include safe resident handling, incident reporting and notification of change of condition and to develop an action plan (lesson plan). Review of the lesson plan agenda (not dated) provided as proof for the AOC which included training on safe assistance with bed mobility, transfers and use of mechanical lifts and slings, and also included training on the writing of the individualized nursing care plan based on individualized needs and on following the residents' plans of care. Review of the sign-in sheets for the meeting held on 09/25/14 at 2:00	F 157	Continued From page 11  All post tests were reviewed immediately upon completion by GSS Rehabilitation / Skilled Consultant to validate re-education was understood and that each individual staff member passed the test. Each individual tested did receive a passing score. CNA #3 is no longer employed with GSS and did not complete re-education. Charge nurse on duty will be notified immediately regarding residents who experience a change in condition. Case Manager will then validate staff involved are following GSS policy and procedure to ensure physician notification occurs timely and that resident(s) receive proper care as directed by the physician (as instructed during re-education sessions). Facility developed a Quality Performance Improvement Project (PIP) Ad Hoc Committee to manage the POC until Quality Committee determines Ad Hoc committee is no longer required. Ad Hoc Committee members include Administrator, DNS, Staff Development / Quality Coordinator, Case Managers, Human Resources, Health Information Management, and the Medical Director.		



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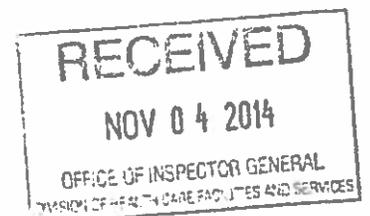
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F 157	<p>Continued From page 12 PM, confirmed the signatures of the attendees.</p> <p>3. Review of the lesson plan developed in the meeting, on 09/25/14 at 2:00 PM, revealed an agenda, content, and SRNA and licensed nurse post-tests to address the Immediate Jeopardy compliance. Review of the lesson plan developed "Providing Resident Care - Individualized, Safe, Documented" revealed an agenda, content, and SRNA and licensed nurse post-tests to address the Immediate Jeopardy compliance. The length of the training session outlined on the agenda was thirty (30) minutes for SRNAs and one (1) hour for licensed nurses with the purpose of the training to be correction activity for Immediate Jeopardy F-tags to include policies regarding safe handling of residents, incident reporting, notification of resident change of condition, data collection and UDA assessment instructions and use of mechanical lifts and slings.</p> <p>4. Interview with Nurse Case Managers #1 and #2, the DON, and the Staff Development Coordinator, on 10/02/14 at 3:06 PM, 3:15 PM, and 3:20 PM, respectively revealed they had attended the meeting held, on 09/25/14 at 4:00 PM, to discuss the Immediate Jeopardy situation, to assign tasks and to communicate mandatory adjusted schedules for the nursing staff. Review of the sign-in sheet for the meeting held on 09/25/14 at 4:00 PM confirmed the signatures of the attendees.</p> <p>5. A group interview including the Administrator, the Director of Nursing, the Staff Development Coordinator, GSS Rehabilitation/Skilled Consultant #2 (per telephone conference call) and Nurse Case Managers #1, #2 and #3, on</p>	F 157	<p>DNS and MDS Coordinators will review residents/resident progress notes daily to identify resident change of condition and to ensure family notifications were completed timely and care provided was documented appropriately. Audits will be completed daily X4 weeks, then weekly X4 weeks, bi-weekly X 1 month, then quarterly X 3. Audit findings will be reported to the Quality Committee monthly x3, then quarterly x3, for further recommendation to ensure continued compliance.</p>		



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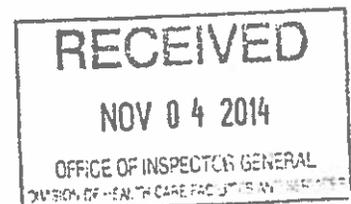
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F 157	<p>Continued From page 13</p> <p>10/02/14 at 2:00 PM, revealed they were all present in person at the meeting held, on 09/26/14 at 5:00 AM, and GSS Rehabilitation/Skilled Consultant #2 provided the re-education to that staff in the meeting with discussion of re-education for the entire active nursing staff. Review of the sign-in sheet for the meeting held on 09/28/14 confirmed the signatures of the attendees.</p> <p>6. Observation of the mechanical lift slings located in the laundry and on each nursing unit, on 10/02/14 at 9:00 AM, revealed there were eighty-eight (88) slings available for use. Twelve (12) of the slings observed were soiled and awaiting washing and inspection. Interview with the Administrator and the Environmental Services Director, on 10/02/14 at 12:16 PM, revealed they both participated in an inventory of the facility mechanical lift slings on 09/28/14. The Administrator and the Environmental Services Director indicated the soiled slings were to be placed in the soiled utility rooms by nursing staff to be laundered and the laundry staff was to launder, dry and inspect the slings before stocking them on each nursing unit the next day. Interview with SRNA #7, on 10/02/14 at 3:50 PM, revealed she would place a soiled sling in a bag in the soiled utility room on the nursing unit to be laundered and it was her understanding the laundry staff would inspect the slings for any defects before returning them to the nursing units. Interview with the Housekeeping/Laundry Supervisor, on 10/02/14 at 4:00 PM, revealed the laundry staff cleaned the mechanical lift slings seven (7) days a week and inspected them before returning them to the nursing units for use. She stated if a sling was defective it would be given to Case Manager #3 for replacement.</p>	F 157		



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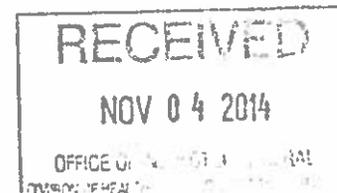
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F 157	<p>Continued From page 14</p> <p>Interview with Case Manager #3, on 10/02/14 at 4:10 PM, revealed he received the defective slings identified by the laundry staff or any nursing personnel and would order a replacement right away and the replacement would usually be provided within a week. Interview with the DON, on 10/02/14 at 4:10 PM, revealed mechanical lift slings were stored in the clean utility rooms on each nursing unit and were laundered and inspected by the laundry staff.</p> <p>7. Further interview with the DON, on 10/02/14 at 4:10 PM, revealed she initiated a one-hundred 100% audit of the seventy-nine (79) residents' Mobilization UDA's in the facility on 09/25/14 and completed the audit on 09/28/14. Review of the UDA's for Resident #17, Resident #18, Resident #19 and Resident #20 revealed they were accurate assessments of the residents' needs. Re-assessment documents were reviewed for ten (10) of the seventy-nine (79) residents reviewed which were completed for three (3) consecutive shifts on 09/27/14 and 09/28/14. Interview with Case Manager #1, and RN #1, on 10/02/14 at 4:15 PM, and 4:20 PM, respectively revealed they assisted with the re-assessments for ten (10) of the seventy-nine (79) residents reviewed which were completed for three (3) consecutive shifts on 09/27/14 and 09/28/14. Review of the audit initiated on 09/27/14 and concluded on 09/28/14 confirmed ten (10) residents were reviewed for reassessment by the DON.</p> <p>8. Observation of Resident #17, on 09/30/14 at 3:25 PM, on 10/01/14 at 8:35 AM, and 10:30 AM, revealed the resident's plan of care was being followed by the nursing staff. Observation of Resident #17, on 10/01/14 at 11:00 AM, revealed two (2) SRNAs performing a mechanical lift</p>	F 157			



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F 157	Continued From page 15 transfer of the resident from the bed to a wheelchair using the appropriate sling identified on the plan of care and using appropriate procedure for the transfer. Observation of Resident #18, on 09/30/14 at 3:45 PM, 10/01/14 at 8:45 AM and 10:45 AM, revealed the resident was being cared for per the assessed nursing/SRNA plan of care. Observation of Resident #19, on 09/30/14 at 3:11 PM and 10/01/14 at 1:30 PM, revealed the resident's plan of care was being followed by the nursing staff. Review of the clinical records for Resident #17, Resident #18 and Resident #19's revealed Minimum Data Set (MDS) comprehensive reviews completed in the past thirty (30) days and compared to the residents' records revealed accurate assessments had been completed. Review of the nursing and SRNA care plans for Resident #17, Resident #18 and Resident #19 revealed they had been created from the comprehensive MDSs, completed in the past thirty (30) days and had been updated/revised as indicated. Review of the Mobilization UDA dated 08/28/14 for Resident #17 revealed the resident was to be transferred using the appropriate sling size with a mechanical lift as assessed. Interview with the DON, on 10/02/14 at 4:10 PM, revealed she initiated a one-hundred 100% audit of the seventy-nine (79) residents' (in the facility at the time) care plans on 09/25/14 and completed that audit on 09/28/14 to ensure care plans and Kardexs included the level of assist for bed mobility and transfer, the number of staff required for use of the lift and the type of lift and sling to be used, if indicated. Review of the audits completed by the DON confirmed they were completed between 09/25/14 and 09/28/14.  9. Review of the SRNA and licensed nurse	F 157			



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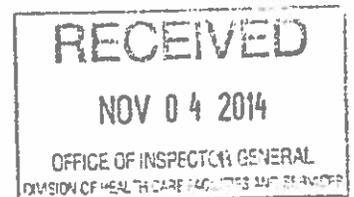
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F 157	Continued From page 16 sign-in sheets for the re-education trainings revealed all but two (2) on-call nursing employees had completed the training between 09/26/14 at 5:00 AM and 09/27/14. A telephone interview with the GSS Rehabilitation/Skilled Consultant #2, on 10/02/14 at 2:00 PM, revealed she had conducted the lesson plan training on 09/26/14 through 09/29/14 with the assistance of Nurse Case Managers #1 and #2. Interview with Nurse Case Managers #1 and #2, on 10/02/14 at 2:20 PM, revealed they had participated in the lesson plan training done on 09/26/14 through 09/27/14. Interview with the Staff Development Coordinator on 10/02/14 at 2:30 PM revealed she had participated in the lesson plan training on use of the slings and mechanical lifts and had observed staff with return demonstrations of use of the slings and lifts on 09/26/14 through 09/29/14. Interview with LPN #2, on 10/02/14 at 3:40 PM, revealed she had attended an in-service training last week about lift use, charting, incident reporting, and calling the doctor. She stated she demonstrated the use of the mechanical lifts and had a written post-test on the training content. Interview with LPN #3, on 10/02/14 at 3:43 PM, revealed she had attended an in-service training on 09/27/14 about mechanical lift use, charting, incident reporting, and calling the doctor. She stated she also demonstrated the use of the mechanical lifts and had a written post-test on the training content. Interview with SRNA #7, on 10/02/14 at 3:48 PM, revealed she attended an in-service training on 09/26/14 about the use of the resident care plans and lift/sling use and she did a return demonstration and had a post-test. Interview with SRNA #8, on 10/02/14 at 3:52 PM, revealed she attended an in-service training on 09/26/14 about the use of the resident care plans and lift/sling use and she did a return	F 157			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 157	<p>Continued From page 17 demonstration and had a post-test.</p> <p>10. Review of the seven (7) daily audits, initiated 09/29/14, confirmed a daily audit by licensed nurses for completion of the Mobilization UDA on each shift in the first twenty-four (24) hrs of admission/readmission and with change of condition, for accurate care planning/Kardexs for level of assist for bed mobility and transfer including number of staff required, type of lift and sling size, if indicated. Interview with LPN #3, on 10/02/14 at 4:20 PM, revealed she had completed three (3) of the required seven (7) daily audits to be done by licensed nurses. Interview with RN #2, on 10/02/14 at 4:25 PM, revealed he had completed two (2) of the required seven (7) daily audits to be done by licensed nurses.</p> <p>11. Review of the audits, initiated 09/27/14, confirmed the audits for proper use of the lift were completed with observations. Interview with LPN #3, on 10/02/14 at 4:20 PM, revealed she had observed SRNA #2, on day shift on 09/29/14, assisting Resident #17 with bed mobility and lift/sling transfer to ensure the safe care per the resident's care plan. LPN #3 stated she had completed three (3) of the required seven (7) daily audits to include the observation of a SRNA giving care per the resident's plan of care. Interview with RN #2, on 10/02/14 at 4:25 PM, revealed he had completed two (2) of the required seven (7) daily audits to be done by licensed nurses, with observations of SRNAs providing care.</p> <p>12. Further interview with LPN #3, on 10/02/14 at 4:20 PM, indicated she also participated in a medical record audit initiated 09/29/14 to ensure</p>	F 157			



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F 157	<p>Continued From page 18</p> <p>an incident report had been completed for an incident occurring on 10/01/14 (not reportable) and the appropriate documentation and resident assessment and monitoring occurred timely. Interview with RN #1, on 10/02/14 at 4:25 PM, revealed she also had completed a medical record audit on 09/29/14 on second (2nd) shift regarding a change in resident condition to ensure the resident's responsible party was notified, the physician was notified, appropriate assessment and monitoring of the resident was completed and timely documentation in the progress notes. Review of that audit sheet indicated RN #1 had completed that audit on 2nd shift on 09/29/14.</p> <p>13. Interview with the Administrator, the DON, the Staff Development Coordinator, the Human Resource Director and the Medical Director, on 10/02/14 at 4:35 PM, revealed they were all to be participants in a newly developed Compliance Ad-Hoc Committee to manage the development of the Plan of Correction (POC) for ongoing compliance. They indicated they are to oversee the implementation of the POC with GSS Consultant support and assistance, ensure all audit results are submitted to the Committee for review and follow-up action, as indicated. The Administrator stated the Ad-Hoc Committee minutes would be reported to the Continuing Quality Improvement Committee monthly. Review of the sign-in sheet for the Ad-Hoc meeting revealed it took place on 09/29/14 with the Administrator, the DON, the Staff Development/Quality Coordinator, the Human Resource Director, the Medical Records Director, both MDS Coordinators, and the Medical Director. The next Quality Assurance meeting is scheduled to be held on 10/28/14.</p>	F 157			

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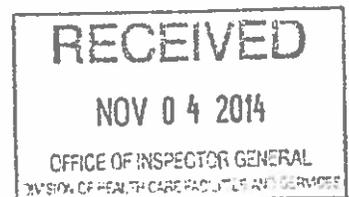
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NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40299		
(X4) ID PREFIX TAG  F 282 SS=J	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG  F 282	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE  10/31/14
	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, closed record review, and review of the facility's policies and procedures, it was determined the facility failed to have an effective system to ensure the comprehensive care plan was implemented to provide the appropriate size sling and the appropriate number of staff present for the positioning of one (1) of sixteen (16) sampled residents, (Resident #14) which resulted in an injury to the resident. (Refer to F323)</p> <p>On 09/18/14 at 11:30 AM, State Registered Nursing Assistant (SRNA) #3, failed to follow Resident #14's care plan for transfers and utilization of a lift. Record review revealed Resident #14's care plan directed staff to use two assist with transfers, and noted the size and type of sling to be used for the resident. However, SRNA #3, without assistance, attempted to reposition Resident #14 for transfer, onto a mechanical lift sling that was smaller than the resident's facility assessed size. While SRNA #3 was positioning the resident onto the lift sling, Resident 14's head hit the lift arm hooks, resulting in a 1.5 centimeter laceration above the right eye, with profuse bleeding. Interviews revealed between 3:30 PM and 4:00 PM, Registered Nurse (RN) #1 and Minimum Data Set (MDS) Nurse #1 found Resident #14 with bruising</p>			<p>An Allegation of Compliance was provided on 09/29/14 alleging removal of the Immediate Jeopardy on 09/30/14. The following steps were taken:</p> <p>1. The resident affected by this incident is deceased. The C.N.A. involved in the incident was suspended pending investigation of the incident. On 09/25/2014 at 2 pm EST, a meeting was held to discuss the investigation, root cause of the IJ, GSS policy &amp; procedures, and action plan. Attendees included Administrator, Director of Nursing Services, Staff Development / Quality Assurance Coordinator, Human Resources Director, GSS Rehabilitation / Skilled Consultants, GSS Quality Improvement Consultant, and GSS Workforce Consultant. GSS policy and procedure review included Safe Resident Handling, Incident Reporting and Notification of Change of Condition. All policies &amp; procedures were found to be appropriate; no revisions were required and a lesson plan was developed for re-education related to F282, F309, F323, and F514.</p>	

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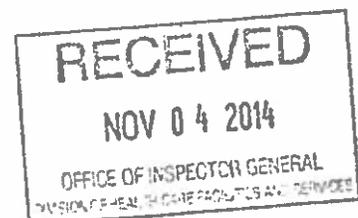
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185288	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  10/02/2014
NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40299		
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F 282	<p>Continued From page 20</p> <p>around the right eye with significant swelling and increased bleeding that had soaked through the initial dressing. At 4:00 PM the Director of Nursing (DON) gave direction to RN #1 to prepare the resident for transfer to the hospital for evaluation. However, interviews revealed neither the physician nor the ambulance service was notified as instructed. At 5:00 PM, the resident was found unresponsive and in respiratory distress. The facility made an urgent call to the ambulance company at 5:08 PM with arrival at 5:18 PM. The resident was found with no pulse or spontaneous respirations and was pronounced dead at 5:20 PM.</p> <p>The facility's failure to have an effective system in place to ensure care plans were implemented placed Resident #14 and other residents at risk in a situation that could cause or was likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 09/24/14 and determined to exist 09/16/14. The facility was notified of the Immediate Jeopardy on 09/25/14.</p> <p>The facility provided an acceptable Allegation of Compliance on 10/01/14 that alleged removal of Immediate Jeopardy on 09/30/14. The State Survey Agency verified Immediate Jeopardy was removed on 09/30/14 as alleged, at 42 CFR 483.20 Resident Assessment (F282) with the scope and severity lowered to a "D" while the facility monitors the effectiveness of the implemented plan of correction.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled, Care Plans, revised December 2005, revealed</p>	F 282	<p>Continued From page 20</p> <p>On 09/25/2014 at 4 pm EST, a meeting was held to communicate UJ situation, assign tasks and communicate mandatory adjusted schedules. Attendees included Director of Nursing Services, Staff Development / Quality Assurance Coordinator, and Nurse Case Managers. On 09/26/2014, an inventory of facility mechanical lift slings was reviewed by Administrator and Environmental Services Director and it was identified that sufficient number of slings were present. For a total of 19 residents requiring the use of a mechanical lift, there are 88 available slings. Soiled slings are placed in the soiled utility rooms by nursing staff to be laundered. Laundry staff cleans and inspect slings before slings are returned to the floor for use. Once slings are sent to laundry, they are returned to the floor clean the very next day. Clean slings are stored on unit AB in room B12 and on unit CD in the clean utility room. On 09/26/2014 at 5:00 am EST, a meeting was held to provide re-education in response to UJ and to discuss re-education to follow for the entire active nursing staff.</p>		



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F 282	<p>Continued From page 21</p> <p>the purpose was to establish a means of recording identified client problems and planned interventions. The care plan provided a means of evaluating the effectiveness of interventions and determining what modifications were necessary.</p> <p>Review of the closed clinical record for Resident #14 revealed the facility admitted the resident on 09/17/08 with diagnoses of Dementia, Anemia, Alzheimer's, Osteoarthritis, Depression, Hypertension, and Anxiety. Review of the resident's comprehensive care plan revealed the resident had an Activities of Daily Living (ADL) deficit related to immobility and dementia, initiated on 06/04/13, and required total assistance using two (2) persons for transfers with the total lift using a large high back sling and two (2) people for turning and repositioning. Review of the Mobilization Support data Collection Tool, dated 01/17/14, revealed the resident required a total lift for transfer between surfaces using a large high back sling. The facility further assessed the resident using the Minimum Data Set (MDS), dated 07/29/14, as requiring extensive assistance with bed mobility and transfers.</p> <p>Interview with SRNA #3, on 09/24/14 at 10:45 AM and 09/25/14 at 9:08 AM, revealed she was going to get the resident out of bed and place him/her in a wheelchair to transport him/her to the dining room for lunch. SRNA #3 stated they were already late and she was rushed to get the resident out of bed. The SRNA said she did not review the resident's care plan in the Kiosk prior to the incident because she had taken care of the resident before and knew he/she used a high back sling; however, the SRNA thought the resident was to use a medium sized sling. The</p>	F 282	<p>Continued From page 21</p> <p>Attendees included Administrator, Director of Nursing Services, Staff Development / Quality Assurance Coordinator, and Nurse Case Managers with re-education provided by GSS Rehabilitation / Skilled Consultant.</p> <p>2. All residents dependent on staff for assistance with bed mobility and transfer had the potential to be affected by this deficiency. 100% of the 79 current residents' Mobilization User Defined Assessments (UDA) were reviewed for accuracy, by the Director of Nursing Services in determining type of assistance required for bed mobility and transfers; this review was initiated on 09/25/2014 and was completed on 09/28/2014. 10 of the 79 residents were re-assessed by completing the Mobilization UDA for 3 consecutive shifts on 09/27/2014 and 09/28/2014; Case Managers and floor nurses completed the re-assessments. 100% of 79 current residents care plans were reviewed by the Director of Nursing Services to ensure care plan and Kardex included level of assist for bed mobility and transfer, including number of staff members, type of lift and sling size if indicated; this review was initiated on 09/25/2014 and was completed on 09/28/2014.</p>		



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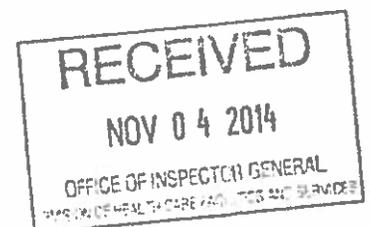
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NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40290		
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F 282	<p>Continued From page 22</p> <p>SRNA indicated the lift sling already under the resident was wet and she was unable to locate a clean sling to use. The SRNA checked the C/D Hall linen closet and the A/D Hall linen closet, but was unable to find a clean lift sling and did not know of another place to look. She decided to use the roommate's sling which was already in the room. The SRNA stated the roommate's sling was a full body, long seat sling in a size small.</p> <p>Continued interview with SRNA #3, on 09/24/14 at 10:45 AM, revealed she knew the sling was different and smaller, however, she was trying to hurry and just needed to make sure the resident was perfectly centered in order for the straps to attach to the mechanical lift. The SRNA stated during the process of trying to attach the straps she realized the resident was going to need to be readjusted again and with the lift still positioned over the resident, she turned the resident to his/her left side. The lift arm hooks where the sling attached to the mechanical lift hit the right side of the resident's head. SRNA #3 explained the resident sustained a cut on the head above the right eye with profuse bleeding. SRNA #3 further detailed she knew she was supposed to use the right type and size sling and had been trained on ensuring the right sling, but she was in a hurry and did not review the care plan or ask for help. The SRNA further stated she was trained to always have two (2) people to assist with turning and repositioning as well as transferring, but she did not ask anyone for help. SRNA #3 said SRNA #5 came into the room once the resident was attached to the lift and helped move the resident safely to the chair, but the injury had already occurred at that point. The SRNA stated the purpose of having someone else there to assist was to help spot potential hazards and prevent</p>	F 282	<p>Continued From page 22</p> <p>3. Re-education for compliance of F282, F309, F323 and F514 was provided to C.N.A staff and licensed nursing staff by GSS Rehabilitation / Skilled Care Consultation, Nurse Case Manager / Safe Resident Handling Coordinator and Staff Development / Quality Assurance Coordinator began at 5:00 am EST on 09/26/2014 with multiple meetings scheduled throughout the day on all shifts through 09/27/2014. Beginning on 1<sup>st</sup> shift of 09/26/2014, no nursing staff member was permitted to provide resident care until re-education was completed. As of 09/29/2014 70 employees, which represents all current full and part time nursing staff, have received the re-education which included passing post-test and return mechanical lift use demonstration. 2 PRN / on call employees who are currently not scheduled to work will receive the re-education prior to working. Re-education included:</p> <p>I. Care Delivered as Per Care Plan A) The plan of care is written to meet the resident's individualized needs based on data collection and assessment UDAs. The care plan needs to be updated with resident's change of condition.</p>		

