

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

PRINTED: 05/31/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185210	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/13/2011
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NAME OF PROVIDER OR SUPPLIER THE JAMES B. HAGGIN MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 484 LINDEN AVENUE HARRODSBURG, KY 40330
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F 000	<p>INITIAL COMMENTS</p> <p>An abbreviated survey investigating complaint # KY00016383 was initiated on 05/03/11 and concluded on 05/13/11. Complaint #KY00016383 was substantiated with deficiencies cited. Immediate Jeopardy was identified on 05/12/11 and was determined to exist on 04/17/11, and is ongoing. The facility was notified of the Immediate Jeopardy on 05/12/11.</p> <p>The facility failed to assess the safety related to the use of side rails with an air mattress for Resident #1. On 04/17/11 the resident was found with his/her arm and shoulder "wedged" between the air mattress and the side rail with the resident's knees on the floor. On 04/23/11, the resident was assessed to have sustained a fracture of the left femur.</p> <p>Immediate Jeopardy was identified at 483.20 (F278, S/S "J" and F280, S/S "J"); 483.25 (F323, S/S "J"); and, 483.75 (F490, S/S "J"). Substandard Quality of Care was identified at 483.25 Quality of Care, F323.</p>	F 000		
F 203 SS=D	<p>483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE</p> <p>Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section.</p> <p>Except when specified in paragraph (a)(5)(ii) of</p>	F 203	<p><i>Please see attached.</i></p> <p>RECEIVED JUN 20 2011 BY: _____</p>	6/10/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER/REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>LNKA</i>	(X8) DATE <i>6/17/11</i>
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any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 203	<p>Continued From page 1</p> <p>this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.</p> <p>The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.</p>	F 203		

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F 203	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide a proper notice of discharge to one (1) of three (3) sampled residents (Resident #5).</p> <p>The findings include:</p> <p>Review of Resident #5 's medical record revealed an original admission date of 06/04/09 and a readmission date of 12/01/10 with diagnoses which included: Acute Psychosis, Bi-Polar Disorder, Coronary Artery Disease, Congestive Heart Failure and Macular Degeneration.</p> <p>Review of the last quarterly Minimum Data Set (MDS) Assessment dated 03/02/11 revealed the facility assessed the resident as being moderately impaired with cognitive skills for daily decision-making and exhibiting verbal and physical behaviors.</p> <p>Review of the discharge letter issued by the facility, dated 09/02/10, written to Resident #5 's Power of Attorney (POA) revealed the resident would be discharged in thirty (30) days for non-payment of bills exceeding \$67,975.88. The Facility Coordinator stated in the letter the POA had been notified of non-payment on several occasions as the facility " patiently awaited the outcomes of the review process by the Medicaid Offices ". She further stated, " We know denial has been issued by that provider " and that " the facility is expecting full payment of the amount due at this time. "</p>	F 203		

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F 203	<p>Continued From page 3</p> <p>Review of letters sent to the POA revealed the facility ' s business office manager and Chief Financial officer wrote the POA numerous times to advise her of the billing situation and non-payment by Medicaid. The letters reviewed were dated 01/26/10; 02/26/10; 03/26/10; 05/20/10; 07/20/10; 08/27/10 and 01/17/11.</p> <p>Interview with the Facility Coordinator on 05/04/11 at 10:45 AM revealed the resident was never discharged and is still being cared for at the facility. She stated she wrote the letter to " get the resident ' s family ' s attention ". She further stated that the POA did not respond to the facility ' s calls and letters concerning payment. When asked if she knew if the resident ' s POA had appealed Medicaid ' s denial of the resident ' s claim at the time she sent the letter, the Facility Coordinator stated she did not know the status of the claim because the family had not communicated with the facility.</p> <p>Further interview with the Facility Coordinator on 05/04/11 at 10:55 AM revealed she had not ever written a discharge letter before but thought she knew how to do it. She stated that after she wrote the letter she realized it did not include several elements required by regulation to be in a discharge letter.</p> <p>Review of the discharge letter revealed no evidence of the following requirements: The location to which the resident is transferred or discharged; A statement that the resident has the right to appeal the action to the state; The name, address and telephone number of the state long term care ombudsman; For nursing facility</p>	F 203		

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F 203	<p>Continued From page 4</p> <p>residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and, For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and advocacy for Mentally Ill Individuals Act.</p> <p>Interview with the Facility Coordinator on 05/04/11 at 10:55 AM revealed she realized the requirements that were lacking in the discharge letter she wrote on 09/02/10.</p> <p>Interview with Resident #5's Attorney on 05/04/11 at 1:35 PM revealed she believed the discharge letter was improper. She stated the facility cannot discharge the resident while the Medicaid appeal is pending and there were several required elements not included in the letter. The attorney stated the facility has dropped their intent to discharge the resident.</p> <p>Interview with the facility 's Social Worker on 05/04/11 at 4:00 PM revealed she sat in on discussion of the resident 's non-payment situation. She stated, " I read the discharge letter but didn't know what had to go in it. I believe the Medicaid claim was in dispute the whole time we were sending letters to them. "</p>	F 203		
F 278 SS=J	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the</p>	F 278	Please see attached.	6/17/11

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F 278	<p>Continued From page 5 resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to accurately assess for safety related to the use of bilateral side rails with an air mattress, identify entrapment risks, and potential hazards for one (1) of three (3) sampled residents (Resident #1). Resident #1</p>	F 278		

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F 278	<p>Continued From page 6</p> <p>was placed on an air mattress with bilateral side rails on 03/09/11. On 04/17/11, between the hours of 3:00 AM and 5:00 AM, Resident #1 was found at 5:00 AM with his/her arm and shoulder entrapped between the air mattress and the side rail. The resident was twisted and wrapped in his/her sheets and blankets with his/her knees on the floor. On 4/23/11, the resident's left knee was found to be swollen and the resident expressed pain with leg movement. X-rays revealed an oblique fracture of the supracondylar portion of the left femur.</p> <p>Based upon the findings it was determined the facility failed to have an effective system in place to accurately assess residents for safety when utilizing half side rails with an air mattress. This failure has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 5/12/11, was determined to exist on 04/17/11, and is ongoing.</p> <p>The findings include:</p> <p>Review of the "Side Rail Policy and Procedure", undated, revealed each resident shall be assessed for the use of side rail(s) upon admission and ongoing assessment for the use of side rail(s) shall be conducted according to the resident's Resident Assessment Instrument (RAI). The policy further stated that each resident shall be assessed to determine the rationale for the use of side rails and whether or not the benefit(s) outweigh the risks for that resident, before the side rails shall be included in the comprehensive plan of care and the nurse assistant care plan.</p>	F 278		

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F 278	<p>Continued From page 7</p> <p>Review of the facility's "Resident Restraint Policy", effective 10/01/08, revealed any device applied to a resident solely for the purpose of position or enhancing resident function was not considered a restraint. Side rails must enable the resident to safely function within their environment and the resident must be able to voluntarily remove the device successfully three (3) times when asked. The Resident Restraint Policy revealed no information related to reassessing the use of a device after the resident had an accident (fall) which may be related to the use of that device.</p> <p>Review of the User Instruction Manual for the Alternate Mattress System stated on page 5, "Seven Zones of Bed Rail Entrapment": WARNING: Bed rail entrapment is a serious health risk that can result in serious injury or even death. (The company) recommends the use of bed rails if they were available. When using an Air Therapy system the caregiver is responsible for seeing that the mattress properly fits the bed frame. It is also the caregiver's ultimate decision whether or not to use bed rails with the patient.</p> <p>Interview, on 05/07/11 at 10:00 AM, with RN #1 the Extended Care Facility (ECF) Coordinator revealed the facility used one (1) standard size air mattress, the Alternate, that had been pre-approved and contracted for any resident of the facility who needed one. The ECF Coordinator stated a company representative installed the air mattresses with half side rails up. She explained whatever was up when the representative left the facility was what the facility implemented. The Coordinator stated side rails</p>	F 278		

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F 278	<p>Continued From page 8</p> <p>were not contraindicated for use with the air mattress; however, explained the facility did not assess a resident to determine the bed's appropriateness and safety before utilizing it for the resident.</p> <p>Review of Resident #1's clinical record revealed the facility admitted Resident #1 on 08/27/07, with diagnoses which included Dementia, Alzheimer's Disease, Cerebrovascular Accident, Left Side Hemiparesis, Degenerative Joint Disease, Osteoarthritis, Seizure Disorder, Chronic Pain and Insomnia. Review of Resident #1's Side Rail Assessment dated 09/27/10, revealed "resident does not use side rail to assist in turning but the benefit of having bilateral half side rails up outweighs the risk." On the 12/29/10, the quarterly update of the Side Rail Assessment, detailed that Resident #1 "uses upper half side rails for positioning and turning during changes." Review of the Nurse's Notes and Physician's Orders, dated 03/09/11, revealed an air mattress was ordered for Resident #1's after the facility assessed and determined the resident had three (3) Stage I pressure sores to the coccyx, on 03/09/11. ECF Coordinator interview, on 05/07/11, revealed the facility implemented the use of half side rails with the air mattress because the air mattress representative did so upon demonstration. She stated the facility did not conduct an assessment to determine safety and appropriateness regarding Resident #1's use of the air mattress with half side rails engaged.</p> <p>Review of the 03/15/11 Side Rail Assessment, quarterly update, revealed Resident #1 "will occasionally use half side rails during personal care for turning and changing positions.";</p>	F 278		

