

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

PRINTED: 06/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185389	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/31/2013
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NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000 INITIAL COMMENTS

F 000

See Attached 6/4/13

An Abbreviated Survey investigating KY#00020232 was initiated on 05/30/13 and concluded on 05/31/13. KY#00020232 was substantiated. Deficiencies were cited with the highest scope and severity of a "G", with the facility having an opportunity to correct before the imposition of remedies.

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

F 280

See Attached 6/4/13

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.

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.



This REQUIREMENT is not met as evidenced by:

Based on interview, record review, and review of

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Deborah Zeel</i>	TITLE <i>Administrator</i>	(X6) DATE <i>7/10/13</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 other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 280 Continued From page 1

the facility's policy, it was determined the facility failed to ensure the Comprehensive Plan of Care was reviewed and revised for one (1) of three (3) sampled residents (Resident #1).

Although the Minimum Data Set (MDS) Assessment, dated 04/15/13, for Resident #1 revealed the facility assessed the resident as requiring the assistance of two (2) staff for transfers, there was no documented evidence the Comprehensive Plan of Care was revised with interventions for two (2) to transfer this resident. On 05/22/13, Resident #1 sustained a fracture of the distal Femur and Tibia after a State Registered Nurse Assistant (SRNA) attempted to transfer the resident independently, and had to lower the resident to the floor. (Refer to F-323)

The findings include:

Review of the facility "Care Plans-Comprehensive", Policy, undated, revealed it was the policy of the facility to develop a Comprehensive Care Plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and psychological needs. Further review revealed the Comprehensive Plan of Care had been designed to prevent declines in the resident's functional status. Care Plans were to be revised as changes in the resident's condition dictated.

Review of Resident #1's clinical record revealed diagnoses which included Anxiety, Depression, Osteoporosis, and a History of a Pelvic Fracture. Review of the Care Area Assessment Summary dated 08/02/12, revealed the resident was not steady with surface to surface transfers and was

F 280 *See attached 6/4/13*

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F 280	<p>Continued From page 2</p> <p>unable to stabilize without human assistance. Review of the Quarterly MDS Assessment, dated 04/15/13, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a nine (9) out of fifteen indicating the resident was moderately impaired in cognition. Further review revealed the facility assessed the resident as requiring total dependence of two (2) staff for transfers.</p> <p>Although the MDS Assessment, dated 04/15/13, revealed the facility assessed the resident as requiring two (2) staff to transfer, the Comprehensive Plan of Care dated April 3013 revealed the resident was at risk for falls and required one (1) to two (2) persons to assist with transfers. Also, review of the Nurse Aide Flow Sheet/Care Plan dated May 2013 revealed the resident required one (1) to two (2) persons to assist with transfers.</p> <p>Review of the Nurse's Notes, dated 05/22/13 at 2:10 PM, revealed Resident #1 was lowered to the floor during a transfer due to the resident's knees giving way. Resident #1 was unable to sit up and complained of right lower extremity pain. The Physician and Emergency Medical Services (EMS) was notified. Review of the Nurse's Note, dated 05/22/13 at 2:20 PM, revealed the resident left the facility per EMS on a back board.</p> <p>Review of the hospital records revealed Resident #1 was admitted to the hospital and diagnosed with a spiral fracture proximal tibia, a nondisplaced fracture of the proximal neck of the fibula, and an oblique fracture through the base of the lateral femoral condyle.</p>	F 280	<i>See attached 6/4/13</i>	

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	<p>F 280 Continued From page 3</p> <p>Interview, on 05/31/13 at 8:45 AM, with Resident #1, who was residing in another skilled facility, revealed she/he had "suffered unmerciful". The resident stated she/he was dropped and now her/his whole body was sore and she/he was in a lot of pain. Resident #1 stated the facility was to have two (2) staff to assist her/him with transfers and usually they did. However, she/he was transferred by a staff member whom she/he had never seen before and the staff member picked her/him up and let her/him drop. The resident stated, she/he landed on both knees which folded underneath her/him.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #1 on 05/30/13 at 2:33 PM, revealed SRNA #3 told her Resident #1 required one (1) to transfer and could bear weight, and she was aware the Nurse Aide Care Plan stated one (1) to two (2) for transfers. Further interview revealed she was doing a pivot transfer with Resident #1 on 05/22/13 from the wheelchair to the bed when the resident's knees went out and she/he went down. She stated the resident landed on her/his knees and she assisted the resident to lay down and went to get the nurse who immediately assessed the resident and called the ambulance. Continued interview revealed the care plan should be specific to state two (2) to transfer if a resident sometimes needs two (2). She indicated the SRNA's did warn her that Resident #1 would sometimes need two (2) to transfer, but did not get specific as to when two (2) staff would be needed.</p> <p>Interview with SRNA #3, on 05/30/13 at 2:15 PM, revealed they used the Nurse Aide Care Plans which were kept in a folder on the outside of the</p>	F 280	See Attached 6/9/13

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F 280	<p>Continued From page 4</p> <p>resident's closet door as a reference for care including transfer technique. She stated she transferred the resident independently with a gait belt unless the resident told her she/he would need two (2) to transfer her/him that day. She further stated if the resident was tired or if the resident told her she may need help, she would get someone else to assist with the transfer. Continued interview revealed she had trained SRNA #1 on how to transfer Resident #1 and had specified the resident could be transferred with one (1) person and a gait belt; however, also warned her if the resident stated she/he would need more help, the resident should be transferred with two (2) staff.</p> <p>Interview with SRNA #4, on 05/30/13 at 2:24 PM, revealed Resident #1 required two (2) to transfer; however, sometimes she would transfer her/him by herself. She stated sometimes the resident did not help with the transfer and would require two (2) to assist from the bed to the wheelchair. Continued interview revealed transferring the resident from the wheelchair to bed depended on the resident's ability, because sometimes the resident was half asleep. She indicated the resident would let her know when she needed more help.</p> <p>Interview, on 05/31/13 at 12:00 PM, with Registered Nurse (RN) #1 revealed she was assigned to Resident #1 on 05/22/13 at the time of the fall. She stated she thought the resident was to be transferred with two (2) staff; however, after the incident when she checked the care plan it stated (1) to two (2) with transfers. Further interview revealed the nurses on the floor reviewed the Nurse Aide Care Plans each</p>	F 280	<p><i>See attached 6/14/13</i></p>

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F 280 Continued From page 5
Sunday for any revisions needed and she had reviewed Resident #1's Nurse Aide Care Plan in the past but did not notice it said one (1) to two (2) for transfers. She indicated if a resident sometimes needed two (2) to transfer, it would be safer to ensure two (2) transferred the resident at all times.

