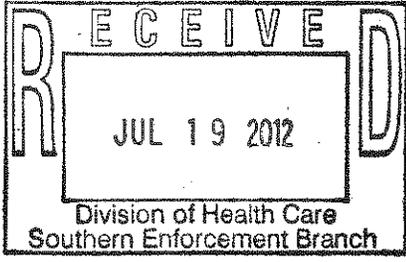


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/06/2012  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION            |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185270 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br>C<br>06/21/2012 |
| NAME OF PROVIDER OR SUPPLIER<br><br>CUMBERLAND VALLEY MANOR |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>301 S MAIN STREET, PO BOX 438<br>BURKESVILLE, KY 42717                 |   |
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| F 000   | INITIAL COMMENTS<br><br>An abbreviated standard survey (KY18495) was initiated on 06/19/12 and concluded on 06/21/12. The complaint was substantiated. Deficient practice was identified with the highest scope and severity at "G" level, with an opportunity to correct.   | F 000  | <i>See Attached:</i>  |   |
| F 157<br>SS=G   | 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)<br><br>A facility must immediately inform the resident, consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).<br><br>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.<br><br>The facility must record and periodically update | F 157  |   |   |



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE Jul 16, 2012

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.

Received Time Jul. 19. 2012 1:18PM No. 9417

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| F 157  | <p>Continued From page 1</p> <p>the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, interview, record review, policy review, and review of the facility investigation it was determined the facility failed to ensure the physician was notified when one of three sampled residents (Resident #2) experienced a change of condition and decline in function after a fall. On 03/27/12, Resident #2 was ambulating, unassisted, from the bed and sustained a fall. The facility notified the resident's physician of the fall and an x-ray was obtained of the resident's pelvis, sacrum, and coccyx which revealed no evidence of fractures. However, Resident #2 suffered pain and a decrease in function following the fall, from 03/28/12 through 04/03/12, a timeframe of seven days, and the physician was not notified of the change in the resident's condition. On 04/03/12, following a radiology examination, Resident #2 was diagnosed to have a fractured pelvis.</p> <p>The findings include:</p> <p>A review of the facility's policy "Physician/Legal Representative Notification," dated June 2003, revealed the facility was required to inform the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status, e.g., deterioration in health, mental, psychosocial status in either life threatening conditions or clinical complications.</p> <p>A review of Resident #2's medical record</p> | F 157   |   |                      |   |

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| F 157   | <p>Continued From page 2</p> <p>revealed the facility admitted the resident on 01/06/12, with diagnoses to include Aftercare Traumatic Fracture of the Right Hip, Anxiety, and Alzheimer's Disease. In addition, the resident was receiving Physical Therapy and Occupational Therapy.</p> <p>A review of an "Event Report Investigation" for Resident #2 revealed on 03/27/12, at 5:03 AM, the resident's personal alarms sounded and, upon entering the resident's room, Licensed Practical Nurse (LPN) #1 found the resident lying on the floor on his/her back. The report revealed the resident hit his/her head and was complaining of hip pain. Based on documentation in the report, the resident experienced no obvious trauma but staff was unable to perform range of motion to assess Resident #2 due to his/her complaints of pain in the right hip/leg area. The report revealed the resident's physician was notified of the fall and the physician requested the resident be transported to the hospital for a radiology examination. A review of a hospital report dated 03/27/12, revealed Resident #2 had fallen at the facility and complained of pelvic pain. An x-ray of the resident's pelvis, sacrum, and coccyx was obtained and revealed no evidence of a fracture.</p> <p>Continued review of Resident #2's medical record revealed physician's orders dated March 2012 and April 2012 for the resident to receive 650 milligrams (mg) of Tylenol (non-opioid analgesic) every four hours as needed for mild to moderate pain. In addition, the physician's orders revealed facility staff could administer 500 mg of Lortab (analgesic) to Resident #2 every eight hours as needed for moderate to severe pain. A review of</p> | F 157  |   |   |

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| F 157  | <p>Continued From page 3</p> <p>Resident #2's medication administration record (MAR) revealed the resident had not requested the pain medication during the month of March until the day of the fall on 03/27/12 and, based on documentation, from 03/27/12 through 04/03/12, the resident received the prescribed Tylenol ten times for mild to moderate pain. Further review of the MAR revealed Resident #2 had not received the prescribed Lortab during the month of March until the day of the fall on 03/27/12 and, based on documentation, from 03/27/12 to 04/03/12, Resident #2 received Lortab for pain three times.</p> <p>A review of Resident #2's Physical Therapy (PT) plan of care, updated 03/05/12, revealed the resident had shown progress in all areas of care, demonstrated improved transfer and gait status, and ambulated with the assistance of one staff person. A review of PT progress notes dated 03/20/12 through 03/26/12, revealed Resident #2 had met the short-term goal to perform transfers from bed to chair with assistance of one person, and to propel self in the wheelchair to meals with verbal cues and supervision. The therapist's written summary revealed the resident continued to participate well, showed progress toward treatment, and required the assistance of one for transfer from bed to chair. Continued review of documentation revealed an updated Physical Therapy plan of care dated 04/03/12, which revealed the resident experienced a fall on 03/27/12, and was transported for x-rays, with no fracture noted. According to the plan of care, the resident had been extremely sore with reported pain levels of 9 out of 10 on the pain scale, had experienced a decline in status with greater assistance required with transfers and</p> | F 157   |   |                      |   |

