

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

PRINTED: 07/13/2012
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185069 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 06/28/2012 |
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| NAME OF PROVIDER OR SUPPLIER MAYFAIR MANOR | STREET ADDRESS, CITY, STATE, ZIP CODE 3308 TATES CREEK ROAD LEXINGTON, KY 40502 |
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| F 000 | INITIAL COMMENTS The Abbreviated Survey to investigate KY#00018484 was initiated on 06/18/12 and concluded on 06/20/12. The allegation was substantiated with no deficient practice. After supervisory review, the investigation was re-opened and the new exit date was 06/28/12. Deficient practice was identified at 42 CFR 483.20 Resident Assessment, F-279 and 42 CFR 483.25 Quality of Care, F-323 at a scope and severity of a "G". | F 000 | | 8/12/12 |
| F 279 SS=G | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced | F 279 | 1. Resident #1 was reassessed by the Minimum Data set coordinator (MDS coordinator) on 7-23-12. Resident #1 comprehensive Plan of Care was reviewed and revised on 7-23-12 by the interdisciplinary team which includes the following: rehab service manager, director of nursing, assistant director of nursing, dietary manager, social service director, minimum data set coordinator, quality of life director, chaplain, and the administrator (IDT) to include individualized interventions based on resident #1 assessment to be measurable objectives and timetables to meet resident #1 medical nursing and mental and psychosocial needs that are identified in the comprehensive assessment. The Brief Interview of Mental Status (BIMS) was reassessed by social service on 7-23-12 to accurately capture the cognition status of resident #1. The State Registered Nursing Assistant (SRNA) care plan was reviewed and revised by the Director of Nursing, Unit Manager and the MDS Director 7-23-12. 2. All residents will receive a brief interview of mental status (BIMS) by the Interdisciplinary team (IDT) by 8-10-12. Any resident that has a Brief Interview of Mental Status (BIMS) of twelve or less will receive a comprehensive review of their minimum data set (MDS) assessment by the Interdisciplinary team (IDT) to be completed by 8-10-12 to ensure the care plan reflects the specific abilities and deficits of the resident with individual interventions based on the resident's current MDS assessment. The Minimum Data set coordinator (MDS) coordinator will ensure resident assessments and the care planning are accurately reflected for each resident identified by 8-10-12. | |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Deuce H. Martin</i> | TITLE Administrator | (X6) DATE 7/26/12 |
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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 her 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 279 | <p>Continued From page 1</p> <p>by: Based on interview, record review, and review of the facility's policy it was determined the facility failed to ensure assessment results were used to develop the care plan for one (1) of three (3) sampled residents (Resident #1). Based on the Admission Minimum Data Set (MDS) assessment, Resident #1 required extensive assistance with transfers, ambulation, toileting and hygiene, and was cognitively impaired. The facility failed to develop a care plan that reflected the specific abilities and deficits of the resident with individualized interventions based on the resident's assessment. On 01/18/12, Resident #1 was found lying in the bathroom floor after being left unattended on the toilet. As a result of the fall, Resident #1 sustained a displaced bimalleolar fracture of the right ankle.</p> <p>The findings include:</p> <p>Review of the facility's "Care Plan" policy, effective December 2010, revealed the care plan provided guidance to all staff caring for the resident. Continued review revealed care was individualized based on identified problems.</p> <p>Review of the clinical record revealed the facility admitted Resident #1 on 2/09/11 with diagnoses which included Dementia, Delirium, and Vertigo. In addition, the resident was status post Compression Injury of the thoracic spine secondary to a fall prior to admission.</p> <p>Review of the Admission Minimum Data Set (MDS) Assessment, dated 12/16/11, revealed the facility assessed Resident #1 to require extensive assistance of two (2) persons for transfers.</p> | F 279 | <p>3. The Interdisciplinary team (IDT), Unit Managers and Staff Development Coordinator will receive education from the Regional Clinical Reimbursement Consultant by 8-1-12 on developing a care plan utilizing assessments to reflect specific abilities and deficits of the resident with individualized interventions. The Staff Development Coordinator (SDC) will educate the licensed staff on the care planning process policy/procedure. The facility Interdisciplinary team (IDT) will review each comprehensive care plan with any resident admission, incident and or change of condition in the clinical meeting which is lead by the director of nursing/assistant director of nursing. Identified non-compliance of the care plan process will be reported to the administrator weekly and forwarded to the weekly at risk meeting for review and follow up.</p> <p>4. The director of nursing/assistant director of nursing/minimum data set coordinator and medical records director will audit quarterly all resident care plans to ensure development of care plans that reflect the specific abilities and deficits of the resident with individual interventions based on the resident assessment. The resident care plans audit results will be forward quarterly to the director of nursing for follow up and review. Care Plan audit results will be reported to the quarterly quality assurance committee to include the administrator and the facility medical director for review and follow up for further recommendations.</p> | |

