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

PRINTED: 09/06/2012
FORM APPROVED
OMB NO. 0938-0391

RECEIVED SEP 7 2012 Division of Health Care Southern Enforcement Branch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185230		C 08/01/2012

NAME OF PROVIDER OR SUPPLIER: MOUNTAIN VIEW HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 345 WEST RUSSELL STREET, ELIZABETHTOWN, KY 42701

(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	INITIAL COMMENTS An abbreviated standard survey (KY18799, KY18821) was initiated on 07/30/12 and concluded on 08/01/12. Both complaints were substantiated. Deficient practice was identified with the highest scope and severity at "G" level, with an opportunity to correct.	F 000	**This Plan of Correction is submitted under Federal and State regulations and status applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of this plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Furthermore, we request this Plan of Correction serve as our credible allegation of compliance.**	
F 280 SS=G	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, medical record review, and review of facility policy/procedure it	F 280	**F # 280** 1a) Resident # 1 was assessed by a licensed nurse on 8/1/12 to determine if a mechanical lift was appropriate for use with this resident. It was determined appropriate and therefore on 8/1/12 resident's care plan was updated to reflect the use of a mechanical lift with two staff members for transfers. The physician and family were notified on 8/1/12. 1b) Resident # 4's care plan was updated on 8/8/12 to reflect interventions needed related to falls occurring on 3/4/12, 3/22/12, and 5/26/12 , after a review of the falls was completed by the Regional Director of Clinical Services, Interim Director of Nursing, Assistant Director or Nursing, Unit Managers, MDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 9/7/12

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185230		C 08/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH CARE CENTER	945 WEST RUSSELL STREET ELKHORN CITY, KY 41522

(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 280	Continued From page 1 was determined the facility failed to ensure the comprehensive care plan for two of six sampled residents (Residents #1 and #4) had been revised/updated to reflect the resident's needs. Resident #1 required the use of a mechanical lift for transfers; however, the resident's comprehensive care plan had not been revised/updated to reflect the resident's need for the mechanical lift or the number of staff required for transfers. Resident #1 fell from the mechanical lift on 07/23/12 and sustained a fractured clavicle (collarbone), fractured scapula (shoulder bone), and a strain to the back and neck. Resident #4 fell on 02/19/12 and sustained two lacerations to the right forehead that required sutures. The facility failed to revise/update the care plan to reflect interventions to prevent further falls and the resident sustained falls on 03/04/12, 03/22/12, and 05/26/12. The findings include: Review of the facility policy titled "Falls Management" (not dated) revealed an interdisciplinary plan of care would be developed, implemented, reviewed, and updated as necessary to reflect each resident's current safety needs and fall reduction interventions. The policy revealed the care plan would be reviewed throughout the course of treatment by the interdisciplinary team to assure the most recent, updated, and resident-specific fall reduction interventions were incorporated, as necessary, into the plan of care. Review of facility policy titled "Falling Star/Falling Leaf Program" (not dated) revealed the care plan would be reviewed and updated as needed to reflect current fall risks and resident-specific interventions designed to	F 280	Coordinators, and Rehab Service Manager. 2) A 100% review of all resident's care plan will be completed by 9/10/12 by the Interim Director of Nursing, Assistant Director of Nursing, Regional Director of Clinical Services, and Unit Managers to ensure that care plans were updated/revised with interventions for each change of condition. All residents were observed to ensure that assistive devices were in use or in place. Any concerns identified were immediately addressed. 3) The Regional Director of Clinical Services and Staff Developmeot Coordinator conducted an inservice on 8/20/12 for the Interim Director of Nursing, MDS Coordinators, and Unit Managers related to revision/updating of care plans and care directives to ensure a new interventions is implemented and follow up is completed to assess effectiveness of interventions implemented after a change in condition. The Staff Development Coordinator completed an inservice on or by August 31, 2012 for all charge nurses related to revision/updating of care plans and care directives after a change in condition to ensure new interventions are implemented and follow up is completed to assess effectiveness of interventions implemented after the change.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185230	A. BUILDING B. WING	C 08/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH CARE CENTER	945 WEST RUSSELL STREET ELKHORN CITY, KY 41522

(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 280	Continued From page 2 reduce a recurrence of falls. 1. Review of the medical record of Resident #1 revealed the facility admitted the resident on 06/12/09 with diagnoses that included senile dementia, depressive disorder, Alzheimer's disease, hypertension, atrial fibrillation, and lack of coordination. A review of the most recent Quarterly Minimum Data Set (MDS) assessment dated 05/14/12 revealed the facility assessed Resident #1 to require extensive assistance of two persons for all transfers and activities of daily living. The facility had assessed Resident #1 to be nonambulatory. There was no assessment for the use of a mechanical lift. Review of the comprehensive care plan for Resident #1 dated 05/14/12 revealed approaches identified to prevent falls included assist with transfers/ambulation as needed, ensure the resident was wearing adequate footwear, and use a Broda chair with thigh straps when out of bed. The care plan did not include the use of a mechanical lift for transfers and/or obtaining weights of the resident. Documentation in the medical record revealed on 07/23/12 Resident #1 sustained a fall from a mechanical lift. Review of the facility's Incident Follow-up and Recommendation Form for Resident #1, dated 07/23/12, revealed the resident "tipped sideways out of the mechanical lift." Facility staff documented a recommendation on the incident form to send the resident to the hospital for evaluation and the follow-up on the form documented "no further incidents." The form contained a "QA Checklist" area with a section to document that the care plan had been	F 280	Any change in resident condition will be reviewed and discussed daily (Monday through Friday) in a daily meeting by the Executive Director, Interim Director of Nursing, Assistant Director of Nursing, Unit Managers, MDS Coordinators, and Rehab Service Manager to ensure causative factors have been identified, interventions have been implemented, and care plans and care directives updated. A weekly falls meeting will be conducted by the Executive Director, Interim Director of Nursing, Assistant Director of Nursing, Unit Managers, MDS Coordinators, and Rehab Service Manager for follow-up and to assess effectiveness of interventions of change in condition related to falls. Falls occurring monthly will be discussed during the Quality Assurance process to ensure completion of follow-up and recommendation forms. 4) Audits of care plans after change in condition will be completed by the Interim Director of Nursing, Assistant Director of Nursing, MDS Coordinators, and Unit Managers after each change daily (Monday through Friday) to ensure causative factor is determined, investigation is complete, interventions have been implemented, care plans, care directives updated, and effectiveness of interventions assessed. These audits will continue daily (Monday through Friday) x 60 days, weekly x 8 weeks, monthly x 2 months, then randomly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185230		C 08/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH CARE CENTER	945 WEST RUSSELL STREET ELKHORN CITY, KY 41522

