

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

PRINTED: 07/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185401	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/10/2014
NAME OF PROVIDER OR SUPPLIER  EDMONSON CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 813 S. MAIN ST. BROWNSVILLE, KY 42210	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p><b>INITIAL COMMENTS</b></p> <p>An Abbreviated Survey Investigating Complaint #KY21882 was conducted on 07/08/14 through 07/10/14 to determine the facility's compliance with Federal requirements. KY21882 was substantiated with deficiencies cited at the highest Scope and Severity of a "G".</p> <p>On 06/04/14, Resident #1 was left on the commode in his/her room unattended by the Certified Nurse Aide (CNA) and the resident fell off the commode and sustained a lateral displacement of the Tibia Shaft as well as non-displaced oblique proximal Fibula Shaft Fracture to the left leg. Resident #1 required surgical intervention to repair the fracture on 06/05/14. The facility admitted Resident #1 on 05/24/14 with diagnoses of a Left Hip Fracture and Cerebral Vascular Accident with left sided weakness and the facility assessed Resident #1 to lean to the left side when in a sitting position and to have decreased awareness of safety needs. However, the facility failed to revise the care plan with interventions to address the supervision needed when the resident was toileted.</p> <p>Resident #2 sustained five falls (04/20/14, 04/27/14, 05/21/14, 06/12/14 and 06/14/14) without any evidence of an assessment and investigation after each fall to identify the root cause of the fall and to develop and implement individualized interventions directed at prevention. On 06/14/14, Resident #2 had an unwitnessed fall in his/her room and sustained a fractured hip that required surgical intervention. The facility failed to investigate Resident #2's falls to identify the root cause of the falls or implement safe</p>	F 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Edmonson Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p>	



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

*Carolyn Younce*

TITLE

*Administrator*

(X6) DATE

*09-05-14*

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 SS=G	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of facility's policy and procedure it was determined the facility failed to revise the care plan for two (2) of three (3) sampled residents (Resident #1 and #2).</p> <p>Resident #1 was re-admitted to the facility on 05/24/14 with diagnosis of a Left Hip Fracture and Cerebral Vascular Accident with left sided</p>	F 280	<p>License Practical Nurse revised/updated Resident #1 care plan for staff to remain present during toileting as resident #1 will allow and if resident request his/her privacy, staff is to remain outside the bathroom door with the door ajar, on 7/14/14.</p> <p>Resident #1 care plan was updated by Licensed Practical nurse on 7/14/14 for left upper extremity arm trough to Brief Interview for Mental Status (BIMS) summary score is 15.</p> <p>Registered Nurse completed device evaluation on 07/14/2014 and revised / updated Resident #2 care plan to reflect a perimeter defined mattress as the least restrictive device, defining the outer edges of the mattress. The mattress was added to Resident #2 s' bed on 07/14/2014.</p> <p>On 7/27/14 The Activity Director reassessed resident # 2's interest and activities with care plan update/revisions to include readers digest, functional kit with items to fold &amp; gospel/country music.</p> <p>Administrator had a one on one discussion with resident #2's son to determine areas of resident's interest on 7/28/14; he was in agreement with interventions.</p>		

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F 280	<p>Continued From page 2</p> <p>weakness. The facility assessed the resident to lean to the left side while sitting and to have decreased safety awareness; however, the facility failed to use the results of the assessment to revise the care plan with interventions to address the supervision the resident would need when toileted. On 06/04/14, Resident #1 was placed on the commode in his/her room and left unattended by Certified Nurse Aide (CNA) #1 and the resident fell off the commode. The resident sustained a Lateral Displacement of the Tibia Shaft as well as a Non-Displaced Oblique Proximal Fibula Shaft Fracture to the left leg that required surgical intervention.</p> <p>Resident #2 was admitted to the facility on 03/28/14 with diagnoses which included Hemiplegia to affect dominant side due to Cerebrovascular Disease and Generalized Weakness. Resident #2 sustained five (5) recurrent falls (04/20/14, 04/27/14, 05/21/14, 06/12/14 and 06/14/14) without any evidence of an assessment and investigation after each fall to identify the root cause of the fall so the care plan could be revised with interventions directed at fall prevention. On 06/14/14, Resident #2 had an unwitnessed fall in his/her room and sustained a Fractured Hip that required surgical intervention.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Care Plans", last revised 01/02/14, revealed a comprehensive individualized care plan would be developed by the interdisciplinary team for each patient. The care plan would include measurable objectives to meet patient needs and goals as identified by the assessment process.</p>	F 280	<p>There have been no additional resident falls resulting in fracture during this time frame.</p> <p>Current residents with falls within the past three months, from April 1, care plans were reviewed, revised and updated as necessary to reflect current resident status, to include appropriate fall interventions, by the, Director of Nursing Services, Assistant Director of Nursing Services, Unit Managers, nurse practice educator and/or Nursing Supervisors by 07/22/14. No other residents were identified.</p> <p>Resident plans of care are reviewed at minimum quarterly by the Interdisciplinary team, which includes Clinical Reimbursement Manager, Social Services Director, Nutritional Services Director, Activities Director and Therapy Program Manager, to ensure they meet the needs of each resident.</p> <p>14 of 14 Licensed Practical Nurses and 11 of 11 Registered Nurses were re-educated by the, Director of Nursing Services, Assistant Director of Nursing Services and Nurse Practice Educator beginning on</p>		