Interview, on 05/31/13 at 1:15 PM, with the MDS Nurse, revealed she had completed the latest MDS and Care Plan for Resident #1. She indicated she coded the residents for the most dependent on the MDS. She stated, prior to completing the Care Plans she interviewed the SRNA's as to how many staff it took to transfer the resident and was told sometimes one (1) person and sometimes two (2) persons depending on how the resident was doing that day. The MDS nurse stated, she also reviewed the ADL tracker which was completed by her after she interviewed the staff about the resident's ability for ADL's when completing the Care Plans. Continued interview revealed she noted the ADL tracker for the seven (7) day assessment period in April 3013 revealed the resident was coded for needing two (2) to transfer; however, thought the resident was only needing two (2) to transfer at that time because the resident was experiencing a Urinary Tract Infection. She stated the Care Plan should have been revised at time. She stated, the MDS Assessment was to guide the Care Plan, and she should have care planned the resident for two (2) assist for transfers.

Interview, on 05/31/13 at 1:42 PM, with the Director of Nursing (DON), revealed the facility fall investigation indicated the root cause of Resident #1's fall was that her/his knees gave

F 280 *See attached 6/4/13*

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F 280	Continued From page 6 out. She further stated the SRNA's knew the residents and knew when either one (1) or two (2) was needed for transfers. However, SRNA #1, who transferred this resident on 05/22/13, was not as familiar with the resident. Further interview revealed the Plan of Care was to be generated from the MDS, which would indicate the Care Plan should have been revised with interventions for two (2) to transfer this resident.	F 280	<i>See Attached 6/4/13</i>		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for one (1) of three (3) sampled residents (Resident #1). Resident #1 was assessed by the facility to require the assistance of two (2) staff for transfers according to the Minimum Data Set (MDS) Assessment dated 04/15/13; however, the Comprehensive Plan of Care and the Nurse Aide Care Plan revealed one (1) to two (2) staff was	F 323	<i>See attached 6/4/13</i>		

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F 323 Continued From page 7
required for transfers. On 05/22/13 a State Registered Nurse Assistant (SRNA) attempted to transfer the resident independently, and had to lower the resident to the floor. The resident sustained a fracture of the distal Femur and Tibia.

The findings include:

Review of the facility's "Falls" Policy, undated, revealed it was the policy of the facility to assess, monitor, and prevent resident injuries from falls.

Review of Resident #1's medical record revealed diagnoses which included Anxiety, Depression, Osteoporosis, and a History of a Pelvic Fracture. Review of the Fall Risk Assessment, dated 04/15/13 revealed the resident was assessed to be at high risk for falls related to intermittent confusion, chair bound, required assistance with elimination, poor vision, was unable to perform gait/balance function, health conditions, and medications.

Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 04/15/13, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a nine (9) out of fifteen (15), indicating the resident was moderately impaired in cognition and as requiring total dependence of two (2) staff for transfers. Review of the seven (7) day Activities of Daily Living (ADL's) Tracking for the MDS dated 04/15/13 revealed Resident #1 required two (2) staff to assist with transfers.

However, review of the Comprehensive Plan of Care, dated April 2013, revealed the resident was at risk for falls related to being unsteady and

F 323 *See attached 6/4/13*

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F 323 Continued From page 8

having a history of falls and required one (1) to two (2) persons to assist with transfers. In addition, review of the Nurse Aide Flow Sheet/Care Plan, dated May 2013 revealed the resident required one (1) to two (2) persons to assist with transfers.

Review of the Nurse's Notes, dated 05/22/13 at 2:10 PM, revealed Resident #1 was lying on the floor beside the bed and staff stated the resident was lowered to the floor during a transfer due to the resident's knees giving way. Further review revealed the resident was unable to sit up and complained of right lower extremity pain. The Physician and Emergency Medical Services (EMS) were notified. Review of the Nurse's Note, dated 05/22/13 at 2:20 PM, revealed the resident exited the facility per EMS on a back board.

Review of the Hospital Discharge Summary, dated 05/29/13, revealed Resident #1 was admitted to the hospital on 05/22/13 after having a controlled fall. Further review revealed the resident was found to have a fractured distal Femur and Tibia and was seen by orthopedics who recommended conservative therapy of her/his fractures. Further review revealed the resident did not wish to go back to the previous facility and as result a bed was found for the resident in another skilled care facility.

Review of the Hospital Radiology Report of the right lower leg, dated 05/24/13, revealed there was a spiral fracture proximal tibia, a nondisplaced fracture of the proximal neck of the fibula, and an oblique fracture through the base of the lateral femoral condyle.

F 323 *See attached 6/14/13*

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F 323	<p>Continued From page 9</p> <p>Interview, on 05/31/13 at 8:45 AM, with Resident #1 who was residing in another skilled facility revealed she/he had "suffered unmerciful". The resident stated she/he was dropped and now her/his whole body was sore and she/he was in a lot of pain. Continued interview revealed the facility was to have two (2) staff to assist her/him with transfers and usually they did. However, she/he was transferred by a staff member whom she/he had never seen before and the staff member picked her/him up and let her/him drop. The resident stated, she/he landed on both knees which foiled underneath her/him. Continued interview revealed most of the time staff would say they needed to wait and get some help when she/he asked to go to bed.</p> <p>Interview, on 05/30/13 at 1:45 PM, with the Physical Therapist at the facility, revealed prior to the incident Resident #1 was able to bear weight and required two (2) staff to transfer or at least one (1) to transfer and one (1) for stand by assistance. She stated she thought two (2) staff members were always transferring this resident.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #1, on 05/30/13 at 2:33 PM, who was assisting Resident #1 with the transfer on 05/22/13, revealed she had started at the facility 05/08/13 and received training about six (6) days with the other SRNA's who trained her on care plans, on how to use the gait belt, and how to transfer different residents. She stated SRNA #3 told her Resident #1 required one (1) to transfer and could bear weight and she was aware the Nurse Aide Care Plan stated one (1) to two (2) assist with transfers. She stated she was doing a pivot transfer with Resident #1 on 05/22/13 from</p>	F 323	<p><i>See attached 6/4/13</i></p>

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F 323	<p>Continued From page 10</p> <p>the wheelchair to the bed when the resident's knees went out and she/he went down. She stated the resident landed on her/his knees and she helped lay the resident down and went to get the nurse who immediately assessed the resident and called the ambulance. SRNA #1 stated she did not get training on transfers from Physical Therapy (PT) or by the nurses, however, did get training on transfers after the incident from PT. Continued interview revealed the care plan should be specific to state two (2) to transfer if a resident sometimes needs two (2). She stated the SRNA's did warn her that Resident #1 would sometimes need two (2) to transfer, but were not specific as to when two (2) staff would be needed.</p> <p>Interview, on 05/31/13 at 12:00 PM, with Registered Nurse (RN) #1 revealed she was assigned to Resident #1 on 05/22/13 at the time of the fall. She stated SRNA #1 came to get her to let her know the resident was on the floor and when she assessed the resident she noted the resident's right leg was shorter and turned out and she immediately contacted the Physician and the ambulance. She said she thought the resident was to be transferred with two (2) staff; however, after the incident when she checked the care plan it stated one (1) to two (2) with transfers. Continued interview revealed the nurses on the floor reviewed the Nurse Aide Care Plans each Sunday for any revisions needed and she had reviewed Resident #1's Nurse Aide Care Plan in the past but did not notice it indicated one (1) to two (2) for transfers. She stated if a resident sometimes needed two (2) to transfer, it would be safer to ensure two (2) staff transferred the resident at all times.</p>	F 323	<p><i>See attached 6/4/13</i></p>