(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 280	Continued From page 3 updated and the date of the update; however, continued review of the incident report for Resident #1 revealed the section was left blank. Documentation in the medical record revealed the resident was transported to an acute care hospital and diagnosed with a fracture to the scapula (shoulder bone), fracture to the clavicle (collarbone), and a strain to the back and neck. Interview with Licensed Practical Nurse (LPN) #2 on 07/31/12, at 9:05 AM, revealed she had developed the care plan dated 05/14/12 for Resident #1. LPN #2 stated if a resident required a mechanical lift for transfers, it should have been identified on the care plan. LPN #2 stated she was aware Resident #1 required a mechanical lift for transfers and/or weights but had failed to place it on the care plan or assess the resident for the use of the mechanical lift. Interview with Licensed Practical Nurse (LPN) #1 on 07/31/12, at 4:12 PM, revealed she was responsible for investigating falls. LPN #1 stated she was responsible for ensuring a follow-up that included interventions was implemented and that the care plan was updated. According to LPN #1, she should have made sure the care plan had been updated. Interview with the Director of Nursing (DON) on 07/31/12, at 4:02 PM, revealed the DON had reviewed LPN #1's fall investigation but failed to ensure the care plan had been updated. 2. A review of the medical record for Resident #4 revealed the facility admitted the resident on 02/10/09, with diagnoses that included Cerebrovascular Accident, Bi-Polar Disorder,	F 280	Any issues identified in these audits will be reviewed monthly in the Performance Improvement Committee Meeting. Revisions will be made to the system as indicated. 5) Date of Compliance – 9/10/12.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185230		C 08/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH CARE CENTER	945 WEST RUSSELL STREET ELKHORN CITY, KY 41522

(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 280	Continued From page 4 Seizure Disorder, Depression, Anxiety, Status Post Colectomy with Colostomy, and Senile Dementia. A review of the most recent quarterly Minimum Data Set (MDS) dated 06/02/12, revealed the facility assessed Resident #4 as being alert and oriented with periods of confusion. Review of the Fall Risk Evaluation dated 06/02/12, revealed Resident #4 was assessed to be at high risk for falls. A review of the comprehensive care plan for Resident #4, reviewed by facility staff on 06/02/12, revealed the approaches developed by staff to prevent falls included: chair alarm at all times, Dycem (an anti-slip pad) to the resident's wheelchair at all times, fall risk assessments to be conducted quarterly or with any significant change, a physical therapy or occupational therapy screen to be requested as needed, and the physician would be notified as needed with changes in condition or for new orders. Further review of the medical record and review of the facility Incident Follow-up and Recommendation Form revealed Resident #4 sustained a fall on 02/19/12, 03/04/12, 03/22/12, and 05/26/12. Review of the Comprehensive Care Plan (reviewed 06/02/12) revealed the care plan had not been updated/revised after each fall. One intervention was added to the care plan on 05/26/12, following a fall, that directed staff to conduct neurological checks per facility protocol due to the fall. Continued review of the Incident Follow-up and Recommendation Form for each of the four falls revealed staff had indicated on the Incident Follow-up and Recommendation Form that the	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185230		C 08/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH CARE CENTER	945 WEST RUSSELL STREET ELKHORN CITY, KY 41522

(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 280	Continued From page 5 care plan had been updated. The review of the Incident Follow-up and Recommendation Form revealed the Interdisciplinary Team (IDT) had reviewed the falls that occurred on 02/19/12, 03/04/12, and 03/22/12, the day after the falls occurred and had indicated the Comprehensive Care Plan had been updated/revised. Documentation on the follow-up report revealed the fall that occurred on Friday, 05/26/12, was reviewed by the IDT on Tuesday, 05/29/12. Interview on 07/31/12, at 3:30 PM, with the MDS Coordinator revealed the MDS staff was responsible for initiating an investigation after any resident fall. The MDS Coordinator stated the MDS staff was to ensure the nurses had updated the care plan to reflect the fall and had included any new interventions on the care plan. The MDS Coordinator stated every fall was discussed in the "morning meeting" with the IDT and the care plan was reviewed in the meeting to ensure the care plan had been updated. The MDS Coordinator stated a care plan conference was also held on 04/03/12 and 06/12/12, and at those times Resident #4's falls were discussed and care plans were reviewed. However, upon review of Resident #4's care plan, the MDS Coordinator stated the care plan had not been updated to reflect Resident #4's falls. The MDS Coordinator stated she did not have an explanation of why the care plan had not been updated to reflect Resident #4's falls and concluded it "must have been an oversight."	F 280	**F # 282** 1) CNA # 1 was inserviced and competency performed on 7/23/12 related to mechanical lift transfers per assist of two staff members as stated in this 2567. The RDCS completed a proactive risk assessment to determine the causative factor of the fall from the mechanical lift. 100% competency was completed for all CNA's related to following mechanical lift guidelines and assist of two persons. The residents care plan was updated to reflect the need for mechanical lift transfer with assist of two staff members. 2) All residents have the potential to be affected. A 100% review of all resident's care plan will be completed by 9/10/12 by the Interim Director of Nursing, Assistant Director of Nursing, Regional Director of Clinical Services, and Unit Managers to ensure that care plans were updated/revised with interventions for each change of condition. All residents were observed to ensure that assistive devices were in use or in place. Any concerns identified were immediately addressed.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in	F 282	CNA # 1 was re-educated on 7/31/12 upon notification by the surveyor that CNA # 1 had performed a one-person assist	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185230		C 08/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH CARE CENTER	945 WEST RUSSELL STREET ELKHORN CITY, KY 41522