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| F 157   | <p>Continued From page 4</p> <p>ambulation, and noted that although the resident was improving daily he/she had not returned to the level of the resident's previous function.</p> <p>An interview conducted with Physical Therapist (PT) #1 on 06/21/12, at 12:14 PM, revealed Resident #2 had been admitted to the facility for rehabilitation following a fracture. According to the therapist, the resident had improved and had shown progress toward mobility and functional status until after the fall sustained on 03/27/12. The therapist stated Resident #2 had increased pain and complained of stiffness and soreness after the fall and had experienced a decline in status. Further interview revealed the PT informed the resident's nurse during the week of 03/26/12 to 04/03/12, of the increase in pain and decline in function. PT #1 acknowledged that she had not called Resident #2's physician to inform him of the increase in pain and decline in function. PT #1 also stated prior to the resident's fall, Resident #2 was transferred with the assistance of one staff person and ambulated with minimal to moderate assistance of one staff person. PT #1 stated after Resident #2 sustained the fall on 03/27/12, Resident #2 required the maximum assistance of two staff members for ambulation.</p> <p>Interview with Certified Nursing Assistant (CNA) #1 on 06/21/12, at 11:37 AM, revealed after Resident #2's fall on 03/27/12, the resident was "hurting really bad." CNA #1 further stated Resident #2 was no longer able to assist staff with activities of daily living and would hold her/his side when staff assisted the resident with such things as transferring from the bed. CNA #1 stated she reported the resident's condition to the</p> | F 157  |   |   |

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| F 157  | <p>Continued From page 5</p> <p>nurse or medication technician and they gave Resident #2 Tylenol for pain.</p> <p>Interview with CNA #2 on 06/21/12, at 11:38 AM, revealed after Resident #2 experienced the fall on 03/27/12, the resident could no longer get out of bed. CNA #2 stated staff had to perform complete bed baths instead of taking the resident to the bathtub and Resident #2 required the assistance of two staff persons after the fall. CNA #2 further stated prior to the fall, Resident #2 was going to therapy, walking up and down the hall, and "doing well."</p> <p>On 04/03/12, Resident #2 had a follow-up appointment with a physician for evaluation of a previous right femoral neck fracture (right hip fracture). A review of the physician's evaluation dated 04/03/12, revealed the physician conducted a follow-up examination of Resident #2 related to the previous right femoral neck fracture (right hip fracture) and based on documentation the physician also noted the resident had sustained a fall, a week prior to the visit, and had experienced pain in the groin area since the fall. An x-ray was obtained on 04/03/12, and revealed Resident #2 had a right inferior pubic rami fracture (a fracture of the right pelvic bone).</p> <p>Interview with Registered Nurse (RN) #1 on 06/21/12, at 11:17 AM, revealed Resident #2 experienced increased pain the week after the fall on 03/27/12, and would hold her/his side when assisted. RN #1 further stated she "kept questioning" the x-ray taken on 03/27/12, that revealed no fracture. Interview further revealed RN #1 could not remember if Resident #2's physician had been notified of the resident's</p> | F 157   |   |                      |   |

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| F 157  | Continued From page 6<br>increased pain and decrease in function.<br><br>Interview with Resident #2's physician on 06/21/12, at 11:15 AM, revealed the physician could not remember if facility staff had contacted him after the resident had sustained the fall on 03/27/12, to inform him of Resident #2's increased complaints of pain and functional decline. Further interview revealed the facility staff would routinely fax him any updates or notes on residents, he would write and sign an order if needed, and fax the order back to the facility. The physician was not able to find notification from the facility related to a change in the resident's condition after the resident's fall on 03/27/12. The physician further stated he would expect facility staff to notify him of a resident's increase in pain and functional decline. | F 157   |   |   |
| F 281<br>SS=D  | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, and review of facility policy it was determined the facility failed to follow physician's orders for one of three sampled residents (Resident #1). Resident #1 did not receive the 9:00 PM medications as prescribed by the physician.<br><br>The findings include:<br><br>A review of the facility policy, "Medications, Administration", dated 07/16/00, revealed   | F 281   |   |   |

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| F 281  | Continued From page 7<br>designated staff members were required to provide medications in accordance with physician's orders, and to document on the resident's medication sheet any failure to administer medications and/or the refusal of the resident to take medications, regardless of the reason.<br><br>A review of Resident #1's physician's orders for June 2012 revealed a physician's order for the resident to receive two 10 milligram (mg) tablets of Namenda (central nervous system drug) at bedtime; one 25 mg tablet of Seroquel (antipsychotic) at bedtime, and 50 mg of Zoloft (antidepressant) at bedtime.<br><br>Although a review of Resident #1's medication administration record (MAR) for June 2012 revealed Medication Technician (MT) #1 administered Namenda, Seroquel, and Zoloft on 06/07/12, at 9:00 PM to Resident #1, interview with MT #1 on 06/19/12, at 7:24 PM, revealed he had failed to administer the medications. According to MT #1, he had prepared medications Namenda, Seroquel, and Zoloft for Resident #1 and prior to giving the medications he had been called away from the medication cart to assist another staff member with another resident. MT #1 stated he put the medications in the cup and locked them in the medication cart and forgot to give the medications to Resident #1 after assisting the other staff member. | F 281   |   |                      |   |
| F 282<br>SS=G  | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of   | F 282   |   |                      |   |