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NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3508 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40299		
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F 282	<p>Continued From page 23 injury to the resident.</p> <p>Interview with SRNA #4, on 09/24/14 at 12:26 PM, and SRNA #2, on 09/25/14 at 9:54 AM, revealed they used two (2) people for the actual transfer with the lift; however, they did not get assistance to put the resident in the sling or to hook the sling to the lift.</p> <p>Interview with SRNA #1, on 09/25/14 at 9:55 AM, revealed she knew transfer information on residents was in the Kiosk on the Kardex. The SRNA stated she was aware two (2) people were required for transfers; however, she did get assistance to place the resident in the sling.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 09/25/14 at 11:29 AM, revealed the purpose of the care plan was to ensure the residents were getting the right care for their personal needs. The LPN stated not following the care plan placed the residents at risk for injury. LPN #1 further stated she did not monitor the SRNAs to ensure the care plan was being followed and assumed they knew what to do since they had worked at the facility for so long.</p> <p>Interview with the DON, on 09/24/14 at 12:30 PM, revealed the SRNAs accessed information from the care plan on the Kardex which was in the computer Kiosk. The DON stated SRNA #3 did not review the Kardex to ensure the appropriate type and size sling needed for Resident #14 was being used. In addition, Resident #14 was care planned to have two (2) people to assist with mobility and that was not done either. The DON said the SRNA had cared for the resident before and should have known what equipment was needed. The DON stated the mechanical lift</p>	F 282	<p>Continued From page 23</p> <p>B) Facility staff must review the care plan / kardex and provide care as documented in the care plan.</p> <p>C) GSS Safe Resident Handling Policy and Procedure</p> <p>D) Mobilization UDA completion.</p> <p>E) Bed Mobility, Transfers, Use of Mechanical Lifts and Proper Lift Sling Utilization with return demonstration. Clean slings are stored on unit AB in room B12 and on unit CD in the clean utility room. If a needed sling cannot be located, report to the nurse, Case Manager or Director of Nursing Services.</p> <p>II. Quality of Care</p> <p>A) Resident care is provided based on resident's data collection and assessment UDAs and the written care plan. This is done to meet the resident's standard of care without injury or decline in resident's condition.</p> <p>B) The licensed nurses are responsible for working with C.N.As and supervising resident care – this is done by observation of care and communication with C.N.As to ensure care is delivered as per care plan.</p>		



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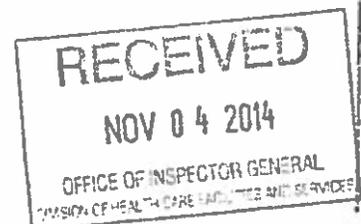
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F 282	<p>Continued From page 24</p> <p>slings were kept in the C/D Hall linen closet, the therapy room, and in room B12 on the other unit. The location of the sling was information included in the mechanical lift training.</p> <p>Continued interview with the DON, on 09/25/14 at 11:50 AM, revealed she monitored the care plans in the care plan meetings and made rounds that included going into resident rooms to ensure the care plans were being followed. However, the DON could not confirm actually watching the SRNAs using the mechanical lift to ensure the appropriate type and size slings were being used.</p> <p>The facility provided an Allegation of Compliance (AOC) on 09/29/14 alleging the Immediate Jeopardy was removed on 09/30/14; the facility took the following steps to remove the Immediate Jeopardy.</p> <ol style="list-style-type: none"> <li>1. The SRNA (SRNA #3) involved in the incident was suspended after the incident on 09/16/14 pending investigation of the incident.</li> <li>2. A meeting was held to discuss the investigation, root cause of the Immediate Jeopardy, Good Samaritan Society policies and procedures (review included safe resident handling, incident reporting and notification of change of condition and action plan), on 09/25/14 at 2:00 PM. Attendees of the meeting on 09/25/14 were the Administrator, Director of Nursing, Staff Development/Quality Assurance Coordinator, Human Resources Director, Good Samaritan Society (GASS) Rehabilitation/Skilled Consultants, Good Samaritan Society Quality Improvement Consultant and a Good Samaritan Society Workforce Consultant.</li> </ol>	F 282	<p>Continued From page 24</p> <p>III. Accidents</p> <p>A) GSS Incident Report Policy and Procedure – incident report completion, vital signs, neuro check UDA if resident hit head or unknown if resident hit head in a fall, pain data collection and assessment UDAs if resident has “new” area of pain related to the incident, fall risk UDA if resident fell. Progress note follow up to the incident each shift for 72 hours or longer until stable. Progress note related to physician notification and family notification.</p> <p>B) GSS Notification of Change of Condition Policy and Procedure – assessing resident, notifying physician, documenting the communication with physician – follow doctor’s orders for sending resident to the hospital / calling EMS – if the resident is in an emergent situation, physician and EMS are both called immediately.</p> <p>IV. Clinical Records</p> <p>A) Documentation must be clear, concise, objective findings using medical terminology and approved GSS abbreviations. Information stated by residents should be documented exactly as heard.</p>	
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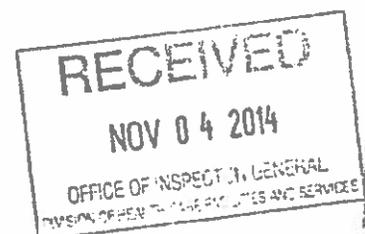
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NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40299		
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F 282	Continued From page 25 3. All policies and procedures reviewed at the 2:00 PM meeting on 09/25/14 were found to be appropriate with no revisions required. A lesson plan was developed by the attendees for re-education. 4. A meeting was held, on 09/25/14 at 4:00 PM, to communicate the immediate Jeopardy situation, assign tasks and communicate mandatory adjusted schedules. Attendees included the Director of Nursing, Staff Development/Quality Assurance Coordinator and Nurse Case Managers. 5. On 09/26/14 at 5:00 AM, a meeting was held to provide re-education in response to the immediate Jeopardy and to discuss re-education to follow for the entire active nursing staff. Attendees included the Administrator, Director of Nursing, Staff Development/Quality Assurance Coordinator, and Nurse Case Managers with re-education provided by a Good Samaritan Society Rehabilitation/Skilled Consultant. 6. On 09/26/14 an inventory of mechanical lift slings was reviewed by the Administrator and the Environmental Services Director and it was identified that a sufficient number of slings were present. There were eighty-eight (88) available slings for a total of nineteen (19) residents requiring the use of a mechanical lift. Soiled slings were placed in the soiled utility rooms by nursing staff to be laundered. Laundry staff cleaned and inspected slings and returned them to the floor the very next day. 7. A one-hundred (100)% review was initiated on 09/25/14 and concluded on 09/28/14 to ensure accuracy (determination of type of assistance	F 282	Continued From page 25 B) Documentation must be timely – at the time of data collection, UDA completion – take the PCC tablet / laptop into resident's room for immediate documentation. In emergency situations, documentation must be completed as a late entry as soon as possible, no later than the end of the shift. Nursing staff are not to leave the building until documentation is complete. PCC will date and time stamp when the entry is made, so when documenting event that occurred at an earlier time, the time of occurrence will be entered in the text of the note. C) Utilize the proper progress note type to document follow up assessment, physician notification and family notification. 4. Audits will be completed by licensed nurse for completion of Mobilization UDA on each shift in the first 24 hours of admission/readmission and with change of condition, for accurate care planning / kardex for level of assist for bed mobility and transfer including number of staff, type of lift and sling size if indicated. Audits will be completed by licensed nurse observing 1 C.N.A. on each unit on each shift in assisting resident with bed mobility and transfer to ensure safe care as per resident's care plan.		



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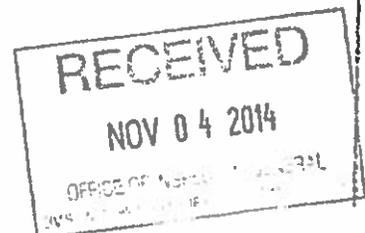
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  10/02/2014
NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40299		
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F 282	Continued From page 28 required for bed mobility and transfers) of seventy-nine (79) current residents' Mobilization User Defined Assessments (UDA) by the Director of Nursing. Ten (10) of the seventy-nine (79) residents were re-assessed by completing the Mobilization UDA for three (3) consecutive shifts on 09/27/14 and 09/28/14 by Nurse Case Managers and floor nurses.  8. One-hundred (100)% review of seventy-nine (79) current residents' care plans was initiated on 09/25/14 and completed on 09/28/14 by the Director of Nursing to ensure care plans and Kardex included the level of assist for bed mobility and transfer, included the number of staff members required for use of the lift, the type of lift to be used, and the sling size, if indicated.  9. Re-education was provided to SRNA staff and licensed nursing staff beginning at 5:00 AM on 09/26/14 on all shifts and continued through 09/27/14 for compliance by Good Samaritan Society Rehabilitation/Skilled Consultant, Nurse Case Manager/Safe Resident Handling Coordinator and Staff Development/Quality Assurance Coordinator. Beginning on first (1st) shift of 09/26/14 no nursing staff member was permitted to provide resident care until re-education was completed. As of 09/29/14 seventy (70) employees (all current full and part-time nursing staff) had received the re-education which included passing a post-test and return demonstration for use of the mechanical lift. Two (2) part/on-call nursing employees who were not scheduled to work will receive the re-education prior to working. The re-education included 1) care delivered per care plan, 2) quality of care, 3) accidents and 4) clinical records.	F 282	Continued From page 26 Medical Record Audits will be completed by licensed nurse to ensure with each incident an Incident report has been completed, GSS #415 (facility investigation) is initiated, physician and resident's responsible party have been notified with appropriate documentation, resident monitoring and assessment is completed and documented in appropriate UDAs and progress notes. All audits will be completed daily X 7 days. The facility has developed a Compliance Ad Hoc Committee which is chaired by the facility Administrator to manage the development of the POC for ongoing compliance of F282, F309, F323 and F514 and oversee the implementation of the POC with GSS Consultant support and assistance. Committee members include Director of Nursing Service, Staff Development / Quality Assurance Coordinator, Nurse Case Managers, Human Resource Director, Health Information Manager, and Medical Director. All audit results will be submitted to the Ad Hoc Committee for review and follow up action as indicated. The Ad Hoc Committee minutes will be reported to the Quality Committee monthly.		



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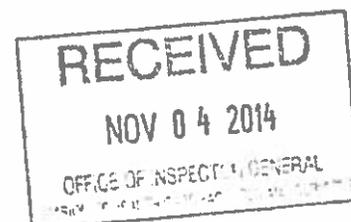
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F 282	Continued From page 27  10. Audits will be completed daily times seven (7) days by licensed nurses for completion of mobilization (UDA) on each shift in the first twenty-four (24) hours of admission/readmission and with change of condition for accurate care planning/Kardex for level of assistance for bed mobility and transfer including number of staff, type of lift, and sling size if indicated.  11. Audits will be completed daily times seven (7) days by licensed nurses observing one (1) SRNA on each unit on each shift in assisting residents with bed mobility and transfer to ensure safe care per the resident's care plan.  12. Medical record audits will be completed daily times seven (7) days by licensed nurses to ensure an incident report has been completed with each incident. Good Samaritan Society facility investigation policy was initiated, physician and resident's responsible party were notified with appropriate documentation, resident monitoring and assessment was completed and documented in appropriate UDA's and progress notes.  13. The facility developed a compliance Ad-Hoc Committee chaired by the facility Administrator to manage the development of the Plan of Correction for ongoing compliance and to oversee the implementation of the Plan of Correction with Good Samaritan Society Consultant support and assistance. Committee members include the Director of Nursing, the Staff Development/Quality Assurance Coordinator, Nurse Case Managers, Human Resource Director, Health Information Manager, and the Medical Director. All audit results will be submitted to the Ad-Hoc Committee for review	F 282	Continued From page 27  POC Start  The resident found to have been affected by the deficient practice (Resident #14) is now deceased.  In identifying other residents having the potential to be affected by the same deficient practice, it was determined that all residents have the potential for requiring use of a mechanical lift for assistance and could be affected. 100% of the 79 current residents' medical record was reviewed on 9/27/14 by the DNS for accuracy of Mobilization User Defined Assessments (UDA) and Care Plan / kardex included level of assist needed for bed mobility and transfer, including number of staff members, type of lift and sling size, if indicated. Review of medical records indicated 19 residents require the use of a lift. The Mobilization UDA for 69 out of 79 residents was accurate. 10 of the 79 residents were re-assessed by completing of the Mobilization UDA for 3 consecutive shifts and care plan / kardex were updated by 09/28/2014. The re-assessments and UDAs were completed by the charge nurses caring for those residents.		



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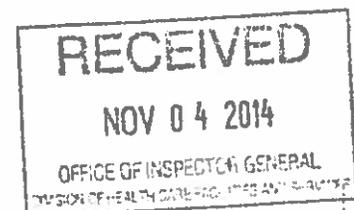
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F 282	Continued From page 28 and follow-up action as indicated. The Ad-Hoc Committee minutes will be reported to the Continuing Quality Improvement Committee Monthly.  Through observation, interview and record review the State Survey Agency validated the Allegation of Compliance with removal of Immediate Jeopardy on 09/30/14 as alleged prior to exit on 10/02/14 as follows:  1. Review of the personnel file for SRNA #3 revealed she was suspended from work after the incident on 09/16/14 pending the facility investigation and remained suspended throughout the survey including date of exit of 10/02/14.  2. A group interview including the Administrator, the Director of Nursing, the Staff Development Coordinator, the Human Resource Director, two (2) Good Samaritan Society Rehabilitation/Skilled Consultants (per telephone conference call), a Good Samaritan Society Quality Improvement (QI) Coordinator (per telephone conference call), and the Good Samaritan Society Workforce Consultant (per telephone conference call), on 10/02/14 at 2:00 PM, revealed the Administrator, the Director of Nursing, the Staff Development Coordinator and the Human Resource Director were present in person at the meeting held, on 09/25/14 at 2:00 PM, and the two (2) GSS Consultants, the GSS QI Coordinator and the GSS Workforce Consultant were at the meeting via telephone conference call to discuss the investigation regarding Resident #14, the root cause of the Immediate Jeopardy, GSS policies and procedures to include safe resident handling, incident reporting and notification of change of	F 282	Continued From page 28 The updated information was then reviewed by the Case Mangers for accuracy and completion on 9/28/2014. Immediate re-education was provided to on September 26, 2014, all licensed nurses and certified nursing assistants (C.N.A.) by GSS Rehabilitation / Skilled Consultant regarding care planning, safe resident handling, use of mechanical lifts and slings. Return demonstration Consultant, Staff Development Coordinator, and Safe Resident Handling Coordinator. All licensed nurses and certified nursing assistants (C.N.A.) were instructed on the importance of following GSS policies and procedures of skills were included in the re-educating sessions to ensure training objectives were met and that the deficient practice does not recur. Training objectives included ability of staff to conduct safe assistance with bed mobility, transfers, use of the mechanical lifts and slings. It was required all staff members complete and pass a post test for all training received prior to working on the floor.		



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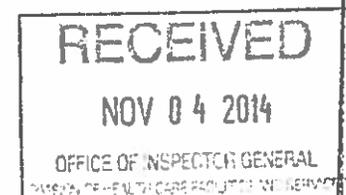
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F 282	<p>Continued From page 29</p> <p>condition and to develop an action plan (lesson plan). Review of the lesson plan agenda (not dated) provided as proof for the AOC which included training on safe assistance with bed mobility, transfers and use of mechanical lifts and slings, and also included training on the writing of the individualized nursing care plan based on individualized needs and on following the residents' plans of care. Review of the sign-in sheets for the meeting held on 09/25/14 at 2:00 PM, confirmed the signatures of the attendees.</p> <p>3. Review of the lesson plan developed in the meeting, on 09/25/14 at 2:00 PM, revealed an agenda, content, and SRNA and licensed nurse post-tests to address the Immediate Jeopardy compliance. Review of the lesson plan developed "Providing Resident Care - Individualized, Safe, Documented" revealed an agenda, content, and SRNA and licensed nurse post-tests to address the Immediate Jeopardy compliance. The length of the training session outlined on the agenda was thirty (30) minutes for SRNAs and one (1) hour for licensed nurses with the purpose of the training to be correction activity for Immediate Jeopardy F-tags to include policies regarding safe handling of residents, incident reporting, notification of resident change of condition, data collection and UDA assessment instructions and use of mechanical lifts and slings.</p> <p>4. Interview with Nurse Case Managers #1 and #2, the DON, and the Staff Development Coordinator, on 10/02/14 at 3:06 PM, 3:15 PM, and 3:20 PM, respectively revealed they had attended the meeting held, on 09/25/14 at 4:00 PM, to discuss the Immediate Jeopardy situation, to assign tasks and to communicate mandatory</p>	F 282	<p>Continued From page 29</p> <p>All post tests were reviewed immediately upon completion by GSS Rehabilitation / Skilled Consultant to validate re-education was understood and that each individual staff member passed the test. Each individual tested did receive a passing score. CNA #3 is no longer employed with GSS and did not complete re-education.</p> <p>Audits will be completed by the MDS Coordinators/ Case Managers and DNS to ensure nursing staff is reviewing kardex prior to delivering care to residents, to monitor completion and accuracy of the mobilization UDA with care plan updates and observation of staff to ensure staff are performing care/transfers per GSS policy and procedure. Audits will be conducted each shift weekly X 4 weeks, each shift bi-weekly X 2 months, then each shift quarterly X 3. DNS or Staff Development Coordinator will audit monthly X 12 months to ensure Mobilization UDA and care plan review is completed with each resident's annual, quarterly and / or significant change MDS to ensure care plans are correct and up to date. Audit findings will be reported to the Quality Committee monthly x3, then quarterly x3, for further recommendation to ensure continued compliance.</p>		



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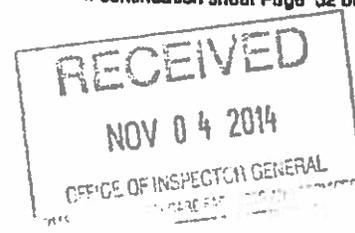
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F 282	Continued From page 30 adjusted schedules for the nursing staff. Review of the sign-in sheet for the meeting held on 09/25/14 at 4:00 PM confirmed the signatures of the attendees.  5. A group interview including the Administrator, the Director of Nursing, the Staff Development Coordinator, GSS Rehabilitation/Skilled Consultant #2 (per telephone conference call) and Nurse Case Managers #1, #2 and #3, on 10/02/14 at 2:00 PM, revealed they were all present in person at the meeting held, on 09/26/14 at 5:00 AM, and GSS Rehabilitation/Skilled Consultant #2 provided the re-education to that staff in the meeting with discusalon of re-education for the entire active nursing staff. Review of the sign-in sheet for the meeting held on 09/26/14 confirmed the signaturos of the attendees.  6. Observation of the mechanical lift slings located in the laundry and on each nursing unit, on 10/02/14 at 9:00 AM, revealed there were eighty-eight (88) slings available for use. Twelve (12) of the slings observed were soiled and awaiting washing and inspection. Interview with the Administrator and the Environmental Services Director, on 10/02/14 at 12:16 PM, revealed they both participated in an inventory of the facility mechanical lift silngs on 09/26/14. The Administrator and the Environmental Services Director indicated the soiled slings were to be placed in the soiled utility rooms by nursing staff to be laundored and the laundry staff was to launder, dry and inspect the slings before stocking them on each nursing unit the next day. Interview with SRNA #7, on 10/02/14 at 3:50 PM, revealed she would place a soiled sling in a bag in the soiled utility room on the nursing unit to be	F 282			



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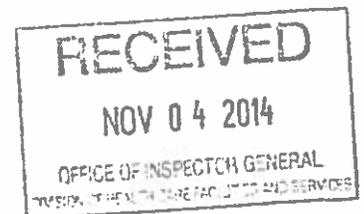
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F 282	<p>Continued From page 31</p> <p>laundered and it was her understanding the laundry staff would inspect the slings for any defects before returning them to the nursing units. Interview with the Housekeeping/Laundry Supervisor, on 10/02/14 at 4:00 PM, revealed the laundry staff cleaned the mechanical lift slings seven (7) days a week and inspected them before returning them to the nursing units for use. She stated if a sling was defective it would be given to Case Manager #3 for replacement. Interview with Case Manager #3, on 10/02/14 at 4:10 PM, revealed he received the defective slings identified by the laundry staff or any nursing personnel and would order a replacement right away and the replacement would usually be provided within a week. Interview with the DON, on 10/02/14 at 4:10 PM, revealed mechanical lift slings were stored in the clean utility rooms on each nursing unit and were laundered and inspected by the laundry staff.</p> <p>7. Further interview with the DON, on 10/02/14 at 4:10 PM, revealed she initiated a one-hundred 100% audit of the seventy-nine (79) residents' Mobilization UDA's in the facility on 09/25/14 and completed the audit on 09/28/14. Review of the UDA's for Resident #17, Resident #18, Resident #19 and Resident #20 revealed they were accurate assessments of the residents' needs. Re-assessment documents were reviewed for ten (10) of the seventy-nine (79) residents reviewed which were completed for three (3) consecutive shifts on 09/27/14 and 09/28/14. Interview with Case Manager #1, and RN #1, on 10/02/14 at 4:15 PM, and 4:20 PM, respectively revealed they assisted with the re-assessments for ten (10) of the seventy-nine (79) residents reviewed which were completed for three (3) consecutive shifts on 09/27/14 and 09/28/14. Review of the audit</p>	F 282			



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F 282	Continued From page 32 initiated on 09/27/14 and concluded on 09/28/14 confirmed ten (10) residents were reviewed for reassessment by the DON.  8. Observation of Resident #17, on 09/30/14 at 3:25 PM, on 10/01/14 at 8:35 AM, and 10:30 AM, revealed the resident's plan of care was being followed by the nursing staff. Observation of Resident #17, on 10/01/14 at 11:00 AM, revealed two (2) SRNA's performing a mechanical lift transfer of the resident from the bed to a wheelchair using the appropriate sling identified on the plan of care and using appropriate procedure for the transfer. Observation of Resident #18, on 09/30/14 at 3:45 PM, 10/01/14 at 8:45 AM and 10:45 AM, revealed the resident was being cared for per the assessed nursing/SRNA plan of care. Observation of Resident #19, on 09/30/14 at 3:11 PM and 10/01/14 at 1:30 PM, revealed the resident's plan of care was being followed by the nursing staff. Review of the clinical records for Resident #17, Resident #18 and Resident #19's revealed Minimum Data Set (MDS) comprehensive reviews completed in the past thirty (30) days and compared to the residents' records revealed accurate assessments had been completed. Review of the nursing and SRNA care plans for Resident #17, Resident #18 and Resident #19 revealed they had been created from the comprehensive MDSs, completed in the past thirty (30) days and had been updated/revised as indicated. Review of the Mobilization UDA dated 08/28/14 for Resident #17 revealed the resident was to be transferred using the appropriate sling size with a mechanical lift as assessed. Interview with the DON, on 10/02/14 at 4:10 PM, revealed she initiated a one-hundred 100% audit of the seventy-nine (79) residents' (in the facility at the	F 282			



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F 282	Continued From page 33  (time) care plans on 09/25/14 and completed that audit on 09/28/14 to ensure care plans and Kardexs included the level of assist for bed mobility and transfer, the number of staff required for use of the lift and the type of lift and sling to be used, if indicated. Review of the audits completed by the DON confirmed they were completed between 09/25/14 and 09/28/14.  9. Review of the SRNA and licensed nurse sign-in sheets for the re-education trainings revealed all but two (2) on-call nursing employees had completed the training between 09/26/14 at 5:00 AM and 09/27/14. A telephone interview with the GSS Rehabilitation/Skilled Consultant #2, on 10/02/14 at 2:00 PM, revealed she had conducted the lesson plan training on 09/26/14 through 09/29/14 with the assistance of Nurse Case Managers #1 and #2. Interview with Nurse Case Managers #1 and #2, on 10/02/14 at 2:20 PM, revealed they had participated in the lesson plan training done on 09/26/14 through 09/27/14. Interview with the Staff Development Coordinator on 10/02/14 at 2:30 PM revealed she had participated in the lesson plan training on use of the slings and mechanical lifts and had observed staff with return demonstrations of use of the slings and lifts on 09/26/14 through 09/29/14. Interview with LPN #2, on 10/02/14 at 3:40 PM, revealed she had attended an in-service training last week about lift use, charting, incident reporting, and calling the doctor. She stated she demonstrated the use of the mechanical lifts and had a written post-test on the training content. Interview with LPN #3, on 10/02/14 at 3:43 PM, revealed she had attended an in-service training on 09/27/14 about mechanical lift use, charting, incident reporting, and calling the doctor. She stated she also demonstrated the use of the	F 282			