(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 282	Continued From page 6 accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility staff training it was determined the facility failed to ensure staff provided care to residents in accordance with the resident's written plan of care for one unsampled resident (Resident A). Staff was observed to use a mechanical lift to obtain a weight for one unsampled resident (Resident A) with the assistance of one staff person when two staff persons were required. The findings include: Interview with the Executive Director (ED) on 07/31/12, at 4:02 PM, revealed the facility did not have a policy/procedure related to the use of mechanical lifts. A review of the manufacturer's guidelines for the mechanical lift observed in use at the facility revealed the facility was required to make certain there was sufficient staff to accomplish the procedure. According to the manufacturer, the mechanical lift could only be used with residents that had been assessed and approved by the facility's professional staff. Additionally, the manufacturer's guidelines required staff to make certain there was sufficient staff to accomplish the procedure. A review of the comprehensive assessment for Resident A, dated 06/21/12, revealed the resident	F 282	transfer using a mechanical lift. CNA # 1 received a disciplinary action as well. All licensed nurses and CNA's were re-inserviced on 8/10/12 by SDC related to how to properly perform a mechanical lift transfer and to never complete a mechanical lift transfer with less than two people. 3) Staff will be inserviced upon hire, annually, and as needed related to mechanical lift transfers with assistance of at least two staff members or more if needed with mechanical lift transfers. Any change in resident condition will be reviewed and discussed daily (Monday through Friday) in a daily meeting by the Executive Director, Interim Director of Nursing, Assistant Director of Nursing, Unit Managers, MDS Coordinators, and Rehab Service Manager to ensure causative factors have been identified, interventions have been implemented, and care plans and care directives updated. The Regional Director of Clinical Services and Staff Development Coordinator conducted an inservice on 8/20/12 for the Interim Director of Nursing, MDS Coordinators, and Unit Managers related to revision/updating of care plans and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185230		C 08/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH CARE CENTER	945 WEST RUSSELL STREET ELKHORN CITY, KY 41522

(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 282	Continued From page 7 required extensive assistance of two staff persons for all transfers. Review of the care plan for Resident A revealed staff was to utilize a mechanical lift for all transfers. Observation on 07/30/12 at 2:45 PM, revealed Certified Nursing Assistant (CNA) #1 entered the room of Resident A with a mechanical lift. The resident was seated in a Broda chair (specialized high-back chair) with a sling underneath the resident. The CNA attached the sling to the mechanical lift and raised the resident from the chair to obtain a weight. No other staff was present during the procedure. Review of the facility's in-service training dated 07/23/12 revealed staff had been instructed in the proper use of the mechanical lifts and that two staff members were required to transfer residents that required a mechanical lift. Review of the staff sign-in sheet revealed CNA #1 had attended the in-service. Interview with CNA #1 on 07/31/12, at 2:45 PM, revealed at times she used the mechanical lift without another staff member assisting. Interview with the facility's Staff Development Nurse on 07/31/12, at 5:40 PM, revealed staff had been instructed to always have two staff persons for all transfers of residents using a mechanical lift.	F 282	care directives to ensure a new interventions is implemented and follow up is completed to assess effectiveness of interventions implemented after a change in condition. The Staff Development Coordinator completed an inservice on or by August 31, 2012 for all charge nurses related to revision/updating of care plans and care directives after a change in condition to ensure new interventions are implemented and follow up is completed to assess effectiveness of interventions implemented after the change. 4) The Director of Nursing, Assistant Director of Nursing or Regional Director of Clinical Services will complete five audits daily of licensed staff or CNA's to ensure care plans are being followed daily x 60 days (Monday-Friday), weekly x 8 weeks, monthly x 2 months, then randomly. Any issues identified in these audits will be reviewed monthly in the Performance Improvement Committee Meeting. Revisions will be made to the system as indicated. 5) Date of Compliance – 9/10/12	
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	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185230	A. BUILDING ____ B. WING ____	C 08/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH CARE CENTER	945 WEST RUSSELL STREET ELKHORN CITY, KY 41522

(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 323	Continued From page 8 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, facility policy/procedure review, and review of manufacturer's guidelines it was determined the facility failed to ensure two of six sampled residents (Residents #1 and #4) received adequate supervision and appropriate use of assistive devices to prevent accidents. The facility failed to ensure staff utilized safe technique while transferring residents with a mechanical lift. Resident #1 sustained a fractured clavicle (collarbone), a fractured scapula (shoulder bone), and a strain to the back and neck when the resident fell from the sling of a mechanical lift on 07/23/12. The resident had been placed in the mechanical lift to obtain a weight by a staff member. The facility's standard of practice was for two staff persons to assist with the mechanical lift; however, only one staff person was in attendance with Resident #1. The facility failed to identify the causative factors related to the fall and implement interventions to prevent further incidents. The facility also failed to follow manufacturer's guidelines related to care of the mechanical lift slings in the facility. Although the manufacturer's guidelines stated the slings were not to be bleached, the facility utilized a chlorine stain lifter when laundering the slings used in the facility.	F 323	**F #323** 1a) A Proactive Risk Assessment was completed on 8/7/12 by the RDCS to determine the causative factor of the fall that occurred on 7/23/12 for resident # 1. Resident # 1's care plans were updated /revised with interventions identified in the Proactive Risk Assessment findings. 1b) Resident # 4's falls for 2/9/12, 3/4/12, 3/22/12, and 5/26/12 were reviewed on 8/8/12 by the Interim Director of Nursing, Assistant Director of Nursing, Rehab Service Manager, and Regional Director of Clinical Services to identify causative factors of falls. Care plans were updated/revised based on findings. 1c) The Housekeeping/Laundry Supervisor began an inservice with laundry aides on 8/1/12 which was completed 8/17/12 related to manufacturers guidelines regarding care of mechanical lift slings. Please note that all slings identified with blue tabs were taken out of service on 7/23/12 with new slings put into place. 2a) All residents have the potential to be affected. The Interim Director of Nursing, Assistant Director of Nursing, and Regional Director of Clinical Services will complete a 100% review of all care plans for all resident's from to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185230	A. BUILDING B. WING	C 08/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH CARE CENTER	945 WEST RUSSELL STREET ELKHORN CITY, KY 41522