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F 280	<p>Continued From page 3</p> <p>Review of the facility's Falls Management Plan, last revised 05/15/14, revealed residents would be assessed for falls risk as part of the nursing assessment process. Those determined to be at risk would receive appropriate interventions to reduce risk and minimize injury.</p> <p>1. Record review revealed the facility readmitted Resident #1 on 05/24/14 with diagnoses which included after care healing of a Traumatic Fractured Left Hip, Hemiplegia Affect on non-dominant side due to Cerebral Vascular Disease, unspecified Closed Fracture of the Ankle, personal history of a fall, Cognitive Deficit due to Cerebrovascular Disease, Abnormal Posture, Cognitive Communication Deficit, Attention or Concentration Deficit, lack of coordination, and Hypertension.</p> <p>Review of the resident's care plan, developed on admission, dated 05/24/14, and identified as the residents current Comprehensive Care Plan, revealed Resident #1 was at risk of falls related to CVA and impaired mobility due to a left hip fracture with interventions to assist the resident in and out of bed with extensive assist of two and to remind to use call light when attempting to ambulate or transfer. Review of the MDS Kardex Report, or Care Card used by Certified Nursing Staff as their plan of care for Resident #1, dated 05/24/14, revealed Resident #1 had no problems with short term or long term memory and was independent in decision making, required extensive to total assistance of two (2) for bed mobility, transfer, partial weight bearing, extensive assistance or total assist of two (2) for activities of daily living including toilet use.</p> <p>Review of the Admission Minimum Data Set</p>	F 280	<p>and completed on 08/06/2014 on immediate interventions after falls, and revising and updating fall care plans with resident change in condition to include individualized fall interventions.</p> <p>13 of 14 Licensed Practical Nurses (one LPN suspended/terminated) and 11 of 11 Registered Nurses completed posttests to ensure understanding of re-education. These posttests were reviewed by the Nurse Practice educator to validate understanding of education on 08/06/2014.</p> <p>38 of 38 Certified Nursing Assistants were re-educated beginning on 07/17/2014 and ending on 07/27/2014, on following residents' plan of care and C.N.A. care card. 38 of 38 Certified Nursing Assistants completed posttests to ensure understanding of re-education. These posttests were reviewed by the Nurse Practice educator to validate understanding of education on 07/27/2014. Any nursing employees not available, ie; pm, on vacation, will be re-educated prior to returning to work by the Nurse Practice Educator.</p>		