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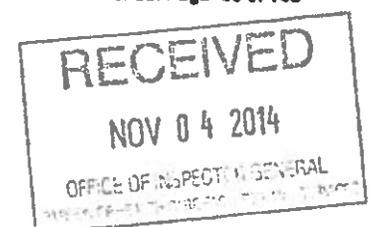
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F 282	<p>Continued From page 34</p> <p>mechanical lifts and had a written post-test on the training content. Interview with SRNA #7, on 10/02/14 at 3:48 PM, revealed she attended an in-service training on 09/26/14 about the use of the resident care plans and lift/sling use and she did a return demonstration and had a post-test. Interview with SRNA #8, on 10/02/14 at 3:52 PM, revealed she attended an in-service training on 09/26/14 about the use of the resident care plans and lift/sling use and she did a return demonstration and had a post-test.</p> <p>10. Review of the seven (7) daily audits, initiated 09/29/14, confirmed a daily audit by licensed nurses for completion of the Mobilization UDA on each shift in the first twenty-four (24) hrs of admission/readmission and with change of condition, for accurate care planning/Kardex for level of assist for bed mobility and transfer including number of staff required, type of lift and sling size, if indicated. Interview with LPN #3, on 10/02/14 at 4:20 PM, revealed she had completed three (3) of the required seven (7) daily audits to be done by licensed nurses. Interview with RN #2, on 10/02/14 at 4:25 PM, revealed he had completed two (2) of the required seven (7) daily audits to be done by licensed nurses.</p> <p>11. Review of the audits, initiated 09/27/14, confirmed the audits for proper use of the lift were completed with observations. Interview with LPN #3, on 10/02/14 at 4:20 PM, revealed she had observed SRNA #2, on day shift on 09/29/14, assisting Resident #17 with bed mobility and lift/sling transfer to ensure the safe care per the resident's care plan. LPN #3 stated she had completed three (3) of the required seven (7) daily audits to include the observation of a SRNA</p>	F 282		
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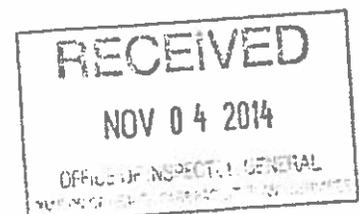
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F 282	<p>Continued From page 35</p> <p>giving care per the resident's plan of care. Interview with RN #2, on 10/02/14 at 4:25 PM, revealed he had completed two (2) of the required seven (7) daily audits to be done by licensed nurses, with observations of SRNAs providing care.</p> <p>12. Further interview with LPN #3, on 10/02/14 at 4:20 PM, indicated she also participated in a medical record audit initiated 09/29/14 to ensure an incident report had been completed for an incident occurring on 10/01/14 (not reportable) and the appropriate documentation and resident assessment and monitoring occurred timely. Interview with RN #1, on 10/02/14 at 4:25 PM, revealed she also had completed a medical record audit on 09/29/14 on second (2nd) shift regarding a change in resident condition to ensure the resident's responsible party was notified, the physician was notified, appropriate assessment and monitoring of the resident was completed and timely documentation in the progress notes. Review of that audit sheet indicated RN #1 had completed that audit on 2nd shift on 09/29/14.</p> <p>13. Interview with the Administrator, the DON, the Staff Development Coordinator, the Human Resource Director and the Medical Director, on 10/02/14 at 4:35 PM, revealed they were all to be participants in a newly developed Compliance Ad-Hoc Committee to manage the development of the Plan of Correction (POC) for ongoing compliance. They indicated they are to oversee the implementation of the POC with GSS Consultant support and assistance, ensure all audit results are submitted to the Committee for review and follow-up action, as indicated. The Administrator stated the Ad-Hoc Committee</p>	F 282			



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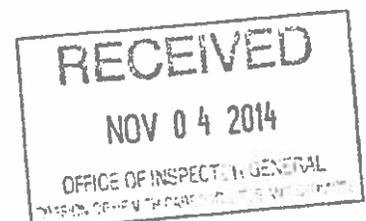
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F 282	Continued From page 36 minutes would be reported to the Continuing Quality Improvement Committee monthly. Review of the sign-in sheet for the Ad-Hoc meeting revealed it took place on 09/29/14 with the Administrator, the DON, the Staff Development/Quality Coordinator, the Human Resource Director, the Medical Records Director, both MDS Coordinators, and the Medical Director. The next Quality Assurance meeting is scheduled to be held on 10/28/14.	F 282			
F 309 SS-J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on interview, closed record review, review of the facility's policies and procedures and incident report, it was determined the facility failed to ensure one (1) of the sixteen (16) sampled residents, Resident #14, received the necessary care and services for a head injury obtained from the mechanical lift during the facility's attempt to transfer the resident. (Refer to F157, F282, F323)  On 09/16/14, the nursing staff failed to obtain initial vital signs and complete a neurological assessment when Resident #14 sustained a 1.5	F 309	An Allegation of Compliance was provided on 09/29/14 alleging removal of the Immediate Jeopardy on 09/30/14. The following steps were taken:  1. The resident affected by this incident is deceased. The C.N.A. involved in the incident was suspended pending investigation of the incident. On 09/25/2014 at 2 pm EST, a meeting was held to discuss the investigation, root cause of the U, GSS policy & procedures, and action plan. Attendees included Administrator, Director of Nursing Services, Staff Development / Quality Assurance Coordinator, Human Resources Director, GSS Rehabilitation / Skilled Consultants, GSS Quality Improvement Consultant, and GSS Workforce Consultant.	10/31/14	



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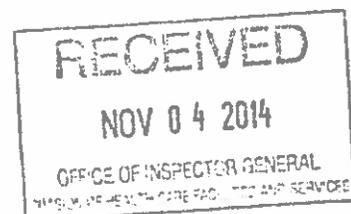
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F 309	<p>Continued From page 37</p> <p>centimeter laceration above the right eye with profuse bleeding during a transfer with a mechanical lift. The Director of Nursing (DON) was not notified of the injury until approximately 2:00 PM and she instructed the staff to apply a dressing to the wound. Interviews revealed between 3:30 PM and 4:00 PM, Registered Nurse (RN) #1 and Minimum Data Set (MDS) Nurse #1 found Resident #14 with bruising around the right eye with significant swelling and increased bleeding that had soaked through the initial dressing. However, interviews and record review revealed no documented evidence of assessment and/or monitoring of Resident #14. At 4:00 PM the DON was again notified of the change of condition and gave direction to RN #1 to prepare the resident for transfer to the hospital for evaluation. However, interviews revealed neither the physician nor the ambulance service was notified as instructed. At 5:00 PM, the resident was found unresponsive and in respiratory distress. The facility made an urgent call to the ambulance company at 5:08 PM with arrival at 5:18 PM. The resident was found with no pulse or spontaneous respirations and was pronounced dead at 5:20 PM.</p> <p>The facility's failure to ensure residents received appropriate care and services and monitoring after an injury placed Resident #14 and other residents at risk in a situation that was likely to cause serious injury, harm, impairment or death to a resident. The Immediate Jeopardy was identified on 09/24/14 and determined to exist 09/16/14. The facility was notified of the Immediate Jeopardy on 09/25/14.</p> <p>The facility provided an acceptable Allegation of Compliance on 10/01/14 that alleged removal of</p>	F 309	<p>Continued From page 37</p> <p>GSS policy and procedure review included Safe Resident Handling, Incident Reporting and Notification of Change of Condition. All policies &amp; procedures were found to be appropriate; no revisions were required and a lesson plan was developed for re-education related to F282, F309, F323, and F514. On 09/25/2014 at 4 pm EST, a meeting was held to communicate U situation, assign tasks and communicate mandatory adjusted schedules. Attendees included Director of Nursing Services, Staff Development / Quality Assurance Coordinator, and Nurse Case Managers. On 09/26/2014, an inventory of facility mechanical lift slings was reviewed by Administrator and Environmental Services Director and it was identified that sufficient number of slings were present. For a total of 19 residents requiring the use of a mechanical lift, there are 88 available slings. Soiled slings are placed in the soiled utility rooms by nursing staff to be laundered. Laundry staff cleans and inspect slings before slings are returned to the floor for use. Once slings are sent to laundry, they are returned to the floor clean the very next day.</p>		



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F 309	Continued From page 38 Immediate Jeopardy on 09/30/14. The State Survey Agency verified Immediate Jeopardy was removed on 09/30/14 as alleged, at 42 CFR 483.25 Quality of Care (F309) with the scope and severity lowered to a "D" while the facility monitored the effectiveness of the implemented plan of correction.  The findings include:  Review of the facility's policy and procedures titled Fallen or Injured Resident, revised June 2014, revealed the purpose was to give prompt treatment and prevent further injury. The policy specified the following steps should be completed in the event of an injury: if bleeding apply continuous firm pressure; do not remove soaked dressing instead add more layers to absorb the blood; take the resident's blood pressure, pulse and respirations to help assess the resident's condition; perform a full body exam, check pulse oximetry, and review the resident's medications for potential complications; notify the physician and follow orders; for residents with suspected head injury notify the physician by phone, not fax; notify the family or responsible party, continue to monitor the resident's condition, and complete the incident report.  Review of the facility's policy and procedures titled Completing Incident/Injury Report Forms, revised December 2010, revealed the purpose was to document a resident's incident/accident, possible causative factors, corrective action, and assure reporting and follow-up of all incidents/accidents involving a resident. The facility's procedure in the event of an incident included: completing a body review for injuries and bleeding, taking vital signs and noting times,	F 309	Continued From page 38 Clean slings are stored on unit AB in room B12 and on unit CD in the clean utility room. On 09/26/2014 at 5:00 am EST, a meeting was held to provide re-education in response to U and to discuss re-education to follow for the entire active nursing staff. Attendees included Administrator, Director of Nursing Services, Staff Development / Quality Assurance Coordinator, and Nurse Case Managers with re-education provided by GSS Rehabilitation / Skilled Consultant.  2. All residents dependent on staff for assistance with bed mobility and transfer had the potential to be affected by this deficiency. 100% of the 79 current residents' Mobilization User Defined Assessments (UDA) were reviewed for accuracy, by the Director of Nursing Services, in determining type of assistance required for bed mobility and transfers; this review was initiated on 09/25/2014 and was completed on 09/28/2014. 10 of the 79 residents were re-assessed by completing the Mobilization UDA for 3 consecutive shifts on 09/27/2014 and 09/28/2014; Case Managers and floor nurses completed the re-assessments.		



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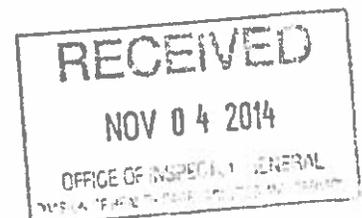
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F 309	<p>Continued From page 39</p> <p>dial 911 if the injury may be serious or if in doubt as to the seriousness of the resident's condition, and use of first aid measures.</p> <p>Review of the closed clinical record for Resident #14 revealed the facility admitted the resident on 09/17/08, with diagnoses of Dementia with Behavioral Disturbances, Anemia, Alzheimer's, Osteoarthritis, Depression, Hypertension, and Anxiety. Review of the resident's comprehensive care plan, initiated on 06/04/13, revealed the resident had a deficit in Activities of Daily Living (ADL) and required total assist of staff for a total lift using a large high back sling and with two (2) people assist to turn and reposition. Review of the Mobilization Support Data Collection Tool, dated 01/17/14, revealed the facility determined the resident required a total lift for transfer between surfaces using a large high back sling. The facility further assessed the resident using the Minimum Data Set (MDS), dated 07/29/14, as requiring extensive assistance with bed mobility and transfers, and determined the Brief Interview for Mental Status (BIMS) score was a two (2) out of a possible fifteen (15).</p> <p>Review of facility's incident report for Resident #14's injury, dated 09/16/14, revealed the wound nurse measured the wound at 0.1 centimeter (cm) x 1.5 cm. The area was cleaned and pressure applied to the wound with some decrease in bleeding. The report indicated the injury type as a laceration located on the face. The resident's pain level was marked as "hurts even more". The form was marked the resident was alert and oriented to person. The injury report noted the family and resident's physician were notified at 1:00 PM on 09/16/14.</p>	F 309	<p>Continued From page 39</p> <p>100% of 79 current residents care plans were reviewed by the Director of Nursing Services to ensure care plan and Kardex included level of assist for bed mobility and transfer, including number of staff members, type of lift and sling size if indicated; this review was initiated on 09/25/2014 and was completed on 09/28/2014.</p> <p>3. Re-education for compliance of F282, F309, F323 and F514 was provided to C.N.A staff and licensed nursing staff by GSS Rehabilitation / Skilled Care Consultation, Nurse Case Manager / Safe Resident Handling Coordinator and Staff Development / Quality Assurance Coordinator began at 5:00 am EST on 09/26/2014 with multiple meetings scheduled throughout the day on all shifts through 09/27/2014. Beginning on 1<sup>st</sup> shift of 09/26/2014, no nursing staff member was permitted to provide resident care until re-education was completed. As of 09/29/2014 70 employees, which represents all current full and part time nursing staff, have received the re-education which included passing post-test and return mechanical lift use demonstration</p>		

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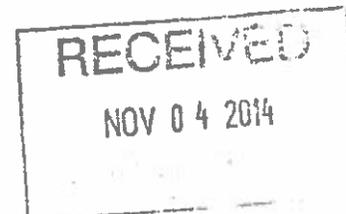
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F 309	<p>Continued From page 40</p> <p>Interview with SRNA #3, on 09/24/14 at 10:45 AM, revealed sometime around 11:30 AM she was getting Resident #14 ready to transfer using a mechanical lift without assistance. She turned Resident #14 to the right side to adjust the sling for the mechanical lift while the mechanical lift was already in position over the resident. SRNA #3 stated the lift arm hooks hit the resident's head as he/she was turned to the side. The SRNA stated when she turned the resident back over she noted a cut above the resident's right eye, which profusely bled. SRNA #3 stated SRNA #5 came into the resident's room to offer assistance and was sent to get the nurse and some washcloths. The SRNA revealed the laceration was already swelling when Licensed Practical Nurse (LPN) #1 entered the room around 11:50 AM. SRNA #3 stated the LPN tried to place steri-strips on the area, but they would not stick due to the bleeding, and an hour after the incident, the area was still bleeding and dripping down the resident's cheek.</p> <p>Interview with SRNA #5, on 09/23/14 at 3:09 PM, revealed the resident hit his/her head on a bolt that held the handle onto the arm of the lift. Per interview, there was a protective cover, but from underneath the bolt was still sharp. SRNA #5 stated she went to get LPN #1, they washed the resident's face, and put a cloth on his/her face. LPN #1 put strips on the wound then added a thick pad and wrapped the resident's head; however, there was a little continuous stream of blood.</p> <p>Interview with LPN #1, on 09/23/14 at 3:21 PM, revealed she was notified approximately 11:50 AM when the resident's head was hit by the mechanical lift hooks while staff attempted to</p>	F 309	<p>Continued From page 40</p> <p>2 PRN / on call employees who are currently not scheduled to work will receive the re-education prior to working. Re-education included:</p> <ol style="list-style-type: none"> <li>I. Care Delivered as Per Care Plan             <ol style="list-style-type: none"> <li>A) The plan of care is written to meet the resident's individualized needs based on data collection and assessment UDAs. The care plan needs to be updated with resident's change of condition.</li> <li>B) Facility staff must review the care plan / kardex and provide care as documented in the care plan.</li> <li>C) GSS Safe Resident Handling Policy and Procedure</li> <li>D) Mobilization UDA completion.</li> <li>E) Bed Mobility, Transfers, Use of Mechanical Lifts and Proper Lift Sling Utilization with return demonstration. Clean slings are stored on unit AB in room B12 and on unit CD in the clean utility room. If a needed sling cannot be located, report to the nurse, Case Manager or Director of Nursing Services.</li> </ol> </li> </ol>	



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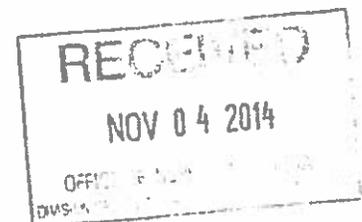
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F 309	<p>Continued From page 41</p> <p>attach the sling. The LPN stated Resident #14 had swelling and a gash above the right eye with a small stream of blood flowing down the resident's face. Continued interview with LPN #1, on 09/24/14 at 12:01 PM, revealed she cleaned the wound and applied steri-strips, but they would not stick due to the bleeding so she asked for MDS Nurse #2 to come and see the resident as she was the wound nurse for the facility. LPN #1 stated MDS #2 cleaned the area again and applied a second set of steri-strips and LPN #1 was told to monitor the wound.</p> <p>Interview with MDS Nurse #2, on 09/24/14 at 12:31 PM, revealed she was notified by LPN #1 that Resident #14 was injured and went to see the resident between 12:45 PM and 1:00 PM on 09/16/14. MDS Nurse #2 stated she tried to get the bleeding to stop for fifteen (15) to twenty (20) minutes then applied another set of steri-strips. The MDS Nurse further stated the bleeding was initially a constant stream down the resident's face, then slowed; however, never stopped completely. MDS Nurse #2 indicated she did not think the injury was emergent; however, she did not inquire of the resident's vital signs and did not complete them herself. The MDS Nurse stated she did look at the resident's pupils but did not document this was ever done. MDS Nurse #2 stated the resident should not have been bleeding an hour after the incident; however, per interview, she never asked when the injury actually occurred to make that determination.</p> <p>Review of MDS #2's nursing notes, dated 09/16/14 at 12:50 PM, revealed the resident had a "split" to skin that was bleeding. The notes specified no deep trauma was noted and did not describe how that was determined. The notes did</p>	F 309	<p>Continued From page 41</p> <p>II. Quality of Care</p> <p>A) Resident care is provided based on resident's data collection and assessment UDAs and the written care plan. This is done to meet the resident's standard of care without injury or decline in resident's condition.</p> <p>B) The licensed nurses are responsible for working with C.N.As and supervising resident care – this is done by observation of care and communication with C.N.As to ensure care is delivered as per care plan.</p> <p>III. Accidents</p> <p>A) GSS Incident Report Policy and Procedure – Incident report completion, vital signs, neuro check UDA if resident hit head or unknown if resident hit head in a fall, pain data collection and assessment UDAs if resident has "new" area of pain related to the incident, fall risk UDA if resident fell. Progress note follow up to the incident each shift for 72 hours or longer until stable. Progress note related to physician notification and family notification.</p>		



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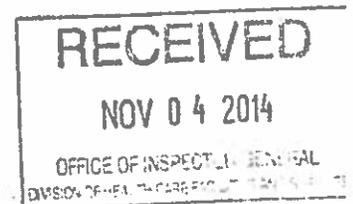
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F 309	<p>Continued From page 42</p> <p>Identify some swelling and bruising, but did not reflect the measures taken to stop the bleeding or that the bleeding never actually stopped.</p> <p>Continued Interview with LPN #1, on 09/24/14 at 12:01 PM, revealed an hour later the wound was a little more swollen and still bleeding with fresh blood streaked down the resident's cheek and on the resident's clothes. The LPN stated she was concerned about the bleeding and notified the DON around 2:00 PM on 09/16/14 of the incident.</p> <p>Interview with the DON, on 09/24/14 at 12:30 PM, revealed she was told around 2:00 PM on 09/16/14 that the resident received a skin tear from hitting his/her head on the mechanical lift. The DON stated she went to look at the resident and did not notice bruising, swelling, or any evidence there had been much bleeding. The DON denied seeing the blood on the resident's face or clothes and said she only noticed a little oozing around the steri-strips. However, the DON did report she told LPN #1 to apply a dressing to see if the bleeding would slow down, and never asked what time the injury actually occurred to determine the length of time the resident had been bleeding. The DON further stated the resident appeared fine; however, she did not complete a neurological assessment or complete a set of vital signs. In addition, the DON stated she was told by LPN #1 that vital signs had been obtained, but she never checked to ensure they were actually done.</p> <p>Continued Interview with LPN #1, on 09/24/14 at 12:01 PM, revealed she was told by the DON the resident would be fine once the bleeding stopped and to apply a dressing. The LPN stated she applied a thick dressing on the wound and</p>	F 309	<p>Continued From page 42</p> <p>B) GSS Notification of Change of Condition Policy and Procedure – assessing resident, notifying physician, documenting the communication with physician – follow doctor's orders for sending resident to the hospital / calling EMS – If the resident is in an emergent situation, physician and EMS are both called immediately.</p> <p>IV. Clinical Records</p> <p>A) Documentation must be clear, concise, objective findings using medical terminology and approved GSS abbreviations. Information stated by residents should be documented exactly as heard.</p> <p>B) Documentation must be timely – at the time of data collection, UDA completion – take the PCC tablet / laptop into resident's room for immediate documentation. In emergency situations, documentation must be completed as a late entry as soon as possible, no later than the end of the shift. Nursing staff are not to leave the building until documentation is complete. PCC will date and time stamp when the entry is made, so when documenting event that occurred at an earlier time, the time of occurrence will be entered in the text of the note.</p>		



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F 309	<p>Continued From page 43</p> <p>wrapped the resident's head with gauze to keep it in place.</p> <p>Interview with SRNA #4, on 09/24/14 at 12:26 PM, revealed she went to see the resident around 2:00 PM and the resident was still bleeding from the head laceration. The SRNA stated LPN #1 applied a dressing and she asked the LPN if they were going to send the resident out to the emergency room. SRNA #4 stated she was told the family would not want the resident to be sent out for treatment.</p> <p>Continued interview with LPN #1, on 09/24/14 at 12:01 PM, revealed she did not notify the resident's family or physician of the injury until the next shift because she was busy with other tasks. She further stated she did not complete the incident report until around 3:00 PM or so. She never obtained the resident's blood pressure, pulse, respirations, or used the pulse oximeter. LPN #1 stated the resident was awake, and did not seem different neurologically, but she never performed a neurological assessment to monitor the resident's condition. However, per the facility's policy and procedures titled Fallen or Injured Resident staff should take the resident's blood pressure, pulse and respirations to help assess the resident's condition; perform a full body-exam, check pulse oximetry; review the resident's medications for potential complications; and, notify the physician and follow orders.</p> <p>Further review of Resident #14's record revealed LPN #1's nursing notes for 09/18/14, which indicated the resident was last observed at 1:30 PM by the LPN. There were no other entries made until the next shift at 3:00 PM.</p>	F 309	<p>Continued From page 43</p> <p>C) Utilize the proper progress note type to document follow up assessment, physician notification and family notification.</p> <p>4. Audits will be completed by licensed nurse for completion of Mobilization UDA on each shift in the first 24 hours of admission/readmission and with change of condition, for accurate care planning / kardex for level of assist for bed mobility and transfer including number of staff, type of lift and sling size if indicated. Audits will be completed by licensed nurse observing 1 C.N.A. on each unit on each shift in assisting resident with bed mobility and transfer to ensure safe care as per resident's care plan. Medical Record Audits will be completed by licensed nurse to ensure with each incident an Incident report has been completed, GSS #415 (facility investigation) is initiated, physician and resident's responsible party have been notified with appropriate documentation, resident monitoring and assessment is completed and documented in appropriate UDAs and progress notes. All audits will be completed daily X 7 days.</p>		