(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 323	Continued From page 9 Additionally, the facility failed to have an effective system to thoroughly investigate falls to determine the possible cause/contributing factors of each fall and failed to implement interventions to prevent further falls for Resident #4. Resident #4 fell on 02/19/12 and sustained two lacerations to the right forehead that required emergency care with six sutures to the lacerated areas. The resident also sustained falls on 03/04/12, 03/22/12, and 05/26/12. However, the facility failed to thoroughly investigate each fall to determine causative factors, failed to assess the effectiveness of the interventions in place at the time of each fall, and failed to implement interventions to prevent further falls. The findings include: A review of the Falls Management Policy (not dated) revealed all falls would be reviewed by the Interdisciplinary Team (IDT) members following the daily "Stand Up" meeting. The IDT was also to review the incident report, fall history, the care plan, and other pertinent data to determine the need for further investigation. The policy revealed the need for further evaluation of the resident's health condition, the environment, equipment, medications, staff, resident practices, or other factors that may have contributed to the incident would be determined by the IDT in order to promote a comprehensive plan of care. According to the policy, the IDT would determine the need for development of any additional facility-wide or resident-specific interventions, staff, resident, and/or family education and training, or other follow-up measures that may be needed to reduce the risk of reoccurrence.	F 323	causative factors have been determined, interventions implemented, and that care plans and care directives have been updated/revised according to findings. 2b) The Housekeeping/Laundry supervisor implemented a mechanical lift sling log on 8/1/12 for laundry aides to utilize. The log consists of date laundered, serial number, weight capacity, size, out of service, notification of central supply, detergent used, air dry, and initials. 3a) The Staff Development Coordinator completed an inservice on 8/10/12 for all licensed staff and CNA's for mechanical lift transfers and the assistance of a minimum of two staff members with all transfers. Please note the Staff Development Coordinator had completed an inservice and competencies for all CNA's after this incident on 7/23/12 with resident # 1 and CNA # 2 was inserviced and signed the inservice roster. 3b) Regional Director of Clinical Services completed an inservice on 8/16/12 for Director of Nursing, Assistant Director of Nursing, Unit Managers, and Rehab Services Manager for the falls management program. Emphasis was placed on finding the causative factor, implementation of interventions, and follow-up to ensure effectiveness of interventions implemented.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185230	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 08/01/2012
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 945 WEST RUSSELL STREET ELKHORN CITY, KY 41522	

(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 323	Continued From page 10 Review of the facility's Mechanical Lift Guidelines dated 12/31/09, revealed all residents who required a mechanical lift would have the following in place: (1) Care Plan, (2) Updated Care Guide. Review of the manufacturer's guidelines for use of the mechanical lift revealed the lift could only be used with patients that had been assessed and approved for the procedure by the facility's professional staff. Further review of the guidelines revealed the facility was to make certain there was sufficient staff to accomplish the procedure. The number of staff requirement must be recorded during the patient's assessment and communicated to the lifting staff. 1. Based on a review of the medical record, the facility admitted Resident #1 on 06/12/09 with diagnoses that included senile dementia, depressive disorder, Alzheimer's disease, hypertension, atrial fibrillation, and lack of coordination. Documentation on the Quarterly Minimum Data Set (MDS) assessment, dated 05/14/12, revealed the facility assessed Resident #1 to be nonambulatory and to require the extensive assistance of two persons for all transfers and activities of daily living. Review of the comprehensive care plan for Resident #1 dated 05/14/12 revealed approaches identified to prevent falls included to assist the resident with transfers/ambulation as needed, to ensure the resident was wearing adequate footwear, and to use a Broda chair (a specialized high-back wheelchair) with thigh straps when the resident was out of bed. There was no documentation on Resident #1's plan of care that facility staff had identified that the resident required the use of a	F 323	Changes in condition will be reviewed and discussed daily (Monday through Friday) in a daily meeting by the Executive Director, Interim Director of Nursing, Assistant Director of Nursing, Unit Managers, MDS Coordinators, and Rehab Service Manager to ensure causative factors have been identified, interventions have been implemented, and care plans and care directives npdated. A weekly falls meeting will be conducted by the Executive Director, Interim Director of Nursing, Assistant Director of Nursing, Unit Managers, MDS Coordinators, and Rehab Service Manager for follow-up and to assess effectiveness of interventions. Falls occurring monthly will be discussed during the Quality Assurance process to ensure completion of follow-up and recommendation forms. 3c) The Housekeeping/Laundry Supervisor began an inservice on 8/1/12 for all laundry aides related to following the manufacturer's guidelines related to care of mechanical lift slings. A log will be maintained in laundry by the laundry aides that includes date laundered, serial number, weight capacity, size, out of service, notification of central supply, detergent used, air dry, and initials. Any change in resident condition will be reviewed and discussed daily (Monday through Friday) in a daily meeting by the Executive Director, Interim Director of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185230		C 08/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH CARE CENTER	945 WEST RUSSELL STREET ELKHORN CITY, KY 41522

(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 323	Continued From page 11 mechanical lift when staff assisted the resident to transfer and/or weigh the resident. Continued review of the medical record revealed Resident #1 sustained a fall on 07/23/12, when staff attempted to obtain the resident's weight with the use of a mechanical lift. Documentation on the facility incident report form revealed the resident slid from the sling of the lift onto the shower room floor and sustained a fracture to the clavicle and scapula in addition to a sprain to the resident's neck and back. Based on documentation on the facility's Incident Follow-Up and Recommendation Form, dated 07/23/12, CNA #7 attempted to weigh Resident #1 with the use of a mechanical lift, and the resident "tipped sideways out of the mechanical lift." Although the investigation contained two witness statements, there was no documented evidence the facility investigated the causative factors of the fall or that the mechanical lift had been utilized by one staff member. There was no documentation on the incident form that the facility had conducted a falls assessment or that the resident's care plan had been updated. Interview on 07/31/12, at 10:12 AM, with Certified Nursing Assistant (CNA) #7 revealed on 07/23/12 the CNA took the resident into the shower room in the Broda chair to provide privacy while the resident's weight was obtained. The CNA stated she used the mechanical lift to obtain the resident's weight. According to the CNA, a sling was already under the resident and the CNA attached the sling to the lift and raised the lift to obtain the weight. CNA #7 stated the resident's foot was touching the chair and, in order to obtain	F 323	Nursing, Assistant Director of Nursing, Unit Managers, MDS Coordinators, and Rehab Service Manager to ensure causative factors have been identified, interventions have been implemented, and care plans and care directives updated. The Regional Director of Clinical Services and Staff Development Coordinator conducted an inservice on 8/20/12 for the Interim Director of Nursing, MDS Coordinators, and Unit Managers related to revision/updating of care plans and care directives to ensure a new interventions is implemented and follow up is completed to assess effectiveness of interventions implemented after a change in condition. 4 (a and b) Audits of care plans and fall investigations after falls will be completed by the Director of Nursing, Assistant Director of Nursing, MDS Coordinators, and Unit Managers after each fall daily (Monday – Friday) to ensure causative factor is determined, investigation is complete, interventions have been implemented, care plans and care directives updated, and effectiveness of interventions assessed. 4c) The Housekeeping/Laundry Supervisor will audit the laundry aide logs daily (Monday-Friday) to ensure mechanical lift slings are laundered per manufacturers guidelines and that the log is completed for mechanical lift slings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185230	A. BUILDING B. WING	C 08/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH CARE CENTER	945 WEST RUSSELL STREET ELKHORN CITY, KY 41522