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F 278	<p>Continued From page 9</p> <p>however, there was no documented detail what the determined benefits versus risks were for Resident #1. Rather the document detailed the answer "no" to, "Is there a risk to the resident if side rails are used?" and "Does the side rail alternatives/interventions create more risks than side rail use?" Review of the assessment revealed explanations of the risks verses benefits were only required with "yes" answers. Additionally, there was no documented evidence the facility had considered the use of the air mattress and the side rails as a contributing factor in determining appropriateness or risk versus benefit. While the assessment detailed the resident would use the half side rail during personal care for turning and repositioning, interview with State Registered Nurse Assistant (SRNA) #1, on 05/12/11 at 4:45 PM, revealed she had not observed Resident #1 use the side rail for mobility. The SRNA stated the resident required total care and the resident did not assist staff with care. Interview, on 05/11/11 at 12:20 PM with LPN #1, revealed "the resident can't use the side rail".</p> <p>Review of the Minimum Data Set (MDS) Assessment, dated 03/16/11, revealed the facility assessed the resident as severely impaired in cognitive skills for daily decision making and totally dependent for assistance with Activities of Daily Living (ADL's). Further review of the MDS revealed the facility assessed the resident as totally dependent upon staff with bed mobility and transfer, requiring two (2) staff for assistance. This assessment detailed side rails were not a restraint for Resident #1.</p> <p>Review of the Comprehensive Care Plan, dated</p>	F 278		

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F 278	<p>Continued From page 10</p> <p>03/23/11, revealed Resident #1 was totally dependent on staff for all ADL's and required the assistance of two (2) staff persons for turning, positioning and transfers.</p> <p>Interview, on 05/06/11 at 3:10 PM with LPN #4, the MDS Assessment Coordinator, revealed "I don't believe the resident could move enough to get over to the side. I think she was repositioned improperly." She explained the facility would address the air mattress for the resident for care of skin breakdown. In additional interview the MDS nurse revealed the facility had no written assessment protocols to evaluate the safety needs of residents when they were put on an air mattress.</p> <p>Interview with the Extended Care Facility (ECF) Coordinator, who was responsible for verifying the accuracy of the MDS assessment, on 05/04/11 at 12:45 PM, revealed she did not believe Resident #1 could move in bed. However interview with SRNA #4, on 05/04/11 at 1:50 PM, revealed Resident #1 "moved around on the air mattress a lot." The SRNA stated the nurses didn't think the resident moved, but he/she did. The SRNA explained the resident moved his/her legs up and down and when the resident moved the leg his/her body would move and would squirm when he/she was in pain. SRNA #4 stated she told the nurses the resident moved a lot and she felt the air mattress was not safe for the resident because of how much the resident moved.</p> <p>Interview with SRNA #2, on 05/04/11 at 12:45 PM, revealed "we had to scoot her over three (3) times in four (4) hours one night". The SRNA</p>	F 278		

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F 278	<p>Continued From page 11</p> <p>explained the resident kept getting too close to the edge. SRNA #2 stated the resident does "wiggle" around and move quite a bit.</p> <p>Interview with LPN # 3, on 5/12/11 at 4:45 PM, revealed several times she observed Resident #1 move in bed to the side nearest the door (the side the resident was entrapped). The LPN stated "I don't know how he/she moved; I would just find him/her. I don't know how he/she got there. I would holler for an aide to help me get him/her back to the center. I can't say how often, not real often. But other people didn't get over like he/she did."</p> <p>Interview with LPN #2, on 05/04/11 at 2:00 PM, revealed "the resident moved easier on the air mattress. I think [he/she] slid out of the bed. [The resident] was on [his/her] side when it happened. I have seen the resident on [his/her] back over toward the edge of the bed a lot. I had to reposition [him/her]. [Resident #1] did move [his/her] legs a lot; that could have caused [him/her] to scoot to the side. I can see that if the resident got over to the edge of the mattress [while lying] on [his/her] side, the resident could roll out over the side of the bed". Interview with LPN #7 revealed on 05/04/11 at 2:10 PM that Resident #1 "moves toward one side more".</p> <p>Interview with State Registered Nurse Assistant (SRNA) #2, on 05/04/11 at 12:45 PM, revealed she positioned Resident #1 on his/her side in the center of the bed on 04/17/11 at 3:00 AM. Review of Nurse's Notes's, dated 04/17/11 at 5:20 AM, written by Licensed Practical Nurse (LPN) #1, revealed upon entering Resident #1's room he found the resident wrapped up in the bed linen,</p>	F 278		

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NAME OF PROVIDER OR SUPPLIER THE JAMES B. HAGGIN MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 464 LINDEN AVENUE HARRODSBURG, KY 40330
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F 278	<p>Continued From page 12</p> <p>on the floor leaning against the bed. The resident's right arm and shoulder was wedged between the air mattress and the side rail. The resident was resting on his/her knees (on the floor). The LPN immediately called for LPN #2 to assist and assess the resident for injuries before moving him/her. The side rail was let down and the LPNs placed the resident back in bed. The LPNs noted red areas to Resident #1's right abdomen and bilateral knees and great toes. The LPN stated in this nurse's note that the resident's mental status was difficult to evaluate due to his/her diagnoses but the resident was absent acute injury. Review of the Nurse's Notes, dated 04/23/11, the resident was diagnosed with a fracture to the left femur.</p> <p>Observations at various times during the complaint investigation revealed the resident was laying on an air mattress in a low bed with raised half side rails on: 05/03/11 at 11:00 AM and 1:30 PM; 05/04/11 at 1:30 PM and 4:00 PM; 05/05/11 at 10:30 PM, 01:00 PM and 3:00 PM; 05/10/11 at 1:00 PM and 3:00 PM; 05/12/13 at 11:00 AM and 3:00 PM and 05/13/11 at 4:00 PM.</p> <p>Interview, on 05/07/11 at 10:00 AM with RN #1, the ECF Coordinator, revealed there was no documented evidence the facility assessed Resident #1 or any resident for safety and appropriateness before placing a resident on an air mattress with raised half side rails: She stated, "We have no specific form of assessment; only the nursing assessments during care." The Coordinator stated the facility's only assessment was the Side Rail Assessment form and all the residents half side rails were assessed as enablers for mobility. She stated the facility had</p>	F 278		

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F 278	Continued From page 13 no restraints.	F 278		
F 280 SS=J	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the facility's policies and procedures, and record review it was determined the facility failed to update the care plan related to the new intervention of an air mattress with bilateral half side rails for one (1) of three (3) sampled residents (Resident #1). On 03/09/11, the resident was ordered an air mattress for the treatment of three (3) Stage I Pressure wounds; however, no interventions were added to the care</p>	F 280	Please see attached.	6/17/11

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F 280	<p>Continued From page 14</p> <p>plan to ensure the safety of the use of the air mattress with half side rails in order to ensure the resident's safety. On 04/17/11, Resident #1 was found entrapped between the side rail and the air mattress. Per the Nurse's Note, the resident was assessed to have redness to the abdomen, knees, and great toes. On 04/23/11, the resident complained of pain and an x-ray was ordered. The resident was diagnosed having a broken femur.</p> <p>Based on the above findings it was determined the facility' failure to update and revise the resident's care plan in order to ensure the resident's safety, contributed to unsafe conditions that had caused or were likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 05/12/11 and was determined to exist on 04/17/11, and is ongoing.</p> <p>The findings include:</p> <p>Review of the facility's Side Rail Policy and Procedure, under Procedure revealed, "1.) Each resident shall be assessed for the use of side rail(s) upon admission. 2.) Ongoing assessment for the use of side rail(s) shall be conducted according to the resident's (non PPS) RAI schedule. 3.) When it has been determined that the resident shall benefit from the use of a side rail(s); it shall be included in the comprehensive plan of care and the nurse assistant care plan. 4.) When the use of the side rail(s) meets the definition of a physical restraint then the Physical Restraint Policy and Procedure shall be implemented."</p>	F 280		