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F 309	<p>Continued From page 44</p> <p>Interview with MDS Nurse #1, on 09/23/14 at 5:07 PM, revealed she was told in report around 3:20 PM that Resident #14 was injured with the lift and had a skin tear. The MDS Nurse stated she went to see the resident after report and found the resident sitting up in a chair with a dressing and gauze wrapped around the resident's head. MDS Nurse #1 stated the resident had bled through the dressing and a large area of blood was on the dressing. She lifted up the bandage and saw the resident's eye had swollen shut and had a dark purple bruise around the eye. The MDS Nurse stated she had been told the DON wanted to just monitor the resident's condition and that the resident only had a skin tear. MDS Nurse #1 said she told RN #1 to go ahead and prepare the paperwork for the resident to be transferred, notify the resident's physician, and call the ambulance service, then left to talk with the DON about the resident's injury.</p> <p>Interview with RN #1, on 09/23/14 at 2:45 PM, revealed he was told of the resident's injury during shift change report around 3:00 PM on 09/16/14. The RN said when he went to assess the resident he noticed approximately a quarter sized area of fresh blood on the resident bandage with minor bruising above and around the resident's right eye and did not notice the swelling. RN #1 stated he was not overly concerned as the resident seemed to be breathing fine. The RN further mentioned MDS Nurse #1 came into the room and said the resident would need stitches and then left to go talk with the DON. The RN stated he directed the SRNAs to return the resident to bed and then left Resident #14 to complete blood sugars and pass medications to the other residents. RN #1 indicated he did not actually assess the resident.</p>	F 309	<p>Continued From page 44</p> <p>The facility has developed a Compliance Ad Hoc Committee which is chaired by the facility Administrator to manage the development of the POC for ongoing compliance of F282, F309, F323 and F514 and oversee the implementation of the POC with GSS Consultant support and assistance. Committee members include Director of Nursing Service, Staff Development / Quality Assurance Coordinator, Nurse Case Managers, Human Resource Director, Health Information Manager, and Medical Director. All audit results will be submitted to the Ad Hoc Committee for review and follow up action as indicated. The Ad Hoc Committee minutes will be reported to the Quality Committee monthly.</p> <p>POC Start</p> <p>The resident found to have been affected by the deficient practice (Resident #14) is now deceased.</p> <p>In identifying other residents having the potential to be affected by the same deficient practice, it was determined that all residents could experience a change of condition and could be affected.</p>	

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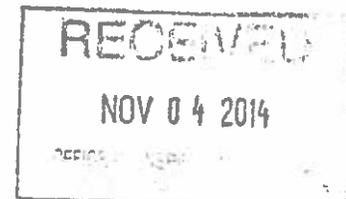
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F 309	<p>Continued From page 45</p> <p>never took vital signs, and did not complete the transfer forms because he thought the DON and LPN #1 would take care of everything.</p> <p>Interview with SRNA #5, on 09/23/14 at 3:09 PM, revealed she went back to check on Resident #14 when the other SRNAs were told to put the resident back in bed between 3:30 PM and 4:00 PM. SRNA #5 said the resident was breathing, but the resident's eyes were no longer open and it was like he/she had gone to sleep. The SRNA further stated it was a good while before a nurse came back in to check on the resident; however, could not specify a length of time.</p> <p>Interview with the DON, on 09/25/14 at 11:50 AM, revealed she went back to the room around 4:00 PM to assess the resident and told RN #1 the resident needed to go immediately for sutures and evaluation at the hospital. The DON said she did not do any type of neurological assessment or complete a set of vital signs because the resident's color looked fine everywhere else, and nothing alarmed her as to the resident's stability.</p> <p>Review of the nursing notes written by the DON, dated 09/16/14 at 4:00 PM, revealed she was notified by RN #1 the resident had increased bleeding. The nursing notes specified the area had become swollen and significantly bruised. The nurse was to notify the physician and the family of the need to go to the hospital for evaluation and was told transportation was arranged.</p> <p>Interview with LPN #1, on 09/24/14 at 12:01 PM, revealed on 09/16/14 at 4:00 PM, she sent a fax to the resident's physician requesting an order to send the resident to the emergency room and</p>	F 309	<p>Continued From page 45</p> <p>Re-education was initiated on 09/26/2014 to all licensed nurses by GSS Rehabilitation / Skilled Consultant regarding GSS Notification of Change of Condition policy and procedures in order to maintain safety for our residents. These staff members were instructed on data collection / assessment, documentation, and communication with physician / family. Specific focus was placed on the importance of obtaining, communicating and documenting complete assessment findings on any resident who experiences a change of condition or suffers an injury to allow immediate intervention for the resident. It was required all staff members complete and pass a post test for all training received prior to working on the floor to ensure the deficient practice does not recur. All post tests were reviewed immediately upon completion by GSS Rehabilitation / Skilled Consultant to validate re-education was understood and that each individual staff member passed the test. Each individual tested, did receive a passing score. CNA #3 is no longer employed with GSS and did not complete re-education.</p>		

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F 309	<p>Continued From page 46</p> <p>called the family for the first time to let them know the resident was injured and required stitches. LPN #1 stated she did not know why she did not page the doctor per the facility's policy and procedure, which stated for residents with suspected head injury notify the physician by phone, not fax.</p> <p>Record review revealed two (2) Facsimile (fax) Transmission Verification Report regarding Resident #14. Review of one Facsimile (fax) Transmission Verification Report, not signed, dated or timed, revealed there was no confirmation of the physician notification ever being sent. Review of the fax revealed the resident obtained a spill/gash measuring 0.1 x 1.5 cm above the right eye during a transfer and had a moderate amount of bleeding and steri-strips were applied.</p> <p>Review of the second Facsimile (fax) Transmission Verification Report, dated 09/16/14, revealed a confirmation time of 4:34 PM. The fax specified the resident sustained a gash above the right eye, it was cleaned with normal saline and steri-strips were applied. The gash continued to moderately bleed and was it okay to send the resident out to be sutured.</p> <p>Interview with the Staff Development Nurse, on 09/25/14 at 12:44 PM, revealed she went to see the resident around 5:00 PM and SRNA #5 was in the room. The Staff Development Nurse indicated the resident was having difficulty breathing and his/her skin color appeared yellow. The Staff Development Nurse stated she was not able to obtain a pulse oximeter reading and turned up the resident's oxygen to three (3) liters per minute. The Staff Development Nurse stated</p>	F 309	<p>Continued From page 46</p> <p>Charge nurse on duty is notified immediately regarding residents who experience a change in condition. Case Manager will then validate staff involved are following GSS policy and procedure to ensure physician notification occurs timely and that care is delivered as per physician order and GSS policy and procedure.</p> <p>MDS Coordinators and DNS will review resident/resident progress notes daily to identify resident change of condition. Electronic medical records of those identified will then be audited to ensure detailed documentation of assessment findings and events, appropriate UDA completion, physician/family notification, and care delivered as per physician order and GSS policy and procedure. Audits will be completed daily X4 weeks, then weekly X 4 weeks, bi-weekly X 1 month, then quarterly X 3. Audit findings will be reported to the Quality Committee monthly x3, then quarterly x3, for further recommendation to ensure continued compliance.</p>		



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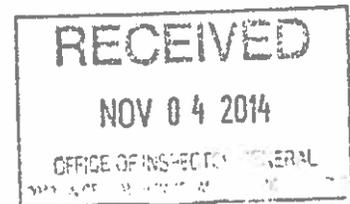
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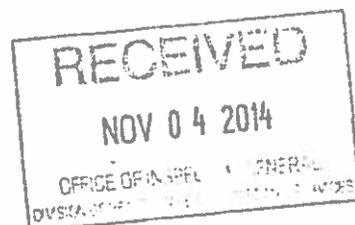
F 309	<p>Continued From page 47</p> <p>she sent SRNA #5 to get the DON immediately.</p> <p>Interview with DON, on 09/24/14 at 12:30 PM, revealed around 5:00 PM SRNA #5 came to her and said she needed to come to Resident #14's room immediately. The DON stated the resident was having difficulty breathing and was already on oxygen at three (3) liters per minute via nasal cannula and the Staff Development Nurse was trying to get a pulse oximeter reading. The DON said the resident's eyes were open, but the resident was not responsive. The DON indicated she was trying to get the patient to respond and turned the oxygen up to seven (7) liters. She left the room and came out to the desk and told RN #1 the situation was now urgent and they needed Emergency Medical Services (EMS). The DON stated she had been told someone had already called the ambulance services for EMS to transfer the resident to the hospital and that it would be an hour wait, so she told RN #1 to call again.</p> <p>Further interview with RN #1, on 09/23/14 at 2:45 PM, revealed he answered a call from the resident's physician who was upset and said if there was an emergency the facility should call and not send a fax. The RN further stated he received an order to transfer the resident to the hospital but did not write the order. RN #1 stated he did not call the ambulance service as was instructed because he thought someone else was taking care of it. However, he heard the ambulance had been called and that it would be an hour to an hour and a half wait. He stated he did not know who had actually called.</p> <p>However, an additional interview with LPN #1, on 09/23/14 at 3:21 PM, revealed RN #1 called the</p>	F 309		
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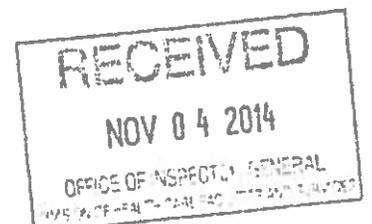
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F 309	<p>Continued From page 48</p> <p>ambulance service at approximately 5:00 PM, but did not know if anyone ever completed the resident's transfer forms.</p> <p>Interview with MDS Nurse #1, on 09/23/14 at 5:07 PM, revealed RN #1 had told her the next day there was only one (1) call made to EMS and he did not realize it was an emergent situation when he had originally been told to call for the ambulance.</p> <p>Interview with Emergency Medical System (EMS) Dispatch Manager, on 09/25/14 at 2:58 PM, revealed all calls were recorded. The Dispatch Manager identified all recordings for 09/16/14 was reviewed and only one call came from the facility on 09/16/14 and that was at 5:08 PM.</p> <p>Review of the Ambulance Run Forms, dated 09/16/14, revealed the initial call was received at 5:09 PM and they were at the resident's side by 5:20 PM. The Ambulance Run Forms specified the resident was found unresponsive, cyanotic, pupils were constricted, and non-reactive. There was no pulse or respirations and was deceased at 5:20 PM on 09/16/14.</p> <p>Interview with Resident #14's physician, on 09/24/14 at 4:42 PM, revealed she was not notified until late afternoon that the resident had been hit in the head. The physician stated she was told the resident needed to go out for stitches and was not aware of when the incident actually occurred. The Physician indicated the head was very vascular and would bleed a lot, but after an hour or hour and a half of bleeding, the resident should have been sent out for stitches. The physician stated she was called later by the facility and told she needed to sign the death</p>	F 309			



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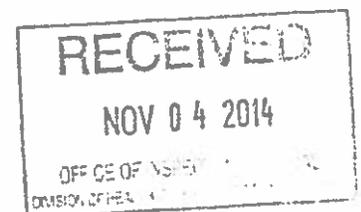
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F 309	<p>Continued From page 49</p> <p>certificate. The physician stated she was very confused by this because she had given an order for the resident to be transferred to the hospital and did not understand why that was not done.</p> <p>Interview with the resident's family member, on 09/24/14 at 11:47 AM, revealed he was not told until late afternoon of the injury and a short while later he received a call that the resident had passed away.</p> <p>Further interview with SRNA #3, on 09/24/14 at 10:45 AM, revealed she was not asked to complete an incident report or write a statement when the injury was reported per the facility's policy. The SRNA stated the procedure had always been that if there was an accident the resident was assessed, vital signs obtained, an incident report completed, and written statements obtained. However, that was not done this time. SRNA #3 stated she was not called until later that evening after the resident had passed away and told she would have to come in and write a statement for the facility.</p> <p>Interview with LPN #1, on 09/25/14 at 11:29 AM, revealed if there was an injury involved with an accident she really was not sure what should be done, and stated as a nurse she should assess the situation and vital signs were a part of that assessment. LPN #1 revealed this was not done with Resident #14 and it should have been. The LPN indicated vital signs and an initial assessment would have provided a baseline to compare to if there were changes in the resident's condition. LPN #1 said she just did not have a reason as to why it was not done.</p> <p>Interview with the DON, on 09/25/14 at 11:50 AM,</p>	F 309			



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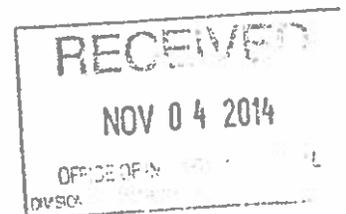
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F 309	<p>Continued From page 50</p> <p>revealed she did not feel she got a clear picture from the nursing staff as to what happened and what was going on. The DON stated she was initially told it was just a skin tear and that they did get vital signs. However, the DON stated she did not ensure the vital signs had been done, did not obtain them herself during assesment, or ensure the ambulance was en route after giving direction to the nursing staff.</p> <p>The facility provided an Allegation of Compliance (AOC) on 09/29/14 alleging the Immediate Jeopardy was removed on 09/30/14; the facility took the following steps to remove the Immediate Jeopardy.</p> <ol style="list-style-type: none"> <li>1. The SRNA (SRNA #3) involved in the incident was suspended after the incident on 09/16/14 pending investigation of the incident.</li> <li>2. A meeting was held to discuss the investigation, root cause of the Immediate Jeopardy. Good Samaritan Society policies and procedures (review included safe resident handling, incident reporting and notification of change of condition and action plan), on 09/25/14 at 2:00 PM. Attendees of the meeting on 09/25/14 were the Administrator, Director of Nursing, Staff Development/Quality Assurance Coordinator, Human Resources Director, Good Samaritan Society (GASS) Rehabilitation/Skilled Consultants, Good Samaritan Society Quality Improvement Consultant and a Good Samaritan Society Workforce Consultant.</li> <li>3. All policies and procedures reviewed at the 2:00 PM meeting on 09/25/14 were found to be appropriate with no revisions required. A lesson plan was developed by the attendees for</li> </ol>	F 309			



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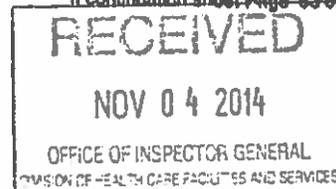
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  10/02/2014
NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40208		
(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 309	Continued From page 51 re-education.  4. A meeting was held, on 09/25/14 at 4:00 PM, to communicate the Immediate Jeopardy situation, assign tasks and communicate mandatory adjusted schedules. Attendees included the Director of Nursing, Staff Development/Quality Assurance Coordinator and Nurse Case Managers.  5. On 09/26/14 at 5:00 AM, a meeting was held to provide re-education in response to the Immediate Jeopardy and to discuss re-education to follow for the entire active nursing staff. Attendees included the Administrator, Director of Nursing, Staff Development/Quality Assurance Coordinator, and Nurse Case Managers with re-education provided by a Good Samaritan Society Rehabilitator/Skilled Consultant.  6. On 09/26/14 an inventory of mechanical lift slings was reviewed by the Administrator and the Environmental Services Director and it was identified that a sufficient number of slings were present. There were eighty-eight (88) available slings for a total of nineteen (19) residents requiring the use of a mechanical lift. Soiled slings were placed in the soiled utility rooms by nursing staff to be laundered. Laundry staff cleaned and inspected slings and returned them to the floor the very next day.  7. A one-hundred (100)% review was initiated on 09/25/14 and concluded on 09/28/14 to ensure accuracy (determination of type of assistance required for bed mobility and transfers) of seventy-nine (79) current residents' Mobilization User Defined Assessments (UDA) by the Director of Nursing. Ten (10) of the seventy-nine (79)	F 309			



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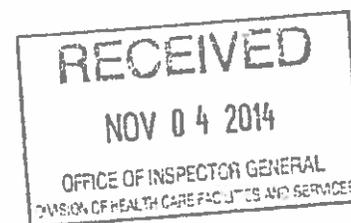
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NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40299		
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F 309	<p>Continued From page 52</p> <p>residents were re-assessed by completing the Mobilization UDA for three (3) consecutive shifts on 09/27/14 and 09/28/14 by Nurse Case Managers and floor nurses.</p> <p>8. One-hundred (100)% review of seventy-nine (79) current residents' care plans was initiated on 09/25/14 and completed on 09/28/14 by the Director of Nursing to ensure care plans and Kardexs included the level of assist for bed mobility and transfer, included the number of staff members required for use of the lift, the type of lift to be used, and the sling size, if indicated.</p> <p>9. Re-education was provided to SRNA staff and licensed nursing staff beginning at 5:00 AM on 09/26/14 on all shifts and continued through 09/27/14 for compliance by Good Samaritan Society Rehabilitation/Skilled Consultant, Nurse Case Manager/Safe Resident Handling Coordinator and Staff Development/Quality Assurance Coordinator. Beginning on first (1st) shift of 09/26/14 no nursing staff member was permitted to provide resident care until re-education was completed. As of 09/29/14 seventy (70) employees (all current full and part-time nursing staff) had received the re-education which included passing a post-test and return demonstration for use of the mechanical lift. Two (2) prn/on-call nursing employees who were not scheduled to work will receive the re-education prior to working. The re-education included 1) care delivered per care plan, 2) quality of care, 3) accidents and 4) clinical records.</p> <p>10. Audits will be completed daily times seven (7) days by licensed nurses for completion of mobilization (UDA) on each shift in the first</p>	F 309			



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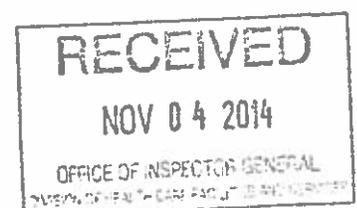
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NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40299		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 309	Continued From page 53 twenty-four (24) hours of admission/readmission and with change of condition for accurate care planning/Kardex for level of assistance for bed mobility and transfer including number of staff, type of lift, and sling size if indicated.  11. Audits will be completed daily times seven (7) days by licensed nurses observing one (1) SRNA on each unit on each shift in assisting residents with bed mobility and transfer to ensure safe care per the resident's care plan.  12. Medical record audits will be completed daily times seven (7) days by licensed nurses to ensure an incident report has been completed with each incident, Good Samaritan Society facility investigation policy was initiated, physician and resident's responsible party were notified with appropriate documentation, resident monitoring and assessment was completed and documented in appropriate UDA's and progress notes.  13. The facility developed a compliance Ad-Hoc Committee chaired by the facility Administrator to manage the development of the Plan of Correction for ongoing compliance and to oversee the implementation of the Plan of Correction with Good Samaritan Society Consultant support and assistance. Committee members include the Director of Nursing, the Staff Development/Quality Assurance Coordinator, Nurse Case Managers, Human Resource Director, Health Information Manager, and the Medical Director. All audit results will be submitted to the Ad-Hoc Committee for review and follow-up action as indicated. The Ad-Hoc Committee minutes will be reported to the Continuing Quality Improvement Committee Monthly.	F 309			



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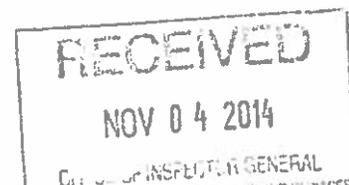
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NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40299		
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F 309	<p>Continued From page 54</p> <p>Through observation, interview and record review the State Survey Agency validated the Allegation of Compliance with removal of Immediate Jeopardy on 09/30/14 as alleged prior to exit on 10/02/14 as follows:</p> <ol style="list-style-type: none"> <li>1. Review of the personnel file for SRNA #3 revealed she was suspended from work after the incident on 09/16/14 pending the facility investigation and remained suspended throughout the survey including date of exit of 10/02/14.</li> <li>2. A group interview including the Administrator, the Director of Nursing, the Staff Development Coordinator, the Human Resource Director, two (2) Good Samaritan Society Rehabilitation/Skilled Consultants (per telephone conference call), a Good Samaritan Society Quality Improvement (QI) Coordinator (per telephone conference call), and the Good Samaritan Society Workforce Consultant (per telephone conference call), on 10/02/14 at 2:00 PM, revealed the Administrator, the Director of Nursing, the Staff Development Coordinator and the Human Resource Director were present in person at the meeting held, on 09/25/14 at 2:00 PM, and the two (2) GSS Consultants, the GSS QI Coordinator and the GSS Workforce Consultant were at the meeting via telephone conference call to discuss the investigation regarding Resident #14, the root cause of the Immediate Jeopardy, GSS policies and procedures to include safe resident handling, incident reporting and notification of change of condition and to develop an action plan (lesson plan). Review of the lesson plan agenda (not dated) provided as proof for the AOC which included training on safe assistance with bed</li> </ol>	F 309		



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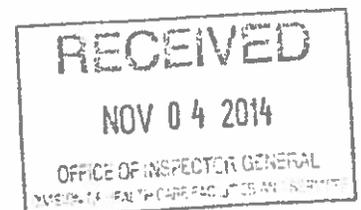
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NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40298		
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F 309	<p>Continued From page 55</p> <p>mobility, transfers and use of mechanical lifts and slings, and also included training on the writing of the individualized nursing care plan based on individualized needs and on following the residents' plans of care. Review of the sign-in sheets for the meeting held on 09/25/14 at 2:00 PM, confirmed the signatures of the attendees.</p> <p>3. Review of the lesson plan developed in the meeting, on 09/25/14 at 2:00 PM, revealed an agenda, content, and SRNA and licensed nurse post-tests to address the Immediate Jeopardy compliance. Review of the lesson plan developed "Providing Resident Care - Individualized, Safe, Documented" revealed an agenda, content, and SRNA and licensed nurse post-tests to address the Immediate Jeopardy compliance. The length of the training session outlined on the agenda was thirty (30) minutes for SRNAs and one (1) hour for licensed nurses with the purpose of the training to be correction activity for Immediate Jeopardy F-tags to include policies regarding safe handling of residents, incident reporting, notification of resident change of condition, data collection and UDA assessment instructions and use of mechanical lifts and slings.</p> <p>4. Interview with Nurse Case Managers #1 and #2, the DON, and the Staff Development Coordinator, on 10/02/14 at 3:06 PM, 3:15 PM, and 3:20 PM, respectively revealed they had attended the meeting held, on 09/25/14 at 4:00 PM, to discuss the Immediate Jeopardy situation, to assign tasks and to communicate mandatory adjusted schedules for the nursing staff. Review of the sign-in sheet for the meeting held on 09/25/14 at 4:00 PM confirmed the signatures of the attendees.</p>	F 309			



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F 309	Continued From page 56  5. A group interview including the Administrator, the Director of Nursing, the Staff Development Coordinator, GSS Rehabilitation/Skilled Consultant #2 (per telephone conference call) and Nurse Case Managers #1, #2 and #3, on 10/02/14 at 2:00 PM, revealed they were all present in person at the meeting held, on 09/26/14 at 5:00 AM, and GSS Rehabilitation/Skilled Consultant #2 provided the re-education to that staff in the meeting with discussion of re-education for the entire active nursing staff. Review of the sign-in sheet for the meeting held on 09/26/14 confirmed the signatures of the attendees.  6. Observation of the mechanical lift slings located in the laundry and on each nursing unit, on 10/02/14 at 9:00 AM, revealed there were eighty-eight (88) slings available for use. Twelve (12) of the slings observed were soiled and awaiting washing and inspection. Interview with the Administrator and the Environmental Services Director, on 10/02/14 at 12:16 PM, revealed they both participated in an inventory of the facility mechanical lift slings on 09/26/14. The Administrator and the Environmental Services Director indicated the soiled slings were to be placed in the soiled utility rooms by nursing staff to be laundered and the laundry staff was to launder, dry and inspect the slings before stocking them on each nursing unit the next day. Interview with SRNA #7, on 10/02/14 at 3:50 PM, revealed she would place a soiled sling in a bag in the soiled utility room on the nursing unit to be laundered and it was her understanding the laundry staff would inspect the slings for any defects before returning them to the nursing units. Interview with the Housekeeping/Laundry	F 309			