(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 323	Continued From page 12 an accurate weight, the CNA pushed the chair away from the resident. At that time, CNA #7 stated she was standing to the left of the resident and the resident "slumped" over and slid out the right side of the sling onto the shower room floor. CNA #7 stated normally there would be two staff members to assist with the use of the mechanical lift for transfers and weights. According to CNA #7, she assumed she could obtain the weight without the assistance of another staff member. The CNA stated she "never imagined that would happen." CNA #7 confirmed it was facility standard of practice to have two staff members whenever a mechanical lift was used for transfers or weights. Interview with Registered Nurse (RN) #2 on 07/31/12, at 10:03 AM, revealed she had been on duty on 07/23/12 when Resident #1 sustained a fall. According to RN #2, she had responded to the CNA's call for help and found Resident #1 on the shower room floor. RN #2 confirmed CNA #7 had used the mechanical lift to obtain the resident's weight without a second staff member to assist. RN #2 stated use of the mechanical lift required two staff persons; however, CNA #7 had used the mechanical lift without assistance. Interview with CNA #6 on 07/31/12, at 9:10 AM, revealed she had been on duty on 07/23/12. CNA #6 stated she had been assigned to obtain resident weights. According to CNA #6 the facility utilized a mechanical lift to obtain resident weights. The CNA stated use of the mechanical lift required two staff members. Interview on 07/30/12, at 5:12 PM, with CNA #4 and CNA #5 revealed there were always two staff	F 323	The Housekeeping/Laundry Supervisor will observe and record the laundry aides laundering mechanical lift slings daily (Monday-Friday) x 60 days, weekly x 8 weeks, monthly x 2 months, then randomly to ensure mechanical lift slings are being laundered correctly. Any issues identified in these audits will be reviewed monthly in the Performance Improvement Committee Meeting. Revisions will be made to the system as indicated. Any change in resident condition will be reviewed and discussed daily (Monday through Friday) in a daily meeting by the Executive Director, Interim Director of Nursing, Assistant Director of Nursing, Unit Managers, MDS Coordinators, and Rehab Service Manager to ensure causative factors have been identified, interventions have been implemented, and care plans and care directives updated. The Regional Director of Clinical Services and Staff Development Coordinator conducted an inservice on 8/20/12 for the Interim Director of Nursing, MDS Coordinators, and Unit Managers related to revision/updating of care plans and care directives to ensure a new interventions is implemented and follow up is completed to assess effectiveness of interventions implemented after a change in condition.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185230		C 08/01/2012

NAME OF PROVIDER OR SUPPLIER: MOUNTAIN VIEW HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 945 WEST RUSSELL STREET, ELKHORN CITY, KY 41522

(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 323	Continued From page 13 persons present when the mechanical lift was in use for patient care. CNA #4 stated she would not operate the mechanical lift without another staff member. Interview with the Director of Nursing (DON) on 07/31/12, at 4:02 PM, revealed the IDT had discussed the fall in the morning stand up meeting. According to the DON, she looked at the facility policy/procedure for use of mechanical lifts and the policy/procedure did not indicate two staff persons were required for use of the mechanical lift. The DON confirmed she did not review Resident #1's assessment nor did she review preventative measures after the incident. 2. Review of the manufacturer's washing instructions for the slings utilized with the mechanical lift revealed the maximum water temperature for washing the slings was 160 degrees, the slings were to be air dried, and bleach was not to be used to launder the slings (bleach could weaken the fibers and cause failure of the sling). Observations of the laundry area on 07/31/12, at 2:35 PM, revealed the facility utilized an ECOLAB three-part laundry system for washing. The system consisted of a detergent concentrate, a softener concentrate, and "Solid Stainaway" concentrate. Review of the Material Data Safety Sheet (MSDS) for the Solid Stainaway revealed the composition of the concentrate was troclosene sodium dihydrate. Troclosene sodium dihydrate can be used for bleaching textiles and, according to the encyclopedia Wikipedia.org, the mechanism action for the sodium dihydrate is noted to be the release of chlorine in low	F 323	5) Date of Compliance – 9/10/12.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185230	A. BUILDING B. WING	C 08/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH CARE CENTER	945 WEST RUSSELL STREET ELKHORN CITY, KY 41522

(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 323	Continued From page 14 concentrations by a constant rate. Observations on 07/31/12, of the mechanical lift slings in use by the facility revealed there were nine white slings that were in use on 07/23/12. There were multiple blue plastic squares approximately one and one-half inches by one inch observed on each of the slings. Interview with the Director of Nursing on 07/31/12, at 2:10 PM, revealed the slings were in use at the time of Resident #1's fall on 07/23/12. The Laundry Supervisor confirmed in interview conducted on 07/31/12, at 2:30 PM, that the slings were washed using the Solid Stainaway concentrate. The Laundry Supervisor was unaware of any manufacturer's care instructions and confirmed no instructions were available for laundry staff. The Laundry Supervisor stated she was unaware the slings could not be bleached. The Laundry Supervisor also stated she was aware of the blue plastic squares on the slings. According to the Laundry Supervisor, staff did not always sort the slings properly and often left disposable incontinence briefs in the slings. The Laundry Supervisor stated the blue closures on the briefs adhered to the slings when they were washed together and could not be removed. 3. A review of the facility's policy entitled Fall Management (not dated) revealed the facility would promote programs geared to improving mobility and stamina, and reduce the risk of falls through a comprehensive, interdisciplinary process of assessment, care plan development, and implementation with ongoing monitoring and review.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185230	A. BUILDING B. WING	C 08/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH CARE CENTER	945 WEST RUSSELL STREET ELKHORN CITY, KY 41522