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F 280	<p>Continued From page 15</p> <p>Review of Resident #1's clinical record revealed the facility admitted Resident #1 on 08/20/07, with diagnoses which included Dementia, Alzheimer's Disease, Cerebrovascular Accident, Left Side Hemiparesis, Degenerative Joint disease, Osteoarthritis, Seizure Disorder, Chronic Pain and Insomnia.</p> <p>Review of the clinical record revealed physician orders, dated 03/09/11, for an air mattress for the treatment of three (3) Stage I Pressure wounds.</p> <p>Review of the User Instruction Manual for the Alternate Mattress System (the bed Resident #1 used) stated on page 5, "Seven Zones of Bed Rail Entrapment": WARNING: Bed rail entrapment is a serious health risk that can result in serious injury or even death. (The company) recommends the use of bed rails if they were available. When using an Air Therapy system the caregiver is responsible for seeing that the mattress properly fits the bed frame. It is also the caregiver's ultimate decision whether or not to use bed rails with the patient.</p> <p>Review of the 03/15/11, Side Rail Use assessment revealed the resident used the half side rails for positioning and turning. However, there was no evidence the facility assessed the use of the side rails with the air mattress.</p> <p>Review of the MDS Assessment dated 03/16/11, revealed the facility assessed the resident as having both long and short term memory deficit and as being severely impaired in cognitive skills for daily decision making. Further review revealed the facility assessed Resident #1 to be totally dependent on staff's assistance for bsd</p>	F 280		

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F 280	<p>Continued From page 16</p> <p>mobility and transfer, requiring the physical assistance of two (2) persons. The facility assessed the resident to have limited range of motion of the upper extremity on one side and impairment on both sides for the lower extremities.</p> <p>Review of the Comprehensive Plan of Care, dated 03/23/11, revealed the resident was to be transferred with a lift and the assistance of two (2) staff; 1/2 upper side rails for positioning and enable; and, an air mattress for the bed. However, there were no interventions on the care plan for increased monitoring for safety once the intervention of an air mattress with half side rails was added to the care plan for the treatment of the Stage I pressure sores.</p> <p>Review of the Nurse's Notes, dated 04/17/11 at 5:00 AM, written by Licensed Practical Nurse (LPN) #1, revealed "upon entering the room noted resident to be wrapped up in bed linen on the floor leaning against bed. Resident appeared to be wedged by right upper arm and shoulder between the air mattress and side rail. Resident resting on knees. Immediately called for other nurse on duty to assist. Resident assessed prior to moving. Side rail let down as the other nurse stabilized the resident. Resident was then, with the assist of two (2) persons, placed back in bed. Red areas were noted on the right side of the abdomen, bilateral knees and bilateral great toes. Resident appeared to be absent of acute injury."</p> <p>Interview with the MDS Coordinator LPN #4, at 3:10 PM on 05/06/11 revealed she believed the Comprehensive Care Plan was appropriately updated on 03/09/11 when the intervention of a</p>	F 280		

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F 280	<p>Continued From page 17</p> <p>"New order for an air mattress to bed" for the treatment of pressure sores was added to the care plan. However, the facility presented no documented evidence that they assessed the use of the side rails and air mattress for safety or added new interventions to the care plan to ensure the safety of the resident through increased monitoring and continuous assessment once he/she was placed on the air mattress with raised half side rails.</p> <p>Interview with the Extended Care Facility (ECF) Coordinator, Registered Nurse (RN) #1, on 05/05/11 at 3:00 PM revealed no one had assessed if residents with raised side rails were at risk for entrapment and there was no formal assessment or document for this purpose. The ECF Coordinator stated that the appropriateness of the air mattress was determined by the historical use of the one preapproved air mattress and by observation during routine care. Per interview the facility's process for protecting residents from side rail entrapment was to provide observation and monitoring during rounds and routine care.</p>	F 280		
F 323 SS=J	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 323	Please see attached.	6/17/11

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F 323	<p>Continued From page 18</p> <p>by:</p> <p>Based on observation, interview, review of the facility's policies, and record review it was determined the facility failed to adequately assess for safety related to the use of an air mattress with bilateral side rails, identify potential hazards and environmental risks, and ensure adequate supervision to prevent accidents for one (1) of three (3) sampled residents (Resident #1). On 04/17/11, Resident #1 was found with his/her arm and shoulder entrapped between the air mattress and the side rail with the resident's knees on the floor. On 04/23/11, the resident's left knee began to swell and the resident demonstrated signs of pain with leg movement. X-rays were ordered and a fracture of the left femur was identified.</p> <p>Based on the above findings it was determined the facility's failure to have an effective system in place to assess residents for safety when utilizing half side rails with an air mattress had caused, or was likely to cause serious injury, harm, impairment or death. Immediate Jeopardy was identified on 05/12/11, and was determined to exist on 04/17/11, and is ongoing.</p> <p>The findings include:</p> <p>Review of the "Side Rail Policy and Procedure", undated, revealed "each resident shall be assessed upon admission and according to the Resident Assessment Instrument (RAI) to determine the rationale for the use of any type of side rail(s), to determine the benefit(s) of their use and to identify the risk factor(s) associated with side rail use that are specific to each resident. When it has been determined that the benefits of the use of side rails outweigh the risk</p>	F 323		

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F 323	<p>Continued From page 19</p> <p>factor(s), side rail(s) may be utilized by the resident." At that point, the use of the side rail(s) "shall be included in the comprehensive plan of care and the nurse assistant care plan."</p> <p>Review of the "Resident Restraint Policy", effective date 10/01/08, revealed no information related to reassessing the use of a restraint after the resident had an accident (fall) which may be related to the use of a restraint.</p> <p>Review of Resident #1's clinical record revealed the facility admitted Resident #1 on 08/20/07, with diagnoses which included Dementia, Alzheimer's Disease, Cerebrovascular Accident (Stroke), Left Side Hemiparesis (Paralysis), Degenerative Joint Disease, Osteoarthritis, Seizure Disorder, Chronic Pain and Insomnia.</p> <p>Review of Nurse's Notes on 03/09/11 revealed a status change to the resident's condition: "Resident has three (3) small Stage I areas on coccyx." The physician was notified and an order was received and carried out. Review of Physician's Telephone Orders dated 03/09/11, revealed an air mattress was ordered to prevent skin breakdown.</p> <p>Review of the Nurses's Note dated 03/10/11, revealed the resident had half side rails for assistance in turning and repositioning. There was no documented evidence in the resident's clinical record that the facility had assessed the resident for the use of bilateral half side rails with the physician ordered air mattress prior to the implementation of their use.</p> <p>Review of the quarterly Side Rail Assessment on</p>	F 323		

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F 323	<p>Continued From page 20</p> <p>03/15/11 revealed the resident "will occasionally use half side rails for positioning and turning during changes."</p> <p>Review of the Minimum Data Set (MDS) Assessment dated 03/16/11, revealed the facility assessed the resident as severely impaired in cognitive skills for daily decision making and totally dependent for assistance with Activities of Daily Living (ADLs). The facility assessed the resident as totally dependent for bed mobility and transfer, requiring the physical assistance of two (2) persons, as well as having no history of falls, but identified as at high risk for falls. Review of the 03/16/11 MDS revealed that bed rails were not assessed as a restraint.</p> <p>Review of the Comprehensive Care Plan, revised on 03/23/11, revealed a falls care plan with interventions which included half upper side rails for positioning enabler, keep bed in lowest position and locked, to anticipate needs and check frequently, and seizure precautions. There was no evidence the facility had implemented interventions to address the use of side rails with an air mattress.</p> <p>Review of the Nurse's Notes written by Licensed Practical Nurse (LPN) #1, on 04/17/11 at 5:00 AM revealed "upon entering room noted resident to be wrapped up in bed linen and on floor leaning against bed. Resident appeared to be wedged by right upper arm and shoulder between air mattress and side rail. Resident resting on knees. Immediately called for other nurse on duty to assist. Resident assessed prior to moving. Side rail let down as other nurse stabilized resident. Resident then, with two (2) person assist, placed</p>	F 323		

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F 323	<p>Continued From page 21</p> <p>in bed. Noted red areas to right side of abdomen, bilateral knees with redness and bilateral great toes with redness. Resident appeared to be absent of acute injury." Review of the clinical record for Resident #1 revealed no documented evidence that any safety assessment was completed after the incident on 04/17/11.</p> <p>Further review of the Nurse's Notes revealed on 04/23/11 at 11:45 AM, revealed the charge nurse was called to evaluate the resident's left knee which was swollen with no warmth to the touch or bruising noted. The resident was able to extend his/her lower leg but grimaced and moaned with movement. The physician was notified and orders were received to x-ray the left knee. The x-ray report was called to the attending physician indicating a fracture to the left femur and orders were received to apply #16 knee immobilizer to the left knee and leg.</p> <p>Observations of Resident #1 on at various times during the complaint survey revealed the resident was now laying on a low bed with half side rails raised on: 05/03/11 at 11:00 AM; 05/04/11 at 10:00 AM and 1:00 PM; 05/05/11 at 10:30 AM and 1:30 PM; 05/10/11 at 11:00 AM; 05/12/11 at 3:00 PM and 05/13/11 at 3:00 PM.</p> <p>Interview on 05/11/11 at 12:20 PM with LPN #1, who found the resident on 04/17/11 at 5:00 AM, revealed "the resident can't use the side rail." The LPN further stated he believed the resident was positioned on his/her side to closely to the side of the bed and then "stretched" to move further and rolled over the side of the bed. He stated the resident was not reassessed for safety after being placed on the air mattress with the</p>	F 323		