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| F 282  | <p>Continued From page 8 care.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on interview, record review, and review of the facility's investigation, it was determined the facility failed to ensure services were provided in accordance with the written plan of care for two of three sampled residents (Residents #1 and #2). A review of Resident #1's plan of care revealed the resident had been assessed to require the use of foot pedals on the wheelchair. However, on 04/25/12, Certified Nursing Assistant (CNA) #3 failed to apply foot pedals to Resident #1's wheelchair and Resident #1 fell out of the wheelchair and hit his/her head on the floor. Resident #1 was later transported to the hospital and diagnosed with a fracture of the spine. In addition, Resident #2's plan of care indicated the resident required the use of an alarm to the wheelchair when the resident was in the wheelchair. On 04/29/12, Resident #2 was seated in a wheelchair in the chapel of the facility and staff left the resident without staff supervision. Documentation revealed Resident #2 stood up out of the wheelchair and attempted to take a step before falling to the ground. It was discovered the alarm on Resident #2's wheelchair was not plugged in and therefore was not working at the time of the fall. Resident #2 did not suffer any injuries due to the fall.</p> <p>The findings include:</p> <p>Interview with the Facility Compliance Officer on 06/21/12, at 5:48 PM, revealed the facility did not have a policy on care plans and stated resident</p> | F 282   |   |                      |   |

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| F 282   | <p>Continued From page 9</p> <p>care plans were updated with each Minimum Data Set (MDS) update and as needed.</p> <p>1. A review of Resident #1's medical record revealed the facility admitted the resident on 01/15/12. Resident #1's diagnoses included Late Effect Stroke, Alzheimer's Disease, Dementia with Depression, Psychosis, and Anxiety.</p> <p>A review of Resident #1's plan of care revealed facility staff assessed Resident #1 on 01/18/12, to have an alteration in mobility related to the risk for falls and a diagnosis of late effect stroke and arthritis. Documentation in the plan of care revealed Resident #1 required extensive assistance with bed mobility, transfers, locomotion on/off unit, was nonambulatory, and was a high risk for falls. Continued review of the plan of care revealed a foot rest was to be used on Resident #1's wheelchair and was to be kept at the nurses' station while not in use. In addition, the plan of care revealed Resident #1 and staff were to be instructed on the appropriate use of assistive/supportive devices.</p> <p>A review of Resident #1's Quarterly Minimum Data Set (MDS) assessment dated 04/03/12, revealed the facility assessed Resident #1's cognition to be moderately impaired. The assessment revealed the resident had upper extremity impairment, used a wheelchair, required extensive assistance of two for transfers, and extensive assistance of one for locomotion to areas off the unit, such as the dining room. In addition, documentation revealed the resident had experienced two falls since the prior assessment that resulted in no injuries.</p> | F 282  |   |                      |   |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>CUMBERLAND VALLEY MANOR</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>301 S MAIN STREET, PO BOX 438</b><br><b>BURKESVILLE, KY 42717</b>   |                      |   |
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| F 282  | <p>Continued From page 10</p> <p>A review of an "Event Report Investigation" for Resident #1 revealed on 04/25/12, at 11:15 AM, Resident #1 sustained a fall from the wheelchair. According to the report, Resident #1 was seated in a wheelchair and CNA #3 was pushing the resident's wheelchair to the dining room when the resident put his/her feet down on the floor causing the wheelchair to tip and the resident fell forward to the floor. The resident was assessed to have a slightly swollen and darker right eye. Further review of the investigation revealed Resident #1 had a physician's order for foot pedals to be placed on the wheelchair when staff was assisting the resident in the wheelchair.</p> <p>Interview with CNA #3 on 06/20/12, at 12:55 PM, revealed Resident #1 was a high risk for falls due to previous falls. CNA #3 stated each resident's care plan stated what interventions facility staff was to put into place to prevent falls, and each resident's care plan was "back there to look at." CNA #3 stated she was pushing Resident #1 in the wheelchair to the dining room on 04/25/12, and Resident #1 put his/her feet down on the floor while the wheelchair was moving. CNA #3 stated the resident was wearing non-skid diabetic shoes and when he/she put the shoes on the floor, he/she fell out of the wheelchair. CNA #3 stated she attempted to stop the resident from falling out of the wheelchair by holding the resident's shoulders, but failed to prevent the fall. Interview further revealed Resident #1 did not have foot pedals on the wheelchair at the time of the fall. CNA #3 stated "honestly" she "didn't know [Resident #1] had them, had never seen [the pedals] on [his/her] wheelchair, didn't know [the pedals] was on the care plan till after" the fall occurred. According to CNA #3, she knew</p> | F 282   |   |                      |   |

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| F 282  | <p>Continued From page 11</p> <p>Resident #1 had foot pedals for the wheelchair previously but was not aware the resident still required the use of the foot pedals.</p> <p>Interview with RN #1 on 06/20/12, at 8:45 AM, revealed she was sitting at the nurses' desk on 04/25/12, when she heard someone say "oh no" and when she looked up over the desk Resident #1 was falling out of the wheelchair. RN #1 stated CNA #3 attempted to hold the resident's shoulders to prevent the fall but was unsuccessful and Resident #1 continued to fall and landed on the upper body with the head on the floor. RN #1 further stated there were no foot pedals on Resident #1's wheelchair at the time of the fall.</p> <p>A review of the hospital record dated 04/25/12, revealed Resident #1 was diagnosed with a C1 ring (part of the cervical spine) fracture and a fracture of the odontoid process (part of the cervical vertebrae).</p> <p>2. A review of Resident #2's medical record revealed the facility admitted the resident on 01/06/12, with diagnoses to include Aftercare Traumatic Hip Fracture, Anxiety, and Alzheimer's Disease. The resident was also to receive physical and occupational therapy.</p> <p>A review of Resident #2's plan of care dated 01/19/12, revealed the resident had an alteration in mobility related to a history of falls and diagnosis of Aftercare Traumatic Fracture of the Hip. According to the plan of care, Resident #2 required assistance from staff with bed mobility, transfers, ambulation, and locomotion. The facility had assessed the resident to require an alarm on the wheelchair at all times as an</p> | F 282   |   |                      |   |