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| F 279 | <p>Continued From page 2</p> <p>ambulation, and toileting. Continued review revealed the resident was cognitively impaired, with a Brief Interview of Mental Status (BIMS) score of 5 out of 15, indicating Resident #1 was severely cognitively impaired.</p> <p>Review of the Comprehensive Care Plan, dated 12/16/11, revealed Resident #1 had a Care Plan for at risk for fall related injury. Interventions included "assist with transfers as needed", "remind resident to request assistance before ambulation and/or transfers" and "assist with ambulation as needed". Further review revealed a Care Plan for Activities of Daily Living (ADL) Self Care Deficit and being at risk for complications related to deficit. Continued review of the Care Plan revealed Resident #1 needed/required assistance with transfers. Interventions included "remind resident to request assistance prior to ambulation and/or transfers" and "staff to assist with transfers as needed". Further review of the Care Plan revealed no documented evidence to reflect the resident's specific abilities or deficits related to transfers, toileting and the use of the call light.</p> <p>Review of the Certified Nursing Assistant (CNA) Care Record, dated January 2012, revealed Resident #1 required the assistance of one (1) person for toileting and the assistance of two (2) persons for ambulation and transfers.</p> <p>Review of the nurse's note, dated 01/18/12 at 2:30 PM, revealed Resident #1 was found on the bathroom floor. The resident's right ankle appeared to be swollen and the decision was made to transfer the resident to the emergency room for an evaluation. Continued review</p> | F 279 | | |

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| F 279 | <p>Continued From page 3</p> <p>revealed the nurse documented, on 01/19/12 at 6:00 AM, Resident #1 had been admitted to the hospital due to a fractured ankle. Further review of a "Late Entry", dated 01/24/12 (no time noted), revealed the nurse documented a Certified Nursing Assistant (CNA) had taken the resident to the bathroom and instructed him/her to ring the call light when finished. Further review revealed the resident was non-compliant and attempted to return to bed without calling for assistance. A subsequent "Late Entry" note dated 01/24/12 was written by the former Director of Nursing (DON). She documented the resident did not use the call bell in order to prove to everyone he/she could do it alone.</p> <p>The CNA who left the resident on the toilet unattended before the fall on 01/19/12 was identified, but was no longer employed at the facility. Multiple attempts to reach the CNA for interview were unsuccessful.</p> <p>Interview with CNA #1, on 06/20/12 at 1:02 PM, revealed Resident #1 knew how to use the call light and could be left alone and instructed to pull the cord. Further interview revealed CNA #1 responded to the call light in Resident #1's room on 01/18/12 and found the resident in the floor and another CNA was present. He stated he did not know who pulled the call light. He continued to state Resident #1's foot was at an angle and the two (2) CNAs picked the resident up and placed him/her in a wheelchair.</p> <p>Review of the admitting hospital History and Physical, dated 01/19/12, revealed Resident #1 sustained a bimalleolar fracture to the right ankle. The resident was admitted and a surgical consult</p> | F 279 | | |

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| F 279 | <p>Continued From page 4 was obtained.</p> <p>Review of the Operative Report, dated 01/19/12, revealed Resident #1 underwent an Open Reduction and Internal Fixation (ORIF) of the right bimalleolar fracture. (An ORIF is a surgical procedure that includes the use of pins and screws to repair the fractured bone.) Continued record review revealed Resident #1 returned to the facility on 01/20/12.</p> <p>Interview with the MDS Coordinator, on 06/28/12 at 3:45 PM, revealed she had completed the admission MDS Assessment for Resident #1. She stated the resident required extensive assistance with transfers, ambulation, toileting and hygiene at the time of the assessment. She further stated the care plan should have been based on the assessment. On further interview, she stated the resident didn't always remember to ring the call light; therefore, an intervention for staff to remind the resident to use the call light was added to the care plan. Continued interview revealed, based on the admission MDS Assessment, the resident should not have been left on the toilet unattended. Review of the care plan with the MDS coordinator revealed it was not specific regarding Resident #1's abilities and deficits, and did not provide clear instructions regarding the amount of assistance and supervision the resident required. The only revision to the care plan prior to the fall on 01/18/12 was related to the addition of bed rails as an enabler.</p> | F 279 | | |
| F 323 SS=G | <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident</p> | F 323 | | |