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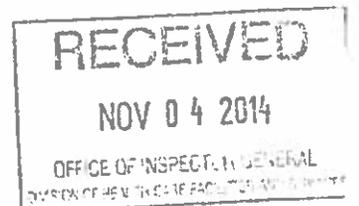
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F 309	<p>Continued From page 57</p> <p>Supervisor, on 10/02/14 at 4:00 PM, revealed the laundry staff cleaned the mechanical lift slings seven (7) days a week and inspected them before returning them to the nursing units for use. She stated if a sling was defective it would be given to Case Manager #3 for replacement. Interview with Case Manager #3, on 10/02/14 at 4:10 PM, revealed he received the defective slings identified by the laundry staff or any nursing personnel and would order a replacement right away and the replacement would usually be provided within a week. Interview with the DON, on 10/02/14 at 4:10 PM, revealed mechanical lift slings were stored in the clean utility rooms on each nursing unit and were laundered and inspected by the laundry staff.</p> <p>7. Further interview with the DON, on 10/02/14 at 4:10 PM, revealed she initiated a one-hundred 100% audit of the seventy-nine (79) residents' Mobilization UDA's in the facility on 09/25/14 and completed the audit on 09/28/14. Review of the UDA's for Resident #17, Resident #18, Resident #19 and Resident #20 revealed they were accurate assessments of the residents' needs. Re-assessment documents were reviewed for ten (10) of the seventy-nine (79) residents reviewed which were completed for three (3) consecutive shifts on 09/27/14 and 09/28/14. Interview with Case Manager #1, and RN #1, on 10/02/14 at 4:15 PM, and 4:20 PM, respectively revealed they assisted with the re-assessments for ten (10) of the seventy-nine (79) residents reviewed which were completed for three (3) consecutive shifts on 09/27/14 and 09/28/14. Review of the audit initiated on 09/27/14 and concluded on 09/28/14 confirmed ten (10) residents were reviewed for reassessment by the DON.</p>	F 309			

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F 309	Continued From page 58 8. Observation of Resident #17, on 09/30/14 at 3:25 PM, on 10/01/14 at 8:35 AM, and 10:30 AM, revealed the resident's plan of care was being followed by the nursing staff. Observation of Resident #17, on 10/01/14 at 11:00 AM, revealed two (2) SRNAs performing a mechanical lift transfer of the resident from the bed to a wheelchair using the appropriate sling identified on the plan of care and using appropriate procedure for the transfer. Observation of Resident #18, on 09/30/14 at 3:45 PM, 10/01/14 at 8:45 AM and 10:45 AM, revealed the resident was being cared for per the assessed nursing/SRNA plan of care. Observation of Resident #19, on 09/30/14 at 3:11 PM and 10/01/14 at 1:30 PM, revealed the resident's plan of care was being followed by the nursing staff. Review of the clinical records for Resident #17, Resident #18 and Resident #19's revealed Minimum Data Set (MDS) comprehensive reviews completed in the past thirty (30) days and compared to the residents' records revealed accurate assessments had been completed. Review of the nursing and SRNA care plans for Resident #17, Resident #18 and Resident #19 revealed they had been created from the comprehensive MDSs, completed in the past thirty (30) days and had been updated/revised as indicated. Review of the Mobilization UDA dated 08/28/14 for Resident #17 revealed the resident was to be transferred using the appropriate sling size with a mechanical lift as assessed. Interview with the DON, on 10/02/14 at 4:10 PM, revealed she initiated a one-hundred 100% audit of the seventy-nine (79) residents' (in the facility at the time) care plans on 09/25/14 and completed that audit on 09/28/14 to ensure care plans and Kardexs included the level of assist for bed mobility and transfer, the number of staff required	F 309		



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F 309	Continued From page 59 for use of the lift and the type of lift and sling to be used, if indicated. Review of the audits completed by the DON confirmed they were completed between 09/25/14 and 09/28/14.  9. Review of the SRNA and licensed nurse sign-in sheets for the re-education trainings revealed all but two (2) on-call nursing employees had completed the training between 09/26/14 at 5:00 AM and 09/27/14. A telephone interview with the GSS Rehabilitation/Skilled Consultant #2, on 10/02/14 at 2:00 PM, revealed she had conducted the lesson plan training on 09/26/14 through 09/29/14 with the assistance of Nurse Case Managers #1 and #2. Interview with Nurse Case Managers #1 and #2, on 10/02/14 at 2:20 PM, revealed they had participated in the lesson plan training done on 09/26/14 through 09/27/14. Interview with the Staff Development Coordinator on 10/02/14 at 2:30 PM revealed she had participated in the lesson plan training on use of the slings and mechanical lifts and had observed staff with return demonstrations of use of the slings and lifts on 09/26/14 through 09/29/14. Interview with LPN #2, on 10/02/14 at 3:40 PM, revealed she had attended an in-service training last week about lift use, charting, incident reporting, and calling the doctor. She stated she demonstrated the use of the mechanical lifts and had a written post-test on the training content. Interview with LPN #3, on 10/02/14 at 3:43 PM, revealed she had attended an in-service training on 09/27/14 about mechanical lift use, charting, incident reporting, and calling the doctor. She stated she also demonstrated the use of the mechanical lifts and had a written post-test on the training content. Interview with SRNA #7, on 10/02/14 at 3:48 PM, revealed she attended an in-service training on 09/26/14 about the use of	F 309			

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F 309	<p>Continued From page 60</p> <p>the resident care plans and lift/sling use and she did a return demonstration and had a post-test. Interview with SRNA #8, on 10/02/14 at 3:52 PM, revealed she attended an in-service training on 09/26/14 about the use of the resident care plans and lift/sling use and she did a return demonstration and had a post-test.</p> <p>10. Review of the seven (7) daily audits, initiated 09/29/14, confirmed a daily audit by licensed nurses for completion of the Mobilization UDA on each shift in the first twenty-four (24) hrs of admission/readmission and with change of condition, for accurate care planning/Kardex for level of assist for bed mobility and transfer including number of staff required, type of lift and sling size, if indicated. Interview with LPN #3, on 10/02/14 at 4:20 PM, revealed she had completed three (3) of the required seven (7) daily audits to be done by licensed nurses. Interview with RN #2, on 10/02/14 at 4:25 PM, revealed he had completed two (2) of the required seven (7) daily audits to be done by licensed nurses.</p> <p>11. Review of the audits, initiated 09/27/14, confirmed the audits for proper use of the lift were completed with observations. Interview with LPN #3, on 10/02/14 at 4:20 PM, revealed she had observed SRNA #2, on day shift on 09/29/14, assisting Resident #17 with bed mobility and lift/sling transfer to ensure the safe care per the resident's care plan. LPN #3 stated she had completed three (3) of the required seven (7) daily audits to include the observation of a SRNA giving care per the resident's plan of care. Interview with RN #2, on 10/02/14 at 4:25 PM, revealed he had completed two (2) of the required seven (7) daily audits to be done by</p>	F 309			

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NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40299		
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F 309	<p>Continued From page 61</p> <p>licensed nurses, with observations of SRNAs providing care.</p> <p>12. Further interview with LPN #3, on 10/02/14 at 4:20 PM, indicated she also participated in a medical record audit initiated 09/29/14 to ensure an incident report had been completed for an incident occurring on 10/01/14 (not reportable) and the appropriate documentation and resident assessment and monitoring occurred timely. Interview with RN #1, on 10/02/14 at 4:25 PM, revealed she also had completed a medical record audit on 09/29/14 on second (2nd) shift regarding a change in resident condition to ensure the resident's responsible party was notified, the physician was notified, appropriate assessment and monitoring of the resident was completed and timely documentation in the progress notes. Review of that audit sheet indicated RN #1 had completed that audit on 2nd shift on 09/29/14.</p> <p>13. Interview with the Administrator, the DON, the Staff Development Coordinator, the Human Resource Director and the Medical Director, on 10/02/14 at 4:35 PM, revealed they were all to be participants in a newly developed Compliance Ad-Hoc Committee to manage the development of the Plan of Correction (POC) for ongoing compliance. They indicated they are to oversee the implementation of the POC with GSS Consultant support and assistance, ensure all audit results are submitted to the Committee for review and follow-up action, as indicated. The Administrator stated the Ad-Hoc Committee minutes would be reported to the Continuing Quality Improvement Committee monthly. Review of the sign-in sheet for the Ad-Hoc meeting revealed it took place on 09/29/14 with the</p>	F 309			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  10/02/2014
NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40209		
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F 309	Continued From page 62 Administrator, the DON, the Staff Development/Quality Coordinator, the Human Resource Director, the Medical Records Director, both MDS Coordinators, and the Medical Director. The next Quality Assurance meeting is scheduled to be held on 10/28/14.	F 309			
F 323 SSaJ	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, closed record review, review of the facility's policies and procedures, the manufacturer's operating instructions for the Ultralift, and the facility's mechanical lift training, it was determined the facility failed to have an effective system to ensure staff received training on the use of assistive devices and failed to ensure assistive devices were used properly to prevent accidents for one (1) of sixteen (16) sampled residents, (Resident #14). The facility staff attempted to transfer Resident #14 without assistance, with the mechanical lift using the wrong size and type of sling that resulted in a head laceration. (Refer to F282).  On 09/18/14 at approximately 11:30 AM, State Registered Nursing Assistant (SRNA) #3 attempted to reposition Resident #14, without the	F 323	An Allegation of Compliance was provided on 09/29/14 alleging removal of the Immediate Jeopardy on 09/30/14. The following steps were taken:  1. The resident affected by this incident is deceased. The C.N.A. involved in the incident was suspended pending investigation of the incident. On 09/25/2014 at 2 pm EST, a meeting was held to discuss the investigation, root cause of the IJ, GSS policy & procedures, and action plan. Attendees included Administrator, Director of Nursing Services, Staff Development / Quality Assurance Coordinator, Human Resources Director, GSS Rehabilitation / Skilled Consultants, GSS Quality Improvement Consultant, and GSS Workforce Consultant.	10/31/14	

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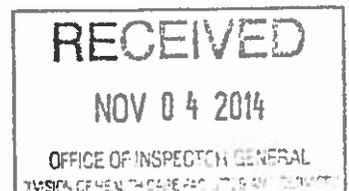
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NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3800 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40289		
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F 323	<p>Continued From page 63</p> <p>assistance of staff to guide the lift arm and protect the resident from injury as directed by the manufacturer's instructions and the resident's care plan. The SRNA further attempted to utilize a mechanical lift sling that was smaller than the resident's assessed size for transfer into a chair. With the mechanical lift positioned over the resident, it placed the lift arm hooks above the resident's head. The SRNA turned the resident to ensure he/she was centered on the sling and the lift arm hooks hit the resident's head and resulted in a 1.5 centimeter laceration above the right eye with profuse bleeding. Interviews revealed between 3:30 PM and 4:00 PM, Registered Nurse (RN) #1 and Minimum Data Set (MDS) Nurse #1 found Resident #14 with bruising around the right eye with significant swelling and increased bleeding that had soaked through the initial dressing. At 4:00 PM the Director of Nursing (DON) gave direction to RN #1 to prepare the resident for transfer to the hospital for evaluation. However, interviews revealed neither the physician nor the ambulance service was notified as instructed. At 5:00 PM, the resident was found unresponsive and in respiratory distress. The facility made an urgent call to the ambulance company at 5:08 PM with arrival at 5:18 PM. The resident was found with no pulse or spontaneous respirations and was pronounced dead at 5:20 PM.</p> <p>The facility's failure to have an effective system in place to ensure assistive devices were used properly to prevent accidents placed Resident #14 and other residents at risk in a situation that was likely to cause serious injury, harm, impairment or death to a resident. The Immediate Jeopardy was identified on 09/24/14 and determined to exist 09/16/14. The facility was</p>	F 323	<p>Continued From page 63</p> <p>GSS policy and procedure review included: Safe Resident Handling, Incident Reporting and Notification of Change of Condition. All policies &amp; procedures were found to be appropriate; no revisions were required and a lesson plan was developed for re-education related to F282, F309, F323, and F514. On 09/25/2014 at 4 pm EST, a meeting was held to communicate IJ situation, assign tasks and communicate mandatory adjusted schedules. Attendees included Director of Nursing Services, Staff Development / Quality Assurance Coordinator, and Nurse Case Managers. On 09/26/2014, an inventory of facility mechanical lift slings was reviewed by Administrator and Environmental Services Director and it was identified that sufficient number of slings were present. For a total of 19 residents requiring the use of a mechanical lift, there are 88 available slings. Soiled slings are placed in the soiled utility rooms by nursing staff to be laundered. Laundry staff cleans and inspect slings before slings are returned to the floor for use.</p>		

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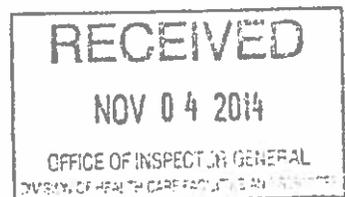
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  10/02/2014
NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40299		
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F 323	Continued From page 64 notified of the Immediate Jeopardy on 09/25/14.  The facility provided an acceptable Allegation of Compliance on 10/01/14 that alleged removal of Immediate Jeopardy on 09/30/14, the State Survey Agency verified Immediate Jeopardy was removed on 09/30/14 as alleged at 42 CFR 483.26 Quality of Care (F323) with the scope and severity lowered to a "D" while the facility monitors the effectiveness of the implemented plan of correction.  The findings include:  Review of the facility's policy and procedures titled Mobility Support and Positioning; Mobility, revised November 2013, revealed safety precautions included inspection of the lift and sling; following specific transfer instructions for the resident; use of the appropriate number of staff required; and proper operation of the lift. Two or more staff should use the total lift to transfer a resident from surface to surface. The procedure for surface to surface transfer with the total lift: check Kiosk for correct lift and sling size; position sling under the resident; position lift in front of or over the resident; position sling bar close enough to attach sling being careful to control the hanger bar to avoid hitting the resident; and, attach the straps.  Review of the manufacturer's Operating Instructions for the Ultralift, copyright 11/23/11, revealed a sequential procedure for staff to follow: identify the correct lift and type of sling; position the sling under the resident; position the lift in front of or over the resident; position the sling bar close enough to attach the sling, taking control over the hanger bar at all times to avoid	F 323	Continued From page 64  Once slings are sent to laundry, they are returned to the floor clean the very next day. Clean slings are stored on unit AB in room B12 and on unit CD in the clean utility room. On 09/26/2014 at 5:00 am EST, a meeting was held to provide re-education in response to U and to discuss re-education to follow for the entire active nursing staff. Attendees included Administrator, Director of Nursing Services, Staff Development / Quality Assurance Coordinator, and Nurse Case Managers with re-education provided by GSS Rehabilitation / Skilled Consultant.  2. All residents dependent on staff for assistance with bed mobility and transfer had the potential to be affected by this deficiency. 100% of the 79 current residents' Mobilization User Defined Assessments (UDA) were reviewed for accuracy, by the Director of Nursing Services, in determining type of assistance required for bed mobility and transfers; this review was initiated on 09/25/2014 and was completed on 09/28/2014.		



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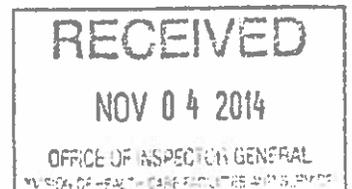
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NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40299		
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F 323	Continued From page 65 hitting the resident.  Review of the closed clinical record for Resident #14 revealed the facility admitted the resident on 09/17/08 with diagnoses of Dementia, Anemia, Alzheimer's, Osteoarthritis, Depression, Hypertension, and Anxiety. Review of the resident's comprehensive care plan, initiated 06/04/13, revealed the resident had an Activities of Daily Living (ADL) deficit and required total assist for a total lift using a large high back sling and to have two (2) people assist to turn and reposition. Review of the Mobilization Support Data Collection Tool, dated 01/17/14, revealed the resident required a total lift for transfer between surfaces using a large high back sling. The facility accessed the resident using the Minimum Data Set (MDS), dated 07/29/14, and determined the resident required extensive assistance with bed mobility and transfers.  Interview with SRNA #3, on 09/24/14 at 10:45 AM, revealed she was going to get the resident up for lunch, on 09/18/14 around 11:30 AM. The SRNA stated she had looked in the C/D Hall linen room, but there were no more slings in the room. Continued interview with SRNA #3, on 09/25/14 at 9:08 AM, revealed she was not positive, but thought the resident normally used a medium high back sling. SRNA #3 stated she knew the information was available in the Kiosk on the Kardex; however, she stated she decided to use the roommate's sling even though it was a different type and a size small. SRNA #3 stated because the pad was so much smaller, positioning of the resident was very important to keep the resident centered. The SRNA further stated the type and size sling the resident normally used wrapped around the resident more	F 323	Continued From page 65  10 of the 79 residents were re-assessed by completing the Mobilization UDA for 3 consecutive shifts on 09/27/2014 and 09/28/2014; Case Managers and floor nurses completed the re-assessments. 100% of 79 current residents care plans were reviewed by the Director of Nursing Services to ensure care plan and kardex included level of assist for bed mobility and transfer, including number of staff members, type of lift and sling size if indicated; this review was initiated on 09/25/2014 and was completed on 09/28/2014.  3. Re-education for compliance of F282, F309, F323 and F514 was provided to C.N.A staff and licensed nursing staff by GSS Rehabilitation / Skilled Care Consultation, Nurse Case Manager / Safe Resident Handling Coordinator and Staff Development / Quality Assurance Coordinator began at 5:00 am EST on 09/26/2014 with multiple meetings scheduled throughout the day on all shifts through 09/27/2014. Beginning on 1 <sup>st</sup> shift of 09/26/2014, no nursing staff member was permitted to provide resident care until re-education was completed.		



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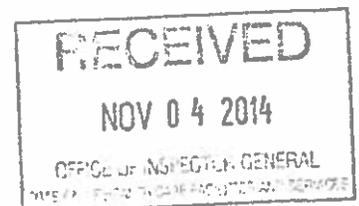
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F 323	<p>Continued From page 66</p> <p>as if to cuddle in the sling and there was more material with which to maneuver.</p> <p>Additional interview with SRNA #3, on 09/24/14 at 10:45 AM, revealed while trying to attach the sling straps to the mechanical lift, she realized the resident was not centered enough to be able to attach all the straps. While the mechanical lift was still in place over the resident and approximately five (5) inches from his/her chest, the SRNA turned the resident to his/her left side to reposition the sling and the lift arm hook hit the right side of the resident's face. SRNA #3 stated she remembered hearing a noise, but the resident never yelled out so she continued to position the resident. She turned the resident back over to attach the sling and noticed a cut above the resident's right eye with profuse bleeding. The SRNA stated SRNA #5 entered the room to see why they had not made it the dining room, and assisted with the transfer to the chair.</p> <p>Interview with SRNA #5, on 09/23/14 at 3:09 PM, revealed the sling was too small and the side of the resident's body was right at the edge. The sling was not long enough either and fell mid-thigh and not right above the knee. SRNA #5 stated the sling was not only too small, but the wrong type. The resident was supposed to use a high back sling for transfers and said the shape of the two (2) slings were completely different. SRNA #5 further stated the resident was observed with a cut above the eye with a little continuous stream of blood.</p> <p>Interview with the DON, on 09/24/14 at 12:30 PM, revealed she was told Resident #14 was hit in the head with the mechanical lift while rushing to get the resident up for lunch. The DON stated the</p>	F 323	<p>Continued From page 66</p> <p>As of 09/29/2014 70 employees, which represents all current full and part time nursing staff, have received the re-education which included passing post-test and return mechanical lift use demonstration. 2 PRN / on call employees who are currently not scheduled to work will receive the re-education prior to working. Re-education included:</p> <ol style="list-style-type: none"> <li>I. Care Delivered as Per Care Plan             <ol style="list-style-type: none"> <li>A) The plan of care is written to meet the resident's individualized needs based on data collection and assessment UDAs. The care plan needs to be updated with resident's change of condition.</li> <li>B) Facility staff must review the care plan / kardex and provide care as documented in the care plan.</li> <li>C) GSS Safe Resident Handling Policy and Procedure</li> <li>D) Mobilization UDA completion.</li> <li>E) Bed Mobility, Transfers, Use of Mechanical Lifts and Proper Lift Sling Utilization with return demonstration.</li> </ol> </li> </ol> <p>Clean slings are stored on unit AB in room B12 and on unit CD in the clean utility room.</p>		



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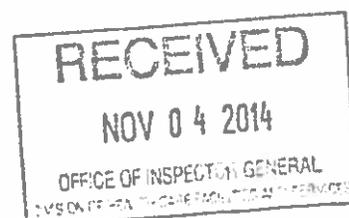
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F 323	<p>Continued From page 67</p> <p>resident was to have two (2) people assist with mobility and SRNA #3 had cared for the resident before and knew what size and type of sling to use for a safe transfer. The DON indicated the sling used was too small for the straps to be safely attached to the mechanical lift.</p> <p>Interview with SRNA #4, on 08/24/14 at 12:26 PM, revealed she used two (2) people for the actual transfer with the lift; however, she usually had the resident already on the sling and hooked up to the lift before getting assistance.</p> <p>Interview with SRNA #2, on 09/25/14 at 9:54 AM, revealed she always used two (2) people to transfer and knew not to turn or reposition someone while the lift was positioned over them; however, she always placed the resident on the sling before asking for assist with the actual transfer.</p> <p>Interview with SRNA #1, on 09/25/14 at 9:55 AM, revealed she was aware two (2) people were required for transfers; however, she always attached the lift sling prior to getting help.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 09/25/14 at 11:29 AM, revealed most of the SRNAs had the same group of residents and know what devices needed to be used. The LPN stated she never went around and monitored them to ensure they were using the mechanical lifts correctly. LPN #1 stated SRNA #3 had worked at the facility for years and took it for granted she would use the correct lift sling and safely position the resident.</p> <p>Interview with the Staff Development Nurse, on 09/24/14 at 2:24 PM, revealed she last trained all</p>	F 323	<p>Continued From page 67</p> <p>If a needed sling cannot be located, report to the nurse, Case Manager or Director of Nursing Services.</p> <p>II. Quality of Care</p> <p>A) Resident care is provided based on resident's data collection and assessment UDAs and the written care plan. This is done to meet the resident's standard of care without injury or decline in resident's condition.</p> <p>B) The licensed nurses are responsible for working with C.N.As and supervising resident care – this is done by observation of care and communication with C.N.As to ensure care is delivered as per care plan.</p> <p>III. Accidents</p> <p>A) GSS Incident Report Policy and Procedure – incident report completion, vital signs, neuro check UDA if resident hit head or unknown if resident hit head in a fall, pain data collection and assessment UDAs if resident has "new" area of pain related to the incident, fall risk UDA if resident fell.</p>



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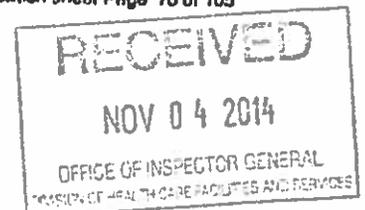
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F 323	<p>Continued From page 68</p> <p>the staff in 06/26/14 (this was not provided to the state agency for review) on the use of the mechanical lift which included a check off for the proper use procedure. However, the Staff Development Nurse revealed it did not include information about not positioning residents while the lift was in position over the resident.</p> <p>Review of SRNA #3's personnel file revealed she had completed training on the use of the lift on 02/03/14 and in 08/04/14. Further interview with SRNA #3, on 09/25/14 at 9:08 AM, revealed she had not been told the lift should not be positioned over the resident during positioning, but she knew she was not supposed to do it because of the potential for injury to the residents. However, per interview, she was rushing to get the resident to the dining room.</p> <p>Interview with the DON, on 09/24/14 at 12:30 PM, revealed she was not aware the training did not include positioning of residents with the mechanical lift in place over the resident. However, review of the facility's policy and procedures and the lift manufacturer's instructions revealed staff should position the sling bar close enough to attach the sling, and to control the hanger bar to avoid hitting the resident.</p> <p>Further interview with the DON, on 09/25/14 at 11:50 AM, revealed she monitored safe handling of residents and use of the mechanical lift by monitoring the incident reports daily and ensured any concerns or blank areas were immediately addressed. The DON did not provide any other evidence of monitoring.</p> <p>The facility provided an Allegation of Compliance</p>	F 323	<p>Continued From page 68</p> <p>Progress note follow up to the incident each shift for 72 hours or longer until stable. Progress note related to physician notification and family notification.</p> <p>B) GSS Notification of Change of Condition Policy and Procedure – assessing resident, notifying physician, documenting the communication with physician – follow doctor's orders for sending resident to the hospital / calling EMS – if the resident is in an emergent situation, physician and EMS are both called immediately.</p> <p>IV. Clinical Records</p> <p>A) Documentation must be clear, concise, objective findings using medical terminology and approved GSS abbreviations. Information stated by residents should be documented exactly as heard.</p> <p>B) Documentation must be timely – at the time of data collection, UDA completion – take the PCC tablet / laptop into resident's room for immediate documentation. In emergency situations, documentation must be completed as a late entry as soon as possible, no later than the end of the shift. Nursing staff are not to leave the building until documentation is complete.</p>		



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NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40288		
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F 323	Continued From page 69 (AOC) on 09/29/14 alleging the Immediate Jeopardy was removed on 09/30/14; the facility took the following steps to remove the Immediate Jeopardy.  1. The SRNA (SRNA #3) involved in the incident was suspended after the incident on 09/16/14 pending investigation of the incident.  2. A meeting was held to discuss the investigation, root cause of the Immediate Jeopardy, Good Samaritan Society policies and procedures (review included safe resident handling, incident reporting and notification of change of condition and action plan), on 09/25/14 at 2:00 PM. Attendees of the meeting on 09/25/14 were the Administrator, Director of Nursing, Staff Development/Quality Assurance Coordinator, Human Resources Director, Good Samaritan Society (GSS) Rehabilitation/Skilled Consultants, Good Samaritan Society Quality Improvement Consultant and a Good Samaritan Society Workforce Consultant.  3. All policies and procedures reviewed at the 2:00 PM meeting on 09/25/14 were found to be appropriate with no revisions required. A lesson plan was developed by the attendees for re-education.  4. A meeting was held, on 09/25/14 at 4:00 PM, to communicate the Immediate Jeopardy situation, assign tasks and communicate mandatory adjusted schedules. Attendees included the Director of Nursing, Staff Development/Quality Assurance Coordinator and Nurse Case Managers.  5. On 09/26/14 at 5:00 AM, a meeting was held to	F 323	Continued From page 69 PCC will date and time stamp when the entry is made, so when documenting event that occurred at an earlier time, the time of occurrence will be entered in the text of the note. C) Utilize the proper progress note type to document follow up assessment, physician notification and family notification.  4. Audits will be completed by licensed nurse for completion of Mobilization UDA on each shift in the first 24 hours of admission/readmission and with change of condition, for accurate care planning / Kardex for level of assist for bed mobility and transfer including number of staff, type of lift and sling size if indicated. Audits will be completed by licensed nurse observing 1 C.N.A. on each unit on each shift in assisting resident with bed mobility and transfer to ensure safe care as per resident's care plan. Medical Record Audits will be completed by licensed nurse to ensure with each incident an incident report has been completed, GSS #415 (facility investigation) is initiated, physician and resident's responsible party have been notified with appropriate documentation, resident monitoring and assessment is completed and documented in appropriate UDAs and progress notes.		