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F 280	<p>Continued From page 4</p> <p>(MDS) assessment, dated 05/31/14, revealed the facility assessed Resident #1's cognition as moderately impaired and had a Brief Interview of Mental Status (BIMS) coded as "99" indicating the resident was unable to complete the interview. The facility assessed Resident #1 to have short term memory problems and moderately impaired decision making. He/she was totally dependent with two (2) plus physical assist for physical mobility and toilet use. Balance during transitions and walking was coded as a two (2), indicating not steady, and the resident was only able to stabilize with staff assistance. The resident had a history of falls prior to admission and had sustained a fall in the last two (2) to six (6) months and sustained a fracture related to a fall in the past six (6) months. Review of a Fall Risk Evaluation dated 05/31/14, revealed a score of fifteen (15), indicating the resident was at high risk for fall.</p> <p>Review of a Device Evaluation, dated 06/03/14, revealed Resident #1's was alert with short term memory impaired and decreased awareness of safety needs. He/she had impaired balance and leaned to the left side when sitting. The evaluation was completed to improve wheel chair positioning, an intervention was put in place to use a half tray to wheelchair to improve wheelchair positioning due to left sided weakness.</p> <p>Further review of the resident's Comprehensive Care Plan, dated 05/24/14, revealed there were no revisions made to the care plan after the 05/31/14 MDS Assessment and Fall Risk Assessment; and the 06/03/14 Device Assessment were completed. The care plan did not address the identified risk of a fall due to the</p>	F 280	<p>Activity re-assessments were completed for high risk fall residents and frequent fall residents since April 1, 2014 by Activity Director, Activity Assistant, Social Services Director, Director of Marketing and Admission, and Administrative Assistant with update/revisions as indicated by 8/12/14.</p> <p>Medication regimen review was completed for residents determined at high risk for falls and for residents that have had frequent falls on 8/12/14 by pharmacy consultant.</p> <p>The Director of Nursing Services, Assistant Director of Nursing Services, Nurse Practice Educator, will review three (3) residents per week including observation of care for four (4) weeks then (3) residents monthly for two (2) months then (2) residents a month for an additional (3) months to monitor that fall care plan reflects current resident status, to include appropriate fall interventions. Corrective action and/or re-education will be provided at point of discovery of discrepancies.</p>	

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F 280	<p>Continued From page 5</p> <p>resident leaning to left side while sitting, the resident's short term memory loss that might prevent the resident to remember to use a call light, and the resident's decreased awareness of safety needs.</p> <p>Review of Change of Condition Documentation Note, dated 06/04/14 at 7:45 AM, revealed Resident #1 had an unwitnessed fall and was found in the bathroom floor on his/her stomach. The resident's left foot noted to be internally rotated. The resident was placed in bed using a mechanical lift. The resident complained of pain in the left leg and ankle. Resident #1's family and medical provider were called. Mobile services x-rays were taken at the facility of Resident # 1's left leg, hip, ankle and knee. Further review of Resident #1's Nurses Notes, dated 06/04/14 at 2:05 PM, revealed Resident #1 was transferred to the local hospital for admission and treatment of a fracture involving the proximal to mid left tibial shaft.</p> <p>Review of the Hospital Diagnostic Imaging Report, dated 06/05/15, revealed there were Oblique Comminuted Fractures present within the proximal one-third (1/3) of the tibia shaft with mild lateral displacement and anterior angulation of the distal fracture component. Non-displaced oblique proximal fibula shaft fractures were also noted.</p> <p>Review of the Hospital Operative Report, dated 06/05/14, revealed Resident #1 required a surgical procedure to repair a unstable comminuted left tibial shaft fracture. A closed intramedullary rodding of the left tibia fracture using a tibial nail size 13 millimeters (mm) diameter x 345 millimeter length, two (2) proximal</p>	F 280	<p>The Director of Nursing Services will report findings to monthly Quality Assurance / Performance Improvement Committee meetings for six (6) months for review and recommendations. These audits will continue as needed per the QA/PI committee recommendations.</p> <p>The Quality Assurance/Performance Improvement Committee consists of the facility's Medical Director, Administrator, Director of Nursing, Social Services Director, Nutritional Services Director, Activity Director and Therapy Program Manager, at a minimum.</p> <p>Completion Date</p>	08/13/14	

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F 280	<p>Continued From page 6 locking screws and two (2) distal locking screws.</p> <p>Interview with CNA #1, on 07/09/14 at 11:40 AM, revealed she and CNA #2 assisted the resident to the bathroom, and the resident asked for privacy because he/she needed to have a bowel movement. CNA #1 stated the care plan did not indicate that Resident #1 needed supervision while on the commode so she left Resident #1 on the commode and stepped into the next room to make another resident's bed.</p> <p>Interview with CNA #2, on 07/10/14 at 08:55 AM, revealed she was familiar with Resident #1's plan of care, she stated it did not say he/she could not be left alone and she thought it was okay to leave him/her unattended.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 07/09/14 at 11:25 AM, revealed Resident # 1's care plan did not indicate if the resident could be left alone on the commode or not.</p> <p>Interview with MDS Coordinator, on 07/10/14 at 1:50 PM, revealed all care plans were prepared by the Interdisciplinary Team using a team approach after looking at therapy notes, interdisciplinary team notes, and documentation from direct care staff . She stated the interventions were determined with a team approach. She revealed if there had been any restriction or changes made for Resident #1 it would have been documented on his/her care plan and nurse aide care card.</p> <p>2. Record review revealed Resident #2 was admitted to the facility on 03/28/14 with diagnoses which included Hemiplegia Affect on dominant side due to Cerebrovascular Disease, and</p>	F 280			