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F 323	Continued From page 11 Interview with SRNA #3, on 05/30/13 at 2:15 PM, revealed they used the Nurse Aide Care Plans, which were kept in a file folder on the outside of the resident's closet door, as a reference for care including transfer technique. She stated she transferred the resident by herself with a gait belt unless the resident told her she/he would need two (2) to transfer her/him that day. She stated if the resident was tired or if the resident told her she may need help, she would get someone else to assist with the transfer. Continued interview revealed she had trained SRNA #1 on how to transfer Resident #1 and had specified the resident could be transferred with one (1) person and a gait belt, but also warned her if the resident stated she/he would need more help, the resident should be transferred with two (2) staff. Interview, on 05/30/13 at 2:00 PM, with SRNA #2 revealed she would sometimes transfer Resident #1 by herself with a gait belt; however, sometimes she would need two (2) to transfer the resident. She indicated she relied on the resident to let her know when two (2) staff members were needed for the transfer. The SRNA stated, if the resident said that she/he needed two (2) people or if the resident said "I'll help you if I can", she would get someone else to help with the transfer. Continued interview revealed it would be safer for this resident to always have two (2) to transfer. Interview with SRNA #4, on 05/30/13 at 2:24 PM, revealed the resident required two (2) to transfer; however, sometimes she would transfer her/him by herself. She stated sometimes the resident did not help with the transfer and required two (2) to assist from the bed to the wheelchair. She	F 323	See attached 6/4/13		

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185389	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/31/2013
NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031	
(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)
F 323	<p>Continued From page 12</p> <p>further stated transferring the resident from the wheelchair to bed depended on the resident's ability, because sometimes the resident was half asleep. She stated the resident would let you know when she/he needed more help.</p> <p>Interview, on 05/31/13 at 12:10 PM, with SRNA #6 revealed there was usually two (2) needed to assist Resident #1 out of bed and one (1) needed to transfer the resident from the wheelchair to the bed. Continued interview revealed the resident's ability to transfer depended on how tired the resident was. Continued interview revealed she knew the resident would be tired on Tuesdays after sitting up a long time to get her/his hair done at the beauty shop and she would get someone to assist her to transfer Resident #1 from the wheelchair to the bed.</p> <p>Interview, on 05/31/13 at 1:15 PM, with the MDS Nurse, revealed she had completed the MDS and the Care Plan for Resident #1. She stated she coded the residents for the most dependent on the MDS. She further stated, prior to completing the Care Plans she interviewed the SRNA's as to how many staff it took to transfer the resident and was told sometimes one (1) person and sometimes two (2) depending on how the resident was doing that day. Continued interview revealed if the resident was participating in the transfer it would only require one (1) person to assist. The MDS nurse stated, she also went by the Activities of Daily Living (ADL) tracker which was completed by her after she interviewed the staff about the resident's ability for ADL's when completing the Care Plans. She stated she noted the ADL tracker for the seven (7) day assessment period in April 2013, revealed the resident was</p>	F 323	<p><i>See attached 6/4/13</i></p>

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

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			(X5) COMPLETION DATE

F 328 Continued From page 13
coded for needing two (2) to transfer each day; however, thought the resident was only needing two (2) to transfer at that time because the resident was experiencing a Urinary Tract Infection, and would not always need two (2) to transfer. Continued interview revealed the MDS Assessment was to guide the Care Plan, and she should have care planned the resident for two (2) assist for transfers.

Interview, on 05/31/13 at 1:42 PM, with the Director of Nursing revealed all the training including transfers was done by the SRNA's for new SRNA's on hire and new SRNA's received at least three (3) twelve (12) hour shifts working with another SRNA on the floor before working by themselves. She stated the facility fall investigation indicated the root cause of Resident #1's fall was that her/his knees gave out. She stated prior to this fall there was no indication any other intervention was needed to prevent falls because this resident's last fall was in 2011. Continued interview revealed the SRNA's knew the residents and knew when either one (1) or two (2) was needed for this resident for transfers. However, SRNA #1, who transferred this resident on 05/22/13, was not as familiar with the resident. Further interview revealed the MDS was coded for the most dependent and the Care Plan was to be generated from the MDS and should be individualized and specific.

F 323

See attached 6/4/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100166	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/31/2013
NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031		
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N 000	INITIAL COMMENTS A Complaint Survey investigating KY#00020232 was initiated on 05/30/13 and concluded on 05/31/13. KY#00020232 was substantiated with deficiencies cited.	N 000	<i>See attached 6/4/13</i>	
N 192	902 KAR 20:300-7(4)(b)3. Section 7. Resident Assessment (4) Comprehensive care plans. (b) A comprehensive care plan shall be: 3. Periodically reviewed and revised by a team of qualified persons after each assessment. This requirement is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure the Comprehensive Plan of Care was reviewed and revised for one (1) of three (3) sampled residents (Resident #1). Although the Minimum Data Set (MDS) Assessment, dated 04/15/13, for Resident #1 revealed the facility assessed the resident as requiring the assistance of two (2) staff for transfers, there was no documented evidence the Comprehensive Plan of Care was revised with interventions for two (2) to transfer this resident. On 05/22/13, Resident #1 sustained a fracture of the distal Femur and Tibia after a State Registered Nurse Assistant (SRNA) attempted to transfer the resident independently, and had to lower the resident to the floor. (Refer to F-323) The findings include: Review of the facility "Care Plans-Comprehensive", Policy, undated, revealed it was the policy of the facility to develop a Comprehensive Care Plan for each resident that	N 192		