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F 323	<p>Continued From page 22</p> <p>raised half side rails because it was not "charted" by the direct care staff that the resident sometimes stretched and moved. LPN #1 stated that he assumed everybody knew the resident "stretched" so he did not communicate this to change the resident's care plan.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #4 on 05/04/11 at 1:50 PM, revealed she had seen Resident #1 move around on the air mattress a lot and was concerned for the resident's safety. She further stated she had informed the nurses that the resident moved a lot in bed but they did not believe it. Interview with SRNA #4 revealed that on the previous pressure reducing mattress, the Flexcare mattress, Resident #1 did not move around in bed as much as on the air mattress.</p> <p>Interview with LPN #2 on 05/05/11 at 1:10 PM revealed she often cared for Resident #1 and stated the resident moved his/her legs a lot in bed. She said she could understand if the resident's legs went over the mattress on the side, she could roll out of the bed. She further stated Resident #1 was unable to utilize the side rail for independent bed mobility.</p> <p>Interview on 05/06/11 at 2:10 PM, with SRNA #3 revealed Resident #1 could kick and move his/her legs and moved about in bed. She stated the resident often slid over to the side of the bed requiring repositioning. She said she had reported this to the nurses in the past. Interview with SRNA #3 further revealed Resident #1 was not able to use the side rail independently for bed mobility.</p>	F 323		

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

PRINTED: 05/31/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185210	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/13/2011
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NAME OF PROVIDER OR SUPPLIER THE JAMES B. HAGGIN MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 464 LINDEN AVENUE HARRODSBURG, KY 40330
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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)	(X6) COMPLETION DATE
F 323	<p>Continued From page 23</p> <p>Interview on 05/12/11 at 4:45 PM with LPN #3 revealed several times she had seen Resident #1 positioned too closely to the side of the bed. LPN #3 stated she did not see the resident move and did not know how he/she moved. She stated "I would just find him/her and I would holler for an aide to help me get him/her back to the center". The LPN stated "I can't say how often, not real often. But other people didn't get over like he/she did. I didn't see the resident move but I think an air mattress can move the resident."</p> <p>Interview with the Extended Care Facility (ECF) Coordinator, Registered Nurse (RN) #1, on 05/05/11 at 3:00 PM revealed no one had determined if residents with raised side rails were at risk for entrapment. She stated there was no formal assessment or document for this purpose. The facility's process for protecting residents from side rail entrapment was to provide observation and monitoring during rounds and routine care. Interview further revealed it was determined in the Side Rail Assessment if side rails were being used as enablers or restraints. She continued to state that they were not required to explain specific benefits and risks for a resident when side rails were being used for mobility and positioning. The ECF Coordinator stated that the appropriateness of the air mattress was determined by the historical use of the one preapproved air mattress and by observation during routine care.</p>	F 323		
F 490 SS=J	<p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest</p>	F 490	Please see attached	6/17/11

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F 490	<p>Continued From page 24 practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the facility's internal investigation, and the air mattress User's Operational Manual, it was determined the facility failed to ensure staff thoroughly assessed the proper use of side rails with an air mattresses; failed to ensure nursing staff completed assessments and updated care plans; and, failed to ensure policies and procedures were implemented related to side rail assessments, care plans and the use of air mattress with half side rails for one (1) of three (3) sampled residents (Resident #1). Resident #1 was placed on an air mattress on 03/09/11 and the use of half side rails continued. Review of the clinical record revealed no documented evidence the facility re-assessed the side rail risk factors during the quarterly side rail assessment on 03/15/11. Resident #1 was found entrapped between the side rail and air mattress, at 5:00 AM on 04/17/11. The resident was assessed to have no injury on 04/17/11; however, on 04/23/11 the resident was identified to have a fractured left femur.</p> <p>Based on the above findings, it was determined the facility's failures to implement their policies and procedures, complete thorough assessments, and revise care plans related to side rails had caused or was likely to cause, serious injury, harm, impairment, or death.</p> <p>Immediate Jeopardy was identified on 05/12/11</p>	F 490		

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F 490	<p>Continued From page 25 and was determined to exist on 04/17/11 and is ongoing, related to Resident #1's use of half side rails with an air mattress.</p> <p>Immediate Jeopardy was identified at 483.20 Resident Assessments, F278 at a scope and severity of a "J" and F280 at a scope and severity of a "J"; 483.25 Quality of Care, F323 at a scope and severity of a "J"; and, 483.75 Administration, F490 at a scope and severity of a "J". Substandard Quality of Care was identified at 483.25 F323.</p> <p>The findings include:</p> <p>The facility failed to accurately assess the risks versus the benefits of the use of side rails with an air mattress. Resident #1 was placed on an air mattress on 03/09/11 and the use of half side rails continued. Review of the clinical record revealed no documented evidence the facility re-assessed the side rail risk factors during the quarterly side rail assessment on 03/15/11. Resident #1 was found entrapped between the side rail and air mattress, at 5:00 AM on 04/17/11. The resident was assessed to have no injury on 04/17/11; however, on 04/23/11 the resident was identified to have a fractured left femur.</p> <p>The facility's Administration failed to ensure an effective system was in place to accurately assess residents for the use of side rails with an air mattress to ensure resident safety. The facility failed to have an effective system to ensure the Comprehensive Plan of Care was reviewed and revised following the addition of an air mattress used on the resident's bed and failed to develop interventions to protect the resident from harm</p>	F 490		

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F 490	<p>Continued From page 26 due to entrapment.</p> <p>The Administration failed to ensure facility staff followed the facility's policy related to the assessment and care planning of side rails. In Addition the Administration failed to ensure staff followed the User Instruction Manual for the Alternate Mattress System (the bed Resident #1 used) to determine the safety of the use of the mattress with half side rails even though it stated on page 5, "Seven Zones of Bed Rail Entrapment": WARNING: Bed rail entrapment is a serious health risk that can result in serious injury or even death. (The company) recommends the use of bed rails if they were available. When using an Air Therapy system the caregiver is responsible for seeing that the mattress properly fits the bed frame. (Refer to F278, F280, and F323)</p> <p>Interview with Extended Care Facility Coordinator, on 05/05/11 at 3:00 PM, revealed the facility had no system in place to determine if residents with side rails were at risk for entrapment and that it was an inherent process, done by observation and monitoring only, during routine care.</p> <p>Further Interview with the Extended Care Facility (ECF) Coordinator on 05/13/11 at 3:30 PM, revealed she provided oversight for resident care by attending the Standards of Care Meetings, which address changes in resident care, and by attending the Care Plan Meetings for each resident.</p> <p>The Administrator was on leave during the abbreviated survey and was unavailable for</p>	F 490		

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F 490	Continued From page 27 interview.	F 490		

**THE JAMES B. HAGGIN MEMORIAL HOSPITAL
EXTENDED CARE FACILITY
SURVEY COMPLETION DATE May 13, 2011**



PLAN OF CORRECTION

483.12(a) (4) - (6) - Notice requirements before transfer/discharge - The facility failed to provide a proper notice of discharge to Resident #5 on 9/02/10.

F203 S/S=D

Completion Date: June 10, 2011

Corrective Action For Residents Found To Have Been Affected By The Deficient Practice:

This facility rescinded the notice of discharge for Resident #5 on January 27, 2011. The latest communication with the POA on 6/9/11 was via telephone with ECF Coordinator and Social Services Director. The POA indicated that the latest hearing denied benefits and they have a third and final appeal available.

The Facility Will Identify Other Residents Having the Potential to Be Affected by the Same Deficient Practice:

No other residents were adversely affected and none identified as having the potential as no other accounts were in arrears without communication. There have been no other notices of discharge/transfer issued.

Measures To Be Put In Place Or Systemic Changes Made To Ensure The Deficient Practices Will Not Recur:

The facility will ensure any notice of transfer/discharge will be provided at least 30 days prior to the planned transfer/discharge and shall ensure notification of resident and, if known, family member or legal representative of a transfer or discharge in a language or manner that they understand; record the reasons in the clinical record; and include in the notice the reason for transfer/discharge; the effective date of the transfer/discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facilities residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy of Mentally Ill Individuals Act by using a standardized letter form that includes of the above components. All transfer/discharge notices will be completed only by authorization of the Administrator and/or Chief Financial

Officer. Education of this process was provided to the ECF management team by ECF Coordinator on 6/8/2011.

How The Facility Plans To Monitor Its Performance To Ensure Solutions Are Sustained:

The Quality Assurance Committee will be responsible to review and ensure the process is in place and follows the plan. Any notices of transfer/discharge will be reported at the monthly and then quarterly Quality Assurance meetings on an ongoing basis by the ECF Coordinator or Administrator.

**THE JAMES B. HAGGIN MEMORIAL HOSPITAL
EXTENDED CARE FACILITY
SURVEY COMPLETION DATE May 13, 2011**

PLAN OF CORRECTION

483.20 Comprehensive Care Plans – An Immediate Jeopardy was found as facility failed to provide evidence that a comprehensive care plan was developed to include measurable objectives and timetables to meet a resident’s medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessments. Care plans are to be developed within 7 days after completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, registered nurse with the responsibility for the resident, and other appropriate staff in disciplines as determined by the resident’s needs, and to the extent practicable, the participation of the resident, the resident’s family or the resident’s legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Resident #1 was found entrapped between the side rail and air mattress on 4/17/11.