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F 280	<p>Continued From page 7 Generalized Weakness.</p> <p>Review of the residents care plan, developed on admission, dated 03/28/14, and identified as the residents current Comprehensive Care Plan, revealed Resident #2 was considered a fall risk related to use of psychotropic medication, impaired balance, history of multiple falls, and generalized weakness. The resident ambulated with a walker and required one (one) assist with bed mobility, transfer, toileting, and dressing. However, review of the MDS Kardex Report, or Care Card used by Certified Nursing Staff as their plan of care for Resident #2, dated 03/28/14, revealed Resident #2 had modified independence in decision making, required supervision to independent in bed mobility, transfer, walk in room and corridor with limited assistance of one (1) for toilet use.</p> <p>Review of the Admission Minimum Data Set (MDS) assessment, dated 04/04/14, revealed the facility assessed Resident #2's cognition as moderately impaired with a Brief Interview of Mental Status (BIMS) score of "7" and he/she required one (1) person physical assist with bed mobility, transfers, and walking in room and corridor.</p> <p>Review of the facility's Risk Management System Report, dated 04/20/14 at 1:00 PM, revealed Resident #2 fell while going to the bathroom unassisted. The resident was placed on a seventy-two (72) hour bowel/bladder evaluation.</p> <p>Review of the Risk Management System Report, dated 04/27/14 at 3:30 AM, revealed Resident #2 fell out of bed and received a one (1) centimeter (cm) laceration to his/her chin. The intervention</p>	F 280			

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F 280	<p>Continued From page 8</p> <p>put into place was a therapy referral for bed mobility and safety awareness.</p> <p>Review of Physical Therapy Note, dated 04/28/14, revealed Resident #2 was currently receiving therapy for strengthening and endurance training and the therapy had been initiated on 03/28/14. Further review of the Comprehensive Care Plan for risk for falls, dated 03/28/14, revealed there were no interventions initiated once therapy evaluated the resident.</p> <p>Review of Speech Therapy Progress Note, dated 04/29/14, revealed Resident #2 required skilled intervention to address cognitive linguistic deficits that hinders his/her ability to be safe in all environments. Further review of the Comprehensive Care Plan for risk for falls, dated 03/28/14, revealed there were no interventions initiated to address speech therapy's evaluation of the resident.</p> <p>Review of the Risk Management System Report, dated 05/21/14 at 11:00 PM, revealed Resident #2 was ambulating in his/her room unassisted and became weak and fell to the floor. The resident sustained a 1.5 cm x 1 cm discoloration area to right knee. The intervention put in place at that time was to encourage the resident to call for assistance with ambulation. Further review of the Care Plan for risk for falls, dated 03/28/14, revealed an intervention was initiated to encourage the resident to call for assistance with ambulation. However, as evidenced by the Comprehensive and CNA Care Plan the resident had a chronic/progressive decline characterized by deficit in memory, judgement, decision making and thought process.</p>	F 280			

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F 280	<p>Continued From page 9</p> <p>Review of the Risk Management System Report, revealed on 06/12/14 at 10:50 AM, Resident #2 was ambulating to the bathroom in his/her room without assistance and fell, resulting in a 1.2 centimeter (cm) skin tear to the left elbow. The resident stated he/she was weak and fell. The intervention put into place was a Bowel and Bladder observation and therapy referral. Further review of the Care Plan for risk for falls, dated 03/28/14, revealed an intervention was initiated to conduct a 72 hour bowel and bladder evaluation and refer to therapy for evaluation. However, the care plan interventions failed to address the resident's continued attempts to transfer and ambulate his/her self.</p> <p>Review of the Risk Management System Report, revealed on 06/14/14 at 1:50 AM, Resident #2 was ambulating to the bathroom without assistance and fell. The resident sustained a fractured right hip requiring surgical repair.</p> <p>Interview with MDS Coordinator, on 07/10/14 at 1:50 PM, revealed the care plans were revised using a Interdisciplinary Team (IDT) approach. She stated the IDT Team reviewed therapy notes, the MDS Assessments, and anything that happened on the unit during care through out the planning period, and the information obtained was used to revise or implement the residents Plan of Care.</p> <p>Interview with the Director of Nursing (DON), on 07/10/14 at 8:45 AM, revealed she felt the interventions put in place after Resident #2's falls were adequate due to the fact that Resident #2 was very independent. She stated she thought after the fall on 06/12/14 the resident's voiding pattern could have changed and that was why</p>	F 280			