RECEIVED
JUL 15 2013
BY: _____

Deborah Zeeh Administrator

TITLE 7/10/13

(X6) DATE

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100166	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/31/2013
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N 192	<p>Continued From page 1</p> <p>Includes measurable objectives and timetables to meet the resident's medical, nursing, and psychological needs. Further review revealed the Comprehensive Plan of Care had been designed to prevent declines in the resident's functional status. Care Plans were to be revised as changes in the resident's condition dictated.</p> <p>Review of Resident #1's clinical record revealed diagnoses which included Anxiety, Depression, Osteoporosis, and a History of a Pelvic Fracture. Review of the Care Area Assessment Summary dated 08/02/12, revealed the resident was not steady with surface to surface transfers and was unable to stabilize without human assistance. Review of the Quarterly MDS Assessment, dated 04/15/13, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a nine (9) out of fifteen indicating the resident was moderately impaired in cognition. Further review revealed the facility assessed the resident as requiring total dependence of two (2) staff for transfers.</p> <p>Although the MDS Assessment, dated 04/15/13, revealed the facility assessed the resident as requiring two (2) staff to transfer, the Comprehensive Plan of Care dated April 30 13 revealed the resident was at risk for falls and required one (1) to two (2) persons to assist with transfers. Also, review of the Nurse Aide Flow Sheet/Care Plan dated May 2013 revealed the resident required one (1) to two (2) persons to assist with transfers.</p> <p>Review of the Nurse's Notes, dated 05/22/13 at 2:10 PM, revealed Resident #1 was lowered to the floor during a transfer due to the resident's knees giving way. Resident #1 was unable to sit up and complained of right lower extremity pain.</p>	N 192	<p><i>See attached 6/4/13</i></p>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100166	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/31/2013
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NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031
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N 192: Continued From page 2

The Physician and Emergency Medical Services (EMS) was notified. Review of the Nurse's Note, dated 05/22/13 at 2:20 PM, revealed the resident left the facility per EMS on a back board.

Review of the hospital records revealed Resident #1 was admitted to the hospital and diagnosed with a spiral fracture proximal tibia, a nondisplaced fracture of the proximal neck of the fibula, and an oblique fracture through the base of the lateral femoral condyle.

Interview, on 05/31/13 at 8:45 AM, with Resident #1, who was residing in another skilled facility, revealed she/he had "suffered unmerciful". The resident stated she/he was dropped and now her/his whole body was sore and she/he was in a lot of pain. Resident #1 stated the facility was to have two (2) staff to assist her/him with transfers and usually they did. However, she/he was transferred by a staff member whom she/he had never seen before and the staff member picked her/him up and let her/him drop. The resident stated, she/he landed on both knees which folded underneath her/him.

Interview with State Registered Nursing Assistant (SRNA) #1 on 05/30/13 at 2:33 PM, revealed SRNA #3 told her Resident #1 required one (1) to transfer and could bear weight, and she was aware the Nurse Aide Care Plan stated one (1) to two (2) for transfers. Further interview revealed she was doing a pivot transfer with Resident #1 on 05/22/13 from the wheelchair to the bed when the resident's knees went out and she/he went down. She stated the resident landed on her/his knees and she assisted the resident to lay down and went to get the nurse who immediately assessed the resident and called the ambulance. Continued interview revealed the care plan

N 192

See attached 6/4/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(IX1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100166	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/31/2013
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NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031
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N 192 Continued From page 3

should be specific to state two (2) to transfer if a resident sometimes needs two (2). She indicated the SRNA's did warn her that Resident #1 would sometimes need two (2) to transfer, but did not get specific as to when two (2) staff would be needed.

Interview with SRNA #3, on 05/30/13 at 2:15 PM, revealed they used the Nurse Aide Care Plans which were kept in a folder on the outside of the resident's closed door as a reference for care including transfer technique. She stated she transferred the resident independently with a gait belt unless the resident told her she/he would need two (2) to transfer her/him that day. She further stated if the resident was tired or if the resident told her she may need help, she would get someone else to assist with the transfer. Continued interview revealed she had trained SRNA #1 on how to transfer Resident #1 and had specified the resident could be transferred with one (1) person and a gait belt; however, also warned her if the resident stated she/he would need more help, the resident should be transferred with two (2) staff.

Interview with SRNA #4, on 05/30/13 at 2:24 PM, revealed Resident #1 required two (2) to transfer; however, sometimes she would transfer her/him by herself. She stated sometimes the resident did not help with the transfer and would require two (2) to assist from the bed to the wheelchair. Continued interview revealed transferring the resident from the wheelchair to bed depended on the resident's ability, because sometimes the resident was half asleep. She indicated the resident would let her know when she needed more help.

Interview, on 05/31/13 at 12:00 PM, with

N 192

See attached 6/4/13

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N 192	Continued From page 4 Registered Nurse (RN) #1 revealed she was assigned to Resident #1 on 05/22/13 at the time of the fall. She stated she thought the resident was to be transferred with two (2) staff; however, after the incident when she checked the care plan it stated (1) to two (2) with transfers. Further interview revealed the nurses on the floor reviewed the Nurse Aide Care Plans each Sunday for any revisions needed and she had reviewed Resident #1's Nurse Aide Care Plan in the past but did not notice it said one (1) to two (2) for transfers. She indicated if a resident sometimes needed two (2) to transfer, it would be safer to ensure two (2) transferred the resident at all times. Interview, on 05/31/13 at 1:15 PM, with the MDS Nurse, revealed she had completed the latest MDS and Care Plan for Resident #1. She indicated she coded the residents for the most dependent on the MDS. She stated, prior to completing the Care Plans she interviewed the SRNA's as to how many staff it took to transfer the resident and was told sometimes one (1) person and sometimes two (2) persons depending on how the resident was doing that day. The MDS nurse stated, she also reviewed the ADL tracker which was completed by her after she interviewed the staff about the resident's ability for ADL's when completing the Care Plans. Continued interview revealed she noted the ADL tracker for the seven (7) day assessment period in April 3013 revealed the resident was coded for needing two (2) to transfer; however, thought the resident was only needing two (2) to transfer at that time because the resident was experiencing a Urinary Tract Infection. She stated the Care Plan should have been revised at time. She stated, the MDS Assessment was to guide the Care Plan, and she should have care planned the	N 192	<i>See attached 6/4/13</i>		

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N 192 Continued From page 5
resident for two (2) assist for transfers.

Interview, on 05/31/13 at 1:42 PM, with the Director of Nursing (DON), revealed the facility fall investigation indicated the root cause of Resident #1's fall was that her/his knees gave out. She further stated the SRNA's knew the residents and knew when either one (1) or two (2) was needed for transfers. However, SRNA #1, who transferred this resident on 05/22/13, was not as familiar with the resident. Further interview revealed the Plan of Care was to be generated from the MDS, which would indicate the Care Plan should have been revised with interventions for two (2) to transfer this resident.

N 192 *See attached 6/4/13*

N 219 902 KAR 20:300-8(7)(a) Section 8. Quality of Care

(7) Accidents. The facility shall ensure that:
(a) The resident environment remains as free of accident hazards as is possible; and

This requirement is not met as evidenced by:
Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for one (1) of three (3) sampled residents (Resident #1).