(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 323	Continued From page 15 A review of the medical record for Resident #4 revealed the facility admitted the resident on 02/10/09, with diagnoses that included Senile Dementia, Anxiety, Seizure Disorder, and Cerebrovascular Accident with right-sided paralysis. Review of the Care Area Assessment (CAA) completed with the annual assessment dated 12/23/11, revealed the facility assessed Resident #4 as at risk for falls due to the need for staff assistance with transfers, ambulation, being impulsive, and the daily use of an antipsychotic medication, antidepressants, diuretics, and frequent urinary incontinence. A review of Resident #4's Annual Minimum Data Set (MDS) assessment signed as complete on 12/23/11, and the most recent quarterly MDS assessment signed as complete on 06/02/12, revealed the facility assessed the resident to require extensive assistance of one person for transfers to or from bed, chair, wheelchair, standing position, toilet use, and hygiene. A review of Resident #4's care plan dated 12/23/11, revised on 06/02/12, revealed the facility identified the resident as at risk for falls. The care plan revealed that approaches the staff could take to prevent resident falls included the use of a chair alarm at all times, an anti-slip pad to the wheelchair at all times, fall risk assessments to be conducted quarterly or with any significant change, a physical therapy or occupational therapy screen as needed, and for the physician to be notified for new orders when the resident experienced a change in condition.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185230		C 08/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH CARE CENTER	945 WEST RUSSELL STREET ELKHORN CITY, KY 41522

(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 323	Continued From page 16 Continued review of the care plan revealed front anti-tip bars on the wheelchair implemented on 12/23/12 were discontinued on 06/14/12. Review of the monthly physician's orders and the Treatment Administration Record (TAR) for July 2012 revealed staff was to ensure Resident #4 had a chair alarm at all times and an anti-slip pad to the seat of the resident's wheelchair. A review of the Daily Care Directive dated 07/31/12, revealed safety devices in place for Resident #4 at that time included a lap tray, a chair pad alarm, and a brace to the resident's right lower leg and foot. The Care Guide further revealed Resident #9 required the assistance of one staff member for mobility/transfer, dressing, and toileting. An interview with Resident #4 on 08/01/12, at 9:35 AM, revealed the resident could reply to questions with one-word answers. When asked about falls Resident #4 stated "slip" and pointed to the wheelchair and then held up the call bell. Observation revealed Resident #4 was sitting in a recliner with an anti-slip pad on the seat of the recliner and a chair pad alarm was noted. Observation of the wheelchair revealed the wheelchair was equipped with a padded tray for only the right side of the wheelchair and had a footrest for the right leg. A chair pad alarm was noted on the wheelchair. A review of documentation in the medical record of Resident #4 and a review of nurse's notes and the facility "Incident Follow-up and Recommendation Forms" revealed Resident #4 had sustained falls on 02/19/12, 03/04/12, 03/22/12, and 05/26/12. According to the incident report dated 02/19/12,	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185230		C 08/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH CARE CENTER	945 WEST RUSSELL STREET ELKHORN CITY, KY 41522

(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 323	Continued From page 17 Resident #4 attempted to ambulate independently and lost his/her balance. However, the incident form contained one witness statement from a CNA that had answered Resident #4's call bell and, based on the CNA's witness statement, Resident #4 reported to the CNA that he/she had fallen out of the chair. It could not be determined by a review of the Incident Form what the resident's activity was at the time of the fall, or if facility staff had interviewed Resident #4 after the fall. Also, it could not be determined by a review of the investigation if the facility had considered causative/contributing factors to the fall. A review of the actions identified by the facility to prevent further falls revealed a therapy screen would be obtained, a "Falling Leaf" program would be implemented for thirty days, and the resident would be re-educated to not throw the chair alarm away. The recommendations/actions developed by the facility failed to document if staff had been educated/in-serviced to ensure the falls interventions were followed. The nurse's notes dated 02/19/12 (the day of the fall), revealed beads from a necklace "covered the floor," however, it could not be determined by a review of the nurse's notes if the resident's chair alarm was intact. As a result of the fall on 02/19/12, Resident #4 sustained two lacerations to the right forehead that required emergency care at the local hospital. According to the nurses' notes one laceration measured 1.2 centimeters by 1.5 centimeters and the second laceration measured 1.0 centimeters by 0.3 centimeters and depth was 0.3 centimeters. The nurse's notes revealed the resident returned to the facility on 02/19/12 with six sutures intact to the lacerated areas. Further review of the incident forms revealed on	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185230	A. BUILDING B. WING	C 08/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH CARE CENTER	945 WEST RUSSELL STREET ELKHORN CITY, KY 41522

(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 323	Continued From page 18 03/04/12 and 03/22/12 Resident #4 fell asleep in the wheelchair and "flipped" out of the wheelchair and onto the floor and sustained bruising to the forehead. Review of the nurse's notes and the incident form failed to reveal if the chair alarm was in place and/or if the alarm sounded, if the front anti-tippers were present on the wheelchair or if a non-skid pad was in place on the seat of the resident's wheelchair. The facility failed to investigate causative factors of the falls and failed to evaluate the effectiveness of the interventions that were in place or document if other interventions had been considered. Also, it could not be determined based on a review of the report if Resident #4 remained on the Falling Leaf Program that was implemented after the fall on 02/19/12. Actions identified by the facility to be taken following the falls on 03/04/12 and 03/22/12 included to encourage the resident to take a rest period in the recliner. Review of the incident form and the nurse's notes revealed Resident #4 sustained a fall on 05/26/12 with no injury. Documentation on the incident form revealed the resident's chair alarm sounded and he/she was found sitting on the floor in front of the wheelchair. Further review of the incident form failed to indicate if the front anti-tippers were present on the wheelchair or if a non-skid pad was intact on the wheelchair seat. The incident form revealed Resident #4 was leaning forward in the wheelchair and slid onto the floor, but failed to indicate what activity the resident was involved in at the time of the fall. There was no documented evidence the facility conducted an interview with Resident #4 to determine his/her activity at the time of the fall or if the facility considered other causative factors. According to the incident form,	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185230	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 08/01/2012
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 945 WEST RUSSELL STREET ELKHORN CITY, KY 41522	