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F 280	Continued From page 10 they implemented the bowel and bladder observation.  Further interview with the DON revealed all fall and condition changes were discussed daily during the departmental stand up meetings, and interventions were discussed at that time by all department heads. She stated the care plans were revised at that time.	F 280			
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 observation, interview, record review, and review of the Hospital Diagnostic Report and Hospital Operative Report and the facility's policy and procedure it was determined the facility failed to ensure two (2) of three (3) residents (Resident #1 and Resident #2) received adequate supervision and assistive devices to prevent accidents.  Resident #1 was re-admitted to the facility on 05/24/14 with diagnoses to include Left Hip Fracture and Cerebral Vascular Accident (CVA) with left sided weakness. On 06/04/14, Resident #1 was placed on the commode in his/her room and left unsupervised by the Certified Nurse Aide	F 323	License Practical Nurse revised/updated Resident #1 care plan , on 7/14/14 for staff to remain present during toileting as resident #1 will allow and if resident request his privacy, staff is to remain outside the bathroom door with the door ajar.  Resident #1 care plan was updated by Licensed Practical nurse on 7/14/14 for left upper extremity arm trough to wheelchair. Brief Interview for Mental Status (BIMS) summary score is 15.  Registered Nurse completed device evaluation on 07/14/2014 and revised / updated Resident #2 care plan to reflect a perimeter defined mattress as the least restrictive device, defining the outer edges of the mattress. The mattress was added to Resident #2 s' bed on 07/14/2014.		

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F 323	<p>Continued From page 11</p> <p>(CNA). Resident #1 fell off the commode and sustained a Lateral Displacement of the Tibia Shaft as well as a Non-displaced Oblique Proximal Fibula Shaft Fracture to the left leg. Resident #1 required surgical intervention to repair the fracture on 06/05/14.</p> <p>Resident #2 was admitted to the facility on 03/28/14 with diagnoses to include Hemiplegia Affect on Dominant side due to Cerebrovascular Disease and Generalized Weakness. Resident #2 sustained five (5) recurrent falls (04/20/14, 04/27/14, 05/21/14, 06/12/14 and 06/14/14) without any evidence of an assessment and investigation after each fall to identify the root cause of the fall so adequate supervision and assistive devices could be provided to prevent accidents. On 06/14/14, Resident #2 had an unwitnessed fall in his/her room and sustained a fractured hip that required surgical intervention.</p> <p>The findings include:</p> <p>Review of the facility 's policy titled, "Falls Management", last revised 05/15/14, revealed the purpose of the policy was to reduce risk for falls and minimize the actual occurrence of falls, develop individualized plan of care, review Intrinsic/Extrinsic Fall Risk Factors and to implement new interventions or remove environmental risk factors to prevent further falls. Residents would be assessed for falls as part of the nursing assessment process. Those determined to be at risk would receive appropriate interventions to reduce risk and minimize injury. Residents experiencing a fall would receive appropriate care and investigation of the cause.</p>	F 323	<p>Activity Director reassessed resident's interest and activities on 7/27/14 with care plan update/revisions to include readers digest functional kit with items to fold &amp; gospel/country music. Administrator had a one on one discussion with resident #2's son to determine areas of resident's interest on 07/28/2014; he was in agreement with interventions.</p> <p>There have been no additional resident falls resulting in fracture during this time frame.</p> <p>Registered Nurses and Licensed Practical Nurses reassessed current residents at risk for falls on 7/14/14. Current residents with falls within the past three months, from April 1, care plans were reviewed, revised and updated as necessary to reflect current resident status, to include appropriate fall interventions, by the, Director of Nursing Services, Assistant Director of Nursing Services, Unit Managers, nurse practice educator and/or Nursing Supervisors by 07/22/14. No other residents were identified.</p>		