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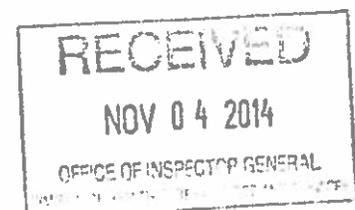
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  10/02/2014
NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40208		
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F 323	<p>Continued From page 70</p> <p>provide re-education in response to the immediate jeopardy and to discuss re-education to follow for the entire active nursing staff. Attendees included the Administrator, Director of Nursing, Staff Development/Quality Assurance Coordinator, and Nurse Case Managers with re-education provided by a Good Samaritan Society Rehabilitation/Skilled Consultant.</p> <p>6. On 09/26/14 an inventory of mechanical lift slings was reviewed by the Administrator and the Environmental Services Director and it was identified that a sufficient number of slings were present. There were eighty-eight (88) available slings for a total of nineteen (19) residents requiring the use of a mechanical lift. Soiled slings were placed in the soiled utility rooms by nursing staff to be laundered. Laundry staff cleaned and inspected slings and returned them to the floor the very next day.</p> <p>7. A one-hundred (100)% review was initiated on 09/25/14 and concluded on 09/28/14 to ensure accuracy (determination of type of assistance required for bed mobility and transfers) of seventy-nine (79) current residents' Mobilization User Defined Assessments (UDA) by the Director of Nursing. Ten (10) of the seventy-nine (79) residents were re-assessed by completing the Mobilization UDA for three (3) consecutive shifts on 09/27/14 and 09/28/14 by Nurse Case Managers and floor nurses.</p> <p>8. One-hundred (100)% review of seventy-nine (79) current residents' care plans was initiated on 09/25/14 and completed on 09/28/14 by the Director of Nursing to ensure care plans and Kardex included the level of assist for bed mobility and transfer, included the number of staff</p>	F 323	<p>Continued From page 70</p> <p>All audits will be completed daily X 7 days</p> <p>The facility has developed a Compliance Ad Hoc Committee which is chaired by the facility Administrator to manage the development of the POC for ongoing compliance of F282, F309, F323 and F514 and oversee the implementation of the POC with GSS Consultant support and assistance. Committee members include Director of Nursing Service, Staff Development / Quality Assurance Coordinator, Nurse Case Managers, Human Resource Director, Health Information Manager, and Medical Director. All audit results will be submitted to the Ad Hoc Committee for review and follow up action as indicated. The Ad Hoc Committee minutes will be reported to the Quality Committee monthly.</p> <p>POC Start</p> <p>The resident found to have been affected by the deficient practice (Resident #14) is now deceased.</p>		

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F 323	Continued From page 71 members required for use of the lift, the type of lift to be used, and the sling size, if indicated.  9. Re-education was provided to SRNA staff and licensed nursing staff beginning at 5:00 AM on 09/28/14 on all shifts and continued through 09/27/14 for compliance by Good Samaritan Society Rehabilitation/Skilled Consultant, Nurse Case Manager/Safe Resident Handling Coordinator and Staff Development/Quality Assurance Coordinator. Beginning on first (1st) shift of 09/26/14 no nursing staff member was permitted to provide resident care until re-education was completed. As of 09/29/14 seventy (70) employees (all current full and part-time nursing staff) had received the re-education which included passing a post-test and return demonstration for use of the mechanical lift. Two (2) prn/on-call nursing employees who were not scheduled to work will receive the re-education prior to working. The re-education included 1) care delivered per care plan, 2) quality of care, 3) accidents and 4) clinical records.  10. Audits will be completed daily times seven (7) days by licensed nurses for completion of mobilization (UDA) on each shift in the first twenty-four (24) hours of admission/readmission and with change of condition for accurate care planning/Kardex for level of assistance for bed mobility and transfer including number of staff, type of lift, and sling size if indicated.  11. Audits will be completed daily times seven (7) days by licensed nurses observing one (1) SRNA on each unit on each shift in assisting residents with bed mobility and transfer to ensure safe care per the resident's care plan.	F 323	Continued From page 71  In identifying other residents having the potential to be affected by the same deficient practice, 100% of the 79 current residents' medical record was reviewed by the DNS on 9/27/14. It was determined that 19 of 79 of residents require use of mechanical lift for assistance and could be affected. Review of medical records ensured accuracy of Mobilization User Defined Assessments (UDA) and Care Plan / kardex outlining level of assist needed for bed mobility and transfer, including number of staff members, type of lift and sling size if indicated. The Mobilization UDA for 69 out of 79 residents was accurate. 10 of the 79 residents were re-assessed by charge nurses and Mobilization UDAs were completed for 3 consecutive shifts and care plans / kardex were updated by 09/28/2014 by charge nurses. The updated information was then reviewed by the Case Managers for accuracy and completion on 9/28/2014.  Initiating on September 26, 2014, re-education was provided to all licensed nurses and certified nursing assistants (C.N.A.) by GSS Rehabilitation / Skilled Consultant, Staff Development Coordinator, and Safe Resident Handling Coordinator.		



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F 323	Continued From page 72  12. Medical record audits will be completed daily times seven (7) days by licensed nurses to ensure an incident report has been completed with each incident. Good Samaritan Society facility investigation policy was initiated, physician and resident's responsible party were notified with appropriate documentation, resident monitoring and assessment was completed and documented in appropriate UDA's and progress notes.  13. The facility developed a compliance Ad-Hoc Committee chaired by the facility Administrator to manage the development of the Plan of Correction for ongoing compliance and to oversee the implementation of the Plan of Correction with Good Samaritan Society Consultant support and assistance. Committee members include the Director of Nursing, the Staff Development/Quality Assurance Coordinator, Nurse Case Managers, Human Resource Director, Health Information Manager, and the Medical Director. All audit results will be submitted to the Ad-Hoc Committee for review and follow-up action as indicated. The Ad-Hoc Committee minutes will be reported to the Continuing Quality Improvement Committee Monthly.  Through observation, interview and record review the State Survey Agency validated the Allegation of Compliance with removal of Immediate Jeopardy on 09/30/14 as alleged prior to exit on 10/02/14 as follows:  1. Review of the personnel file for SRNA #3 revealed she was suspended from work after the incident on 09/16/14 pending the facility investigation and remained suspended	F 323	Continued From page 72  All staff members were instructed on the importance of following GSS Safe Resident Handling and Incident Reporting. Return demonstration of staff's ability to conduct safe assistance with bed mobility, transfers, use of the mechanical lifts and slings was included in the re-education sessions to ensure the deficient practice does not recur. In addition to the return demonstration of skills it was required all staff members complete and pass a post test for training received prior to working on the floor. All post tests were reviewed immediately upon completion by GSS Rehabilitation / Skilled Consultant to validate re-education was understood and that each individual staff member passed the test. Each individual tested, did receive a passing score. CNA #3 is no longer employed with GSS and did not complete re-education. Incident reports are reviewed each business day by the Investigative team (Administrator, Director of Social Services and DNS) for accuracy and completion. If findings are incomplete, the licensed nurse will be provided one on one education, counseling and or corrective action appropriately by the DNS.		

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F 323	Continued From page 73 throughout the survey including date of exit of 10/02/14.  2. A group interview including the Administrator, the Director of Nursing, the Staff Development Coordinator, the Human Resource Director, two (2) Good Samaritan Society Rehabilitation/Skilled Consultants (per telephone conference call), a Good Samaritan Society Quality Improvement (QI) Coordinator (per telephone conference call), and the Good Samaritan Society Workforce Consultant (per telephone conference call), on 10/02/14 at 2:00 PM, revealed the Administrator, the Director of Nursing, the Staff Development Coordinator and the Human Resource Director were present in person at the meeting held, on 09/25/14 at 2:00 PM, and the two (2) GSS Consultants, the GSS QI Coordinator and the GSS Workforce Consultant were at the meeting via telephone conference call to discuss the investigation regarding Resident #14, the root cause of the Immediate Jeopardy, GSS policies and procedures to include safe resident handling, incident reporting and notification of change of condition and to develop an action plan (lesson plan). Review of the lesson plan agenda (not dated) provided as proof for the AOC which included training on safe assistance with bed mobility, transfers and use of mechanical lifts and slings, and also included training on the writing of the individualized nursing care plan based on individualized needs and on following the residents' plans of care. Review of the sign-in sheets for the meeting held on 09/25/14 at 2:00 PM, confirmed the signatures of the attendees.  3. Review of the lesson plan developed in the meeting, on 09/25/14 at 2:00 PM, revealed an agenda, content, and SRNA and licensed nurse	F 323	Continued From page 73 MDS Coordinators/ Case Managers and DNS will observe staff when providing care to residents to include review of kardex prior to delivering care to residents, monitoring accuracy of the mobilization UDA and care plan. Direct observation of transfers and repositioning will occur to validate CNAs are performing care/transfers per GSS policy and procedure. Audits will be conducted each shift weekly X 4 weeks, each shift bi-weekly X 2 months, then each shift quarterly X 3. In addition, an audit will be completed by the DNS upon review of each incident report weekly x 4 weeks, monthly x 2 months, then quarterly x 3. Audit findings will be reported to the Quality Committee monthly x3, then quarterly x3, for further recommendation to ensure continued compliance.		

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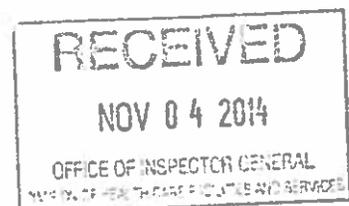
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F 323	<p>Continued From page 74</p> <p>post-tests to address the Immediate Jeopardy compliance. Review of the lesson plan developed "Providing Resident Care - Individualized, Safe, Documented" revealed an agenda, content, and SRNA and licensed nurse post-tests to address the Immediate Jeopardy compliance. The length of the training session outlined on the agenda was thirty (30) minutes for SRNAs and one (1) hour for licensed nurses with the purpose of the training to be correction activity for Immediate Jeopardy F-lags to include policies regarding safe handling of residents, incident reporting, notification of resident change of condition, data collection and UDA assessment instructions and use of mechanical lifts and slings.</p> <p>4. Interview with Nurse Case Managers #1 and #2, the DON, and the Staff Development Coordinator, on 10/02/14 at 3:06 PM, 3:15 PM, and 3:20 PM, respectively revealed they had attended the meeting held, on 09/25/14 at 4:00 PM, to discuss the Immediate Jeopardy situation, to assign tasks and to communicate mandatory adjusted schedules for the nursing staff. Review of the sign-in sheet for the meeting held on 09/25/14 at 4:00 PM confirmed the signatures of the attendees.</p> <p>5. A group interview including the Administrator, the Director of Nursing, the Staff Development Coordinator, GSS Rehabilitation/Skilled Consultant #2 (per telephone conference call) and Nurse Case Managers #1, #2 and #3, on 10/02/14 at 2:00 PM, revealed they were all present in person at the meeting held, on 09/26/14 at 5:00 AM, and GSS Rehabilitation/Skilled Consultant #2 provided the re-education to that staff in the meeting with</p>	F 323			

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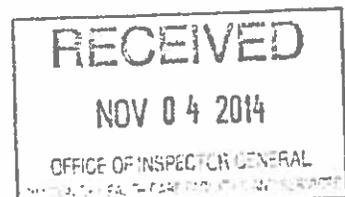
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F 323	Continued From page 75 discussion of re-education for the entire active nursing staff. Review of the sign-in sheet for the meeting held on 09/26/14 confirmed the signatures of the attendees.  6. Observation of the mechanical lift slings located in the laundry and on each nursing unit, on 10/02/14 at 9:00 AM, revealed there were eighty-eight (88) slings available for use. Twelve (12) of the slings observed were soiled and awaiting washing and inspection. Interview with the Administrator and the Environmental Services Director, on 10/02/14 at 12:16 PM, revealed they both participated in an inventory of the facility mechanical lift slings on 09/26/14. The Administrator and the Environmental Services Director indicated the soiled slings were to be placed in the soiled utility rooms by nursing staff to be laundered and the laundry staff was to launder, dry and inspect the slings before stocking them on each nursing unit the next day. Interview with SRNA #7, on 10/02/14 at 3:50 PM, revealed she would place a soiled sling in a bag in the soiled utility room on the nursing unit to be laundered and it was her understanding the laundry staff would inspect the slings for any defects before returning them to the nursing units. Interview with the Housekeeping/Laundry Supervisor, on 10/02/14 at 4:00 PM, revealed the laundry staff cleaned the mechanical lift slings seven (7) days a week and inspected them before returning them to the nursing units for use. She stated if a sling was defective it would be given to Case Manager #3 for replacement. Interview with Case Manager #3, on 10/02/14 at 4:10 PM, revealed he received the defective slings identified by the laundry staff or any nursing personnel and would order a replacement right away and the replacement would usually be	F 323			



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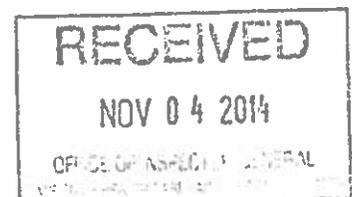
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F 323	<p>Continued From page 76</p> <p>provided within a week. Interview with the DON, on 10/02/14 at 4:10 PM, revealed mechanical lift slings were stored in the clean utility rooms on each nursing unit and were laundered and inspected by the laundry staff.</p> <p>7. Further interview with the DON, on 10/02/14 at 4:10 PM, revealed she initiated a one-hundred 100% audit of the seventy-nine (79) residents' Mobilization UDA's in the facility on 09/25/14 and completed the audit on 09/28/14. Review of the UDA's for Resident #17, Resident #18, Resident #19 and Resident #20 revealed they were accurate assessments of the residents' needs. Re-assessment documents were reviewed for ten (10) of the seventy-nine (79) residents reviewed which were completed for three (3) consecutive shifts on 09/27/14 and 09/28/14. Interview with Case Manager #1, and RN #1, on 10/02/14 at 4:15 PM, and 4:20 PM, respectively revealed they assisted with the re-assessments for ten (10) of the seventy-nine (79) residents reviewed which were completed for three (3) consecutive shifts on 09/27/14 and 09/28/14. Review of the audit initiated on 09/27/14 and concluded on 09/28/14 confirmed ten (10) residents were reviewed for reassessment by the DON.</p> <p>8. Observation of Resident #17, on 09/30/14 at 3:25 PM, on 10/01/14 at 8:35 AM, and 10:30 AM, revealed the resident's plan of care was being followed by the nursing staff. Observation of Resident #17, on 10/01/14 at 11:00 AM, revealed two (2) SRNAs performing a mechanical lift transfer of the resident from the bed to a wheelchair using the appropriate sling identified on the plan of care and using appropriate procedure for the transfer. Observation of Resident #18, on 09/30/14 at 3:45 PM, 10/01/14</p>	F 323			



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F 323	<p>Continued From page 77</p> <p>at 8:45 AM and 10:45 AM, revealed the resident was being cared for per the assessed nursing/SRNA plan of care. Observation of Resident #19, on 09/30/14 at 3:11 PM and 10/01/14 at 1:30 PM, revealed the resident's plan of care was being followed by the nursing staff. Review of the clinical records for Resident #17, Resident #18 and Resident #19's revealed Minimum Data Set (MDS) comprehensive reviews completed in the past thirty (30) days and compared to the residents' records revealed accurate assessments had been completed. Review of the nursing and SRNA care plans for Resident #17, Resident #18 and Resident #19 revealed they had been created from the comprehensive MDSs, completed in the past thirty (30) days and had been updated/revised as indicated. Review of the Mobilization UDA dated 08/28/14 for Resident #17 revealed the resident was to be transferred using the appropriate sling size with a mechanical lift as assessed. Interview with the DON, on 10/02/14 at 4:10 PM, revealed she initiated a one-hundred 100% audit of the seventy-nine (79) residents' (in the facility at the time) care plans on 09/25/14 and completed that audit on 09/28/14 to ensure care plans and Kardexs included the level of assist for bed mobility and transfer, the number of staff required for use of the lift and the type of lift and sling to be used, if indicated. Review of the audits completed by the DON confirmed they were completed between 09/25/14 and 09/28/14.</p> <p>9. Review of the SRNA and licensed nurse sign-in sheets for the re-education trainings revealed all but two (2) on-call nursing employees had completed the training between 09/26/14 at 5:00 AM and 09/27/14. A telephone interview with the GSS Rehabilitation/Skilled Consultant #2, on</p>	F 323			



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NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40299		
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F 323	Continued From page 78 10/02/14 at 2:00 PM, revealed she had conducted the lesson plan training on 09/26/14 through 09/29/14 with the assistance of Nurse Case Managers #1 and #2. Interview with Nurse Case Managers #1 and #2, on 10/02/14 at 2:20 PM, revealed they had participated in the lesson plan training done on 09/26/14 through 09/27/14. Interview with the Staff Development Coordinator on 10/02/14 at 2:30 PM revealed she had participated in the lesson plan training on use of the slings and mechanical lifts and had observed staff with return demonstrations of use of the slings and lifts on 09/26/14 through 09/29/14. Interview with LPN #2, on 10/02/14 at 3:40 PM, revealed she had attended an in-service training last week about lift use, charting, incident reporting, and calling the doctor. She stated she demonstrated the use of the mechanical lifts and had a written post-test on the training content. Interview with LPN #3, on 10/02/14 at 3:43 PM, revealed she had attended an in-service training on 09/27/14 about mechanical lift use, charting, incident reporting, and calling the doctor. She stated she also demonstrated the use of the mechanical lifts and had a written post-test on the training content. Interview with SRNA #7, on 10/02/14 at 3:48 PM, revealed she attended an in-service training on 09/26/14 about the use of the resident care plans and lift/sling use and she did a return demonstration and had a post-test. Interview with SRNA #8, on 10/02/14 at 3:52 PM, revealed she attended an in-service training on 09/26/14 about the use of the resident care plans and lift/sling use and she did a return demonstration and had a post-test.  10. Review of the seven (7) daily audits, initiated 09/29/14, confirmed a daily audit by licensed nurses for completion of the Mobilization UDA on	F 323			

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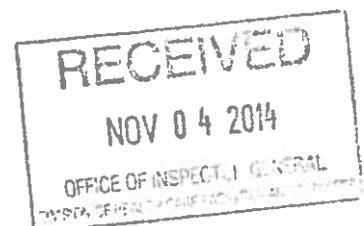
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185288	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  10/02/2014
NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40299		
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F 323	<p>Continued From page 79</p> <p>each shift in the first twenty-four (24) hrs of admission/readmission and with change of condition, for accurate care planning/Kardex for level of assist for bed mobility and transfer including number of staff required, type of lift and sling size, if indicated. Interview with LPN #3, on 10/02/14 at 4:20 PM, revealed she had completed three (3) of the required seven (7) daily audits to be done by licensed nurses. Interview with RN #2, on 10/02/14 at 4:25 PM, revealed he had completed two (2) of the required seven (7) daily audits to be done by licensed nurses.</p> <p>11. Review of the audits, initiated 09/27/14, confirmed the audits for proper use of the lift were completed with observations. Interview with LPN #3, on 10/02/14 at 4:20 PM, revealed she had observed SRNA #2, on day shift on 09/29/14, assisting Resident #17 with bed mobility and lift/sling transfer to ensure the safe care per the resident's care plan. LPN #3 stated she had completed three (3) of the required seven (7) daily audits to include the observation of a SRNA giving care per the resident's plan of care. Interview with RN #2, on 10/02/14 at 4:25 PM, revealed he had completed two (2) of the required seven (7) daily audits to be done by licensed nurses, with observations of SRNAs providing care.</p> <p>12. Further interview with LPN #3, on 10/02/14 at 4:20 PM, indicated she also participated in a medical record audit initiated 09/29/14 to ensure an incident report had been completed for an incident occurring on 10/01/14 (not reportable) and the appropriate documentation and resident assessment and monitoring occurred timely. Interview with RN #1, on 10/02/14 at 4:25 PM,</p>	F 323			

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NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40299		
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F 323	Continued From page 80 revealed she also had completed a medical record audit on 09/29/14 on second (2nd) shift regarding a change in resident condition to ensure the resident's responsible party was notified, the physician was notified, appropriate assessment and monitoring of the resident was completed and timely documentation in the progress notes. Review of that audit sheet indicated RN #1 had completed that audit on 2nd shift on 09/29/14.	F 323			
F 431 SS=D	13. Interview with the Administrator, the DON, the Staff Development Coordinator, the Human Resource Director and the Medical Director, on 10/02/14 at 4:35 PM, revealed they were all to be participants in a newly developed Compliance Ad-Hoc Committee to manage the development of the Plan of Correction (POC) for ongoing compliance. They indicated they are to oversee the implementation of the POC with GSS Consultant support and assistance, ensure all audit results are submitted to the Committee for review and follow-up action, as indicated. The Administrator stated the Ad-Hoc Committee minutes would be reported to the Continuing Quality Improvement Committee monthly. Review of the sign-in sheet for the Ad-Hoc meeting revealed it took place on 09/29/14 with the Administrator, the DON, the Staff Development/Quality Coordinator, the Human Resource Director, the Medical Records Director, both MDS Coordinators, and the Medical Director. The next Quality Assurance meeting is scheduled to be held on 10/28/14.  483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of	F 431			