(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 323	Continued From page 19 the recommendations/actions to be taken by staff after the fall sustained on 05/26/12, included the same interventions identified as a result of the falls that occurred on 03/04/12, 03/22/12, and 05/26/12, with the addition of a recommendation to encourage the resident not to lean forward in the chair. An interview conducted with LPN #6 on 07/31/12, at 4:10 PM, revealed she was responsible for conducting fall investigations to ensure interventions were in place. LPN #6 stated every fall is discussed in the morning meeting to try to determine the cause of the fall and what actions to take to prevent additional falls. LPN #6 stated Resident #4 refused a bed, preferred to sleep in a recliner, and frequently fell asleep in the wheelchair. LPN #6 stated the intervention to encourage Resident #4 to sleep in the recliner had not been an effective intervention to prevent falls, and a new wheelchair had been purchased for Resident #4. An interview with the Director of Nursing (DON) on 07/31/12, at 4:40 PM, revealed when a resident sustained a fall, nursing staff was required to completed an incident report, conduct an investigation of the incident, and notify the resident's guardian and physician. According to the DON, the Interdisciplinary Team (IDT) reviewed all incident reports the morning after a fall occurred, reviewed the resident's care plan, and reviewed and evaluated interventions for effectiveness. In addition, the DON stated a therapy screen would be requested if the resident did not receive therapy. Continued interview on 07/31/12, at 4:40 PM, with	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185230		C 08/01/2012

NAME OF PROVIDER OR SUPPLIER: MOUNTAIN VIEW HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 945 WEST RUSSELL STREET, ELKHORN CITY, KY 41522

(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 323	Continued From page 20 the DON revealed incident forms, the medical record, and interviews with staff were conducted as part of the investigation process. The DON stated all falls were discussed at the morning meeting to determine the effectiveness of the interventions. According to the DON, interventions used by the facility to prevent falls included the "Falling Leaf" program, to closely monitor the resident, to ensure personal items were in reach of the resident, encourage the use of the call bell, and to ensure the resident's pathways were clear. After review of the incident form for Resident #4's falls on 02/19/12, 03/04/12, 03/22/12, and 05/26/12, the DON confirmed the investigations were not thorough to determine causative factors, interventions were not evaluated to determine effectiveness, and different interventions had not been implemented.	F 323	**F # 520** 1) A Proactive Risk Assessment was completed by the Regional Director of Clinical Services on 8/7/12 to determine the causative factor of the fall that occurred on 7/23/12 for resident # 1. Resident # 1's a care plans/care directive were updated/revised with interventions identified in the Proactive Risk Assessment findings. Resident # 4's falls for 2/9/12, 3/4/12, 3/22/12, and 5/26/12 were reviewed on 8/8/12 by the Interim Director of Nursing, Assistant Director of Nursing, Rehab Service Manager, and Regional Director of Clinical Services to identify causative factors of falls. Care plans were updated/revised based on findings.	
F 520 SS=G	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee	F 520	2) All residents have the potential to be affected by this practice. A 100% review of all resident's care plans will be completed by 9/10/12 by the Director of Nursing, Assistant Director of Nursing, Regional Director of Clinical Services, and Unit Managers to ensure that care plans were updated/revised with interventions for each occurrence. Each resident was observed to ensure that assistive devices were in use or in place for each resident. Any concerns identified were immediately addressed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185230		C 08/01/2012

NAME OF PROVIDER OR SUPPLIER: MOUNTAIN VIEW HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 945 WEST RUSSELL STREET, ELKHORN CITY, KY 41522

(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 520	Continued From page 21 except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility quality management material it was determined the facility failed to identify issues which required quality assessment and assurance and to develop an appropriate plan of action. A review of facility incident reports/investigations revealed evidence of deficient practice related to the revision and updating of resident care plans. A review of two of six sampled residents (Residents #1 and #4) revealed the facility failed to identify the causative factors related to resident falls and to ensure plans of action to prevent resident falls had been implemented. Resident #1 and Resident #4 had sustained falls with injuries (Refer to F280 and F323). In addition, the facility failed to ensure a plan of correction for the deficiencies cited during the standard survey ending 05/17/12 had been implemented. The findings include: Review of the facility's written description of the Quality Management process (no date) revealed quality problems would be identified through the QA process and the committee would develop a	F 520	3) A Quality Assurance Meeting was conducted on 8/6/12 , attended by the Regional Vice President, Regional Director of Clinical Services, Medical Director, Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Managers, MDS Coordinators, and Rehab Service Manager, to review the Plan of Correction for the survey completed on 5/17/12 to implement a plan to correct issues identified with the survey as it related to care plan revision. A second Quality Assurance will be conducted on 8/31/12 to review incident reports/investigations findings and findings of mechanical lift usage over the past six months. The Regional Director of Clinical Services and Staff Development Coordinator conducted an inservice on 8/20/12 for the Interim Director of Nursing, MDS Coordinators, and Unit Managers related to revision/updating of care plans and care directives after a change in condition to ensure a new interventions is implemented. The Staff Development Coordinator completed an inservice on or by August 31, 2012 for all charge nurses related to revision/updating of care plans and care directives	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185230		C 08/01/2012

NAME OF PROVIDER OR SUPPLIER: MOUNTAIN VIEW HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 945 WEST RUSSELL STREET, ELKHORN CITY, KY 41522