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F 323	<p>Continued From page 12</p> <p>1. Record review revealed the facility readmitted Resident #1 on 05/24/14 with diagnoses which included after care healing Traumatic Fracture Left Hip, Hemiplegia affect non-dominant side due to Cerebral Vascular Disease, unspecified Closed Fracture of the Ankle, personal history of a fall, Cognitive Deficit due to Cerebrovascular Disease, Abnormal Posture, Cognitive Communication Deficit, Attention or Concentration Deficit, lack of Coordination, and Hypertension. Review of the Admission Minimum Data Set (MDS) Assessment, dated 05/31/14, revealed Resident #1 had a Brief Interview of Mental Status (BIMS) score of "99" indicating the resident was unable to complete the interview. The facility assessed Resident #1 to have short term memory problems and moderately impaired decision making. Review of a Fall Risk Evaluation, dated 05/31/14, revealed a score of fifteen (15), indicating the resident was at high risk for falls.</p> <p>Review of the Nursing Assessment, dated 05/31/14, revealed Resident #1 was oriented to person, place, time, and situation with encouragement; decision making was moderately impaired and poor with supervision; and, the resident required the assist of two (2) people for transfers with functional limitations.</p> <p>Review of a Device Evaluation, dated 06/03/14, revealed the facility assessed Resident #1's short term memory was impaired and the resident had decreased awareness of safety needs. In addition, the resident was assessed to have impaired balance and would lean to the left side when sitting. The evaluation determined to improve wheel chair positioning a half tray to wheelchair would be implemented due to left</p>	F 323	<p>Current residents assessed at high risk for falls per fall evaluation were reviewed for appropriate interventions for prevention of falls, reduce risk and minimize injury by the Director of Nursing, Assistant Director of Nursing or Licensed Nurse on 7/22/2014. Interventions and care plan updates completed as indicated.</p> <p>The Nurse Practice Educator, Director of Nursing, Assistant Director of Nursing initiated re-education with the 14 of 14 Licensed Practical Nurses, 11 of 11 Registered Nurses, 38 of 38 Certified Nursing Assistants, and 2 of 2 Recreation staff beginning on 7/17/2014 and ending on 08/06/2014 on adequate supervision and appropriate interventions for preventing falls, reduce risk and minimize injury related to falls.</p> <p>13 of 14 Licensed Practical Nurses (one LPN suspended/terminated), 11 of 11 Registered Nurses, 38 of 38 Certified Nursing Assistants, and 2 of 2 Recreation staff completed post tests to ensure understanding of re-education on 08/06/2014. Nurse Practice Educator reviewed and validated post tests on 08/06/2014. Any nursing employees not available, ie; pm, on vacation, will be</p>		

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F 323	<p>Continued From page 13 sided weakness.</p> <p>Review of the residents care plan, developed on admission, dated 05/24/14, and identified as the residents current Comprehensive Care Plan, revealed there were no revisions made to the care plan to address the identified risk of a fall due to the resident leaning to left side while sitting, the short term memory loss that might prevent the resident to remember to use a call light, and the resident's decreased awareness to ensure the resident received adequate supervision and assistive devices to prevent accidents.</p> <p>Review of Change of Condition Documentation Note, dated 06/04/14 at 7:45 AM, revealed Resident #1 was found in the bathroom on the floor laying on his/her stomach with the left foot internally rotated. The resident was transferred to the bed with a mechanical lift and complained of pain in the left leg and ankle. Mobile services x-rays were conducted on the resident left leg, hip, ankle and knee. Further review of the Nurse's Notes, revealed at 2:05 PM, Resident #1 was diagnosed with a Proximal to Mid Left Tibial Shaft Fracture and was transferred to the local hospital.</p> <p>Review of Hospital Diagnostic Imaging Report, dated 06/05/14, revealed the resident was identified as having Oblique Comminuted Fractures within the proximal one-third (1/3) of the Tibia Shaft with mild lateral displacement and anterior angulation of the distal fracture component. A Non-Displaced Oblique Proximal Fibula Shaft Fracture was also identified.</p> <p>Review of Hospital Operative Report, dated 06/05/14, revealed Resident #1 had surgery to</p>	F 323	<p>reeducated prior to returning to work by Nurse Practice Educator.</p> <p>Three residents at high risk for falls will be checked including observation of care by the Director of Nursing, Assistant Director of Nursing, Nurse Practice Educator, or Unit Manager three (3) residents a week for a month, then three (3) residents a month for two months, then (2) residents a month for (3) additional months to ensure adequate supervision and appropriate interventions to prevent falls, reduce risk and minimize injury related to falls. Corrective action and/or re-education will be provided at point of discovery of any discrepancies.</p> <p>The Director of Nursing will report findings to the monthly Performance Improvement Committee for six (6) months for further recommendations. Audits will continue per Quality Assurance/ Performance Improvement committee recommendations.</p>	