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| F 323 | <p>Continued From page 5</p> <p>environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, 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).</p> <p>The facility failed to ensure adequate supervision for Resident #1 who was assessed to require the assistance of two (2) staff for transfers and toileting. Resident #1's Fall Risk Evaluation indicated he/she was at high risk for falls. On 01/18/12, the resident was found lying in the bathroom floor after being left unattended on the toilet. As a result of the fall, Resident #1 sustained a displaced bimalleolar fracture of the right ankle.</p> <p>The findings include:</p> <p>Review of the facility's Fall Policy, revised February 2009, revealed residents were to be provided with "assistance and supervision in an effort to avoid falls and minimize injury and complications that may result from a resident falling".</p> | F 323 | <p>1. Resident #1 was reassessed by the Minimum Data set coordinator (MDS) on 7-23-12. Resident #1 comprehensive Plan of Care was reviewed and revised on 7-23-12 by the Interdisciplinary team which includes the following: rehab service manager, director of nursing, assistant director of nursing, dietary manager, social service director, minimum data set coordinator, quality of life director, chaplain, and the administrator, (IDT) to reflect adequate supervision required and assistive devices to prevent accidents for resident #1. The state registered nursing assistant (SRNA) care plan was reviewed and revised by the Minimum Data set coordinator (MDS), unit manager and the director of nursing (DON) on 7/23/12. Brief Interview of mental Status (BIMS) was reassessed by social service on 7-23-12 to accurately capture the cognition status of resident #1. On 7-23-12 the Minimum Data set coordinator (MDS) completed a falls risk assessment to capture the current fall risk of resident #1. Education was completed by the staff development coordinator (SDC) on 7-23-12 to the clinical nursing staff caring for resident #1 to include fall risk, supervision, assistive device required for safety and following resident plan of care.</p> | |

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| F 323 | <p>Continued From page 6</p> <p>Review of the clinical record revealed the facility admitted Resident #1 on 12/09/11 with diagnoses which included Dementia, Delirium, and Vertigo. In addition, the resident was status post Compression Injury of the thoracic spine secondary to a fall prior to admission.</p> <p>Review of the Fall Risk Evaluation, dated 12/10/11, revealed Resident #1 scored 24, where a value greater than 10 indicated the resident was at risk for falls.</p> <p>Review of the Admission Minimum Data Set (MDS) Assessment, dated 12/16/11, revealed the facility assessed Resident #1 to require extensive assistance of two (2) persons for transfers and toileting. Continued review revealed the resident was cognitively impaired, with a Brief Interview of Mental Status (BIMS) score of 5 out of 15, which indicated the resident's cognitive status was severely impaired.</p> <p>Review of the Comprehensive Care Plan, dated 12/16/11, revealed Resident #1 had a Care Plan for at risk for fall related injury. Interventions included "assist with transfers as needed", "remind resident to request assistance before ambulation and/or transfers" and "assist with ambulation as needed". Further review revealed a Care Plan for Activities of Daily Living (ADL) Self Care Deficit and being at risk for complications related to deficit. Continued review of the Care Plan revealed Resident #1 needed/required assistance with transfers. Interventions included "remind resident to request assistance prior to ambulation and/or transfers" and "staff to assist with transfers as needed". Further review of the Care Plan revealed no</p> | F 323 | <p>2. A Fall Risk Evaluation and a Brief Interview of Mental Status (BIMS) will be reviewed and evaluated on all residents by the interdisciplinary team by 8-10-12. The comprehensive care plans and the state registered nursing assistant (SRNA) care plans will be reviewed and revised by the Minimum Data set coordinator (MDS); assistant director of nursing (ADON); unit manager; and director of nursing (DON) by 8-10-12 according to the completed evaluations to ensure adequate supervision and assistive devices to prevent accidents.</p> <p>3. The Interdisciplinary team (IDT) will receive education from the Regional Clinical Reimbursement Consultant by 8-1-12 on developing a care plan utilizing assessment results to ensure adequate supervision is assessed, care planned and assistive devices are part of the plan provided to ensure a safe environment to prevent accidents for residents. The facility Interdisciplinary team (IDT) will review each comprehensive care plan with any resident admission, incident or change of condition in the clinical meeting, which is lead by the director of nursing, to determine the supervision and assistive device (as indicated) required for each resident. Any resident assessed with a Fall Risk Evaluation of 10 or higher will be provided mobility</p> | |