F 280 Comprehensive Care Plans

Completion Date: 6/17/11

Corrective Action For Residents Found To Have Been Affected By The Deficient Practice:

This facility will ensure that this resident had a comprehensive care plan developed, prepared and periodically reviewed by members of the interdisciplinary team (ECF Coordinator (RN), Charge Nurse (RN), Activity Director, MDS Coordinator (LPN) and Social Services). Resident #1 had assessments of her activities of daily living, particularly related to bed mobility, turning and repositioning; but also including transferring, locomotion on/off unit, dressing, eating, toileting, personal hygiene and bathing; as well as a new side rail assessment with a new tool (included) completed on 5/16/2011 by members of the interdisciplinary team consisting of ECF Coordinator (RN), Charge Nurse (RN), Activity Director, MDS Coordinator (LPN) and Social Services. The side rail utilization assessment indicates resident is primarily immobile with L hemiparesis and non-wt bearing status. Resident #1 is out of bed for meals and activities with use of geri-chair, transferred with the assist of two and Hoyer Lift. After review of the resident’s assessment and care plan, the physician was contacted and orders were received for the use of other alternatives including: low bed (initiated 4/18/11), mats on floor (initiated 4/18/11), bed alarm (initiated 4/18/11) and curved mattress (initiated 5/12/11). The air mattress was discontinued on 5/9/11 per physician order. It also shows that Resident #1 has used upper ½ side rail in past for positioning on one side with cueing and assist. Resident #1 has been added to the q 1 hr positioning tool which was initiated on 5/17/11 (included) by the ECF Coordinator and Charge Nurse. The interdisciplinary team considered other factors including the environment due to furniture placement in room as well as a past history of seizures. There have been no known occurrences of recent seizure activity. Recommendation was to discontinue side rails. They were lowered per physician order on 5/17/11. Discussion was held with POA via telephone and noted on the assessment. At this time, the Care Plan was also updated (5/17/11) by the MDS Coordinator and ECF Coordinator to reflect the current status of the ADLs (activities of daily

living). The Care Card for the aides was also modified on 5/17/11 by the MDS Coordinator and reviewed by the ECF Coordinator.

A Room Rounding Tool (included) for use by nursing staff at change of shift and approximately every 4 hours was implemented by the ECF Coordinator and Charge Nurse beginning on 5/17/11 to ensure the proper side rails were utilized as per care plan and to address any discrepancies with the aides immediately.

The Facility Will Identify Other Residents Having The Potential To Be Affected By The Same Practice:

All residents have the potential to be affected, but no others were at this time based on an assessment completed for all residents utilizing the new side rail assessment tool by the ECF Coordinator and Charge Nurse between 5/19/11 – 5/23/11. All residents/Powers of Attorney were contacted for discussion. Between 5/19/11- 6/3/11, contact was made with Dr. Jackson for a change in order for three (3) residents that precipitated a change in use of side rails. The Care Plans and Care Cards for all residents were reviewed and updated by members of the interdisciplinary team (ECF Coordinator, MDS Coordinator, Charge Nurse, Activity Director, and Social Services Director) for proper designation of assistance levels on 5/18 – 5/20/11 and again on 5/23/11 to ensure that the ability to move, turn and reposition was current. Based on this review, the new Positioning Tool (included) was implemented for 11 other residents by 5/20/11 through determination of need by members of the interdisciplinary team consisting of ECF Coordinator (RN), Charge Nurse (RN), Activity Director, MDS Coordinator (LPN) and Social Services. These residents were deemed to be at risk for several reasons (ex. skin integrity, side rail reduction, compliance, etc.). This intervention was added to the care plans for these residents by the MDS Coordinator. Education for the new Positioning Tool was provided on 5/16 and 5/17 2011 by the ECF Charge Nurse as well as between 5/ 21 – 5/23 during the mandatory inservices noted below.

Measures To Be Put In Place Or Systemic Changes Made To Ensure The Deficient Practice Will Not Recur:

The ADL's (Activities of Daily Living) which include bed mobility, turning and repositioning; transferring, locomotion on/off unit, dressing, eating, toileting, personal hygiene and bathing, will be checked weekly on Tuesday by the MDS Coordinator/ECF Coordinator and brought to the morning meeting for review of accuracy. The review of the new ECF Nurse Change of Shift Report Checklist and 24 hour log by the Charge Nurse will be brought to the morning meeting on Monday – Friday to ensure status changes in the residents' ability to move, turn and reposition is noted. If changes are warranted, the care plan and care cards will be brought to the Standards of Care meeting held on Tuesdays at 2:00 pm to be updated. The interdisciplinary team (ECF Coordinator, MDS Coordinator, Charge Nurse, Activity Director, Dietary Director and Social Services Director) will also review to determine if a significant change of condition is warranted at this time.

On Saturdays, Sundays and Holidays the ECF Coordinator or Charge Nurse will monitor to ensure that the ECF Nurse Change of Shift Report Checklist and 24 hour log are completed until the Immediate Jeopardy situation is resolved.

A new Policy for Resident Rounds (included) was developed on 5/19/11 by the ECF Coordinator. It was reviewed by the CEO, Administrator, CNO, Medical Director and ECF Coordinator. It ensures communication of new orders based on assessment recommendations for side rail use, adherence to the proper care plan regarding side rail use and visual tour of each resident to verify safety by the nurses.

A Room Rounding Tool (included) for use by nursing staff at change of shift and approximately every 4 hours was implemented beginning on 5/17/11 to ensure resident safety by inspection that the proper side rails are utilized as per care plan and to address any discrepancies with the aides immediately.

All Care Plans for all residents were reviewed by the Interdisciplinary team to ensure accuracy by 6/15/11.

Education (included) for all ECF aides and nursing team members was provided by ECF Coordinator or Charge Nurse on complete and accurate communication and documentation for all residents' activities of daily living (ADLs) and changes for residents of ADL status on 5/21 – 5/23. Administration determined that if a team member was unable to receive the education at this time that the particular team member would not be permitted to work until such time as the education was completed. Letters were sent on 5/23/11 to those team members informing them of the need to complete this mandatory education prior to returning to work. Employee swipe badges will be disabled to ensure compliance.

How The Facility Plans To Monitor Its Performance To Ensure Solutions Are Sustained:

The ECF Coordinator will perform a daily audit of all MDS, Care Plans and Care Cards until such time as the Immediate Jeopardy is resolved to ensure the reviews are done and accuracy is maintained. The audit will then be completed weekly for four weeks by the ECF Coordinator. After those four weeks, the audit will be completed on a monthly basis to ensure that compliance continues.

The QA Committee (Administrator, CEO, CNO, PI Coordinator, Medical Director, ECF Coordinator, Charge Nurse, Pharmacist Consultant, and Dietary Director) and special guests Physical Plant Director and Staff Development Coordinator held a special meeting on Monday, May 23, 2011 to review and approve the Allegations of Compliance Document and attachments. The QA Committee met on 6/3/2011 and plans to meet again on 6/28/2011 to review measures and ensure systems are in place. The QA Committee, which normally meets quarterly, will meet weekly until the Immediate Jeopardy situation is resolved and then monthly for 3 months to ensure compliance.

PLAN OF CORRECTION

THE JAMES B. HAGGIN MEMORIAL HOSPITAL EXTENDED CARE FACILITY SURVEY COMPLETION DATE May 13, 2011

483.20 Assessments – An Immediate Jeopardy was found as facility failed to accurately assess Resident #1 for her ability to move, turn and reposition. The facility's MDS assessment documented Resident #1 required total assistance of two (2) for turning and repositioning, however the side rail assessment indicated the resident was able to assist staff with turning and repositioning. Additionally, the resident's care plan did not reflect the need for 2 staff to turn and reposition the resident. On 4/17/11 one staff member turned and repositioned resident. Later that morning resident was found entrapped between the side rail and air mattress.

F278 Accurate Assessments

Completion Date: 6/17/11

Corrective Action For Residents Found To Have Been Affected By The Deficient Practice:

This facility will ensure that this resident was accurately assessed for ability to move, turn and reposition. Resident #1 care plan updated 5/17/11 by MDS Coordinator and ECF Coordinator after new side rail assessment was completed by members of the interdisciplinary team (ECF Coordinator, Charge Nurse, Activities Director, MDS Coordinator and Social Services) on 5/16/11 to include specifically that she requires two (2) persons to not only transfer but to turn and reposition as per the MDS. The Care Card for use by aides was also amended on May 17, 2011 to reflect that she requires two (2) persons to turn and reposition. She is able to use the side rail on one side with cueing and assist but this does not remove the necessity for two (2) persons to turn and reposition resident. Although she is able to use one side rail the risks associated with entrapment outweigh the benefit of this use so the side rails are not recommended for use. An order was obtained from the physician to discontinue the use of side rails on 5/17/11. A new Positioning Tool created by the ECF Coordinator on May 16, 2011 (included) was initiated by the ECF Coordinator and Charge Nurse on May 17, 2011 for hourly positioning checks for this resident so aides may document the correct position and track repositioning.