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| F 282  | <p>Continued From page 12 approach to prevent falls.</p> <p>A review of the facility's investigation, including the Event Report dated 04/29/12, revealed on 04/29/12, Resident #2 was in the chapel, left unattended by staff, and attempted to stand from the wheelchair and take a step when the resident fell to the floor. Further review of the fall investigation revealed the alarm on the wheelchair did not sound when the resident stood up from the wheelchair. Documentation on the report revealed the personal alarm had not been properly connected to the resident's wheelchair at the time of the resident's fall.</p> <p>Interview with CNA #5 on 06/20/12, at 11:40 AM, revealed the CNA had assisted Resident #2 into the wheelchair prior to the resident being transported to the chapel on 04/29/12. CNA #5 stated when the resident was assisted out of bed and into the wheelchair, the alarm on the bed and the floor alarm were sounding, and when she turned around to turn the alarms off, another staff member left the room with Resident #2 in the wheelchair. CNA #5 stated she did not check to ensure the wheelchair alarm was plugged in and properly working before the facility staff left the room with the resident. However, CNA #5 stated she was aware Resident #2 required the use of an alarm on the wheelchair to prevent falls.</p> <p>Interview with Certified Nursing Assistant (CNA) #4 on 06/20/12, at 11:21 AM, revealed interventions that were required to be put in place to assist residents and prevent falls were listed on each resident's plan of care. CNA #4 further stated she had been educated by the facility on falls. Interview with CNA #4 further revealed on</p> | F 282   |   |                      |   |

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| F 282  | Continued From page 13<br>04/29/12, the CNA was assisting residents from the chapel and to their rooms. CNA #4 reported she was walking back to the chapel to assist more residents when she observed visitors that had been in the chapel standing in the hallway stating a resident had fallen. CNA #4 stated she observed Resident #2 lying on the floor of the chapel and although there was an alarm on the wheelchair the alarm was not sounding. CNA #4 stated she had not checked the alarm since other staff members had brought the resident into the chapel and the CNA assumed the staff would have ensured the alarm was working when the resident was assisted into the wheelchair.<br><br>Interview with the Restorative Coordinator on 06/20/12, at 2:54 PM, revealed it was the responsibility of the CNA who transported Resident #2 into the chapel to ensure the alarm was working properly prior to leaving the resident in the chapel. The Restorative Coordinator further stated the Restorative Department was responsible for checking each resident's alarm one time a day. CNAs who worked on the floor were responsible for ensuring all alarms were in place and functioning properly prior to leaving the resident and every two hours throughout the day. | F 282   |   |                      |   |
| F 309<br>SS=G  | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.   | F 309   |   |                      |   |

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| F 309   | Continued From page 14<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, and a review of the facility policy it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, psychosocial well-being for one of three sampled residents (Resident #2). Resident #2 experienced a fall on 03/27/12; an x-ray that same day revealed no fractures. However, from 03/27/12 to 04/03/12, the resident experienced an onset of pain and a decline in functional ability. Facility staff failed to evaluate Resident #2's pain to determine the cause and characteristics of the pain and factors that influenced the pain. On 04/03/12, seven days after the resident sustained the fall, a second x-ray revealed the resident had a right pelvic fracture. According to the resident's physician, it was not uncommon for a fracture not to show on the first x-ray due to swelling.<br><br>The findings include:<br><br>A review of the facility's "Pain Management" policy and procedure, not dated, revealed all residents would be assessed for their level of pain and the effectiveness of pain management therapy would be monitored. In addition, the policy revealed staff was to conduct a Clinical Pain Assessment of all residents upon admission, quarterly, and with any significant change in their behavior or activity level. According to the policy, if staff identified a resident had issues and/or met certain criteria, such as use of "as needed" pain medications which required the assessment of the severity of pain, staff was to implement an | F 309  |   |                      |   |

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| F 309   | <p>Continued From page 15</p> <p>electronic pain management record. The policy revealed staff was also to conduct observations on each shift, and as needed, of the resident's level of pain and cognition.</p> <p>A review of Resident #2's medical record revealed the facility admitted the resident on 01/06/12, with diagnoses of Aftercare for Traumatic Hip Fracture, Anxiety, and Alzheimer's Disease. The resident was also receiving physical and occupational therapy. A review of the resident's admitting Minimum Data Set (MDS) dated 01/13/12, revealed facility staff assessed Resident #2 to require extensive assistance of two staff persons for bed mobility, transfers, and when walking in the room. Further review revealed prior to admission the resident had a history of falls with fracture. Continued review of the MDS revealed the resident had indicated during the five days prior to the date of the assessment completed on 01/13/12, that the resident had not experienced pain that made it difficult to sleep and indicated that "mild" pain had limited the resident's day to day activities. A review of a quarterly MDS dated 04/02/12, revealed under the pain assessment the resident had not received a scheduled pain medication, an as needed pain medication, or a non-medication intervention for pain in the five days prior. When asked if the resident had pain or any hurting in the last five days according to the MDS the resident responded no. However, review of Resident #2's Medication Administration Record revealed the resident did receive pain medication the five days prior to the completion of the MDS.</p> <p>A review of the plan of care developed by facility staff for Resident #2 and dated 01/18/12,</p> | F 309  |   |                      |   |