Resident #1 was assessed by the facility to require the assistance of two (2) staff for transfers according to the Minimum Data Set (MDS) Assessment dated 04/15/13; however, the Comprehensive Plan of Care and the Nurse Aide Care Plan revealed one (1) to two (2) staff was required for transfers. On 05/22/13 a State Registered Nurse Assistant (SRNA) attempted to

N 219 *See attached 6/4/13*

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N 219	Continued From page 6 transfer the resident independently, and had to lower the resident to the floor. The resident sustained a fracture of the distal Femur and Tibia. The findings include: Review of the facility's "Falls" Policy, undated, revealed it was the policy of the facility to assess, monitor, and prevent resident injuries from falls. Review of Resident #1's medical record revealed diagnoses which included Anxiety, Depression, Osteoporosis, and a History of a Pelvic Fracture. Review of the Fall Risk Assessment, dated 04/15/13 revealed the resident was assessed to be at high risk for falls related to intermittent confusion, chair bound, required assistance with elimination, poor vision, was unable to perform gait/balance function, health conditions, and medications. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 04/15/13, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a nine (9) out of fifteen (15), indicating the resident was moderately impaired in cognition and as requiring total dependence of two (2) staff for transfers. Review of the seven (7) day Activities of Daily Living (ADL's) Tracking for the MDS dated 04/15/13 revealed Resident #1 required two (2) staff to assist with transfers. However, review of the Comprehensive Plan of Care, dated April 2013, revealed the resident was at risk for falls related to being unsteady and having a history of falls and required one (1) to two (2) persons to assist with transfers. In addition, review of the Nurse Aide Flow Sheet/Care Plan, dated May 2013 revealed the	N 219	<i>See attached 6/4/13</i>		

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N 219	Continued From page 7 resident required one (1) to two (2) persons to assist with transfers. Review of the Nurse's Notes, dated 05/22/13 at 2:10 PM, revealed Resident #1 was lying on the floor beside the bed and staff stated the resident was lowered to the floor during a transfer due to the resident's knees giving way. Further review revealed the resident was unable to sit up and complained of right lower extremity pain. The Physician and Emergency Medical Services (EMS) were notified. Review of the Nurse's Note, dated 05/22/13 at 2:20 PM, revealed the resident exited the facility per EMS on a back board. Review of the Hospital Discharge Summary, dated 05/29/13, revealed Resident #1 was admitted to the hospital on 05/22/13 after having a controlled fall. Further review revealed the resident was found to have a fractured distal Femur and Tibia and was seen by orthopedics who recommended conservative therapy of her/his fractures. Further review revealed the resident did not wish to go back to the previous facility and as result a bed was found for the resident in another skilled care facility. Review of the Hospital Radiology Report of the right lower leg, dated 05/24/13, revealed there was a spiral fracture proximal tibia, a nondisplaced fracture of the proximal neck of the fibula, and an oblique fracture through the base of the lateral femoral condyle. Interview, on 05/31/13 at 8:45 AM, with Resident #1 who was residing in another skilled facility revealed she/he had "suffered unmerciful". The resident stated she/he was dropped and now her/his whole body was sore and she/he was in a lot of pain. Continued interview revealed the	N 219	<i>See Attached 6/4/13</i>	

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N 219	Continued From page 8 facility was to have two (2) staff to assist her/him with transfers and usually they did. However, she/he was transferred by a staff member whom she/he had never seen before and the staff member picked her/him up and let her/him drop. The resident stated, she/he landed on both knees which folded underneath her/him. Continued interview revealed most of the time staff would say they needed to wait and get some help when she/he asked to go to bed. Interview, on 05/30/13 at 1:45 PM, with the Physical Therapist at the facility, revealed prior to the incident Resident #1 was able to bear weight and required two (2) staff to transfer or at least one (1) to transfer and one (1) for stand by assistance. She stated she thought two (2) staff members were always transferring this resident. Interview with State Registered Nursing Assistant (SRNA) #1, on 05/30/13 at 2:33 PM, who was assisting Resident #1 with the transfer on 05/22/13, revealed she had started at the facility 05/08/13 and received training about six (6) days with the other SRNA's who trained her on care plans, on how to use the gait belt, and how to transfer different residents. She stated SRNA #3 told her Resident #1 required one (1) to transfer and could bear weight and she was aware the Nurse Aide Care Plan stated one (1) to two (2) assist with transfers. She stated she was doing a pivot transfer with Resident #1 on 05/22/13 from the wheelchair to the bed when the resident's knees went out and she/he went down. She stated the resident landed on her/his knees and she helped lay the resident down and went to get the nurse who immediately assessed the resident and called the ambulance. SRNA #1 stated she did not get training on transfers from Physical Therapy (PT) or by the nurses; however, did get	N 219	<i>See Attached 6/4/13</i>		

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FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100166	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/31/2013
NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031	
(X4) IIC PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IIC PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
			(X5) COMPLETE DATE

N 219: Continued From page 9

training on transfers after the incident from PT. Continued interview revealed the care plan should be specific to state two (2) to transfer if a resident sometimes needs two (2). She stated the SRNA's did warn her that Resident #1 would sometimes need two (2) to transfer, but were not specific as to when two (2) staff would be needed.

Interview, on 05/31/13 at 12:00 PM, with Registered Nurse (RN) #1 revealed she was assigned to Resident #1 on 05/22/13 at the time of the fall. She stated SRNA #1 came to get her to let her know the resident was on the floor and when she assessed the resident she noted the resident's right leg was shorter and turned out and she immediately contacted the Physician and the ambulance. She said she thought the resident was to be transferred with two (2) staff; however, after the incident when she checked the care plan it stated one (1) to two (2) with transfers. Continued interview revealed the nurses on the floor reviewed the Nurse Aide Care Plans each Sunday for any revisions needed and she had reviewed Resident #1's Nurse Aide Care Plan in the past but did not notice it indicated one (1) to two (2) for transfers. She stated if a resident sometimes needed two (2) to transfer, it would be safer to ensure two (2) staff transferred the resident at all times.

Interview with SRNA #3, on 05/30/13 at 2:15 PM, revealed they used the Nurse Aide Care Plans, which were kept in a file folder on the outside of the resident's closet door, as a reference for care including transfer technique. She stated she transferred the resident by herself with a gait belt unless the resident told her she/he would need two (2) to transfer her/him that day. She stated if the resident was tired or if the resident told her

N 219

See attached 6/4/13

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 219	Continued From page 10 she may need help, she would get someone else to assist with the transfer. Continued Interview revealed she had trained SRNA #1 on how to transfer Resident #1 and had specified the resident could be transferred with one (1) person and a gait belt, but also warned her if the resident stated she/he would need more help, the resident should be transferred with two (2) staff. Interview, on 05/30/13 at 2:00 PM, with SRNA #2 revealed she would sometimes transfer Resident #1 by herself with a gait belt; however, sometimes she would need two (2) to transfer the resident. She indicated she relied on the resident to let her know when two (2) staff members were needed for the transfer. The SRNA stated, if the resident said that she/he needed two (2) people or if the resident said "I'll help you if I can", she would get someone else to help with the transfer. Continued interview revealed it would be safer for this resident to always have two (2) to transfer. Interview with SRNA #4, on 05/30/13 at 2:24 PM, revealed the resident required two (2) to transfer; however, sometimes she would transfer her/him by herself. She stated sometimes the resident did not help with the transfer and required two (2) to assist from the bed to the wheelchair. She further stated transferring the resident from the wheelchair to bed depended on the resident's ability, because sometimes the resident was half asleep. She stated the resident would let you know when she/he needed more help. Interview, on 05/31/13 at 12:10 PM, with SRNA #6 revealed there was usually two (2) needed to assist Resident #1 out of bed and one (1) needed to transfer the resident from the wheelchair to the bed. Continued interview revealed the resident's ability to transfer depended on how tired the	N 219	<i>See attached 6/4/13</i>		