Do not upload or scan this worksheet into the medical record

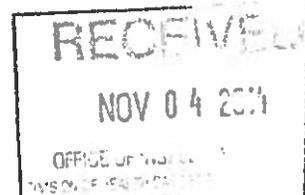
C/D Night Nurse Duty Checklist	Initial & date each item you complete		
Check door alarms and document			
Check fax machines for orders-refill paper			
Check lab calendar - verify lab orders			
Check calendar for scheduled appointment for residents for next day			
Print transfer record and MAR/med list for the next day's appointments			
Check wanderguards per TAR -change out those due			
Clean nebulizer masks and O2 concentrator filters as scheduled			
Replace O2 tubings as needed			
Calibrate glucometers and restock supplies used			
Confirm CNAs washed wheelchairs			
Check med refridgerators for expired meds/ remove any expired meds			
Clean and stock med carts - spoons, cups, med cups, gloves, wipes			
Check med room/ treatment room for expired supplies/remove any expired supplies (every Monday)			

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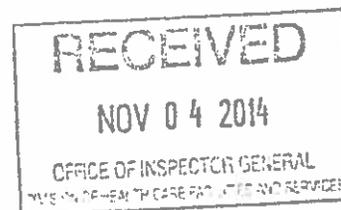
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  10/02/2014
NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40209		
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F 431	<p>Continued From page 81</p> <p>a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to dispose of expired biological tubes in one (1) of three (3) medication rooms. Lab supplies</p>	F 431	<p>Continued From page 81</p> <p>The expired blood draw tubes were disposed of on October 21, 2014 by the DNS.</p> <p>In identifying residents having the potential to be affected by the deficient practice, it was determined that any resident with orders to obtain stat labs could be affected. All medication rooms and supply room were inspected on October 21, 2014 by MDS Coordinator/ Case Manager. No other expired biologicals were found.</p> <p>Effective 10/24/14, all lab supplies will be kept in the treatment room. Third shift nursing checklists for duties will be updated to include checking med rooms and treatment room for expired supplies weekly.</p> <p>Audits will be completed by Case Managers or DNS to ensure no expired biologicals are found in the med rooms and treatment room. Audits will be completed weekly x4 weeks, monthly x2 months, then quarterly x3. Audit findings will be reported to the Quality Committee monthly x3, then quarterly x3, for further recommendation to ensure continued compliance.</p>	11/08/14	



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F 431	<p>Continued From page 82</p> <p>maintained by the facility were found expired and available for use by staff.</p> <p>The findings include:</p> <p>Observation, on 09/25/14 at 3:15 PM, of the A/B Unit medication room revealed eleven (11) blue top tubes expired August 2014; one (1) gray top tube expired March 2014; one (1) culture swab expired September 2014; two (2) navy blue top tubes expired August 2014; and two (2) white top tubes expired August 2014.</p> <p>Interview, on 09/25/14 at 10:45 AM, with Licensed Practical Nurse (LPN) #3 revealed nurses performed only STAT (immediate) lab draws. LPN #3 stated the night shift nurses were responsible for checking the medication room and ensuring there were no expired supplies. The nurse stated there was an assigned task checklist kept at the nurses station.</p> <p>Observation and review, on 09/25/14 at 3:15 PM, of the September 2014 task checklist revealed checking lab supplies was not part of the assigned duties.</p> <p>Continued interview with LPN #3, on 09/25/14, revealed she did not know checking lab supplies was not on the check list. The LPN indicated using expired lab supplies could result in incorrect test results and delayed treatment.</p> <p>Interview, on 09/25/14 at 3:28 PM, with A/B Unit Minimum Data Set (MDS) Case Manager #3 revealed nurses were responsible for checking the medication rooms for expired supplies. She further stated Case Managers were assigned to monitor the medication rooms.</p>	F 431			



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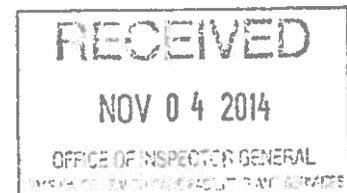
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F 431	Continued From page 83  Interview, on 09/25/14 at 3:30 PM, with the C/D Unit MDS Case Manager #1 revealed she was not monitoring the lab supplies stored in the medication room.  Interview the Medical Records/Certified Medication Technician (CMT), on 09/25/14 at 3:40 PM, revealed she inspected medication rooms monthly for expired medications and returned those medications to the pharmacy. She further stated she did not check lab supplies.  Interview with the Director of Nursing (DON), on 09/25/14 at 4:00 PM, revealed the facility used an outside lab service to draw labs at the facility. The DON stated they stored some lab supplies at the facility. These lab supplies were kept in the treatment room on the C/D Unit, the medication room on the A/B Unit, and the supply area downstairs. She indicated it was the responsibility of the Supply Coordinator to check the expiration dates of supplies including facility held lab supplies.  The DON stated she was not aware there were expired lab supplies in the A/B unit medication room. She further stated she had previously found expired lab supplies in the C/D unit treatment room and those items had been removed. She stated the Supply Coordinator was currently in the process of cleaning and organizing the supply area. She said she had specifically told the nurses to check the expiration dates on all drugs and biologics.	F 431			
F 497 SS=E	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE	F 497			

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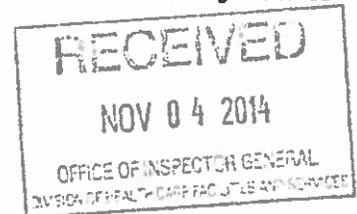
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F 497	<p>Continued From page 84</p> <p>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide evidence of twelve (12) hours per year of regular in-service education (to include the care of the cognitively impaired resident) for eleven (11) of thirty-five (35) State Registered Nursing Assistants (SRNA) based on the outcome of annual performance reviews for every nurse aide employed by the facility.</p> <p>The findings include: The facility did not provide a policy regarding the required in-service education for nurse aides. Review of the training records for all of the facility nurse aides revealed eleven (11) SRNAs did not have their required in-service education based on an annual performance review and calculated by the nurse aides' employment dates.</p>	F 497	<p>Continued From page 84</p> <p>The SRNAs found to not have their 12 hours of regular in-service education (to include the care of the cognitively impaired resident), based on their annual performance evaluation and calculated by their anniversary date, will complete all necessary education by November 10, 2014.</p> <p>On October 23, 2014, the Staff Development Coordinator identified the SRNAs needing education by reviewing all SRNAs education record who have been employed for over 12 months (total of 26). Eleven (11) SRNAs, two (2) of which are on medical leave, are not in compliance with their annual education requirement. The 9 active SRNAs have been contacted by the Staff Development Coordinator on October 24, 2014 and will have their training completed by November 10, 2014.</p> <p>Beginning November 1, 2014 all newly hired SRNAs, upon completion of orientation, will participate in ongoing required education on a monthly basis. Topics to include are care of the cognitively impaired resident, required SRNA skills, as well as other topics that are outlined by the Good Samaritan Society. Education is provided through instructor led courses, as well as the web-based learning management system, called the "Learning Center", which tracks all education at the Good Samaritan Society.</p>	11/11/14	



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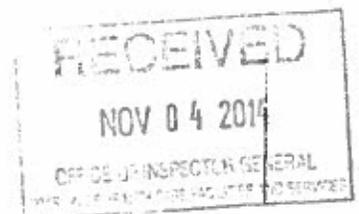
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F 497	Continued From page 85 Interview with the Staff Development Coordinator, on 09/25/14 at 11:00 AM, revealed she was aware some of the aides did not have their required regular in-service education. She stated it was her responsibility to notify the staff when their in-service education was due and if they did not respond timely, she was to notify the Director of Nursing (DON) She further stated she thought the DON was to implement the necessary corrective action to include not scheduling the aide to work if they had not completed their education, but she was not aware if this was done.  Interview with the DON, on 09/25/14 at 4:00 PM, revealed she had not received notification regarding the aides' lack of in-service education from the Staff Development Coordinator in a timely manner. She stated she had reported this to the Administrator, but she was not sure what had been done about the situation. She further stated she was not aware if she had aides scheduled to work who were out of compliance with the regulation regarding their twelve (12) hours of in-service education.  Interview with the Administrator, on 10/02/14 at 4:40 PM, revealed the facility had a system in place to ensure the aides had their in-service education and he did not know it wasn't working. He stated he did receive some notification from the Staff Development Coordinator regarding aides who were out of compliance with the regulation, but he thought it was being worked out between the Staff Development Coordinator and the Director of Nursing.	F 497	Continued From page 85 The Learning Center tracks the name of the activity, the activity type, date, and credits of the learning activity upon completion of the education activity. The Staff Development Coordinator in collaboration with the DNS will ensure the SRNAs attend all required education; whether instructor led or through the learning center. Via email, the Staff Development Coordinator will notify the DNS of all SRNAs who have not completed required education two weeks prior to the education deadline. Via email, the DNS will notify the Staff Development Coordinator of any SRNA's educational need upon completion of their annual performance evaluation. This method will ensure all SRNAs receive at least 12 hours of regular in-service education to include the care of the cognitively impaired resident based on the outcome of the annual performance reviews and calculated by each SRNA's employment date. Any SRNA who fails to complete required education by the deadline will be immediately removed from the schedule until required education is complete.  The Human Resources Director will audit the education record of all SRNAs monthly x 3 and then quarterly x 3 to ensure SRNAs are completing the required education within the set timeframe. Audit findings will be reported in Quality Committee meeting monthly x 3 and then quarterly x 3 for further recommendations.		
F 514 SS-J	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB	F 514			



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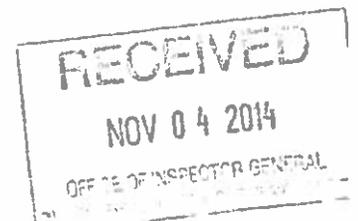
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NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40299		
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F 514	<p>Continued From page 86</p> <p>LE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, closed record review, review of the facility's policy Completing Incident/Injury Report Forms, it was determined the facility failed to have an effective system in place to ensure the clinical record completely and accurately reflected the resident's base line status, injury and change of condition for one (1) of the sixteen (16) sampled residents, (Resident #14). (Refer to F157 and F309).</p> <p>The facility staff failed to document in the clinical record specific information regarding the details of how an injury occurred to Resident #14, a baseline status and assessment of the resident, notification of the family and resident's physician, care and services the resident received, decline in the resident's condition, and emergent care provided to the resident by facility staff. On 09/16/14, Resident #14 sustained a 1.5</p>	F 514	<p>Continued From page 86</p> <p>An Allegation of Compliance was provided on 09/29/14 alleging removal of the Immediate Jeopardy on 09/30/14. The following steps were taken:</p> <ol style="list-style-type: none"> <li>1. The resident affected by this incident is deceased. The C.N.A. involved in the incident was suspended pending investigation of the incident. On 09/25/2014 at 2 pm EST, a meeting was held to discuss the investigation, root cause of the IJ, GSS policy &amp; procedures, and action plan. Attendees included Administrator, Director of Nursing Services, Staff Development / Quality Assurance Coordinator, Human Resources Director, GSS Rehabilitation / Skilled Consultants, GSS Quality Improvement Consultant, and GSS Workforce Consultant. GSS policy and procedure review included Safe Resident Handling, Incident Reporting and Notification of Change of Condition. All policies &amp; procedures were found to be appropriate; no revisions were required and a lesson plan was developed for re-education related to F282, F309, F323, and F514.</li> </ol>	10/31/14	



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NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40299	
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F 514	<p>Continued From page 87</p> <p>centimeter laceration above the right eye, with profuse bleeding, during a transfer with a mechanical lift. Interviews and record review revealed no documented evidence of assessment and/or monitoring of Resident #14. At 4:00 PM the Director of Nursing (DON) gave direction to RN #1 to prepare the resident for transfer to the hospital for evaluation. However, interview and record review revealed neither the physician nor the ambulance service was notified as instructed. At 5:00 PM, the resident was found unresponsive and in respiratory distress. The facility made an urgent call to the ambulance company at 5:08 PM with arrival at 5:18 PM. The resident was found with no pulse or spontaneous respirations and was pronounced dead at 5:20 PM.</p> <p>The facility's failure to ensure the clinical record completely and accurately reflected the resident's base line status, injury, and change of condition placed Resident #14 and other residents at risk in a situation that was likely to cause serious injury, harm, impairment or death to a resident. The Immediate Jeopardy was identified on 09/24/14 and determined to exist 09/16/14. The facility was notified of the Immediate Jeopardy on 09/25/14.</p> <p>The facility provided an acceptable Allegation of Compliance on 10/01/14 that alleged removal of Immediate Jeopardy on 09/30/14. The State Survey Agency verified Immediate Jeopardy was removed on 09/30/14 as alleged, at 42 CFR 483.75 Administration (F514) with the scope and severity lowered to a "D" while the facility monitored the effectiveness of the implemented plan of correction.</p> <p>The findings include:</p>	F 514	<p>Continued From page 87</p> <p>On 09/25/2014 at 4 pm EST, a meeting was held to communicate U situation, assign tasks and communicate mandatory adjusted schedules. Attendees included Director of Nursing Services, Staff Development / Quality Assurance Coordinator, and Nurse Case Managers. On 09/26/2014, an inventory of facility mechanical lift slings was reviewed by Administrator and Environmental Services Director and it was identified that sufficient number of slings were present. For a total of 19 resident s requiring the use of a mechanical lift, there are 88 available slings. Soiled slings are placed in the soiled utility rooms by nursing staff to be laundered. Laundry staff cleans and inspect slings before slings are returned to the floor for use. Once slings are sent to laundry, they are returned to the floor clean the very next day. Clean slings are stored on unit AB in room B12 and on unit CD in the clean utility room. On 09/26/2014 at 5:00 am EST, a meeting was held to provide re-education in response to U and to discuss re-education to follow for the entire active nursing staff.</p>	



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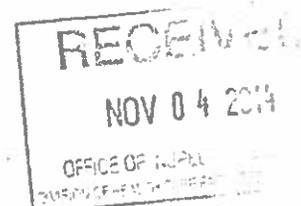
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  10/02/2014
NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40299		
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F 514	Continued From page 88  The facility did not provide a policy for Charting and Documentation.  Review of the facility's policy and procedure Completing Incident/Injury Report Forms, revised December 2010, revealed the purpose was to document a resident's incident/accident, possible causative factors, corrective action, and assure reporting and follow-up of all incidents/accidents involving a resident. The facility's procedure in the event of an incident included: completing a body review for injuries and bleeding; obtaining vital signs and noting times; calling 911 if the injury might be serious or if in doubt as to the seriousness of the resident's condition; and, use of first aid measures.  Review of the closed clinical record for Resident #14 revealed the facility admitted the resident on 09/17/08 with the diagnoses of Dementia, Alzheimer's, Osteoarthritis, Depression, Hypertension, and Anxiety. The facility assessed the resident using the Minimum Data Set (MDS), dated 07/29/14, as requiring extensive assistance with bed mobility and transfers.  Review of facility's incident report for Resident #14's injury, dated 09/16/14, revealed the wound nurse measured the wound at 0.1 centimeter (cm) x 1.5 cm. The area was cleaned and pressure applied to the wound with some decrease in bleeding. The report indicated the injury type as a laceration located on the face. The resident's pain level was marked as "hurts even more". The form was marked the resident was alert and oriented to person. The injury report noted the family and resident's physician were notified at 1:00 PM on 09/16/14. However,	F 514	Continued From page 88  Attendees included Administrator, Director of Nursing Services, Staff Development / Quality Assurance Coordinator, and Nurse Case Managers with re-education provided by GSS Rehabilitation / Skilled Consultant.  2. All residents dependent on staff for assistance with bed mobility and transfer had the potential to be affected by this deficiency. 100% of the 79 current residents' Mobilization User Defined Assessments (UDA) were reviewed for accuracy, by the Director of Nursing Services in determining type of assistance required for bed mobility and transfers; this review was initiated on 09/25/2014 and was completed on 09/28/2014. 10 of the 79 residents were re-assessed by completing the Mobilization UDA for 3 consecutive shifts on 09/27/2014 and 09/28/2014; Case Managers and floor nurses completed the re-assessments. 100% of 79 current residents care plans were reviewed by the Director of Nursing Services to ensure care plan and Kardex included level of assist for bed mobility and transfer, including number of staff members, type of lift and sling size if indicated; this review was initiated on 09/25/2014 and was completed on 09/28/2014.		

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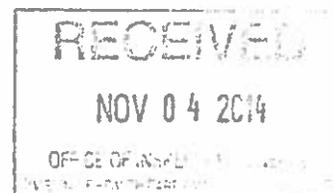
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NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40299		
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F 514	<p>Continued From page 89</p> <p>there was no documented evidence in the resident's clinical record this notification was conducted.</p> <p>Interview with SRNA #3, on 09/24/14 at 10:45 AM, revealed while getting Resident #14 up for lunch with the mechanical lift on 09/16/14 between 12:00 PM and 12:30 PM, the SRNA turned the resident to the right side to adjust the sling for the mechanical lift while the lift was already in position over the resident. The SRNA stated the sling was the wrong type and size for the resident and the lift arm hooks hit the resident's head and inflicted a cut above the eye that was profusely bleeding.</p> <p>Review of LPN #1's nursing notes, dated 09/16/14 at 12:00 PM, revealed the LPN described the wound as a gash with no mention of the swelling around the injury or that the blood was streaming down the resident's face to the point steri-strips would not stick. There was no documentation that vital signs or a neurological assessment were completed following the head injury.</p> <p>Review of LPN #1's nurse note entry, dated 09/16/14 at 1:30 PM, revealed the right eye gash continued to have a small amount of bleeding and the wound was cleaned and a dressing was applied. The note indicated the DON was notified who stated to continue to monitor and reapply steri-strips when the bleeding stops. There was no other documentation entered in the record or evidence the resident was seen again until the next shift.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 09/23/14 at 3:21 PM, revealed the injury above</p>	F 514	<p>Continued From page 89</p> <p>3. Re-education for compliance of F282, F309, F323 and F514 was provided to C.N.A staff and licensed nursing staff by GSS Rehabilitation / Skilled Care Consultation, Nurse Case Manager / Safe Resident Handling Coordinator and Staff Development / Quality Assurance Coordinator began at 5:00 am EST on 09/26/2014 with multiple meetings scheduled throughout the day on all shifts through 09/27/2014. Beginning on 1<sup>st</sup> shift of 09/26/2014, no nursing staff member was permitted to provide resident care until re-education was completed. As of 09/29/2014 70 employees, which represents all current full and part time nursing staff, have received the re-education which included passing post-test and return mechanical lift use demonstration. 2 PRN / on call employees who are currently not scheduled to work will receive the re-education prior to working. Re-education included:</p> <p>I. Care Delivered as Per Care Plan</p> <p>A) The plan of care is written to meet the resident's individualized needs based on data collection and assessment UDAs. The care plan needs to be updated with resident's change of condition.</p>		



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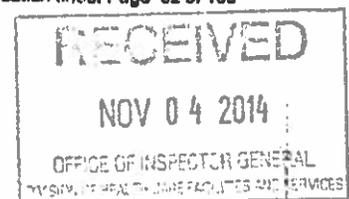
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NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40299		
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F 514	<p>Continued From page 90</p> <p>the eye had some swelling and was bleeding down the resident's face. Further interview, on 09/24/14 at 12:01 PM, revealed the LPN applied steri-strips, but they would not stick due to the amount of bleeding and she notified the wound nurse to come and assess the resident. Further interview, on 09/25/14 at 11:29 AM, revealed documentation in the record was to show what was going on with the resident and what the resident's condition was at a given time. LPN #1 stated if you do not document no one would know what care was provided, and it would be like nothing happened.</p> <p>Interview with MDS Nurse #2, on 09/24/14 at 12:31 PM, revealed she was the facility's wound nurse and was notified around 12:45 PM that Resident #14 had sustained a head injury and was bleeding. The MDS Nurse initially stated the resident had a skin tear, then, said it did not fit the definition for a skin tear and that the injury was a gash. She further stated the injury was a clean cut, then, decided the wound was actually a laceration. The MDS nurse revealed the bleeding was a constant stream down the resident's face and every time she cleaned it, it would start bleeding again. MDS Nurse #2 stated she continued to try and control the bleeding for fifteen (15) to twenty (20) minutes, but it never completely stopped. The MDS nurse revealed she did carry a pen light and checked the resident's pupils; however, could not report the size or response with the light as none of the information above was documented.</p> <p>Review of Minimum Data Set (MDS) Nurse #2's nursing notes, dated 09/16/14 at 12:50 PM, revealed the resident's wound was a split to the skin that was bleeding. The notes revealed no</p>	F 514	<p>Continued From page 90</p> <p>B) Facility staff must review the care plan / kardex and provide care as documented in the care plan.</p> <p>C) GSS Safe Resident Handling Policy and Procedure</p> <p>D) Mobilization UDA completion.</p> <p>E) Bed Mobility, Transfers, Use of Mechanical Lifts and Proper Lift Sling Utilization with return demonstration. Clean slings are stored on unit AB in room B12 and on unit CD in the clean utility room. If a needed sling cannot be located, report to the nurse, Case Manager or Director of Nursing Services.</p> <p>II. Quality of Care</p> <p>A) Resident care is provided based on resident's data collection and assessment UDAs and the written care plan. This is done to meet the resident's standard of care without injury or decline in resident's condition.</p> <p>B) The licensed nurses are responsible for working with C.N.As and supervising resident care – this is done by observation of care and communication with C.N.As to ensure care is delivered as per care plan.</p>		



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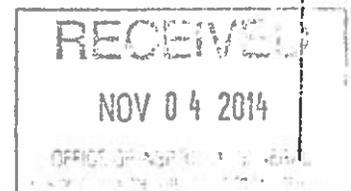
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F 514	<p>Continued From page 91</p> <p>deep trauma was noted, but did not describe how that was determined. The notes did identify some swelling and bruising, but did not reflect the measures taken to stop the bleeding or that the bleeding never stopped during that shift.</p> <p>Continued interview with MDS Nurse #2, on 09/16/14 at 12:31 PM, revealed she did not completely and accurately chart what she observed while in the resident's room and knew she was supposed to document everything. The MDS nurse stated she thought someone else would document what happened.</p> <p>Interview with MDS Nurse #1, on 09/23/14 at 5:07 PM, revealed she was told the resident sustained an injury from the mechanical lift and saw the resident around 3:20 PM. The MDS nurse stated the resident's eye was swollen shut, had dark purple bruising above and around the eye and the wound was still bleeding. The MDS nurse further stated she told RN #1 the resident needed stitches, and he needed to call the physician, call the ambulance, and get the paperwork ready.</p> <p>However, review of the late entry nurses notes, dated 09/16/14, revealed no evidence MDS Nurse #1 documented any activity in the record. There was no evidence of documentation as to when the resident's condition changed, that vital signs or a neurological assessment was completed, or who and when the ambulance service was notified.</p> <p>Further review of the late entry nurses note by RN #1, dated 09/16/14 at 3:00 PM, revealed the resident had normal coloring and no signs or symptoms of distress. The notes did not mention the swelling or bruising on the resident's face.</p>	F 514	<p>Continued From page 91</p> <p>III. Accidents</p> <p>A) GSS Incident Report Policy and Procedure – incident report completion, vital signs, neuro check UDA if resident hit head or unknown if resident hit head in a fall, pain data collection and assessment UDAs if resident has "new" area of pain related to the incident, fall risk UDA if resident fell. Progress note follow up to the incident each shift for 72 hours or longer until stable. Progress note related to physician notification and family notification.</p> <p>B) GSS Notification of Change of Condition Policy and Procedure – assessing resident, notifying physician, documenting the communication with physician – follow doctor's orders for sending resident to the hospital / calling EMS – if the resident is in an emergent situation, physician and EMS are both called immediately.</p> <p>IV. Clinical Records</p> <p>A) Documentation must be clear, concise, objective findings using medical terminology and approved GSS abbreviations. Information stated by residents should be documented exactly as heard.</p>	