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| F 309   | <p>Continued From page 16</p> <p>revealed staff assessed the resident to have a "problem" area related to pain and developed interventions which included to evaluate the resident's pain in accordance with facility policy, administer pain medications as ordered, and evaluate the effectiveness of the pain medication.</p> <p>A review of a facility investigation, including an "Event Report" revealed on 03/27/12, facility staff heard Resident #2's safety alarms sounding and upon entering the resident's room observed the resident lying on the floor on his/her back. Resident #2 reported he/she hit her/his head and was having hip pain. Documentation revealed facility staff was unable to perform range of motion due to the resident's complaints of right hip/leg pain. Based on documentation, Resident #2 was sent to the hospital on 03/27/12, for evaluation and according to documentation dated 03/27/12, an x-ray was obtained and revealed no evidence of a fracture.</p> <p>A review of Resident #2's clinical pain assessment dated 03/30/12, revealed staff assessed the resident's pain during the five days (03/25/12 through 03/29/12) prior to the assessment date, and noted the resident had experienced pain almost constantly, which made it difficult for the resident to sleep at night, and limited the resident's day to day activities. The resident reported the pain was located in the right hip/back area and the resident described the pain as "sharp," "dull", "shooting," and "aching." In addition, the resident reported sitting down made the pain less intense, while walking/lying made the pain worse. Facility staff also assessed the resident's nonverbal indications of pain such as crying, whining, gasping, moaning, or groaning,</p> | F 309  |   |   |

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| F 309  | <p>Continued From page 17</p> <p>and facial expressions such as grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth; or jaw. Documentation revealed staff also observed during the five day look back period physical indications of the resident's pain such as protective body movements and/or postures (such as bracing, guarding, rubbing, or massaging a body part/area, clutching or holding a body part during movement). Continued review of the assessment revealed the resident should be repositioned often, have frequent rest periods with activity, Tylenol/Lortab was to be administered "as needed," and staff was to contact the resident's physician with an increase in the resident's pain or pain that was not relieved with the administration of the "as needed" medications.</p> <p>A review of a pain roster established by facility staff to monitor Resident #2's pain revealed Resident #2 had been assessed for pain 78 times from 03/01/12 through 03/26/12, and prior to the resident's fall on 03/27/12, and the resident had only reported pain 6 of the 72 times. However, documentation on the pain assessment roster from the time of the resident's fall on 03/27/12 and through 04/03/12, revealed facility staff had assessed Resident #2 26 times for pain and the resident had reported pain on 9 occasions. In addition, a review of Resident #2's Medication Administration Record (MAR) revealed the resident had not requested the prescribed pain medication during the month of March until the day of the fall on 03/27/12, and based on documentation, from 03/27/12 through 04/03/12, the resident received the prescribed Tylenol ten times for mild to moderate pain. Further review of the MAR revealed Resident #2 had not</p> | F 309   |   |                      |   |

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| F 309   | <p>Continued From page 18</p> <p>received the prescribed Lortab during the month of March until the day of the fall on 03/27/12, and based on documentation, from 03/27/12 to 04/03/12, Resident #2 received Lortab for pain three times.</p> <p>A review of a Physical Therapy updated plan of care dated 04/03/12, revealed Resident #2 experienced a fall on 03/27/12, and was transported to the hospital for an x-ray which revealed no evidence of a fracture. Documentation by Physical Therapist #1 revealed the resident had been extremely sore with a reported pain level of 9 out of 10. In addition, based on documentation in the therapist's notes, Resident #2 experienced a decline in status with greater assistance required with transfers and ambulation.</p> <p>Documentation in the medical record revealed Resident #2 experienced a decline in condition and an increase in pain after the fall sustained on 03/27/12. However, a review of nursing notes and physician's orders from 03/27/12 (the day of the fall) through 04/03/12, revealed no documentation that Resident #2's physician had been notified of Resident #2's increase in pain, requirement of pain medication daily, or the decline in the resident's function. While review of the medical record revealed facility staff assessed Resident #2's pain level and location of the pain prior to administering pain medication, there was no documentation that facility staff was attempting to find the origin of the pain and reason for the decline in function.</p> <p>Interview with Physical Therapist (PT) #1 on 06/21/12, at 12:14 PM, revealed since the</p> | F 309  |   |                      |   |