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NAME OF PROVIDER OR SUPPLIER EDGEMONT HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031	

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N 219 Continued From page 11

resident was. Continued interview revealed she knew the resident would be tired on Tuesdays after sitting up a long time to get her/his hair done at the beauty shop and she would get someone to assist her to transfer Resident #1 from the wheelchair to the bed.

interview, on 05/31/13 at 1:15 PM, with the MDS Nurse, revealed she had completed the MDS and the Care Plan for Resident #1. She stated she coded the residents for the most dependent on the MDS. She further stated, prior to completing the Care Plans she interviewed the SRNA's as to how many staff it took to transfer the resident and was told sometimes one (1) person and sometimes two (2) depending on how the resident was doing that day. Continued interview revealed if the resident was participating in the transfer it would only require one (1) person to assist. The MDS nurse stated, she also went by the Activities of Daily Living (ADL) tracker which was completed by her after she interviewed the staff about the resident's ability for ADL's when completing the Care Plans. She stated she noted the ADL tracker for the seven (7) day assessment period in April 2013, revealed the resident was coded for needing two (2) to transfer each day, however, thought the resident was only needing two (2) to transfer at that time because the resident was experiencing a Urinary Tract Infection, and would not always need two (2) to transfer. Continued Interview revealed the MDS Assessment was to guide the Care Plan, and she should have care planned the resident for two (2) assist for transfers.

Interview, on 05/31/13 at 1:42 PM, with the Director of Nursing revealed all the training including transfers was done by the SRNA's for new SRNA's on hire and new SRNA's received at

N 219

See Attached 6/4/13

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N 219	Continued From page 12 least three (3) twelve (12) hour shifts working with another SRNA on the floor before working by themselves. She stated the facility fall investigation indicated the root cause of Resident #1's fall was that her/his knees gave out. She stated prior to this fall there was no indication any other intervention was needed to prevent falls because this resident's last fall was in 2011. Continued interview revealed the SRNA's knew the residents and knew when either one (1) or two (2) was needed for this resident for transfers. However, SRNA #1, who transferred this resident on 05/22/13, was not as familiar with the resident. Further interview revealed the MDS was coded for the most dependent and the Care Plan was to be generated from the MDS and should be individualized and specific.	N 219	<i>See attached 6/4/13</i>	

Plan of Correction/Allegation of Compliance**F280 Right to Participate Planning Care-Revise CP (sampled resident #1**

(Please note if no specific date noted, that interventions done and/or were repeated shall be considered as completed as of date of compliance listed at end of tag POC).

#1- Resident no longer resides at the facility. R1 was admitted to hospital during annual survey being conducted, and was discharged before complaint survey the following week, May 30, 13. (Facility had implemented change in care plan, had in-serviced staff member involved- along with other nursing staff after incident which was prior to complaint survey initiated). R1 nor responsible party attended care plan meetings even though invited, but did discuss goals/wishes other times. Both R1 and resp. party's goal was for resident to remain as independent as possible, and facility provided interventions for keeping resident at highest level of fcn while also addressing safety concerns/risks. Along with having no previous history of falls from transfers, care plan interventions include number of staff, physical/psychosocial/mental risk factors, strengths/weaknesses, and there were no significant changes in resident's condition prior to fall/discharge. (FYI-other fractures as mentioned in 2567, occurred prior to placement at facility. R1's statement regarding how fell had to referring to events/placement prior to this facility as statement made by R1's fall did not occur in way described to surveyor). In addition the 2567 did note other Care plans/assessments performed revealed that resident was to be transferred with 1-2 assist. R1 had a lift chair and used one transfer most of day except may use 2 regardless based on either the staff member or R1. CP already included for 2assist based on various other conditions for staff to use if needed based on the staff/ R1's condition (was able to vocalize if extra tired/pain/etc). Did not change coding as RAI guidelines are to code highest level of staff used (we have two 12 hr shifts/day) regardless of reason as well as discharged before needing amended MDS.

#2- Residents with high risk for falls with variable number of assistance needed for transfers have potential to be affected by said practice. No other residents were identified as being affected from said practice. This was assured when at least 16 care plans and transfers were reviewed/monitored by state surveyors/IDT team along with reviewing residents that had high risk for falls/with many of those residents 1-2 staff /had previous falls during annual survey (same week as occurrence of sampled resident week of incident) that resulted in no findings of assessments/care plans/transfers, etc. In addition, IDT team reviewed assessments/ care plans of residents who were at high risk for falls/had falls along with being coded as 1-2 staff assistance to assess if any changes needed to be made. No other residents were affected by said practice as of compliance date. *During annual survey, transfers, care plans and assessments for multiple people were also reviewed with no deficient practices noted, even with staff member #1 along with multiple other staff/residents.

#3/4

Interdisciplinary team in-serviced by Administrator/D.O.N on 5/31/13 after survey exit to identify residents at high risk/ with recent falls to compare assessments against care plans to assure accuracy of information by reviewing assessments against care plans, etc for those coded as having had falls/high risk for falls and care planned as resident needing 1-2 for transfers. IDT team initiated process starting that evening and completed as of compliance date. Shall continue to review/change information with other residents ongoing with any change of condition, after falls, and when residents' RAI process is due. *Even for those residents not as described above with special circumstances. (ie: high risk for falls but have not had any, state only highest level number of staff members needed for transfer, etc).* In addition to the RAI/care plans assessed for sampled residents that surveyors reviewed, Care Plan team assured those Assessment and Care Plans updated/reviewed, included interventions for accuracy to ensure they adequately meet the needs of the residents as of 6/3/13, and ongoing when due with RAI process, significant change condition, or has a fall. Facility shall continue to discuss at morning clinical meetings any falls from previous business day along with weekly QI meetings, that includes both the I.D.T team as well as therapy. Plan of Care/charts are brought in for review and any changes needing to be made will be documented on weekly clinical meeting logs for internal QA process. (DON signature on MDS assessments shall be used during this 60 days as assuring monitoring for accuracy of ADL/transfer/interventions are correct as well vs. just to show completion date being done timely).