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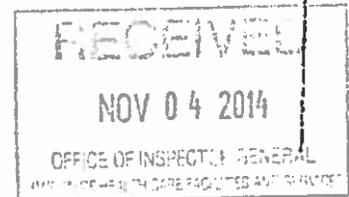
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185288	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  10/02/2014
NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40299	
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F 514	<p>Continued From page 92 and did not mention the directives given by MDS Nurso #1.</p> <p>Interview with Registered Nurse (RN) #1, on 09/23/14 at 2:45 PM, revealed the physician called back and gave an order to transfer the resident to the hospital. However, RN #1 stated he never wrote the order to transfer to the hospital because he thought someone else had already done that. The RN further stated he never looked in the computer to ensure it was actually done.</p> <p>Intorview with the DON, on 09/24/14 at 12:30 PM, revealed Resident #14's documentation did not contain a lot of information, and she did not realize there had been so very little documented until reviewing the information after the resident passed away. The DON stated the facility was told by their corporate office to not make any more late entries into Resident #14's clinical record because it was not good practice. The DON further stated during her chart audits she reviewed the entire chart for any incidents that occurred. She had noticed incorrect coding and charting before and talked with that person individually as problems arose. The DON further indicated there had been training before on documentallon.</p> <p>Interview with Staff Development, on 09/25/14 at 12:44 PM, revealed there had never been any training on ensuring documentation during incident/accidents or what to include. Staff Development stated the training completed involved using User Defined Assessments (USD) which would prompt the nurse what to chart for certain medical problems; however, not emergent concerns.</p>	F 514	<p>Continued From page 92</p> <p>B) Documentation must be timely -- at the time of data collection, UDA completion -- take the PCC tablet / laptop into resident's room for immediate documentation. In emergency situations, documentation must be completed as a late entry as soon as possible, no later than the end of the shift. Nursing staff are not to leave the building until documentation is complete. PCC will date and time stamp when the entry is made, so when documenting event that occurred at an earlier time, the time of occurrence will be entered in the text of the note.</p> <p>C) Utilize the proper progress note type to document follow up assessment, physician notification and family notification.</p> <p>4. Audits will be completed by licensed nurse for completion of Mobilization UDA on each shift in the first 24 hours of admission/readmission and with change of condition, for accurate care planning / kardex for level of assist for bed mobility and transfer including number of staff, type of lift and sling size if indicated.</p>	



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F 514	Continued From page 93  The facility provided an Allegation of Compliance (AOC) on 09/29/14 alleging the Immediate Jeopardy was removed on 09/30/14; the facility took the following steps to remove the Immediate Jeopardy.  1. The SRNA (SRNA #3) involved in the incident was suspended after the incident on 09/16/14 pending investigation of the incident.  2. A meeting was held to discuss the investigation, root cause of the Immediate Jeopardy, Good Samaritan Society policies and procedures (review included safe resident handling, incident reporting and notification of change of condition and action plan), on 09/25/14 at 2:00 PM. Attendees of the meeting on 09/25/14 were the Administrator, Director of Nursing, Staff Development/Quality Assurance Coordinator, Human Resources Director, Good Samaritan Society (GASS) Rehabilitation/Skilled Consultants, Good Samaritan Society Quality Improvement Consultant and a Good Samaritan Society Workforce Consultant.  3. All policies and procedures reviewed at the 2:00 PM meeting on 09/25/14 were found to be appropriate with no revisions required. A lesson plan was developed by the attendees for re-education.  4. A meeting was held, on 09/25/14 at 4:00 PM, to communicate the Immediate Jeopardy situation, assign tasks and communicate mandatory adjusted schedules. Attendees included the Director of Nursing, Staff Development/Quality Assurance Coordinator and Nurse Case Managers.	F 514	Continued From page 93  Audits will be completed by licensed nurse observing 1 C.N.A. on each unit on each shift in assisting resident with bed mobility and transfer to ensure safe care as per resident's care plan. Medical Record Audits will be completed by licensed nurse to ensure with each incident an incident report has been completed, GSS #415 (facility investigation) is initiated, physician and resident's responsible party have been notified with appropriate documentation, resident monitoring and assessment is completed and documented in appropriate UDAs and progress notes. All audits will be completed daily X 7 days.  The facility has developed a Compliance Ad Hoc Committee which is chaired by the facility Administrator to manage the development of the POC for ongoing compliance of F282, F309, F323 and F514 and oversee the implementation of the POC with GSS Consultant support and assistance. Committee members include Director of Nursing Service, Staff Development / Quality Assurance Coordinator, Nurse Case Managers, Human Resource Director, Health Information Manager, and Medical Director.		



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F 514	Continued From page 94  5. On 09/26/14 at 5:00 AM, a meeting was held to provide re-education in response to the Immediate Jeopardy and to discuss re-education to follow for the entire active nursing staff. Attendees included the Administrator, Director of Nursing, Staff Development/Quality Assurance Coordinator, and Nurse Case Managers with re-education provided by a Good Samaritan Society Rehabilitation/Skilled Consultant.  6. On 09/26/14 an inventory of mechanical lift slings was reviewed by the Administrator and the Environmental Services Director and it was identified that a sufficient number of slings were present. There were eighty-eight (88) available slings for a total of nineteen (19) residents requiring the use of a mechanical lift. Soiled slings were placed in the soiled utility rooms by nursing staff to be laundered. Laundry staff cleaned and inspected slings and returned them to the floor the very next day.  7. A one-hundred (100)% review was initiated on 09/25/14 and concluded on 09/28/14 to ensure accuracy (determination of type of assistance required for bed mobility and transfers) of seventy-nine (79) current residents' Mobilization User Defined Assessments (UDA) by the Director of Nursing. Ten (10) of the seventy-nine (79) residents were re-assessed by completing the Mobilization UDA for three (3) consecutive shifts on 09/27/14 and 09/28/14 by Nurse Case Managers and floor nurses.  8. One-hundred (100)% review of seventy-nine (79) current residents' care plans was initiated on 09/25/14 and completed on 09/28/14 by the Director of Nursing to ensure care plans and	F 514	Continued From page 94  All audit results will be submitted to the Ad Hoc Committee for review and follow up action as indicated. The Ad Hoc Committee minutes will be reported to the Quality Committee monthly.  POC Start  The resident found to have been affected by the deficient practice (Resident #14) is now deceased.  In identifying other residents having the potential to be affected by the same deficient practice, it was determined that all residents could experience a change of condition and could be affected.  Re-education was initiated on 09/26/2014 to all licensed nurses by GSS Rehabilitation / Skilled Consultant. These staff members were instructed on data collection / assessment, documentation, and communication with physician / family. Specific focus was placed on the importance of obtaining, communicating and documenting complete assessment findings on any resident who experiences a change of condition or suffers an injury to allow immediate intervention for the resident.		

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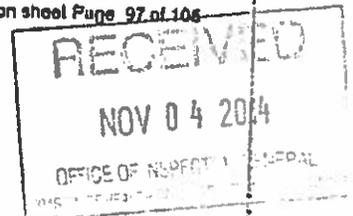
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NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3800 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40299		
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F 514	Continued From page 95 Kardexs included the level of assist for bed mobility and transfer, included the number of staff members required for use of the lift, the type of lift to be used, and the sling size, if indicated.  9. Re-education was provided to SRNA staff and licensed nursing staff beginning at 5:00 AM on 09/28/14 on all shifts and continued through 09/27/14 for compliance by Good Samaritan Society Rehabilitation/Skilled Consultant, Nurse Case Manager/Safe Resident Handling Coordinator and Staff Development/Quality Assurance Coordinator. Beginning on first (1st) shift of 09/28/14 no nursing staff member was permitted to provide resident care until re-education was completed. As of 09/29/14 seventy (70) employees (all current full and part-time nursing staff) had received the re-education which included passing a post-test and return demonstration for use of the mechanical lift. Two (2) prn/on-call nursing employees who were not scheduled to work will receive the re-education prior to working. The re-education included 1) care delivered per care plan, 2) quality of care, 3) accidents and 4) clinical records.  10. Audits will be completed daily times seven (7) days by licensed nurses for completion of mobilization (UDA) on each shift in the first twenty-four (24) hours of admission/readmission and with change of condition for accurate care planning/Kardox for level of assistance for bed mobility and transfer including number of staff, type of lift, and sling size if indicated.  11. Audits will be completed daily times seven (7) days by licensed nurses observing one (1) SRNA on each unit on each shift in assisting residents	F 514	Continued From page 95 It was required all staff members complete and pass a post test for all training received prior to working on the floor to ensure the deficient practice does not recur. All post tests were reviewed immediately upon completion by GSS Rehabilitation / Skilled Consultant to validate re-education was understood and that each individual staff member passed the test. Each individual tested, did receive a passing score. CNA #3 is no longer employed with GSS and did not complete re-education. Charge nurse on duty will be notified immediately regarding residents who experience a change in condition. Case Manager will ensure staff involved are following GSS policy and procedure to ensure physician notification occurs timely and that resident(s) receive proper care as directed by the physician (as instructed during re-education sessions). Incident reports are reviewed each business day by the investigative team (Administrator, Director of Social Services and DNS) for completion and accuracy. If findings are incomplete the licensed nurse will be provided one on one education, counseling and or corrective action appropriately by the DNS.		

Handwritten signature and date: 10/16/2014

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  10/02/2014
NAME OF PROVIDER OR SUPPLIER  THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY JEFFERSONTOWN, KY 40299		
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F 514	<p>Continued From page 96 with bed mobility and transfer to ensure safe care per the resident's care plan.</p> <p>12. Medical record audits will be completed daily times seven (7) days by licensed nurses to ensure an incident report has been completed with each incident. Good Samaritan Society facility investigation policy was initiated, physician and resident's responsible party were notified with appropriate documentation, resident monitoring and assessment was completed and documented in appropriate UDA's and progress notes.</p> <p>13. The facility developed a compliance Ad-Hoc Committee chaired by the facility Administrator to manage the development of the Plan of Correction for ongoing compliance and to oversee the implementation of the Plan of Correction with Good Samaritan Society Consultant support and assistance. Committee members include the Director of Nursing, the Staff Development/Quality Assurance Coordinator, Nurse Case Managers, Human Resource Director, Health Information Manager, and the Medical Director. All audit results will be submitted to the Ad-Hoc Committee for review and follow-up action as indicated. The Ad-Hoc Committee minutes will be reported to the Continuing Quality Improvement Committee Monthly.</p> <p>Through observation, interview and record review the State Survey Agency validated the Allegation of Compliance with removal of Immediate Jeopardy on 09/30/14 as alleged prior to exit on 10/02/14 as follows:</p> <p>1. Review of the personnel file for SRNA #3 revealed she was suspended from work after the</p>	F 514	<p>Continued From page 96</p> <p>MDS Coordinators and DNS will review resident/resident progress notes daily to identify resident change of condition. Electronic medical records of those identified will then be audited to ensure detailed documentation of assessment findings and events, appropriate UDA completion, physician/family notification, and care delivered as per physician order and GSS policy and procedure. Audits will be completed daily X4 weeks, then weekly X 4 weeks, bi-weekly X 1 month, then quarterly X 3. Audit findings will be reported to the Quality Committee monthly x3, then quarterly x3, for further recommendation to ensure continued compliance.</p>		



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F 514	Continued From page 97 incident on 09/16/14 pending the facility investigation and remained suspended throughout the survey including date of exit of 10/02/14.  2. A group interview including the Administrator, the Director of Nursing, the Staff Development Coordinator, the Human Resource Director, two (2) Good Samaritan Society Rehabilitation/Skilled Consultants (per telephone conference call), a Good Samaritan Society Quality Improvement (QI) Coordinator (per telephone conference call), and the Good Samaritan Society Workforce Consultant (per telephone conference call), on 10/02/14 at 2:00 PM, revealed the Administrator, the Director of Nursing, the Staff Development Coordinator and the Human Resource Director were present in person at the meeting held, on 09/25/14 at 2:00 PM, and the two (2) GSS Consultants, the GSS QI Coordinator and the GSS Workforce Consultant were at the meeting via telephone conference call to discuss the investigation regarding Resident #14, the root cause of the Immediate Jeopardy, GSS policies and procedures to include safe resident handling, incident reporting and notification of change of condition and to develop an action plan (lesson plan). Review of the lesson plan agenda (not dated) provided as proof for the AOC which included training on safe assistance with bed mobility, transfers and use of mechanical lifts and slings, and also included training on the writing of the individualized nursing care plan based on individualized needs and on following the residents' plans of care. Review of the sign-in sheets for the meeting held on 09/25/14 at 2:00 PM, confirmed the signatures of the attendees.  3. Review of the lesson plan developed in the	F 514			

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F 514	<p>Continued From page 98</p> <p>meeting, on 09/25/14 at 2:00 PM, revealed an agenda, content, and SRNA and licensed nurse post-tests to address the Immediate Jeopardy compliance. Review of the lesson plan developed "Providing Resident Care - Individualized, Safe, Documented" revealed an agenda, content, and SRNA and licensed nurse post-tests to address the Immediate Jeopardy compliance. The length of the training session outlined on the agenda was thirty (30) minutes for SRNAs and one (1) hour for licensed nurses with the purpose of the training to be correction activity for Immediate Jeopardy F-tags to include policies regarding safe handling of residents, incident reporting, notification of resident change of condition, data collection and UDA assessment instructions and use of mechanical lifts and slings.</p> <p>4. Interview with Nurse Case Managers #1 and #2, the DON, and the Staff Development Coordinator, on 10/02/14 at 3:06 PM, 3:15 PM, and 3:20 PM, respectively revealed they had attended the meeting held, on 09/25/14 at 4:00 PM, to discuss the Immediate Jeopardy situation, to assign tasks and to communicate mandatory adjusted schedules for the nursing staff. Review of the sign-in sheet for the meeting held on 09/25/14 at 4:00 PM confirmed the signatures of the attendees.</p> <p>5. A group interview including the Administrator, the Director of Nursing, the Staff Development Coordinator, GSS Rehabilitation/Skilled Consultant #2 (per telephone conference call) and Nurse Case Managers #1, #2 and #3, on 10/02/14 at 2:00 PM, revealed they were all present in person at the meeting held, on 09/26/14 at 5:00 AM, and GSS</p>	F 514			

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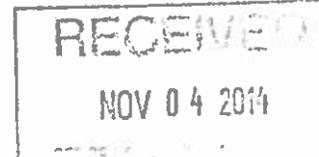
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F 514	<p>Continued From page 99</p> <p>Rehabilitation/Skilled Consultant #2 provided the re-education to that staff in the meeting with discussion of re-education for the entire active nursing staff. Review of the sign-in sheet for the meeting held on 09/26/14 confirmed the signatures of the attendees.</p> <p>6. Observation of the mechanical lift slings located in the laundry and on each nursing unit, on 10/02/14 at 9:00 AM, revealed there were eighty-eight (88) slings available for use. Twelve (12) of the slings observed were soiled and awaiting washing and inspection. Interview with the Administrator and the Environmental Services Director, on 10/02/14 at 12:16 PM, revealed they both participated in an inventory of the facility mechanical lift slings on 09/26/14. The Administrator and the Environmental Services Director indicated the soiled slings were to be placed in the soiled utility rooms by nursing staff to be laundered and the laundry staff was to launder, dry and inspect the slings before stocking them on each nursing unit the next day. Interview with SRNA #7, on 10/02/14 at 3:50 PM, revealed she would place a soiled sling in a bag in the soiled utility room on the nursing unit to be laundered and it was her understanding the laundry staff would inspect the slings for any defects before returning them to the nursing units. Interview with the Housekeeping/Laundry Supervisor, on 10/02/14 at 4:00 PM, revealed the laundry staff cleaned the mechanical lift slings seven (7) days a week and inspected them before returning them to the nursing units for use. She stated if a sling was defective it would be given to Case Manager #3 for replacement. Interview with Case Manager #3, on 10/02/14 at 4:10 PM, revealed he received the defective slings identified by the laundry staff or any nursing</p>	F 514			

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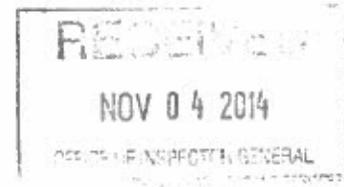
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F 514	Continued From page 100 personnel and would order a replacement right away and the replacement would usually be provided within a week. Interview with the DON, on 10/02/14 at 4:10 PM, revealed mechanical lift slings were stored in the clean utility rooms on each nursing unit and were laundered and inspected by the laundry staff.  7. Further interview with the DON, on 10/02/14 at 4:10 PM, revealed she initiated a one-hundred 100% audit of the seventy-nine (79) residents' Mobilization UDA's in the facility on 09/25/14 and completed the audit on 09/28/14. Review of the UDA's for Resident #17, Resident #18, Resident #19 and Resident #20 revealed they were accurate assessments of the residents' needs. Re-assessment documents were reviewed for ten (10) of the seventy-nine (79) residents reviewed which were completed for three (3) consecutive shifts on 09/27/14 and 09/28/14. Interview with Case Manager #1, and RN #1, on 10/02/14 at 4:15 PM, and 4:20 PM, respectively revealed they assisted with the re-assessments for ten (10) of the seventy-nine (79) residents reviewed which were completed for three (3) consecutive shifts on 09/27/14 and 09/28/14. Review of the audit initiated on 09/27/14 and concluded on 09/28/14 confirmed ten (10) residents were reviewed for reassessment by the DON.  8. Observation of Resident #17, on 09/30/14 at 3:25 PM, on 10/01/14 at 8:35 AM, and 10:30 AM, revealed the resident's plan of care was being followed by the nursing staff. Observation of Resident #17, on 10/01/14 at 11:00 AM, revealed two (2) SRNAs performing a mechanical lift transfer of the resident from the bed to a wheelchair using the appropriate sling identified on the plan of care and using appropriate	F 514			



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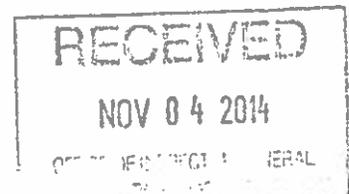
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F 514	Continued From page 101 procedure for the transfer. Observation of Resident #18, on 09/30/14 at 3:45 PM, 10/01/14 at 8:45 AM and 10:45 AM, revealed the resident was being cared for per the assessed nursing/SRNA plan of care. Observation of Resident #19, on 09/30/14 at 3:11 PM and 10/01/14 at 1:30 PM, revealed the resident's plan of care was being followed by the nursing staff. Review of the clinical records for Resident #17, Resident #18 and Resident #19's revealed Minimum Data Set (MDS) comprehensive reviews completed in the past thirty (30) days and compared to the residents' records revealed accurate assessments had been completed. Review of the nursing and SRNA care plans for Resident #17, Resident #18 and Resident #19 revealed they had been created from the comprehensive MDSs, completed in the past thirty (30) days and had been updated/revised as indicated. Review of the Mobilization UDA dated 08/28/14 for Resident #17 revealed the resident was to be transferred using the appropriate sling size with a mechanical lift as assessed. Interview with the DON, on 10/02/14 at 4:10 PM, revealed she initiated a one-hundred 100% audit of the seventy-nine (79) residents' (in the facility at the time) care plans on 09/25/14 and completed that audit on 09/28/14 to ensure care plans and Kardexs included the level of assist for bed mobility and transfer, the number of staff required for use of the lift and the type of lift and sling to be used, if indicated. Review of the audits completed by the DON confirmed they were completed between 09/25/14 and 09/28/14.  9. Review of the SRNA and licensed nurse sign-in sheets for the re-education trainings revealed all but two (2) on-call nursing employees had completed the training between 09/26/14 at	F 514			



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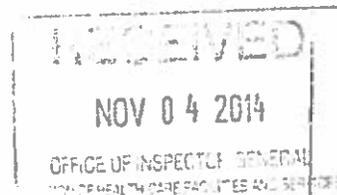
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F 514	Continued From page 102 5:00 AM and 09/27/14. A telephone interview with the GSS Rehabilitation/Skilled Consultant #2, on 10/02/14 at 2:00 PM, revealed she had conducted the lesson plan training on 09/28/14 through 09/29/14 with the assistance of Nurse Case Managers #1 and #2. Interview with Nurse Case Managers #1 and #2, on 10/02/14 at 2:20 PM, revealed they had participated in the lesson plan training done on 09/26/14 through 09/27/14. Interview with the Staff Development Coordinator on 10/02/14 at 2:30 PM revealed she had participated in the lesson plan training on use of the slings and mechanical lifts and had observed staff with return demonstrations of use of the slings and lifts on 09/26/14 through 09/29/14. Interview with LPN #2, on 10/02/14 at 3:40 PM, revealed she had attended an in-service training last week about lift use, charting, incident reporting, and calling the doctor. She stated she demonstrated the use of the mechanical lifts and had a written post-test on the training content. Interview with LPN #3, on 10/02/14 at 3:43 PM, revealed she had attended an in-service training on 09/27/14 about mechanical lift use, charting, incident reporting, and calling the doctor. She stated she also demonstrated the use of the mechanical lifts and had a written post-test on the training content. Interview with SRNA #7, on 10/02/14 at 3:48 PM, revealed she attended an in-service training on 09/26/14 about the use of the resident care plans and lift/sling use and she did a return demonstration and had a post-test. Interview with SRNA #8, on 10/02/14 at 3:52 PM, revealed she attended an in-service training on 09/26/14 about the use of the resident care plans and lift/sling use and she did a return demonstration and had a post-test.  10. Review of the seven (7) daily audits, initiated	F 514			



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F 514	<p>Continued From page 103</p> <p>09/29/14, confirmed a daily audit by licensed nurses for completion of the Mobilization UDA on each shift in the first twenty-four (24) hrs of admission/readmission and with change of condition, for accurate care planning/Kardex for level of assist for bed mobility and transfer including number of staff required, type of lift and sling size, if indicated. Interview with LPN #3, on 10/02/14 at 4:20 PM, revealed she had completed three (3) of the required seven (7) daily audits to be done by licensed nurses. Interview with RN #2, on 10/02/14 at 4:25 PM, revealed he had completed two (2) of the required seven (7) daily audits to be done by licensed nurses.</p> <p>11. Review of the audits, initiated 09/27/14, confirmed the audits for proper use of the lift were completed with observations. Interview with LPN #3, on 10/02/14 at 4:20 PM, revealed she had observed SRNA #2, on day shift on 09/29/14, assisting Resident #17 with bed mobility and lift/sling transfer to ensure the safe care per the resident's care plan. LPN #3 stated she had completed three (3) of the required seven (7) daily audits to include the observation of a SRNA giving care per the resident's plan of care. Interview with RN #2, on 10/02/14 at 4:25 PM, revealed he had completed two (2) of the required seven (7) daily audits to be done by licensed nurses, with observations of SRNAs providing care.</p> <p>12. Further interview with LPN #3, on 10/02/14 at 4:20 PM, indicated she also participated in a medical record audit initiated 09/29/14 to ensure an incident report had been completed for an incident occurring on 10/01/14 (not reportable) and the appropriate documentation and resident</p>	F 514			



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F 514	Continued From page 104 assessment and monitoring occurred timely. Interview with RN #1, on 10/02/14 at 4:25 PM, revealed she also had completed a medical record audit on 09/29/14 on second (2nd) shift regarding a change in resident condition to ensure the resident's responsible party was notified, the physician was notified, appropriate assessment and monitoring of the resident was completed and timely documentation in the progress notes. Review of that audit sheet indicated RN #1 had completed that audit on 2nd shift on 09/29/14.  13. Interview with the Administrator, the DON, the Staff Development Coordinator, the Human Resource Director and the Medical Director, on 10/02/14 at 4:35 PM, revealed they were all to be participants in a newly developed Compliance Ad-Hoc Committee to manage the development of the Plan of Correction (POC) for ongoing compliance. They indicated they are to oversee the implementation of the POC with GSS Consultant support and assistance, ensure all audit results are submitted to the Committee for review and follow-up action, as indicated. The Administrator stated the Ad-Hoc Committee minutes would be reported to the Continuing Quality Improvement Committee monthly. Review of the sign-in sheet for the Ad-Hoc meeting revealed it took place on 09/29/14 with the Administrator, the DON, the Staff Development/Quality Coordinator, the Human Resource Director, the Medical Records Director, both MDS Coordinators, and the Medical Director. The next Quality Assurance meeting is scheduled to be held on 10/28/14.	F 514			

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