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| F 309  | <p>Continued From page 19</p> <p>resident was admitted on 01/06/12, Resident #2 had displayed progress related to mobility and functional status. The PT stated Resident #2 experienced an increase in pain, complaints of stiffness and soreness, and experienced a decline from the fall on 03/27/12 until the diagnosis of a right pelvic fracture on 04/03/12. Further interview revealed the PT informed the resident's nurse during the week of 03/26/12 to 04/03/12, of the increase in pain and decline in function. PT #1 acknowledged that she had not called Resident #2's physician to inform him of the increase in pain and decline in function.</p> <p>Interview with Registered Nurse (RN) #1 on 06/21/12, at 11:17 AM, Certified Nursing Assistant (CNA) #1 on 06/21/12, at 11:37 AM, and CNA #2 on 06/21/12, at 11:38 AM, revealed they had observed Resident #2 experience an increase in pain and a decline in function after Resident #2's fall on 03/27/12. CNA #1 stated Resident #2 was "hurting really bad" after the fall on 03/27/12, and had a decline in his/her abilities such as getting out of bed. CNA #1 stated she informed the nurses and they administered pain medication to the resident. CNA #2 stated after the fall on 03/27/12, staff was no longer able to get Resident #2 from the bed into the bathtub; facility staff had to perform bed baths each day. CNA #2 stated prior to the fall Resident #2 had been ambulating in the hall, "doing well," and after the fall the resident was a total assist of two staff persons. In addition, RN #1 stated she kept "questioning" while talking to other facility staff the x-ray which indicated no fracture. RN #1 further stated after the resident's fall on 03/27/12, when staff assisted Resident #2 to a standing position, the resident would hold his/her side. RN #1 stated</p> | F 309   |   |                      |

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| F 309  | <p>Continued From page 20</p> <p>she could not remember if she contacted Resident #2's physician between 03/27/12 and 04/03/12, related to the increase in pain and decline in function.</p> <p>Interview with Resident #2's family member on 06/20/12, at 4:00 PM, revealed the resident was admitted to the facility for rehabilitation after a fall at home that resulted in a right hip fracture. In addition, the family member stated the resident fell on 03/27/12, at the facility and was sent to the hospital for an x-ray which revealed no evidence of a fracture. According to the family member, during the week following the fall, Resident #2 experienced an increase in pain and went from ambulating in the hall with assistance of one staff person to not ambulating at all. The family member stated she had spoken to the physical therapist during the week of 03/27/12 to 04/03/12, and was told if Resident #2 did not start showing improvement and a decrease in pain, the facility would "need to do something." Further interview revealed the resident's family member accompanied Resident #2 to a previously scheduled appointment to the resident's orthopedic surgeon on 04/03/12, to follow up from the right hip fracture that had occurred prior to admission. The resident's family member stated he/she informed the surgeon of the resident's fall on 03/27/12, and the increase in pain and decrease in function. According to the family member, the surgeon performed another x-ray and diagnosed Resident #2 with a fractured right pelvic bone.</p> <p>A review of an evaluation from Resident #2's follow-up visit on 04/03/12, with the orthopedic surgeon revealed the resident fell about a week</p> | F 309   |   |                      |   |

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| F 309   | Continued From page 21<br>ago and had experienced pain in the groin area, difficulty standing, and a hard time walking since the fall. Further review revealed an x-ray was taken on 04/03/12, which showed a right inferior pubic rami (a part of the pelvic bone) fracture.<br><br>Interview with Resident #2's attending physician on 06/21/12, at 5:00 PM, revealed the physician could not recall if the facility staff had informed him the resident experienced an increase in pain and/or a decline in physical functioning after the fall sustained on 03/27/12. The resident's attending physician stated that facility staff would either call or fax him regarding reports or updates of resident conditions and would usually fax him a form with any information he needed to be aware of regarding the residents. The attending physician stated he was unable to find any faxed information from facility staff related to the resident's increase in pain and decline in function after the fall sustained on 03/27/12. Interview further revealed it was not uncommon for a fracture to not show up on the first x-ray. The physician stated sometimes it takes time for the swelling to go down and the fracture to show up on the x-ray. | F 309  |   |                      |   |
| F 323<br>SS=G   | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  | F 323  |   |                      |   |

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| F 323  | <p>Continued From page 22</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, interview, record review, policy review, and review of the facility's investigation, it was determined the facility failed to ensure adequate supervision and assistive devices were provided to prevent accidents for one of three sampled residents (Resident #1). Resident #1 was assessed by facility staff to be at risk for falls, and facility staff had developed a care plan for the resident that included the use of foot pedals to the resident's wheelchair. On 04/25/12, staff failed to ensure the foot pedals were in place on the resident's wheelchair and the resident sustained a fall from the wheelchair when staff was wheeling the resident to the dining room. A review of documentation revealed Resident #1 was diagnosed with a fracture of the vertebrae as a result of the fall.</p> <p>The findings include:</p> <p>A review of the facility's policy, "Falling Stars" (not dated) revealed a fall risk assessment was required to be completed on all residents upon admission, quarterly, when a change of status occurred, and after a fall. The policy indicated if a resident scored "high risk" the resident would be placed on the "Falling Stars" program and staff would be alerted to the resident's status and the need for possible interventions by a "gold star" placed on the resident's door. Continued review of the policy revealed it was the responsibility of all staff members to monitor all residents assessed to be in the "Falling Star" program and that all falls would be addressed and investigated for any/all factors by the interdisciplinary team.</p> | F 323   |   |                      |   |