(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 520	Continued From page 22 plan, implement the plan, and monitor until determined the quality problem had been resolved. Review of the facility's plan of correction for deficiencies cited during the standard survey completed on 05/17/12 revealed the Nursing Management Team reviewed the 24-hour reports and care plans on a daily basis, Monday through Friday, to ensure proper documentation, notification of physician and responsible party, and care plan revisions had occurred. The plan also indicated the Director of Nursing (DON) and the Unit Supervisors would conduct audits of the 24-hour shift report to ensure care plans had been revised, as indicated, for changes in resident condition. According to the plan of correction, any issues identified in the audits would be reviewed monthly in the Performance Improvement Committee Meeting. In addition, the facility's plan of correction revealed a 100 percent audit of all care plans was completed on 06/08/12 to ensure care plans were followed as written. Review of the comprehensive care plan for Resident #1 dated 05/14/12 revealed the care plan failed to address the resident's use of a mechanical lift for transfers. On 07/23/12, Resident #1 sustained a fall from a mechanical lift. The resident was transported to an acute care hospital and diagnosed with a fracture to the scapula (shoulder bone), fracture to the clavicle (collarbone), and a strain to the back and neck. Review of the facility's Incident Follow-up and Recommendation Form for Resident #1, dated 07/23/12, revealed a "QA Checklist" area with a	F 520	after a change in condition to ensure new interventions are implemented. Any issues identified will be discussed and addressed in the QA meeting scheduled for 8/31/12. Any change in condition will be reviewed and discussed daily (Monday through Friday) in a daily meeting by the Executive Director, Interim Director of Nursing, Assistant Director of Nursing, Unit Managers, MDS Coordinators, and Rehab Service Manager to ensure causative factors have been identified, interventions have been implemented, and care plans and care directives updated. A weekly falls meeting will be conducted by the Executive Director, Interim Director of Nursing, Assistant Director of Nursing, Unit Managers, MDS Coordinators, and Rehab Service Manager for follow-up and to assess effectiveness of interventions. Falls occurring monthly will be discussed during the Quality Assurance process to ensure completion of follow-up and recommendation forms. Staff will be inserviced upon hire, annually, and as needed related to mechanical lift transfers with assistance of at least two staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185230	A. BUILDING B. WING	C 08/01/2012

NAME OF PROVIDER OR SUPPLIER: MOUNTAIN VIEW HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 945 WEST RUSSELL STREET, ELKHORN CITY, KY 41522

(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 520	Continued From page 23 section to document that the care plan had been updated and the date of the update; however, the section was blank. Review of the facility's Change of Condition Audit used to track care plan updates/revisions, dated 07/24/12, revealed the resident's medical record had been audited due to the patient's fall and the care plan had been updated. The audit form contained documentation of the resident's room number, date, name, any pertinent charting, and whether the physician and family were notified. Additionally, the form had an area for documentation of nursing note start date and nursing note stop date which was not dated for any of the audits conducted. Review of the facility's daily "stand up" meeting, dated 07/25/12, revealed the Director of Nursing was in attendance; however, there was no evidence the Executive Director (ED) was in attendance as required by the ED's signature on the attendance form. Review of the documentation of the meeting discussion revealed the committee discussed the fall sustained by Resident #1 on 07/23/12; however, there was no documentation the facility reviewed the resident's care plan or implemented any preventative measures to ensure the resident's safety. Interview with the Unit Supervisor for the Hope Hall on 08/01/12, at 10:20 PM, revealed she had been responsible for conducting the change of condition audit for Resident #1. The Unit Supervisor stated she checked the resident's care plan and thought it had been updated after the fall. The Unit Supervisor was unaware the	F 520	members or more if needed with mechanical lift transfers. 4) Audits of care plans after a change in condition will be completed by the Interim Director of Nursing, Assistant Director of Nursing, MDS Coordinators, and Unit Managers after each change in condition daily (Monday through Friday) to ensure causative factor is determined, investigation is complete, interventions have been implemented, care plans, care directives updated, and effectiveness of interventions assessed. These audits will continue daily (Monday through Friday) x 60 days, weekly x 8 weeks, monthly x 2 months, then randomly. Any issues identified in these audits will be reviewed monthly in the Performance Improvement Committee Meeting. Revisions will be made to the system as indicated 5) Date of Compliance – 9/10/12.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185230	A. BUILDING B. WING	C 08/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH CARE CENTER	945 WEST RUSSELL STREET ELKHORN CITY, KY 41522

(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 520	Continued From page 24 care plan had no new interventions to prevent further falls related to the mechanical lift. Interview with the Director of Nursing (DON) on 07/31/12, at 4:35 PM, revealed the DON was responsible to ensure care plans were updated. According to the DON, the facility just "missed the ball" on Resident #1. 2. A review of the comprehensive care plan for Resident #4 revealed facility staff reviewed the plan on 06/02/12, and developed approaches to prevent falls. The plan included a chair alarm at all times, an anti-slip pad to the resident's wheelchair at all times, fall risk assessments to be conducted quarterly or with any significant change, a physical therapy or occupational therapy screen as needed, and to notify the physician of changes in the resident's condition. A review of the facility Incident Follow-up and Recommendation Form revealed Resident #4 had sustained falls on 02/19/12, 03/04/12, 03/22/12, and 05/26/12. A review of Resident # 4's Comprehensive Care Plan revealed staff had reviewed the plan on 06/02/12; however, the care plan had not been updated/revised after each fall. One intervention was added to the care plan on 05/26/12, following a fall, that required staff to conduct neurological checks, per facility protocol; however, there were no interventions developed to prevent further falls. Further review noted staff had indicated on the Incident Follow-up and Recommendation Form that the care plan had been updated. An interview conducted on 07/31/12, at 3:30 PM, with the Minimum Data Set (MDS) Coordinator	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185230		C 08/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH CARE CENTER	945 WEST RUSSELL STREET ELKHORN CITY, KY 41522

(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 520	Continued From page 25 revealed the MDS staff was responsible to ensure nursing staff on the units had updated the care plan to reflect the fall and had included any new interventions on the care plan. The MDS Coordinator stated every fall was discussed in the "morning meeting" with the Interdisciplinary Team (IDT) and the care plan was reviewed in the meeting to ensure the care plan had been updated. The MDS Coordinator stated a care plan conference had been held on 04/03/12 and 06/12/12, and at those times Resident #4's falls were discussed and care plans were reviewed. However, upon review of Resident #4's care plan, the MDS Coordinator confirmed the care plan had not been updated to reflect Resident #4's falls. The MDS Coordinator stated the failure of staff to update the care plan to reflect Resident #4's falls "must have been an oversight." During an interview with the ED on 07/31/12, at 5:15 PM, it was revealed the Interdisciplinary Team (IDT) was required to update the care plans at the morning meetings conducted by the supervisory staff. According to the ED, she does not verify staff has completed the required updates of the care plans. The ED stated the audit reports were taken to the facility's Quality Improvement meetings and discussed, but she did not personally review the audits.	F 520		