Director of Nursing/Physical Therapy Services in-serviced/rein-serviced nursing staff (CNA's, KMA's, and Nurses) regarding transfers with gait belts with return demonstration performed on 5/29/13 and after survey exit on 5/31/13, and again on 6/3/13. This included safe/proper lowering of resident to floor and to use more than one staff member regardless if uncertain based on resident needs regardless of care plan or if different than normal need of assistance (ie: appearing lethargic, change in normal behavior, etc). CNA as noted in 2567, demonstrated safe transfers and knowledge of resident's care based on their conditions/knowing to review CNA care plans both after incident occurred along with in-services given after date of survey exit. (all done prior to date of compliance for nsg staff regarding monitoring transfers)

At least 12 residents have had their Assessments checked along with Care Plans as of compliance date. In addition to when MDS/ Care Plans being updated/reviewed, including interventions, with RAI process as noted when due on calendar for completion as well as when a significant change in condition/fall, and with weekly clinical meetings for falls identified ongoing with DON/IDT to assist with documentation updates in plan of care.

Administrator/designee shall be present during weekly clinical meetings and review that recommendations are documented on weekly basis during clinical meetings times 60 days to ensure compliance/corrections are done to maintain compliance. Shall repeat in-servicing or other measures as deemed appropriate to staff if any concerns are noted regarding non-compliance.

QA- Fall and Care Plan Policies reviewed and dated, Regulations for F280/323, interventions, survey issues were reviewed /discussed on 6/3/2013) by QA team /Medical Director and documented on QA attendance log with information discussed /reviewed. An additional QA follow up meeting was set to review checklists, assuring compliance with interventions based on scope/severity on 6/12/2013 which included information from annual survey that had no actual harm and additional tags at that time. (but 1st QA meeting on 6/3/2012 satisfied requirement prior to compliance date)

Audits and concerns with QI monitoring shall be discussed at next scheduled QI meeting to review outcomes as listed above and address any ongoing issues in addition to the weekly QI audits.

Date of Compliance: 6/4/2013

Person Responsible: Director of Nursing

Plan of Correction/Allegation of Compliance for F323 Free of Accident Hazards/Supervision/Devices Sampled Resident- R #1

#1- Sampled resident R1- no longer resides in facility, was discharged prior to survey entrance. Care plan was updated after incident regardless in anticipation prior to being notified of discharge or even complaint survey. R1 also had a lift reclining chair when normally transferred to from w/c with one assist which is when this event occurred. Also, SRNA #1 was oriented and had transferred R1 on numerous occasions including entire day of assisting with lowering to floor during state annual survey.

SRNA#1 monitored and observed during resident care as of 5/23/13. Physical Therapy Services in-serviced/rein-serviced SRNA #1 individually regarding return demonstration stand/pivot transfers with gait belt use and proper technique on: 5/29/13 and 5/31/13, and 6/3/13 in addition to in-services given to nursing staff (CNA's, KMA's, Nurses).

#2- All residents with high risk for falls have potential to be affected by said practice. No residents identified have been affected by said practice by reviewing falls/incidents/hazards/supervision during morning meeting since date of compliance and reviewing/monitoring resident transfers/assessments/care plans/staff supervision along with reviewing all the assessments against care plans as noted in the F280 POC regarding care planning/assessments reviewed.

#3/4-Interdisciplinary team in-serviced by Administrator/D.O.N on 5/31/13 after survey exit to identify residents at high risk/ with recent falls to compare assessments against care plans to assure accuracy of information by reviewing assessments against care plans, etc for those coded as having had falls/high risk for falls and care planned as resident needing 1-2 for transfers. IDT team initiated process starting that evening and completed as of compliance date. Shall continue to review/change information with other residents ongoing with any change of condition, after falls, and when residents' RAI process is due. *Even for those residents not as described above with special circumstances. (ie: high risk for falls but have not had any, state only highest level number of staff members needed for transfer, etc).* In addition to the RAI/care plans assessed for sampled residents that surveyors reviewed, Care Plan team assured those Assessment and Care Plans updated/reviewed, included interventions for accuracy to ensure they adequately meet the needs of the residents as of 6/3/13, and ongoing when due with RAI process, significant change condition, or has a fall. Facility shall continue to discuss at morning clinical meetings any falls from previous business day along with weekly QI meetings, that includes both the I.D.T team as well as therapy. Plan of Care/charts are brought in for review and any changes needing to be made will be documented on weekly clinical meeting logs for internal QA process. (DON signature on MDS assessments shall be used during this 60 days as assuring monitoring for accuracy of ADL/transfer/interventions are correct as well vs. just to show completion date being done timely).

Director of Nursing/Physical Therapy Services in-serviced/rein-serviced nursing staff (CNA's, KMA's, and Nurses) regarding transfers with gait belts with return demonstration performed on 5/29/13 and after survey exit on 5/31/13, and again on 6/3/13. This included safe/proper lowering of resident to floor and to use more than one staff member regardless if uncertain based on resident needs regardless of care plan or if different than normal need of assistance (ie: appearing lethargic, change in normal behavior, etc). CNA as noted in 2567, demonstrated safe transfers and knowledge of resident's care based on their conditions/knowing to review CNA care plans both after incident occurred along with in-services given after date of survey exit. (all done prior to date of compliance for nsg staff regarding monitoring transfers)

At least 12 residents have had their Assessments checked along with Care Plans as of compliance date (which are residents with high risk/had falls/and noted as using 1-2 with transfer assist. In addition to when MDS/ Care Plans being updated/reviewed, including interventions, with RAI process as noted when due on calendar for completion as well as when a significant change in condition/fall, and with weekly clinical meetings for falls identified ongoing with DON/IDT to assist with documentation updates in plan of care.

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Audits and concerns with QI monitoring shall be discussed at next scheduled QI meeting to review outcomes as listed above and address any ongoing issues in addition to the weekly QI audits

Date of Compliance: 6/4/13

Responsible: Administrator/ Director of Nursing

Plan of Correction/Allegation of Compliance**NI92 Right to Participate Planning Care-Revise CP (sampled resident #1**

(Please note if no specific date noted, that interventions done and/or were repeated shall be considered as completed as of date of compliance listed at end of tag POC).

#1- Resident no longer resides at the facility. R1 was admitted to hospital during annual survey being conducted, and was discharged before complaint survey the following week, May 30, 13. (Facility had implemented change in care plan, had in-serviced staff member involved- along with other nursing staff after incident which was prior to complaint survey initiated). R1 nor responsible party attended care plan meetings even though invited, but did discuss goals/wishes other times. Both R1 and resp. party's goal was for resident to remain as independent as possible, and facility provided interventions for keeping resident at highest level of fcn while also addressing safety concerns/risks. Along with having no previous history of falls from transfers, care plan interventions include number of staff, physical/psychosocial/mental risk factors, strengths/weaknesses, and there were no significant changes in resident's condition prior to fall/discharge. (FYI-other fractures as mentioned in 2567, occurred prior to placement at facility. R1's statement regarding how fell had to referring to events/placement prior to this facility as statement made by R1's fall did not occur in way described to surveyor). In addition the 2567 did note other Care plans/assessments performed revealed that resident was to be transferred with 1-2 assist. R1 had a lift chair and used one transfer most of day except may use 2 regardless based on either the staff member or R1. CP already included for 2assist based on various other conditions for staff to use if needed based on the staff/ R1's condition (was able to vocalize if extra tired/pain/etc). Did not change coding as RAI guidelines are to code highest level of staff used (we have two 12 hr shifts/day) regardless of reason as well as discharged before needing amended MDS.