The Facility Will Identify Other Residents Having The Potential To Be Affected By The Same Practice:

All residents have the potential to be affected, but no others were at this time based on the Care Plans and Care Cards for all residents were reviewed and updated by members of the interdisciplinary team (ECF Coordinator, MDS Coordinator, Charge Nurse, Activity Director, and Social Services Director) for proper designation of assistance levels on 5/18 – 5/20/11 and again on 5/23/11 to ensure that the ability to move, turn and reposition was current by comparing orders, assessments, care plans, care cards and doing observations and interviews with team members. Based on this review, the new Positioning Tool was implemented on May 17, 2011 for 11 other residents through determination of need by members of the interdisciplinary team

consisting of ECF Coordinator (RN), Charge Nurse (RN), Activity Director, MDS Coordinator (LPN) and Social Services. These residents were deemed to be at risk for several reasons (ex. skin integrity, side rail reduction, compliance, etc.). This intervention was documented on the Care Plan by the MDS Coordinator.

The Care Plans and Care Cards will be reviewed for all residents for all areas to ensure the accuracy and completion by the Interdisciplinary Team.

Measures To Be Put In Place Or Systemic Changes Made To Ensure The Deficient Practice Will Not Recur:

The ADL's (Activities of Daily Living) which include bed mobility, turning and repositioning; transferring, locomotion on/off unit, dressing, eating, toileting, personal hygiene and bathing, will be checked weekly for all residents on Tuesday by the MDS Coordinator/ECF Coordinator and brought to the morning meeting for review of accuracy. The review of the new ECF Nurse Change of Shift Report Checklist which was developed by the ECF Coordinator, CNO, and CEO on May 19, 2011 and 24 hour log by the Charge Nurse/ECF Coordinator will be brought to the morning meeting on Monday – Friday to ensure status changes in the residents' ability to move, turn and reposition are noted.

If changes are warranted, the care plan and care cards will be brought to the Standards of Care meeting held on Tuesdays at 2:00 pm to be updated. The interdisciplinary team (ECF Coordinator, MDS Coordinator, Charge Nurse, Activity Director, Dietary Director and Social Services Director) will also review to determine if a significant change of condition is warranted at this time.

On Saturdays, Sundays and Holidays the ECF Coordinator and/or Charge Nurse will make rounds on the ECF unit and ensure that the ECF Nurse Change of Shift Report Checklist is completed and if changes are warranted that Care Plans and Care Cards are updated until such time as the Immediate Jeopardy is resolved.

Education (included) for all ECF aides and nursing team members was provided by ECF Coordinator or Charge Nurse on complete and accurate communication and documentation for all residents' ADLs and changes for residents of ADL status on 5/21 – 5/23 (included). Administration determined that if a team member was unable to receive the education at this time that the particular team member would not be permitted to work until such time as the education was completed. Letters were sent on 5/23/11 by the ECF Coordinator to those team members informing them of the need to complete this mandatory education prior to returning to work. Employee swipe badges will be disabled to ensure compliance.

How The Facility Plans To Monitor Its Performance To Ensure Solutions Are Sustained:

The ECF Coordinator will perform a daily audit of all MDS, Care Plans and Care Cards to ensure the reviews are done and accuracy is maintained until the Immediate Jeopardy is resolved. The audit will then be completed weekly for four weeks by the ECF Coordinator. After those four weeks, the audit will be completed on a monthly basis to ensure that compliance continues. If there are errors or changes found during review, the care plans and care cards will be updated immediately upon discovery and further education provided to the team members responsible.

The QA Committee (Administrator, CEO, CNO, PI Coordinator, Medical Director, ECF Coordinator, Charge Nurse, Pharmacist Consultant, and Dietary Director) and special guests Physical Plant Director and Staff Development Coordinator held a special meeting on Monday, May 23, 2011 to review and approve the Allegations of Compliance Document and attachments. The QA Committee met on 6/3/2011 and plans to meet again on 6/28/2011 to review interventions and ensure systems are in place. The QA Committee, which normally meets quarterly, will meet weekly until the Immediate Jeopardy is resolved and then monthly for the next three months for monitoring of the revised processes.

PLAN OF CORRECTION

THE JAMES B. HAGGIN MEMORIAL HOSPITAL EXTENDED CARE FACILITY SURVEY COMPLETION DATE May 13, 2011

483.25 Accidents – An Immediate Jeopardy was found as facility failed to have an effective system in place to ensure the safe and effective use of side rails for residents. Resident #1 was found entrapped between the side rail and air mattress on 4/17/11.

F323 Accidents

Completion Date: 6/17/11

Corrective Action For Residents Found To Have Been Affected By The Deficient Practice:

This facility will have an effective system in place to ensure safe and effective use of side rails for residents. Resident #1 had a risk assessment for bed entrapment per FDA 7 Zone Entrapment Assessment tool (included) on 5/17/11 by Physical Plant Director. Zone 1 showed openings in rails 3 ¾", Zone 2 had 1", Zone 3 measured 3 ½", Zone 4 was N/A as straight rail and all were at same height. Zone 5 was N/A as there was no split rail, Zone 6 showed potential for risk and recommended mitigation measures and Zone 7 had good mattress fit with minimal shifting of < 2". This passed the assessment, however, per the new side rail assessment tool, the side rails were recommended to be discontinued.

As the investigation into the event unfolded, the causes were difficult to ascertain but certainly proper positioning was a major concern. In-service education on proper positioning (included) was completed at team meetings on 4/27/11 and 4/28/11 as well as at a mandatory team meeting on 5/12/11 by the ECF Coordinator, Charge Nurse and CNO. Staff Education Director prepared educational materials on proper positioning (included) for all ECF nursing and aide team members to be completed by 5/23/11.

A new Positioning Tool created by the ECF Coordinator on May 16, 2011 (included) was initiated by the ECF Coordinator and Charge Nurse on May 17, 2011 for hourly positioning checks for this resident so aides may document the correct position and track repositioning.

The Facility Will Identify Other Residents Having The Potential To Be Affected By The Same Practice:

All residents have the potential to be affected, but no others were at this time. However, the FDA 7 Zone Entrapment assessment was completed for all residents by the Physical Plant Director by 5/19/11. Appropriate modifications were made by 5/23/11 as a result of the assessment tool. These modifications included padding any side rails measuring > 4" in Zone 1 and replacing four zone 7 beds. Zone 5 parameters were not an issue because we do not use split rails on any beds.

Measures To Be Put In Place Or Systemic Changes Made To Ensure The Deficient Practice Will Not Recur:

The FDA 7 Zone Bed Risk Assessment will be completed for any new beds or mattresses when they are put into service or when repairs to bed or side rails are made by the Physical Plant Director. Additionally, the FDA 7 Zone Bed Assessment will be performed by the Physical Plant Director every six months times two and annually thereafter to ensure compliance. An audit (included) of all bed and chair alarms was completed by the ECF Charge Nurse between 5/16/11 and 5/21/11 to ensure they are in place and working properly. A new Side Rail Policy was developed (included) on May 19, 2011 by the ECF Coordinator. It was reviewed by the CEO, CNO, Administrator, Medical Director and ECF Coordinator. The new policy provides for a new assessment tool designed to recommend proper side rail use. It includes input from resident and/or POA. It also includes a decision tree for consideration of alternatives if the assessment does not allow for clear recommendations. The policy also has a consent form to be discussed and signed by resident/POA if the side rail use is determined to be a restraint. The new assessment tool will be implemented as the tool for all future side rail assessments, which are completed by ECF Charge Nurse or MDS Coordinator/ECF Coordinator upon admission and at least quarterly. A new Policy for Resident Rounds (included) was developed by the ECF Coordinator, CNO and CEO on May 19, 2011. It ensures communication of new orders based on assessment recommendations for side rail use, adherence to the proper care plan regarding side rail use and visual tour of each resident to verify safety by the nurses.

A Room Rounding Tool (included) for use by nursing staff at change of shift and approximately every 4 hours was implemented beginning on 5/17/11. The purpose of the Room Rounding Tool is to ensure resident safety by inspection that the proper side rails are utilized as per care plan and to address any discrepancies with the aides immediately.

The new Positioning tool was implemented on 5/17/11 for use by aides for hourly checks to document the correct position and track re-positioning for residents as determined by the interdisciplinary team (ECF Coordinator, MDS Coordinator, Charge Nurse, Activity Director and Social Services Director) to benefit from hourly checks.

Education (included) for all ECF aides and nursing team members was provided by ECF Coordinator or Charge Nurse on all of the new measures and also regarding accurate, complete and timely communication and documentation on 5/21 – 5/23 (included). Administration determined that if a team member was unable to receive the education at this time that the particular team member would not be permitted to work until such time as the education was completed. Letters were sent on 5/23/11 by the ECF Coordinator to those team members informing them of the need to complete this mandatory education prior to returning to work. Employee swipe badges will be disabled to ensure compliance.