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| F 323 | <p>Continued From page 7</p> <p>documented evidence to reflect the resident's specific abilities or deficits related to transfers, toileting and the use of the call light.</p> <p>Interview with the MDS Coordinator, on 06/28/12 at 3:45 PM, revealed she had completed the admission MDS Assessment for Resident #1. She stated the resident required extensive assist with transfers, ambulation, toileting and hygiene at the time of the assessment. She stated the resident didn't always remember to ring the call light, therefore, an intervention for staff to remind the resident to use the call light was added to the care plan. Continued interview revealed, based on the MDS Assessment and the Care Plan, the resident would not be able to sit on the commode alone and it could not be assured the resident would remember to use the call light for assistance.</p> <p>Review of the Occupational Therapy Discharge Summary, dated 01/06/12, revealed Resident #1 had reached his/her maximum potential. Continued review revealed the initial plan for the resident to return to the assisted living facility was no longer practical as the resident continued to require more assistance than that facility could provide. It was determined the resident would remain in the long-term care facility due to the continued need for assistance with activities of daily living (ADLs) and the resident required minimum to close supervision related to problem-solving abilities.</p> <p>Interview, on 06/28/12 at 4:05 PM, with the Occupational Therapist who completed the discharge summary, revealed the resident was discharged from Occupational Therapy due to a</p> | F 323 | <p>supervision. This will be indicated on the state registered nursing assistant care plan as a fall risk. The Staff Development Coordinator (SDC) will educate the clinical staff on the care planning process policy/procedure, the utilization of the (SRNA) care plan for specific assistance, supervision and the use of the required assistive devices and to follow the developed plan of care for each resident. The assistant director of nursing and staff development nurse will remain responsible to continue to educate and monitor staff for non-compliance of supervision, assistive devices as indicated and following the resident plan of care.</p> <p>4. The director of nursing/ assistant director of nursing /unit manager will monitor weekly 20% of the facility residents to ensure supervision is provided to each resident per the comprehensive assessment and state registered nursing assistant plan of care. The audit will continue until 100% compliant for four weeks and then bimonthly for four weeks then monthly for three months. All non-compliance for supervision to a resident will be reported immediately to the director of nursing and administrator. The staff member responsible for non-compliance will be coached and disciplined accordingly. Supervision results for non-compliance will be reported to the quarterly quality assurance committee to include the administrator and the facility medical director for review and follow up for further recommendations.</p> | |

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| F 323 | <p>Continued From page 8</p> <p>Lack of continued progression: She stated the resident had "plateaued", i.e. maximum potential had been reached. She clarified, "maximum potential did not mean independent". Continued interview revealed the Therapist had always stayed with the resident in the bathroom, as the resident could be impulsive with standing. Further interview revealed Resident #1 did not always exhibit adequate judgment and safety awareness. The Therapist stated her main concern was the resident's fluctuating cognitive status throughout the day, and from day to day.</p> <p>Review of the Physical Therapy Discharge Summary, dated 01/06/12, revealed Resident #1 was discharged from the service due to "highest practical level achieved". Continued review revealed the resident had no measurable improvement in lower extremity strength after four (4) weeks of therapy. In addition, although the resident increased his/her time to remain standing, balance was only fair with bilateral upper extremity support. Further review of comments related to ambulation revealed the resident dragged her right foot, constantly swayed from the line of progression, and was a high fall risk without assistance. (The line of progression refers to the resident's ability to move forward in a straight line.)</p> <p>Review of the Restorative Nursing Program for Ambulation notes, dated 01/10/12, revealed Resident #1 required minimal assistance during ambulation, including verbal and tactile cues to maintain the line of progression. In addition, the resident was noted to have fair balance.</p> <p>Review of the nursing Weekly Summary, dated</p> | F 323 | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185069 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 06/28/2012 |
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| NAME OF PROVIDER OR SUPPLIER MAYFAIR MANOR | STREET ADDRESS, CITY, STATE, ZIP CODE 3300 TATES CREEK ROAD LEXINGTON, KY 40502 |
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| F 323 | <p>Continued From page 9</p> <p>01/11/12, revealed Resident #1 had short- and long-term memory problems and required limited assistance with transfers and toileting.</p> <p>Review of the Daily Skilled Nurses' Notes revealed Resident #1 exhibited impaired decision making and disorganized thinking daily from 01/07/12 through 01/12/12. Continued review revealed the resident exhibited disorganized thinking on 01/13/12 and impaired decision making on 01/14/12. Daily notes for 01/15/12 through 01/18/12 were not present.</p> <p>Review of the nurses' note, dated 01/18/12 at 2:30 PM, revealed Resident #1 was found in the bathroom floor. The resident's right ankle appeared to be swollen and the decision was made to transfer the resident to the emergency room for an evaluation. Continued review revealed the nurse documented, on 01/19/12 at 6:00 AM, the resident had been admitted to the hospital due to a fractured ankle. Further review of a "Late Entry", dated 01/24/12 (no time noted), revealed the nurse documented the Certified Nursing Assistant (CNA) had taken the resident to the bathroom and instructed Resident #1 to ring the call light when finished. The nurse further documented the resident was non-compliant and attempted to return to bed without calling for assistance. A subsequent "Late Entry" note dated 01/24/12 was written by the former Director of Nursing (DON). She documented she sat with the resident after the fall while waiting the arrival of the ambulance. Continued review revealed the resident stated he/she wanted to prove to everyone he/she could do it alone.</p> <p>The CNA who left the resident in the bathroom</p> | F 323 | | |