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| F 323   | <p>Continued From page 23</p> <p>According to the policy, if a resident experienced a fall an assessment and updated interventions would be discussed and documented by the interdisciplinary team or fall prevention team. In addition, the policy indicated residents in the "Falling Star" program were to be monitored closely when transferring from one surface to another, ambulating or attempting to ambulate, attending activities, and standing up after they had been sitting or lying down for a while.</p> <p>A review of Resident #1's medical record revealed the facility admitted the resident on 01/15/12, with diagnoses that included Late Effect Stroke, Alzheimer's Disease, Dementia with Depression, Psychosis, and Anxiety.</p> <p>A review of Resident #1's plan of care with a date of 01/18/12, revealed facility staff assessed Resident #1 on 01/18/12, to have an alteration in mobility related to the risk for falls and diagnoses of Late Effect Stroke and Arthritis. Based on the plan of care, Resident #1 required extensive assistance with bed mobility, transfers, locomotion on/off the units, and was nonambulatory and a high risk for falls. The plan of care revealed a foot rest was to be used on Resident #1's wheelchair and was to be kept at the nurses' station while not in use, and staff was to be instructed on the appropriate use of assistive/supportive devices. A review of the Certified Nurse Aide (CNA) care plan for April 2012 also revealed the resident was to have a wheelchair foot rest on the wheelchair and the foot rest was to be kept at the nurses' desk when the wheelchair was not in use. In addition, a review of Resident #1's physician's orders for April 2012 revealed an order for a wheelchair foot</p> | F-323  |   |                      |   |

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| F 323   | <p>Continued From page 24 rest.</p> <p>A review of a fall risk assessment dated 04/02/12, revealed Resident #1 had an assessment score of 100 and was at risk for falls. According to the fall risk assessment a score of 65 or greater meant the resident was at a high risk for falls.</p> <p>A review of Resident #1's Quarterly Minimum Data Set (MDS) assessment dated 04/03/12, revealed the facility assessed Resident #1 to be moderately cognitively impaired. Further review of the assessment revealed the resident required extensive assistance of two staff persons for transfers and the extensive assistance of one for locomotion to areas off the unit, such as the dining room. Further review revealed the resident was assessed to have upper extremity impairment, used a wheelchair, and had experienced two falls since the prior assessment that resulted in no injuries.</p> <p>A review of the facility "Event Report Investigation" revealed on 04/25/12, at 11:15 AM, Resident #1 sustained a fall from the wheelchair. According to the report, Resident #1 was seated in a wheelchair and CNA #3 was pushing the resident's wheelchair to the dining room when the resident put his/her feet down on the floor causing the wheelchair to tip and the resident fell forward to the floor. The resident was noted with a slightly swollen and darker right eye. Continued review of the investigation revealed Resident #1 had a physician's order for foot pedals to be placed on the wheelchair when staff was assisting the resident in the wheelchair. Further review of the investigation revealed CNA #3 received a verbal warning for not following the</p> | F 323   |   |   |

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| F 323  | <p>Continued From page 25</p> <p>resident's plan of care by not having the foot pedals on the wheelchair when she wheeled the resident in the wheelchair to the dining room.</p> <p>Interview with CNA #3 on 06/20/12, at 12:55 PM, revealed Resident #1 was a high risk for falls due to previous falls. CNA #3 stated each resident's care plan stated what interventions facility staff had put into place to prevent falls, and each resident's care plan was "back there to look at." CNA #3 stated she was pushing Resident #1 in the wheelchair to the dining room on 04/25/12, and the resident put his/her feet on the floor while being wheeled. According to CNA #3, Resident #1 had non-skid shoes on and when he/she put his/her feet down while being wheeled, the wheelchair tipped and the resident fell to the floor. CNA #3 further stated she tried to stop the resident from falling out of the wheelchair by holding his/her shoulders but could not keep the resident from hitting the floor. Interview further revealed Resident #1 did not have foot pedals on the wheelchair at the time of the fall. CNA #3 stated "honestly" she "didn't know [Resident #1] had them, had never seen [the pedals] on [his/her] wheelchair, didn't know [the pedals] was on the care plan till after" the fall occurred. CNA #3 further stated Resident #1 had foot pedals for the wheelchair previously but was not aware the resident still required the use of the foot pedals.</p> <p>Interview with the Restorative Coordinator on 06/20/12, at 2:45 PM, revealed Resident #1 was assessed to require the wheelchair foot pedals when staff was transporting the resident in the wheelchair. The Coordinator stated Resident #1 wheeled him/herself at times and there was a possibility the resident would get his/her feet</p> | F 323   |   |                      |   |

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| F 323  | <p>Continued From page 26</p> <p>caught in the foot pedals and fall, and it had been decided the foot pedals were to be kept at the nurses' desk when staff was not transporting the resident. According to the Restorative Coordinator, facility staff was to place the foot pedals on the wheelchair when they assisted the resident in the wheelchair and acknowledged CNA #3 failed to place the foot pedals on at the time of the fall on 04/25/12.</p> <p>Interview with Resident #1 on 06/21/12, at 2:41 PM, revealed staff did not offer to put the foot pedals on the wheelchair the day the resident fell. Resident #1 stated facility staff was pushing the resident in the wheelchair to the dining room when the resident put his/her feet down and fell out of the wheelchair. The resident further stated he/she did not need the foot pedals on the wheelchair and facility staff never attempted to the put the pedals on the wheelchair.</p> <p>A review of the hospital record dated 04/25/12, revealed Resident #1 was diagnosed with a C1 ring (part of the cervical spine) fracture and a fracture of the odontoid process (part of the cervical vertebrae).</p> | F 323   |   |                      |   |

**Plan of Action  
Cumberland Valley Manor  
Complaint Survey 06/21/2012**

**Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.**

**F 157          Physician Notification**

**A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility as specified in 483.12(a).**

**Criteria 1:**    The physician and family have been updated by the DON on the pain and ADL status for Resident #2.

**Criteria 2:**    The 24 hour reports for the last 30 days have been reviewed by the DON/ADON to determine that the physician and family have been notified of residents identified with changes in pain and/or ADL status.