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F 323	<p>Continued From page 14</p> <p>repair the unstable Comminuted Left Tibial Shaft Fracture. A closed intramedullary rodding of the left tibia fracture using a tibial nail size 13 millimeters (mm) diameter x 345 millimeter length, two (2) proximal locking screws and two (2) distal locking screws.</p> <p>Interview with the Administrator, on 07/08/14 at 3:45 PM, revealed on 06/04/14, Resident #1 was assisted to the bathroom in room #204 by two (2) Certified Nursing Assistants (CNA). She stated Resident #1 had asked for privacy so CNA #1 left the resident unsupervised on the commode and went two (2) doors down to make a bed. She stated the resident was advised to use his/her call light when finished. She also stated Resident #1 had been more confused since his/her stroke.</p> <p>Interview with Certified Medication Tech (CMT) #1, on 07/09/14 at 11:15 AM, revealed she was standing at the nursing station in front of Resident #1's door, and heard the crash and ran to the bathroom and the resident was laying on the bathroom floor. The CMT stated she called for the nurse to help and CNA #1 came running from another room. CMT #1 stated CNA #1 had been making a bed in a room with the door closed.</p> <p>Interview with CNA #1, on 07/09/14 at 11:40 AM, revealed she and CNA #2 assisted the resident to the bathroom, and the resident asked for privacy because he/she needed to have a bowel movement. CNA #1, stated she left Resident #1 on the commode and went to the next room to make a bed.</p> <p>Interview with CNA #2, on 07/10/14 at 8:55 AM, revealed she and CNA #1 assisted Resident #1 to the commode. She stated she was coming out of</p>	F 323	<p>The Quality Assurance/Performance Improvement Committee consists of the facility's Medical Director, Administrator, Director of Nursing, Social Services Director, Nutritional Services Director, Activity Director and Therapy Program Manager, at a minimum.</p> <p>Completion Date</p>	08/13/14	

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F 323	<p>Continued From page 15</p> <p>the dining room and was asked by CNA #1 to help her take Resident #1 to the bathroom. The CNA revealed when they left the resident on the commode in the bathroom she thought CNA #1 would be waiting outside the bathroom door. She stated she told the resident to turn on his/her call light when he/she was done. She stated she was assigned to work on another hall that day and went back to the dining room after she helped put the resident on the commode.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 07/09/14 at 11:25 AM, revealed the resident was alert and oriented at the time and the care plan did not indicate if the resident could be left alone on the commode or not.</p> <p>Interview with the Speech and Language Pathologist, on 07/10/14 at 8:30 AM, revealed she had worked with Resident #1 since his/her admission. She stated based on what she knew about the resident's balance and the resident's leaning she felt the resident could fall. She stated she did not think it would be safe to leave the resident unsupervised. She revealed therapy had been working on his/her left visual field because the resident had left visual field neglect due to his/her recent CVA. She stated it would not be safe to leave him/her unsupervised because of his/her inability to recognize anything on his left side.</p> <p>Interview with the Physical Therapist, on 07/10/14 at 10:25 AM, revealed based on Resident #1's status of being a total assist of two (2) staff for transfer and his/her cognitive impairment it would not be safe to leave him/her unsupervised in the bathroom.</p>	F 323			

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F 323	<p>Continued From page 16</p> <p>Interview with Director of Nursing (DON) , on 07/10/14 at 8:20 AM, revealed she was unsure if the admission assessment showed a true picture of Resident #1, as the resident had good days and bad days and was able to make his/her needs known that day. The DON stated CNA #1 left the room because the resident requested privacy and remained in "ear shot of the resident". The DON stated the CNA was only a room away and she felt comfortable with the CNA leaving the resident unsupervised on the commode.</p> <p>Interview with Resident #1's Physician, on 07/10/14 at 9:45 AM, revealed he was not aware Resident # 1 was left unsupervised in the bathroom on the day of the fall. He stated he thought the CNA was standing outside the bathroom door, and didn't realize she had left the room. The Physician stated he did not think it was safe to leave the resident considering he/she was a maximum assist of two (2) for transfers. He revealed he thought it would have been safer to have someone right there to supervise the resident.</p> <p>2. Record review revealed Resident #2 was admitted to the facility on 03/28/14 with diagnoses which included Hemiplegia Affect on dominant side due to Cerebrovascular Disease, and Generalized Weakness. Review of the Admission Minimum Data Set (MDS) assessment, dated 04/04/14, revealed the facility assessed Resident #2's cognition as moderately impaired with a Brief Interview of Mental Status (BIMS) score of "7" and he/she required one (1) person physical assist with bed mobility, transfers, and walking in room and corridor.</p> <p>Observation of Resident #2, on 07/09/14 at 10:50</p>	F 323		