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| F 323 | <p>Continued From page 10</p> <p>before the fall on 01/18/12 was identified, but was no longer employed at the facility. Multiple attempts to contact the CNA for interview were unsuccessful.</p> <p>Interview with CNA #3, on 06/20/12 at 1:30 PM, revealed she had left Resident #1 alone in the bathroom before. She further stated the resident could use the call light. Continued interview revealed a CNA, on 01/18/12, had reported Resident #1 was in the bathroom and to watch for him/her. Further interview revealed the aide did not know how long the resident was in the bathroom before she heard a scream coming from the room. She stated she entered to find the resident on the floor and noted the ankle was twisted in a way it shouldn't be. She further stated the resident's call light was not on.</p> <p>Interview with CNA #1, on 06/20/12 at 1:02 PM, revealed Resident #1 knew how to use the call light and could be left alone and instructed to pull the cord. Continued interview revealed the CNA responded to the call light in the resident's bathroom on 01/18/12 and found the resident was in the floor and another CNA was present. He stated he did not know who rang the call light. He further stated the resident's foot was at an angle and the two (2) CNAs and a nurse picked the resident up and placed him/her in the wheelchair.</p> <p>Interview with Licensed Practical Nurse (LPN) #6, on 06/19/12 at 3:05 PM, revealed she did not know how the resident got into the bathroom. She stated she heard one of the aides took the resident. She further stated the aide would have instructed the resident to use the emergency light, but did not know if the resident used it or</p> | F 323 | | |

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| F 323 | <p>Continued From page 11</p> <p>not. Continued interview revealed the resident stated he/she did not use the call bell and tried to get up without assistance.</p> <p>Interview with the Administrator, on 06/20/12 at 1:25 PM, revealed Resident #1 required one-person assist for transfers and toileting. She stated the resident had improved in physical and cognitive abilities since admission. She further stated an aide assisted the resident to the bathroom and told one of the other aides the resident was on the toilet.</p> <p>Further review of the clinical record revealed the nurses' notes from 01/15/12 to 01/18/12, the day of the fall, could not be located by the facility. In addition, the facility could not provide the incident report, fall investigation or statements from staff related to the fall. Interview with the Administrator, on 06/28/12 at 4:40 PM, revealed the facility had completed the missing documents. She stated she believed all documentation related to the incident were together in a file, which had been misplaced.</p> <p>Review of the admitting hospital History and Physical, dated 01/19/12, revealed Resident #1 sustained a bimalleolar fracture to the right ankle. The resident was admitted and a surgical consult was obtained.</p> <p>Review of the Operative Report, dated 01/19/12, revealed Resident #1 underwent an Open Reduction and Internal Fixation (ORIF) of the right bimalleolar fracture. (An ORIF is a surgical procedure that includes the use of pins and screws to repair the fractured bone.) Further record review revealed Resident #1 returned to</p> | F 323 | | |

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| F 323 | <p>Continued From page 12 the facility on 01/20/12.</p> <p>Interview with the Director of Nursing (DON), on 06/28/12 at 6:37 PM, revealed she was not employed by the facility at the time Resident #1 fell, and was not familiar with the resident's physical and cognitive status at that time. She stated she had looked, but been unable to find the nurse's notes for 01/15 to 01/18/12.</p> <p>Interview with the Administrator, on 06/28/12 at 7:55 PM, revealed Resident #1 had used the call light in the past, before the fall. Continued interview revealed she had been unable to locate the file containing the Daily Skilled Nurse's Notes, incident report, fall investigation and staff interviews obtained after the incident.</p> | F 323 | | |