**Criteria 3:**    Facility RN's and LPN's have received inservice education on the need to immediately inform the physician and family of resident changes, including but not limited to changes in pain and ADL status, and to document this notification, as provided by the DON and ADON on 06/22/12

**Criteria 4:**    -The CQI indicator for the monitoring of physician and family notification of changes will be utilized monthly X 2 months and then quarterly under the supervision of the DON.

-The DON/ADON will review the 24 hour nursing reports daily during the week, and on Monday for the weekend reports, to identify any resident changes. They will then review the chart to determine that physician and family notification has been completed and documented.

**Criteria 5:**    June 25, 2012

**F 281   Services Provided Meet Professional Standards**

**The services provided or arranged by the facility must meet professional standards of quality.**

**Criteria 1:** Resident #1 is provided medications in accordance with MD orders as determined in the med pass observation performed on 07/03/12 by the DON/ADON.

**Criteria 2:** Med pass observations have been performed for all medication administration staff by the DON/ADON/MDS Nurses/QA Nurse/ Infection Control Nurse/Restorative Nurse on 06/22/12-07/03/12 to determine that medications are administered in accordance with MD orders.

**Criteria 3:** Inservice education has been provided for medication administration staff by the DON/ADON/ MDS Nurses/QA Nurse/ Infection Control Nurse/Restorative Nurse on 06/22/12-07/03/12 on the administration of medications in accordance with MD orders.

**Criteria 4:** The CQI indicator for the monitoring of compliance with med pass in accordance with MD orders will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the DON/ADON.

**Criteria 5:** July 4, 2012.

## **F282 Comprehensive Care Plans**

**The services provided or arranged by the facility shall be provided by qualified staff in accordance with each resident's plan of care.**

**Criteria 1:** -Resident #1 has the wheelchair foot buddy in place as indicated on the care plan.  
-Resident #2 has wheelchair/bed alarms in place as indicated on the care plan.

**Criteria 2:** Fall prevention intervention devices including but not limited to wheelchair foot pedals and alarms are utilized as indicated on the resident care plans as determined by weekly compliance rounds conducted by the DON/ADON/MDS Nurses/ QA Nurse/ Infection Control Nurse/Restorative Nurse.

**Criteria 3:** The non-licensed nursing staff have received inservice education on 06/19/12-06/24/12 as provided by the DON/ADON/ MDS Nurses/ QA Nurse/ Infection Control Nurse/Restorative Nurse on the utilization of fall prevention interventions in accordance with each resident's care plan.

**Criteria 4:** The CQI indicator for the monitoring of utilization of fall prevention interventions in accordance with the care plan will be utilized monthly X 2 months and then quarterly as per the established CQI calendar, under the supervision of the DON.

**Criteria 5:** June 25, 2012

## **F 309 Quality of Care**

**Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.**

**Criteria 1:** Resident #2 has been assessed for pain, and the pain management medication plan addressed on the care plan and reviewed with the attending physician by the DON/ADON.

**Criteria 2:** An audit was completed of all residents triggering section J pain on the most recent MDS. Pain assessments were completed on these residents, with review of the pain management medication care plans by the MDS Nurses.

**Criteria 3:** The licensed nursing staff have received inservice education on 06/22/12 - 06/24/12 as provided by the DON/ADON/ MDS Nurses/ QA Nurse/ Infection Control Nurse/Restorative Nurse on pain assessment, and documentation, including addressing pain management on the care plan.

**Criteria 4:** The CQI indicator for the monitoring of pain management will be utilized monthly X 2 months and then every six months as per the established CQI calendar, under the supervision of the DON.

**Criteria 5:** June 25, 2012

### **F 323 Accidents and Supervision**

**The facility must ensure that the resident environment remains as free of accident hazards as is possible.**

**Criteria 1:** Residents #1 and 2 have been reviewed by the Fall Review Committee on 06/24/12 to determine that the current fall prevention interventions in place are appropriate and being implemented in accordance with the care plan.

**Criteria 2:** -An audit was completed on 06/24/12 by the Fall Review Committee for all residents with falls in the last 30 days to determine that the current fall prevention interventions in place are appropriate and being implemented in accordance with the care plan.

**Criteria 3:** -The Fall Review Committee has received inservice education on 6/28/12 by the Nurse Consultant on fall management program components including but not limited to: timely review of all falls and resident fall logs to investigate the trends and potential causes of falls and the fall prevention interventions indicated; the need to implement alternative interventions when residents are refusing or are non-compliant; timely follow up on committee recommendations to determine that fall prevention interventions are successfully implemented.

-Licensed and non-licensed nursing staff has received inservice education on 06/22/12 - 06/24/12 as provided by the DON/ADON/ MDS Nurses/ QA Nurse/ Infection Control Nurse/Restorative Nurse on fall management including but not limited to: the utilization of fall

prevention interventions in accordance with the care plan; the need to report observations of resident activities which increase their risk for falls; and the need to report resident non-compliance with fall prevention interventions so that alternatives can be addressed.

**Criteria 4:** The CQI indicator for the monitoring of fall management will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the DON.

**Criteria 5:** June 29, 2012