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F 323	<p>Continued From page 17</p> <p>AM, revealed the resident was on his/her back, with the head of the bed elevated slightly. The resident stated "I can't remember a lot about the fall, but it would be all right if hadn't fell, now I can't walk".</p> <p>Record review revealed, Resident #2 had sustained five (5) falls since admission.</p> <p>Review of the facility's Risk Management System report, dated 04/20/14 at 1:00 PM, revealed Resident #2 fell while going to the bathroom unassisted. Resident #2 reported he/she also fell on the previous day but got up and didn't tell staff until the next day. Further review revealed there was no documented evidence of an assessment or investigation to determine the root cause of the fall. The intervention put in place was to implement a seventy-two (72) hour bowel and bladder evaluation to determine a voiding pattern.</p> <p>Review of the Risk Management System Report, dated 04/27/14 at 3:30 AM, revealed Resident #2 fell out of bed and received a one (1) centimeter (cm) laceration to his/her chin. The intervention put into place was a therapy referral for bed mobility and safety awareness.</p> <p>Review of Physical Therapy note, dated 04/28/14, revealed Resident #2 was currently receiving therapy for strengthening and endurance training and the therapy had been initiated on 03/28/14. Resident #2 reported to the therapist he/she had fallen and had bruises on his/her forearm, wrist and a cut to his/her chin. In addition. Resident #2 complained of being sore from the fall.</p> <p>Review of Speech Therapy Progress Note, dated 04/29/14, revealed Resident #2 required skilled</p>	F 323		
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F 323	<p>Continued From page 18</p> <p>intervention to address cognitive linguistic deficits that hinders his/her ability to be safe in all environments.</p> <p>Review of the Risk Management System report, dated 05/21/14 at 11:00 PM, revealed Resident #2 was ambulating in his/her room unassisted and became weak and fell to the floor. The resident sustained a 1.5 centimeter x 1 centimeter discoloration area to right knee. The intervention put in place at that time was to encourage to call for assistance with ambulation; however, the facility had assessed the resident to have short term memory loss and cognitive deficits that hindered his/her ability to be safe in all environments.</p> <p>Review of the Risk Management System Report, revealed on 06/12/14 at 10:50 AM, Resident #2 was ambulating to the bathroom in his/her room without assistance and fell, resulting in a 1.2 centimeter (cm) skin tear to the left elbow. The resident stated he/she was weak and fell. The care plan intervention put into place was a Bowel and Bladder observation and therapy referral, which were previous interventions implemented after the resident's falls on 04/20/14 and 04/27/14, respectively. Further review revealed there was no documented evidence of an assessment/investigation to determine the root cause of the fall, if the resident had an unmet need or if other factors could have contributed to the residents decision to ambulate to the bathroom without assistance. The care plan interventions failed to address the resident's continued attempts to transfer and ambulate his/her self.</p> <p>Review of the Risk Management System report,</p>	F 323			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185401	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/10/2014
NAME OF PROVIDER OR SUPPLIER  EDMONSON CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 813 S. MAIN ST. BROWNSVILLE, KY 42210		
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F 323	<p>Continued From page 19</p> <p>revealed on 06/14/14 at 1:50 AM, Resident #2 was ambulating to the bathroom without assistance, fell and sustained a fractured right hip requiring surgical repair.</p> <p>Interview with Speech and Language Pathologist on 07/10/14 at 8:30 AM, revealed she had been working with Resident #2 for safety awareness and short term memory problems. She stated Resident # 2 did not have good safety awareness due to his/her short term memory problems.</p> <p>Interview with the Director of Nursing (DON), on 07/10/14 at 8:45 AM, revealed she felt the interventions implemented after Resident #2's falls were adequate due to the fact that Resident #2 was very independent.</p> <p>Further interview with the Director of Nursing, on 07/10/14 at 8:45 AM, revealed a departmental stand up meeting was held every day to discuss falls and condition changes for residents. She stated during the meetings interventions were discussed by all department heads and assessments were done to help determine the cause of the falls. She revealed interventions were then put in place that the department heads had determined would address the resident's falls.</p>	F 323			