How The Facility Plans To Monitor Its Performance To Ensure Solutions Are Sustained:

The Room Rounding Tool (included) will be collected by the ECF Charge Nurse/ECF Coordinator Monday – Friday to verify use, note any concerns and address issues that are documented. On Saturdays, Sundays and Holidays the ECF Coordinator and/or Charge Nurse will make rounds on the ECF unit and ensure that the Rounding Tool is completed and if

changes are warranted that Care Plans and Care Cards are updated until the Immediate Jeopardy situation is resolved.

The Side Rail Policy and the use of side rails will be reviewed by members of the interdisciplinary team (ECF Coordinator, MDS Coordinator, Charge Nurse, Activity Director, Social Services Director and Unit Clerk) each Monday – Friday at morning meeting. This will be accomplished by the Charge Nurse/ECF Coordinator reporting on the collection and monitoring of the tools from the Observation Book. Also, this team will look at the assessments on, at least a weekly basis until the Immediate Jeopardy is resolved and then on a monthly basis for three months and then quarterly since it is part of the evaluation done for each resident as part of the MDS/Care Planning process. The ECF Coordinator will perform a daily audit of all MDS, Care Plans and Care Cards to ensure the reviews are done and accuracy is maintained until the Immediate Jeopardy is resolved.

The QA Committee (Administrator, CEO, CNO, PI Coordinator, Medical Director, ECF Coordinator, Charge Nurse, Pharmacist Consultant, and Dietary Director)) and special guests Physical Plant Director and Staff Development Coordinator held a special meeting on Monday, May 23, 2011 to review and approve the Allegations of Compliance Document and attachments. The QA Committee met on 6/3/2011 and plans to meet again on 6/28/2011 to review measures are in place and ensure systems follow the plan. The QA Committee, which normally meets quarterly, will meet weekly until the Immediate Jeopardy is resolved and then monthly thereafter for the next three months for monitoring of the revised processes.

PLAN OF CORRECTION

THE JAMES B. HAGGIN MEMORIAL HOSPITAL EXTENDED CARE FACILITY SURVEY COMPLETION DATE May 13, 2011

483.75 Administration – An Immediate Jeopardy was found as facility failed to be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This failure is evidenced by the above cited deficiencies at the Substandard Care, Immediate Jeopardy level resulting in Resident #1 becoming entrapped between the side rail and air mattress on 4/17/11.

F 490 Administration

Completion Date: 6/17/11

Corrective Action For Residents Found To Have Been Affected By The Deficient Practice: Administration will ensure that this facility uses its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of this resident. Through an interdisciplinary process through many meetings, several steps were taken to ensure that Resident #1 would not become entrapped between the side rail and air mattress again. These steps included the development of new policies, procedures, assessments and tools specifically to prevent entrapment. These include the following: a new side rail assessment tool (included) was completed for Resident #1 on 5/16/2011 by members of the interdisciplinary team consisting of ECF Coordinator (RN), Charge Nurse (RN), Activity Director, MDS Coordinator (LPN) and Social Services. The side rail utilization assessment indicates resident is primarily immobile with L hemiparesis and non-wt bearing status. Resident #1 is out of bed for meals and activities, transferred per assist of two and Hoyer lift to geri-chair. After review of the resident's assessment and care plan the physician was contacted and orders were received for the use of other alternatives including: low bed (initiated 4/18/11), mats on floor (initiated 4/18/11), bed alarm (initiated 4/18/11) and curved mattress (initiated 5/12/11). The air mattress was discontinued on 5/9/11 per physician order. It also shows that Resident #1 has used upper ½ side rail in past for positioning on one side with cueing and assist. Resident #1 has been added to the q 1 hr positioning tool, which was initiated on 5/17/11 (included) by ECF Coordinator/ECF Charge Nurse. The Interdisciplinary Team considered other factors including the environment due to furniture placement in room as well as a past history of seizures. There have been no known occurrences of recent seizure activity. Recommendation per assessment completed by members of the interdisciplinary team was to discontinue side rails. This was communicated to the physician and they were lowered per physician order on 5/17/11. Discussion was held with POA via telephone and noted on the assessment. A Room Rounding Tool (included) for use by nursing staff at change of shift and approximately every 4 hours was implemented beginning on 5/17/11 to ensure the proper side rails were utilized as per care plan and to address any discrepancies with the aides immediately.

Resident #1 care plan updated 5/17/11 by MDS Coordinator and ECF Coordinator after new side rail assessment completed to include specifically that she requires two (2) persons to not only transfer but to turn and reposition as per the MDS. The Care Plan and the Care Card for use by aides was also amended on 5/17/11 to reflect that she requires two (2) persons to turn and reposition. Resident #1 is able to use the side rail on one side with cueing and assist but this does not remove the necessity for two (2) persons to turn and reposition resident. Although Resident #1 is able to use one side rail the risks associated with entrapment outweigh the benefit of this use so the side rails are not recommended for use. An order was obtained from the physician to discontinue the use of side rails on 5/17/11. A new Positioning Tool (included) was initiated for hourly positioning checks for this resident so aides may document the correct position and track repositioning.

Resident #1 had risk assessment for bed entrapment per FDA 7 Zone Entrapment Assessment tool (included) on 5/17/11 by Physical Plant Director. Zone 1 showed openings in rails 3 ¾", Zone 2 had 1", Zone 3 measured 3 ½", Zone 4 was N/A as straight rail and all were at same height. Zone 5 was N/A as there was no split rail, Zone 6 showed potential for risk and recommend mitigation measures and Zone 7 had good mattress fit with minimal shifting of < 2". This passed the assessment, however, per the new side rail assessment tool, the side rails were recommended to be discontinued.

As the investigation into the event unfolded, the causes were difficult to ascertain but certainly proper positioning was a major concern. In-service education on proper positioning (included) was completed at team meetings on 4/27/11 and 4/28/11 as well as at mandatory team meeting on 5/12/11 by ECF Coordinator, Charge Nurse and CNO. Staff Education Director prepared educational materials for all ECF nursing and aide team members to be completed by 5/23/11.

The Chairman of the Board of Directors of The James B. Haggin Memorial Hospital is receiving a communication from the Chief Executive Officer and/or Administrator on Monday through Friday. A comprehensive report updating the progress to the Board of Directors is emailed weekly from the Chief Executive Officer and/or Administrator. This communication will continue until the Immediate Jeopardy is resolved. A monthly update will be presented by the Chief Executive Officer and/or Administrator at the regularly occurring Board of Directors monthly meetings for the next three months.

The Facility Will Identify Other Residents Having The Potential To Be Affected By The Same Practice:

Administration will ensure that this facility uses its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being for all residents. All residents have the potential to be affected, but no others were at this time. The new policies, procedures, assessments and tools developed specifically to prevent entrapment that were utilized with Resident #1 were also utilized for all residents.

An assessment was completed for all residents utilizing the new side rail assessment tool by 5/23/11. All residents/Powers of Attorney were contacted for discussion. Contact with the physician to request change in order was done for those that precipitated a change in use of side rails.

The Care Plans and Care Cards for all residents were reviewed and updated by members of the interdisciplinary team (ECF Coordinator, MDS Coordinator, Charge Nurse, Activity Director, and Social Services Director) for proper designation of assistance levels on 5/18 – 5/20/11 and again on 5/23/11 to ensure that the ability to move, turn and reposition was current. Based on this review, the new Positioning Tool was implemented for 11 other residents through determination of need by members of the interdisciplinary team consisting of ECF Coordinator (RN), Charge Nurse (RN), Activity Director, MDS Coordinator (LPN) and Social Services. These residents were deemed to be at risk for several reasons (ex. skin integrity, side rail reduction, compliance, etc.).

Additionally, the FDA 7 Zone Entrapment assessment was completed for all residents by the Physical Plant Director on May 19, 2011. As a result of the findings of this tool, appropriate modifications were made by 5/23/11. These modifications included padding any side rails measuring > 4” in Zone 1 and replacing four zone 7 beds. Zone 5 parameters were not an issue because we do not use split rails on any beds.

The Chairman of the Board of Directors of The James B. Haggin Memorial Hospital is receiving a communication from the Chief Executive Officer and/or Administrator on Monday through Friday. A comprehensive report updating the progress to the Board of Directors is emailed weekly from the Chief Executive Officer and/or Administrator. This communication will continue until the Immediate Jeopardy is resolved. A monthly update will be presented by the Chief Executive Officer and/or Administrator at the regularly occurring Board of Directors monthly meetings for the next three months.

Measures To Be Put In Place Or Systemic Changes Made To Ensure The Deficient Practice Will Not Recur:

Administration will ensure that the changes in policy, procedure and practice that were developed to prevent entrapment remain in place. The Board of Directors will ensure that all of the elements identified in this AOC are carried out by Administration, the Management Team and ECF Staff. On May 16, 2011 the CEO informed the Board of Directors of the Immediate Jeopardy situation and explained the gravity of the citation. The Chairman of the Board of Directors of The James B. Haggin Memorial Hospital is receiving a communication from the Chief Executive Officer and/or Administrator on Monday through Friday. A comprehensive report updating the progress to the Board of Directors is emailed weekly from the Chief Executive Officer and/or Administrator. This communication will continue until the Immediate Jeopardy is resolved. A monthly update will be presented by the Chief Executive Officer and/or Administrator at the regularly occurring Board of Directors monthly meetings for the next three months.