#2- Residents with high risk for falls with variable number of assistance needed for transfers have potential to be affected by said practice. No other residents were identified as being affected from said practice. This was assured when at least 16 care plans and transfers were reviewed/monitored by state surveyors/IDT team along with reviewing residents that had high risk for falls/with many of those residents 1-2 staff /had previous falls during annual survey (same week as occurrence of sampled resident week of incident) that resulted in no findings of assessments/care plans/transfers, etc. In addition, IDT team reviewed assessments/ care plans of residents who were at high risk for falls/had falls along with being coded as 1-2 staff assistance to assess if any changes needed to be made. No other residents were affected by said practice as of compliance date. *During annual survey, transfers, care plans and assessments for multiple people were also reviewed with no deficient practices noted, even with staff member #1 along with multiple other staff/residents.

#3/4

Interdisciplinary team in-serviced by Administrator/D.O.N on 5/31/13 after survey exit to identify residents at high risk/ with recent falls to compare assessments against care plans to assure accuracy of information by reviewing assessments against care plans, etc for those coded as having had falls/high risk for falls and care planned as resident needing 1-2 for transfers. IDT team initiated process starting that evening and completed as of compliance date. Shall continue to review/change information with other residents ongoing with any change of condition, after falls, and when residents' RAI process is due. *Even for those residents not as described above with special circumstances. (ie: high risk for falls but have not had any, state only highest level number of staff members needed for transfer, etc).* In addition to the RAI/care plans assessed for sampled residents that surveyors reviewed, Care Plan team assured those Assessment and Care Plans updated/reviewed, included interventions for accuracy to ensure they adequately meet the needs of the residents as of 6/3/13, and ongoing when due with RAI process, significant change condition, or has a fall. Facility shall continue to discuss at morning clinical meetings any falls from previous business day along with weekly QI meetings, that includes both the I.D.T team as well as therapy. Plan of Care/charts are brought in for review and any changes needing to be made will be documented on weekly clinical meeting logs for internal QA process. (DON signature on MDS assessments shall be used during this 60 days as assuring monitoring for accuracy of ADL/transfer/interventions are correct as well vs. just to show completion date being done timely).

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At least 12 residents have had their Assessments checked along with Care Plans as of compliance date. In addition to when MDS/ Care Plans being updated/reviewed, including interventions, with RAI process as noted when due on calendar for completion as well as when a significant change in condition/fall, and with weekly clinical meetings for falls identified ongoing with DON/IDT to assist with documentation updates in plan of care.

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QA- Fall and Care Plan Policies reviewed and dated, Regulations for F280/323, interventions, survey issues were reviewed /discussed on 6/3/2013 by QA team /Medical Director and documented on QA attendance log with information discussed /reviewed. An additional QA follow up meeting was set to review checklists, assuring compliance with interventions based on scope/severity on 6/12/2013 which included information from annual survey that had no actual harm and additional tags at that time. (but 1st QA meeting on 6/3/2012 satisfied requirement prior to compliance date)

Audits and concerns with QI monitoring shall be discussed at next scheduled QI meeting to review outcomes as listed above and address any ongoing issues in addition to the weekly QI audits.

Date of Compliance: 6/4/2013

Person Responsible: Director of Nursing

**Plan of Correction/Allegation of Compliance for N219 Free of Accident Hazards/Supervision/Devices
Sampled Resident- R #1**

(Please note if no specific date noted, that interventions done and/or were repeated shall be considered as completed as of date of compliance listed at end of tag POC).

#1- Sampled resident R1- no longer resides in facility, was discharged prior to survey entrance. Care plan was updated after incident regardless in anticipation prior to being notified of discharge or even complaint survey. R1 also had a lift reclining chair when normally transferred to from w/c with one assist which is when this event occurred. Also, SRNA #1 was oriented and had transferred R1 on numerous occasions including entire day of assisting with lowering to floor during state annual survey.

SRNA#1 monitored and observed during resident care as of 5/23/13. Physical Therapy Services in-serviced/rein-serviced SRNA #1 individually regarding return demonstration stand/pivot transfers with gait belt use and proper technique on: 5/29/13 and 5/31/13, and 6/3/13 in addition to in-services given to nursing staff (CNA's, KMA's, Nurses).

#2- All residents with high risk for falls have potential to be affected by said practice. No residents identified have been affected by said practice by reviewing falls/incidents/hazards/supervision during morning meeting since date of compliance and reviewing/monitoring resident transfers/assessments/care

plans/staff supervision along with reviewing all the assessments against care plans as noted in the F280 POC regarding care planning/assessments reviewed.

#3/4- Interdisciplinary team in-serviced by Administrator/D.O.N on 5/31/13 after survey exit to identify residents at high risk/ with recent falls to compare assessments against care plans to assure accuracy of information by reviewing assessments against care plans, etc for those coded as having had falls/high risk for falls and care planned as resident needing 1-2 for transfers. IDT team initiated process starting that evening and completed as of compliance date. Shall continue to review/change information with other residents ongoing with any change of condition, after falls, and when residents' RAI process is due. *Even for those residents not as described above with special circumstances. (ie: high risk for falls but have not had any, state only highest level number of staff members needed for transfer, etc).* In addition to the RAI/care plans assessed for sampled residents that surveyors reviewed, Care Plan team assured those Assessment and Care Plans updated/reviewed, included interventions for accuracy to ensure they adequately meet the needs of the residents as of 6/3/13, and ongoing when due with RAI process, significant change condition, or has a fall. Facility shall continue to discuss at morning clinical meetings any falls from previous business day along with weekly QI meetings, that includes both the I.D.T team as well as therapy. Plan of Care/charts are brought in for review and any changes needing to be made will be documented on weekly clinical meeting logs for internal QA process. (DON signature on MDS assessments shall be used during this 60 days as assuring monitoring for accuracy of ADL/transfer/interventions are correct as well vs. just to show completion date being done timely).

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At least 12 residents have had their Assessments checked along with Care Plans as of compliance date (which are residents with high risk/had falls/and noted as using 1-2 with transfer assist. In addition to when MDS/ Care Plans being updated/reviewed, including interventions, with RAI process as noted when due on calendar for completion as well as when a significant change in condition/fall, and with weekly clinical meetings for falls identified ongoing with DON/IDT to assist with documentation updates in plan of care.

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Audits and concerns with QI monitoring shall be discussed at next scheduled QI meeting to review outcomes as listed above and address any ongoing issues in addition to the weekly QI audits

Date of Compliance: 6/4/13

Responsible: Administrator/ Director of Nursing