A new Side Rail Policy was developed by the ECF Coordinator (included) on May 19, 2011. It was reviewed by the CEO, CNO, Administrator, Medical Director and ECF Coordinator. The new policy provides for a new assessment tool designed to recommend proper side rail use. It includes input from each resident and/or POA. It also includes a decision tree for consideration of alternatives if the assessment does not allow for clear recommendations. The policy also has a consent form to be discussed and signed by the resident and/or POA if the side rail use is determined to be a restraint. The new assessment tool will be implemented as the tool for all future side rail assessments, which are completed by the ECF Charge Nurse or MDS

Coordinator/ECF Coordinator upon admission and at least quarterly. A new Policy for Resident Rounds (included) was developed on May 19, 2011 by the ECF Coordinator. It was reviewed by the CEO, CNO, Administrator, Medical Director and ECF Coordinator. It ensures communication of new orders based on assessment recommendations for side rail use, adherence to the proper care plan regarding side rail use and visual tour of each resident to verify safety by the nurses.

A Room Rounding Tool (included) for use by nursing staff at change of shift and approximately every 4 hours was implemented beginning on 5/17/11 to ensure resident safety by inspection that the proper side rails are utilized as per care plan and to address any discrepancies with the aides immediately.

Education for all ECF aides and nursing team members was provided by ECF Coordinator or Charge Nurse on the new policy on 5/21 – 5/23 (included). Administration determined that if a team member was unable to receive the education at this time that the particular team member would not be permitted to work until such time as the education was completed. Letters were sent on 5/23/11 to those team members informing them of the need to complete this mandatory education prior to returning to work. Employee swipe badges will be disabled to ensure compliance.

The ADL's (Activities of Daily Living) which include bed mobility, turning and repositioning; transferring, locomotion on/off unit, dressing, eating, toileting, personal hygiene and bathing will be checked weekly on Tuesday by the MDS Coordinator/ECF Coordinator and brought to the morning meeting for review of accuracy. The review of the new ECF Nurse Change of Shift Report Checklist and 24 hour log by the Charge Nurse will be brought to the morning meeting on Monday – Friday and also checked by the ECF Coordinator/Charge Nurse on Sat/Sun/Holidays until such time as the Immediate Jeopardy is removed to ensure status changes in the residents' ability to move, turn and reposition are noted. If changes are warranted, the care plan and care cards will be brought to the Standards of Care meeting held on Tuesdays at 2:00 pm to be updated. The interdisciplinary team (ECF Coordinator, MDS Coordinator, Charge Nurse, Activity Director, Dietary Director and Social Services Director) will also review to determine if a significant change of condition is warranted at this time.

The FDA 7 Zone Bed Risk Assessment will be completed for any new beds or mattresses when they are put into service or when repairs to beds or side rails are made by the Physical Plant Director. Additionally, the FDA 7 Zone Bed Risk Assessment will be performed every six months times two and annually thereafter by the Physical Plant Director to ensure compliance. An audit (included) of all bed and chair alarms was completed by the ECF Charge Nurse between 5/16/11 and 5/21/11 to ensure they are in place and working properly. A new Positioning Tool (included) was instituted on 5/17/11 by the ECF Coordinator and ECF Charge Nurse for use by the aides on those residents determined by members of the interdisciplinary team to benefit from hourly checks.

How The Facility Plans To Monitor Its Performance To Ensure Solutions Are Sustained:

Administration shall ensure that the solutions that were put in place to prevent entrapment will be sustained. This will be accomplished through the ECF Coordinator, ECF Charge Nurse and ECF Interdisciplinary Team with oversight from the ECF QA Committee, Administration and ultimately the Board of Directors. This process includes utilization of the Room Rounding Tool, Positioning Tool, ECF Nurse Change of Shift Checklist. The Room Rounding Tool (included)

will be collected by the ECF Charge Nurse/ECF Coordinator Monday – Friday to verify use, note any concerns and address issues that are documented. On Saturdays, Sundays and Holidays the ECF Coordinator and/or Charge Nurse will make rounds on the ECF unit and ensure that the Rounding Tool, Positioning Tool and ECF Nurse Change of Shift Checklist are completed and if changes are warranted that Care Plans and Care Cards are updated until the Immediate Jeopardy situation is resolved.

The ECF Coordinator will perform a daily audit of all MDS, Care Plans and Care Cards to ensure the reviews are done and accuracy is maintained until the Immediate Jeopardy situation is resolved. Then the audits will be performed weekly times four weeks and then monthly thereafter.

The QA Committee (Administrator, CEO, CNO, PI Coordinator, Medical Director, ECF Coordinator, Charge Nurse, Pharmacist Consultant, and Dietary Director) and special guests Physical Plant Director and Staff Development Coordinator held a special meeting on Monday, May 23, 2011 to review and approve the Allegations of Compliance Document and attachments. The QA Committee met on 6/3/2011 and plans to meet again on 6/28/2011 to review measures and ensure systems are in place and follow plan. The QA Committee, which normally meets quarterly, will meet weekly until the Immediate Jeopardy issue is resolved and then monthly for the next three months for monitoring of the revised processes.

On May 16, 2011 the CEO informed the Board of Directors of the Immediate Jeopardy situation and explained the gravity of the citation. The Chairman of the Board of Directors of The James B. Haggin Memorial Hospital is receiving a communication from the Chief Executive Officer and/or Administrator on Monday through Friday. A comprehensive report updating the progress to the Board of Directors is emailed weekly from the Chief Executive Officer and/or Administrator. This communication will continue until the Immediate Jeopardy is resolved. A monthly update will be presented by the Chief Executive Officer and/or Administrator at the regularly occurring Board of Directors monthly meetings for the next three months.

THE JAMES B. HAGGIN MEMORIAL HOSPITAL

POLICIES AND PROCEDURES

ORIGINATING DEPARTMENT: ECF

EFFECTIVE DATE: 5/19/11

LAST REVISED: N/A

TITLE: Side Rails

APPROVAL:

PURPOSE: For each resident to attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints.

SCOPE: All ECF team members

APPLICABLE STANDARDS AND REGULATIONS: 483.10 Resident Rights, 483.13 Resident Behavior and Facility Practices, 483.25 Quality of Care

DEFINITIONS: Physical Restraints – any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident’s body that the individual cannot remove easily which restricts freedom of movement or normal access to one’s body.

Discipline – any action taken by the facility for the purpose of punishing or penalizing residents.

Convenience – any action taken by the facility to control a resident’s behavior or manage a resident’s behavior with a lesser amount of effort by the facility and not in the best interest of the resident.

Medical Symptom – an indication or characteristic of a physical or psychological condition.

TAR – Treatment Administration Record

POLICY: It is the policy of The James B. Haggin Memorial Hospital Extended Care Facility to utilize a systematic approach of evaluation and care planning to identify residents at risk for side rail/restraint use and to promote the reduction and least restrictive measures for those residents. Each resident will be assessed to determine the rationale for the use of any type of side rail and to determine the benefit(s) of use and to identify the risk(s) associated with side rail use specific to each resident.

There will be no use of lower half side rails where split rails are on beds unless specifically ordered by physician. All four rails may be used for emergency transport situations only.

PROCEDURE:

- 1) Each resident, upon admission, and at least quarterly thereafter, will have a side rail utilization assessment completed as part of the routine assessment. (attached)
 - Side rails should not be ordered upon admission to the facility prior to an interdisciplinary assessment and the use of appropriate alternatives.

- 2) After assessment is completed, use the information from it and, if necessary, the *Side Rail and Alternative Equipment Decision Tree* to assist in decision making process. (attached)
- 3) A physician's order will be obtained prior to implementation of any measures.
- 4) The order is to include: type of side rail, reason for use, frequency of use and release parameters.
- 5) If the side rail is utilized as an enabler/positioning tool, it is not a restraint.
- 6) If the side rail is utilized and determined NOT to be the least restrictive device, it is considered a type of restraint. An informed consent will be obtained. (attached)
- 7) The interdisciplinary team will develop a comprehensive care plan for specific alternatives or side rail use and, if side rails, will identify measures to prevent adverse outcomes.
- 8) Assess and document continued use at least every 90 days or more frequently if there is a change of condition utilizing the Side Rail Utilization Assessment Tool. Upon completion of the assessment, the Resident/POA will sign the tool as well as the staff member.
- 9) Each shift will document alternative measures and/or side rails on the TAR, including release if a restraint.

Kelly Windsor
Approved by:

5/23/11
Date:

Andrea Kelly
Approved by:

5/23/11
Date:

Thomas Jackson M.D.
Approved by:

5-23-11
Date:

Richard J. Reed
Approved by:

6/23/11
Date:

Paul C. Meyer
Approved by:

5/23/11
Date: