

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

PRINTED: 01/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185342	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/07/2012
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NAME OF PROVIDER OR SUPPLIER  COLONIAL HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 708 BARTLEY AVENUE BARDSTOWN, KY 40004
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F 000	<p>INITIAL COMMENTS</p> <p>AMENDED 01/03/13</p> <p>An abbreviated/partial extended survey was initiated on 11/26/12 and concluded on 12/07/12, to investigate KY19385. The Division of Health Care substantiated the allegation with Immediate Jeopardy and Substandard Quality of Care identified on 11/29/12 and determined to exist on 11/15/12.</p> <p>On 11/15/12 at 5:15 AM, Resident #1 was transported by a staff member in a wheelchair without foot rests to the shower room for toileting. The facility previously identified Resident #1 to be dependent with the use of the wheelchair due to the resident's inability to raise and hold the feet during wheelchair transportation, required the use of foot rests on the wheelchair at all times. Resident #1 fell from the wheelchair, landed face down on the hallway floor, sustained facial injuries with bleeding, and demonstrated verbal and non-verbal signs and symptoms of pain. The Attending Physician was notified by phone of the fall and injuries sustained by Resident #1, and the resident was returned to bed per physician order as documented in the Nurse's Notes. Resident #1 was not assessed or treated for pain. Staff did not notify the Administrator, Director of Nursing, or Charge Nurse on duty of the fall and injuries sustained by Resident #1 at the time of the incident. Upon arrival of the dayshift staff, Resident #1 was transferred to a local hospital at 8:30 AM for evaluation and treatment. Resident #1 was diagnosed with Left Maxillary Wall Fracture, Bilateral Displaced Nasal Bone Fractures, and Cervical Spine Fracture of the second cervical vertebrae dens and was</p>	F 000	<p>F 000</p> <p>The preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiency. This Plan of Correction is prepared and executed solely because it is required by Federal and State law.</p>	
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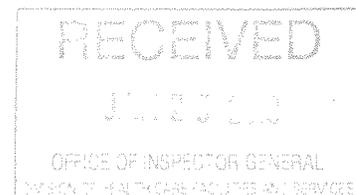
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Russell Bank</i>	TITLE <i>Administrator</i>	(X6) DATE <i>1/3/2013</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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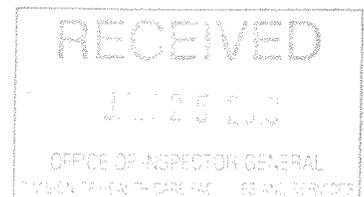
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F 000	Continued From page 1 transferred to the regional Level I Trauma Center for further treatment on 11/15/12 at 2:00 PM. Resident #1 was subsequently designated as palliative treatment only, and expired on 11/16/12 at 3:20 PM.  The facility was notified on 11/29/12 of the Immediate Jeopardy with deficiencies cited at 42 CFR 483.13 Resident Behavior and Facility Practice (F224) scope and severity J, 42 CFR 483.20 Resident Assessment (F280) scope and severity J, 42 CFR 483.25 Quality of Care (F309 & F323) scope and severity J, 42 CFR 493.75 Administration (F490) scope and severity J, with Substandard Quality of Care identified in 42 CFR 483.13 (F224) and 42 CFR 483.25 (F309 and F323). Deficient practice was also identified at F328 at a scope and severity of a D.  An acceptable Allegation of Compliance (AOC) was received on 12/07/12, alleging compliance on 12/07/12. The state agency verified Immediate Jeopardy was removed as alleged on 12/07/12 prior to exit on 12/07/12 which lowered the scope and severity to a D for 42 CFR 483.13 Resident Behavior and Facility Practice (F224), 42 CFR 483.20 Resident Assessment (F280), 42 CFR 483.25 Quality of Care (F309 & F323), and 42 CFR 493.75 Administration (F490), while the facility developed and implemented a plan of correction to achieve substantial compliance with regulation and while the facility's Quality Assurance continues to monitor the effectiveness of staff education, effectiveness of resident assessments and care planning, utilization of tools developed, and revisions to policies and procedures.	F 000			
F 224	483.13(c) PROHIBIT	F 224			



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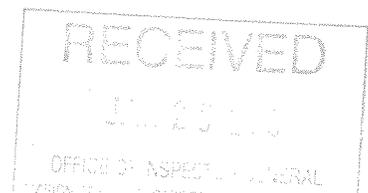
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F 224 SS=J	Continued From page 2 MISTREATMENT/NEGLECT/MISAPPROPRIATN  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy for Abuse Prohibition, it was determined the facility failed to identify and investigate an incident of resident neglect for one (1) of six (6) sampled residents (Resident #1). On 11/15/12 at 5:15 AM, Resident #1 fell face forward onto the hallway floor after staff assisted the resident to transfer in a wheelchair without foot rests to the shower room for toileting. Resident #1 sustained facial injuries and bleeding and was returned to bed per physician order. Resident #1 demonstrated both verbal and non-verbal signs and symptoms of pain; however, no documentation of a pain evaluation or evidence of pain treatment was documented by staff. Staff reported the fall and injuries sustained by Resident #1 to the Attending Physician, on 11/15/12 at 5:15 AM, and the resident was returned to bed per physician order. Staff failed to report Resident #1's injuries to the Administrator, Director of Nursing, and the Charge Nurse at the time of the incident. Resident #1 was transferred to a local hospital for evaluation and treatment of injuries after a dayshift staff member intervened to report	F 224	F-224  1. Resident #1 is no longer a resident of the facility  2. Corporate Consultant and Administrator reviewed all reports of abuse completed over the previous 6 months. Corporate Consultant and Administrator reviewed all reports of incidents (falls, injury of unknown origin, resident to resident altercation) for past 30 days to ensure appropriate investigations were completed as evident by completion of post-fall, post- injury and post altercation investigation. Review was to ensure that all reports were reviewed by the falls committee and that there was evidence that a root cause is identified. This was completed 12-5-12. On December 6, 2012 facility initiated resident and family interviews to determine if resident or family have experienced and/or observed any type of abuse or neglect that they have not reported. These interviews were conducted by	



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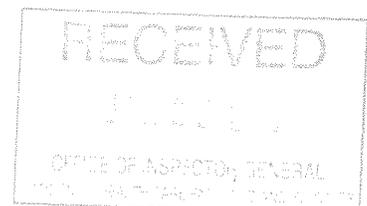
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F 224	<p>Continued From page 3</p> <p>Resident #1's injuries and the need for emergent treatment to the Attending Physician on 11/15/12 at 7:30 AM, and was transferred to the local hospital at 8:30 AM. The facility's failure to identify and investigate an incident of neglect placed residents at risk in a situation that was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 11/29/12 and was found to exist on 11/15/12.</p> <p>The facility provided a Credible Allegation of Compliance (AOC) on 12/07/12 and the state agency verified Immediate Jeopardy was removed on 12/07/12 prior to exit on 12/07/12. The scope and severity was lowered to a D at 42 CFR 483.13 (F224) Prohibit Mistreatment, Neglect, Misappropriation while the facility develops and implements the Plan of Correction to establish an effective system to ensure incidents of neglect are identified and investigated.</p> <p>The findings include:</p> <p>Review of the facility's policy for Abuse Prohibition, dated 02/05/03, revealed the policy was developed to prohibit mistreatment, neglect or abuse of residents, and to provide a means for individuals to report acts, incidents, or events related to resident mistreatment, neglect, abuse, and misappropriation of resident property. The policy defined neglect as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.</p> <p>Review of the clinical record for Resident #1 revealed an admission date of 07/27/11 and diagnoses of Osteoarthritis, Osteoporosis, Knee</p>	F 224	<p>the Director of Social Services and Admissions Coordinator. On December 6, 2012 the facility initiated staff interviews to determine if any employee had observed any type of resident abuse or neglect that they did not report. These interviews were conducted by a Corporate Consultant, Administrator, Medical Records and MDS Coordinator. Interviews were completed on December 20, 2012</p> <p>3. A mandatory in-service on the Abuse Policy and Procedure was provided to all staff on 12-4-12 by the Director of Staff Development and no staff was permitted to work prior to completion of the mandatory education. To evaluate understanding of the facility policy on Abuse staff were asked to complete a questionnaire related to the policy. These were reviewed by the Director of Staff Development for accuracy.</p>	



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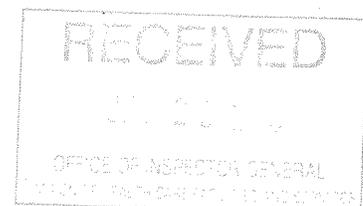
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F 224	<p>Continued From page 4</p> <p>Replacement, Dementia, and a history of Cervical Spine Surgery (Spinal Fusion). A physician order, dated 06/27/12, revealed Resident #1 was an assist of two (2) staff for transfers with the use of the mechanical lift as needed. Review of the Falls Risk Screen for Resident #1, revealed no documented falls; however, review of the facility Falls log revealed Resident #1 fell in the shower due to weakness on 05/27/12, and on 08/22/12 the resident fell during an attempt to transfer unassisted by staff. Review of the annual Minimum Data Set for Resident #1, dated 06/12/12, revealed the functional status for transfer was total dependence with a two person physical assist and cited physical limitations as weakness due to recent hospitalization, limited range of motion, poor coordination, poor balance, visual impairment, and pain.</p> <p>Review of the CNA Care Tracker documentation revealed documentation by staff of Resident #1's transfers without the assist of two (2) staff members, on twenty (20) days in October, 2012 and six (6) days in November 2012. During the combined months of October and November, 2012, Resident #1 was transferred without the assist of two (2) staff members by CNA #1 on one (1) day, CNA #3 on two (2) days, CNA #9 on one (1) day, CNA #11 on two (2) days, CNA #12 on four (4) days, CNA #13 on eight (8) days, CNA #14 on three (3) days, CNA #15 on one (1) day, CNA #16 on one (1) day, and CNA #17 on three (3) days.</p> <p>Review of the facility's incident report, dated 11/15/12 which detailed the fall of Resident #1, was witnessed by one (1) staff member, CNA #1, and detailed the injuries: abrasion to the shoulder</p>	F 224	<p>Corporate Consultant reviewed the Abuse Policy and Procedure including identification of abuse or neglect, types of abuse and neglect, investigation of abuse or neglect, including conducting staff interviews, the initial report, the 5 day report and need to arrive at a conclusion, also discussed protection of residents during the investigation., with the facility Administrator, Director of Nursing, MDS Coordinator, Restorative Nurse, Nurse Supervisor and Director of Staff Development on 12-4-12. A post test was administered to those attending to evaluate understanding of the Abuse Policy.</p> <p>In-service for staff on Abuse Policy and Procedure will be repeated monthly for 3 months then quarterly for 3 quarters then no less than annually. All newly hired employees will be educated on the Abuse Policy during orientation. This will be the responsibility of the Director of Staff Development.</p>



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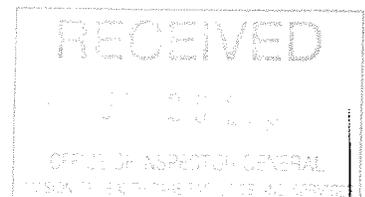
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F 224	Continued From page 5 and right hip, laceration to the bridge of the nose and forehead, and left leg shorter than right. Review of the facility Post Fall Investigation Tool detailed that Resident #1 was pushed in the hall by CNA #1 without foot rests on the wheelchair and fell face forward out of the wheelchair, and the investigation revealed Resident #1 was wearing non-skid socks at the time of the fall. The facility evaluation of findings and documentation of conclusion was stated as "Resident did not have foot pedals on," and included an immediate facility response to reiterate the importance of foot rests.  Interview, on 11/26/12 at 2:35 PM, with CNA #1 revealed on 11/15/12 at 5:15 AM she assisted Resident #1 to stand, pivot, and sit in a wheelchair without assistance and transported the resident to the shower room for toileting. CNA #1 said her shift ended at 6:00 AM and she was in a hurry to complete all of her job functions and did not think to put the foot rests on the wheelchair. CNA #1 stated as she pushed Resident #1 in the wheelchair, the resident lunged forward out of the wheelchair and landed face first on the floor. CNA #1 said Resident #1 was bleeding from her head and nose, and groaned in pain. CNA #1 said Resident #1 was returned to bed after the physician had been notified of the fall. CNA #1 stated she was not aware of a physician order that required staff to utilize an assist of two (2) when transferring Resident #1.  Review of the Nurse's Notes, dated 11/15/12 at 5:15 AM, detailed Resident #1 had lacerations to the forehead and nose with abrasions to shoulder and throughout face, and was non-verbal but	F 224	4. All reports of Abuse will be reviewed by the Corporate Consultant monthly to ensure appropriate investigation and if indicated reporting is completed. All reports of incidents will be reviewed by the Administrator weekly to ensure any incident that appropriate investigation occurs. Director of Social Services to interview each resident or if resident not interviewable, a family member or responsible party, quarterly on if they have observed or experienced any form of abuse or neglect that they have not reported. Director of Social Services or Activities Director to review the facility Policy on Abuse in the monthly Resident Council meeting and request feedback regarding any concerns related to abuse or neglect. Any concerns voiced will be immediately investigated and if appropriate reported to the appropriate agencies.		



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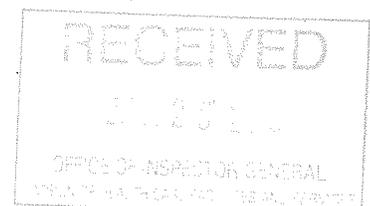
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F 224	<p>Continued From page 6</p> <p>grimaced with movement. Nursing documentation revealed the status of Resident #1 was reported to the physician and an order was obtained to return the resident to bed and to clean lacerations and apply steri-strips. The nursing documentation included vital signs; however, there was no assessment of pain and no documentation of pain medication administration for Resident #1. Further review of the Medication Administration Record for Resident #1, detailed the resident had an order for Ibuprofen 600 milligrams to be given daily at 9:00 AM, and Acetaminophen 325 milligrams, two (2) tablets to be given every four (4) hours for pain.</p> <p>Interview by telephone, on 11/26/12 at 3:30 PM, with LPN #1, revealed she was not aware she did not provide a pain assessment for Resident #1, and stated she was more concerned with the physical injuries the resident sustained. LPN #1 stated when she reported the extent of Resident #1's injuries to the physician, and he asked if the resident was a DNR (Do Not Resuscitate) status, she confirmed the DNR status of the resident, the physician requested the resident be returned to bed. LPN #1 stated she was not aware that she could have called the Medical Director on the behalf of Resident #1 to request emergent treatment, and did not know she had the authority to contact EMS (Emergency Medical Systems) for transfer of the resident to an acute facility without an order from the physician in case of a resident emergency.</p> <p>Interview by telephone, on 11/26/12 at 4:03 PM, with RN #1 revealed she was working on 11/15/12 and was the designated Charge Nurse</p>	F 224	<p>Facility has established a QA sub-committee that will meet monthly to review the implementation of the POC and monitor compliance. This sub-committee is comprised of the Administrator, Director of Nursing, Director of Staff Development, Nurse Supervisor, MDS Coordinator, a staff nurse, a nursing assistant and corporate consultant. Results of all audits, reviews and interviews will be reviewed by the QA Sub-committee and then reported to the facility QA Committee no less than quarterly for one year.</p> <p>Date of completion 12-27-12</p>	



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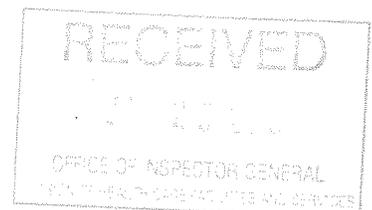
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F 224	<p>Continued From page 7</p> <p>when Resident #1 fell. RN #1 stated she was not told by LPN #1 that Resident #1 fell, she overhead another staff member discussing the fall at 6:00 AM or 6:30 AM that morning. RN #1 said the shift had been very busy, but she went to take a look at Resident #1, and returned to the nurse's station and told LPN #1 the resident needed to "go out (to the hospital)." RN #1 stated a short time later, LPN #2 from day shift arrived and assisted LPN #1 to transfer Resident #1 to the hospital. RN #1 said she was a new nurse and stated she was "not always sure what to do" when she was assigned to the Charge Nurse role.</p> <p>Interview, on 11/27/12 at 7:10 AM, with CNA #3 revealed she was working on 11/15/12 at 5:15 AM when she heard a loud "thud," and what sounded like a wheelchair turned over. CNA #3 said she came out of a resident room and found Resident #1 lying face down on the hallway carpet with arms folded underneath the resident. CNA #3 said Resident #1 was bleeding from the face and noticed one leg appeared to be longer than the other. CNA #3 stated Resident #1 was in "obvious pain" and was returned to bed after physician notification. CNA #3 stated she stayed with Resident #1 in the resident's room from 5:30 AM until 7:30 AM, as the resident continued to bleed from the face and moan in pain. CNA #3 stated she reported the continued bleeding to the LPN #1 multiple times as she attempted to control the bleeding and told LPN #1 that Resident #1 was bleeding, in pain, and needed to go to the hospital. CNA #3 stated LPN #1 did not return to observe or assess Resident #1, from 5:30 AM until 7:30 AM.</p>	F 224		



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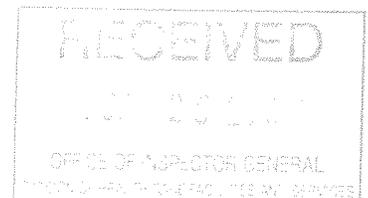
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F 224	<p>Continued From page 8</p> <p>Interview, on 11/27/12 at 1:40 PM, with CNA #6 revealed on 11/15/12 she arrived to work at 6:00 AM and did walking rounds with CNA #1 and was told that Resident #1 had fallen face forward from the wheelchair without foot rests. CNA #6 said when she went into Resident #1's room she was shocked at what she saw; CNA #3 was holding wash cloths on the residents face, but the bleeding would not stop, the amount of blood was "awful", the resident groaned, and it was obvious the resident was in pain. CNA #6 said she did not finish rounds, she stayed with CNA #3 to try to stop the bleeding. CNA #6 said CNA #3 went several times to tell the nursing staff that Resident #1 continued to bleed, and CNA #6 said no nurses came to the resident's room, so at 7:00 AM, she went to speak with LPN #3 who had just clocked in to work and told her Resident #1 was bleeding badly. CNA #6 said LPN #3 told her, "Yes, I know, I have been told, just go to the room and apply pressure." CNA #6 said LPN #3 came into the room sometime later, just prior to the arrival of EMS. CNA #6 stated she did not believe the nursing staff responded appropriately to the concerns she and CNA #3 had reported and said Resident #1 should have not suffered like that, and stated the accident was avoidable if the foot rests had been placed on the wheelchair.</p> <p>Interview, on 11/27/12 at 2:37 PM, with LPN #3 revealed that she was working on 11/15/12 and received report from LPN #2 regarding the fall of Resident #1. LPN #3 stated Resident #1 was weak in both lower extremities and stated it would be dangerous to transport Resident #1 in the wheelchair without the foot rests on the wheelchair because the resident could not raise and hold his/her feet up for staff assisted</p>	F 224		



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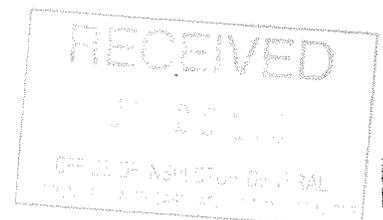
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F 224	<p>Continued From page 9</p> <p>wheelchair transfers. LPN #3 stated after obtaining report from LPN #2 at 7:00 AM, she went to observe Resident #1 and found the resident was bleeding from both nares, had multiple facial lacerations, and thought it was obvious the resident had a broken nose. Resident #1 told LPN #3 that he/she "hurt all over."</p> <p>Interview, on 11/30/12 at 2:30 PM, with the Vice President of Operations (VPO) revealed Resident #1's fall on 11/15/12 was an accident and should not have happened and was a result of the foot rests not being replaced on the wheelchair. The VPO stated as a result of the facility's investigation it was understood that Resident #1 did not have the strength or mobility to lunge from the wheelchair as reported by CNA #1, and it was determined by the facility investigation that the resident's feet became entangled under the wheelchair which caused the resident to be propelled from the wheelchair. The VPO stated CNA #1 and LPN #1 had been suspended pending the results of the facility investigation, and stated CNA #1 voluntarily terminated her employment with the facility. The VPO stated LPN #1 was terminated on 11/30/12 as a result of her failure to take emergent action to obtain emergency treatment, failure to follow the emergency procedure, and failure to document appropriate actions for Resident #1 on 11/15/12.</p> <p>Interview by telephone, on 12/02/12 at 10:50 PM, with LPN #6 revealed she was aware Resident #1 was a two (2) person assist and required foot rests on the wheelchair at all times because the resident was not able to self-propel in the the wheelchair due to limited mobility in the lower</p>	F 224			



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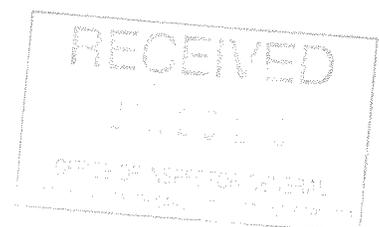
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F 224	<p>Continued From page 10</p> <p>extremities. LPN #6 defined neglect as not taking care of a resident in the proper way, and stated when Resident #1 fell out of the wheelchair on 11/15/12, this was an incident of neglect because the foot rests were required to maintain the resident's safety.</p> <p>Interview, on 12/05/12 at 2:28 PM, with LPN #2 revealed when she arrived to begin her shift on 11/15/12 at 7:00 AM, she was told by CNA #6 that Resident #1 had fallen, was injured, and needed to go to the hospital for treatment. LPN #2 said she went to observe the extent of the injuries to Resident #1, and quickly determined the resident needed to be transferred to the hospital for treatment. LPN #2 stated due to the extent of Resident #1's injuries, she thought the resident was experiencing pain. LPN #2 said she noted the resident was doing a lot of swallowing and thought the resident may have been swallowing blood. LPN #2 stated her primary concern for Resident #1 was to get the resident to the hospital before the resident developed impaired respiratory function as a result of a non-apparent internal injury. LPN #2 stated neglect was defined as withholding care, food, treatment, or pain medication. LPN #2 stated Resident #1 should have been treated for pain and EMS (Emergency Medical Systems) should have been called when the accident occurred and failure to do so would constitute neglect.</p> <p>Interview, on 12/05/12 at 1:43 PM, with the Medical Director revealed he participated in a Quality Assurance and Assessment meeting by phone during the prior week to determine facility interventions to prevent recurrence of falls, such as the fall sustained by Resident #1. The Medical</p>	F 224			



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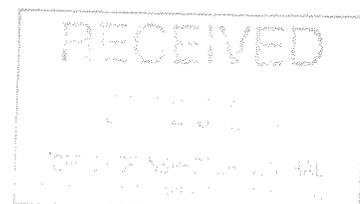
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F 224	<p>Continued From page 11</p> <p>Director stated he could not comment on what the appropriate nursing actions were when Resident #1 fell because he did not know what exactly happened and was not told of the extent of the injuries. The Medical Director stated when possible head trauma was suspected, it would be prudent to transfer the resident, even if the resident was a DNR (Do Not Resuscitate) status, to the hospital for an evaluation as soon as possible to ensure the best outcome, and said failure to take emergent action could be interpreted as neglect.</p> <p>Review of the acceptable Allegation of Compliance (AOC), on 12/07/12, revealed the facility took the following immediate actions:</p> <ol style="list-style-type: none"> <li>1. The Medical Director was advised of the Immediate Jeopardy on 11/29/12.</li> <li>2. The Corporate Consultant reviewed the Abuse Policy and Procedure with the facility Administrator, Director of Nursing, MDS Coordinator, Restorative Nurse, Nurse Supervisors, and Director of Staff Development on 12/04/12.</li> <li>3. A mandatory in-service of the Abuse Policy and Procedure was provided to staff on 12/04/12, by the Director of Staff Development and no staff was permitted to work prior to completion of the mandatory education.</li> <li>4. The Corporate Consultant and Administrator reviewed all reports of abuse completed over the prior six (6) months and it was determined there were no reports of abuse. In addition, the Corporate Consultant and Administrator reviewed</li> </ol>	F 224		



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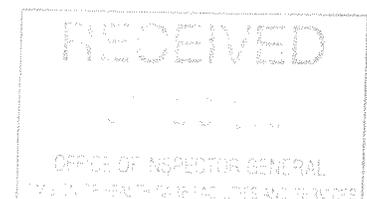
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F 224	<p>Continued From page 12</p> <p>all incident reports over the last thirty (30) days to ensure all appropriate investigations were completed by the facility to determine a conclusion or root cause.</p> <p>5. All current residents were interviewed by the Master Social Services Worker (MSSW) to determine if any resident experienced or exhibited any signs of abuse or neglect. In the case of current residents who were identified not to be cognitively intact, the MSSW interviewed a responsible party for the resident to identify any signs or symptoms of abuse or neglect.</p> <p>The State Agency validated the AOC on 12/07/12 prior to exit as follows:</p> <p>1. The State Agency validated by interview with the Medical Director, on 12/05/12 at 12:55 PM, revealed he was contacted by the facility Administrator and Corporate Consultant and advised of the Immediate Jeopardy, but was not certain of the date of notification.</p> <p>2. The State Agency validated by review of the content of the Abuse Policy and Procedure, and review of the signed attendance sheet that the Administrator, DON, MDS Coordinator, Restorative Nurse, Nurse Supervisors, and Director of Staff Development received the training on 12/04/12. Validation was supported by review of the post-test examinations which demonstrated understanding of the Abuse Policy and Procedure.</p> <p>3. The State Agency validated by review of the content of the Abuse Policy and Procedure, and review of the signed attendance sheet that the</p>	F 224		



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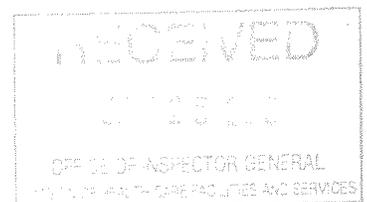
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F 224	Continued From page 13 staff received abuse and neglect training on 12/04/12 and no staff members were permitted to return to work prior to completion of the mandatory abuse training. Staff abuse interviews, on 12/01/12 at 12:45 PM with LPN #4, and on 12/06/12 at 6:30 AM with CNA #8, revealed both staff identified failure to provide necessary goods and services to a resident to meet their needs was neglect. Both LPN #4 and CNA #8 recognized failure to assess and treat resident pain constituted resident neglect.  4. The State Agency validated by record review and interview of the Administrator on 12/07/12 at 7:00 PM, there were no reports of abuse or neglect made within the facility in the last six (6) months. Further interview with the Administrator revealed all incident reports in the facility for the last thirty (30) days were reviewed and were initialed by the Administrator and the Corporate Consultant to validate the root cause of all incidents were determined after the facility completed a thorough investigation.  5. The State Agency validated by interview, on 12/07/12 at 6:45 PM, with the Director of Social Services that all cognitively intact residents were surveyed by the facility to determine if any residents had experienced or witnessed abuse or neglect in the facility. Review of the Resident Roster, used by the Director of Social Services for interview, revealed all cognitively intact residents were interviewed, and the responsible party was interviewed for residents who were not identified to be cognitively intact. It was determined that no residents or responsible parties of residents had experienced or witnessed abuse or neglect in the facility.	F 224			



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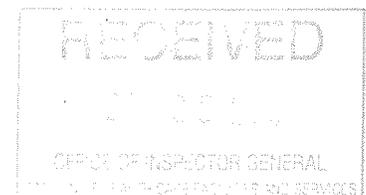
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F 224	Continued From page 14	F 224			
F 280 SS=J	<p>6. Attempts to further interview CNA #1, LPN #1, and RN #1 during the extended partial survey did not occur as multiple phone messages were not returned by the staff members. Interview, on 11/30/12 at 2:30 PM, with the VP of Operations revealed CNA #1 and RN #1 voluntarily terminated employment at the facility, and the employment of LPN #1 was terminated on behalf of the facility, on 11/30/12.</p> <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</p>	F 280	<p>F-280</p> <p>1. Resident #1 is no longer a resident of the facility. The Care Plan for Resident #4 related to Impaired Cognition was located and provided to the surveyor prior to exit. MDS Coordinator reviewed the care plan to ensure it was current and placed the care plan in the care plan binder accessible to all staff.</p> <p>The Care Plan for resident #5 related to Pressure Ulcers was located and provided to the surveyor prior to exit. MDS Coordinator reviewed the care plan to ensure it was current and placed the care plan in the care plan binder accessible to all staff.</p>		



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F 280	Continued From page 15 by: Based on observation, interview, record review, and review of the CMS Care Plan instructions provided by the facility, it was determined the facility failed to ensure the Nursing and CNA Care Plans for one (1) of six (6) sampled residents included interventions to ensure the use of foot rests on the wheelchair to maintain resident safety after it was determined the resident was dependent with use of the wheelchair and required foot rests at all times to maintain resident safety. On 11/15/12 at 5:15 AM, Resident #1 was transported in a wheelchair by staff without the use of foot rests on the wheelchair. Resident #1 fell from the wheelchair face forward onto the floor and sustained head injuries. Resident #1 was transferred to a local hospital for assessment and treatment on 11/15/12 at 8:30 AM and was diagnosed with Left Maxillary Wall Fracture, Bilateral Displaced Nasal Bone Fractures, and Cervical Spine Fracture of the second cervical vertebrae dens. On 11/15/12 at 2:00 PM, Resident #1 was transferred to the regional Level I Trauma Center for further treatment. The Resident expired on 11/16/12 at 3:20 PM. In addition, the facility failed to ensure the Nursing Care plans for three (3) of six (6) sampled residents (Residents #4, #5, and #6) were updated to reflect all necessary nursing interventions. The failure of the facility to ensure Nursing and CNA Care Plans were updated placed residents at risk in a situation that was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 11/29/12 and was found to exist on 11/15/12.  The facility provided a Credible Allegation of Compliance (AOC) on 12/07/12 and the State	F 280	The Care Plan for Resident #6 related to Urinary Incontinence was developed on December 27, 2012 by Administrative Nurse. The care plan was placed in the care plan binder accessible to all staff.  2. On December 3, 2012 the Director of Nursing, MDS Coordinator, Director of Social Services, Restorative Nurse, restorative Aide, Therapy Manager, and Director of Staff development reviewed all resident care plans and nurse aide assignment sheets to ensure care plans were reflective of care and services provided to each resident. Included in this review was transfer status, safety devices, fall prevention interventions, non-use of foot pedals, restraints, and toileting programs. Care plan revisions were made as indicated. On December 28, 2012 MDS Coordinator, Administrative Nurse, and Social Service	



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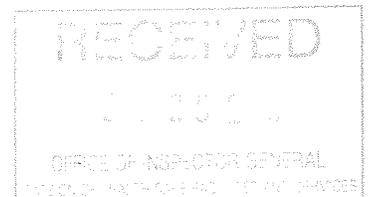
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F 280	<p>Continued From page 16</p> <p>Agency verified Immediate Jeopardy was removed on 12/07/12 prior to exit on 12/07/12. The scope and severity was lowered to a D at 42 CFR 483.20 (F280) Revised Care Plan, while the facility develops and implements the Plan of Correction to establish an effective system to ensure care plans are revised appropriately and available to staff.</p> <p>The findings include:</p> <p>Review of the CMS 4.7 RAI (Resident Assessment Instrument) and Care Planning (copy) provided by the facility as the basis for the care plan function, determined the comprehensive care plan was an interdisciplinary communication tool that included measurable objectives, time frames, and described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan was to be reviewed and revised periodically and the services provided or arranged should be consistent with each resident's written plan of care.</p> <p>1. Review of the clinical record for Resident #1 revealed an admission date of 07/27/11, with diagnoses of Osteoarthritis, Osteoporosis, Knee Replacement, Dementia, and a surgical history of cervical spine fusion. Review of the Falls Risk Screen for Resident #1, revealed no documented falls; however, review of the facility's Falls Log revealed Resident #1 fell in the shower due to weakness on 05/27/12, and on 08/22/12 the resident fell during an attempt to transfer unassisted by staff.</p>	F 280	<p>Director reviewed the CAA's of the most recent Comprehensive MDS for each resident and compared the CAA to the current Care Plan. Care Plans were revised as needed, CAA's were amended if indicated, to ensure all areas identified as requiring care plans were addressed .</p> <p>An interdisciplinary Team (Director of Nursing, Restorative Nurse, MDS Coordinator, Therapy Manager, Administrator, Staff Development Director and Director Of Social Services) met on Nov 29, 2012 to evaluate all residents utilizing a wheelchair for mobility to determine the need for wheelchair pedals and establish facility policy as it relates to the use of foot pedals. The facility practice will be to have foot pedals on all wheelchairs unless care planned otherwise, such as residents who are self- mobile in the wheelchair who use their feet to propel the wheelchair.</p>	



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F 280	<p>Continued From page 17</p> <p>Review of the annual Minimum Data Set for Resident #1, dated 06/12/12, revealed the functional status for transfer was total dependence with a two person physical assist and cited physical limitations of weakness due to recent hospitalization, limited range of motion, poor coordination, poor balance, visual impairment, and pain. Further review of the MDS revealed no documentation regarding Resident #1's prior falls on 05/27/12 or 8/22/12. Review of the Care Area Assessment (CAA) Summary revealed Resident #1 triggered for Falls. The facility's 'Review of Indicators of Falls' detailed the facility's plan to develop a care plan for Resident #1 to address falls, based on risk factors related to the care area such as diuretic use with Incontinence, arthritis, osteoporosis, and depression.</p> <p>Review of the facility's Care Plan for Resident #1, revealed the problem of falls was addressed by the facility as a result of diuretic use, glasses, and anti-depressant use with interventions developed to address the related problems identified. Resident #1's prior falls on 05/27/12 and 08/22/12 were not addressed by the care plan and no specific interventions were identified to address the falls risk such as required foot rests on the wheelchair.</p> <p>Review of the CNA (Certified Nursing Assistant) Care Plan, updated 10/23/12, revealed Resident #1 required assist of two (2) staff for transfers, with glasses, and oxygen as needed. The need for foot rests on the wheelchair for Resident #1 to maintain resident safety was not included on the CNA Care Plan.</p>	F 280	<p>Residents were identified and evaluated as 1. Residents who utilize and require foot pedals to be transported safely.2. Residents who are self -mobile in wheelchair by using their feet to propel the wheelchair and are able to raise their feet for staff assisted transport.3. Residents who are self-mobile in their wheelchair by using their feet to propel the wheelchair but are unable to raise their feet for staff assisted transport and would require foot pedals for staff assisted transport.4. Residents who are self-mobile in the wheelchair by suing their feet to propel the wheelchair but are unable to raise their feet for staff assisted transport and will not utilize foot pedals so will be walk assisted transport.</p> <p>2. Nurse Aide Assignment sheet format was updated Dec. 4, 2012 by the Director of Nursing to reflect the use of foot pedals based on the reviews completed Dec 3, 2012. Changes to the nurse aide assignment sheet will</p>	



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F 280	<p>Continued From page 18</p> <p>Review of the facility incident report, dated 11/15/12, which documented the fall of Resident #1 detailed the injuries as: abrasion to the shoulder and right hip, laceration to the bridge of the nose and forehead, and left leg shorter than right. Review of the facility Post Fall investigation tool detailed that Resident #1 was pushed in the hall by CNA #1 without foot rests on the wheelchair and fell face forward out of the wheelchair and the investigation revealed Resident #1 was wearing non-skid socks at the time of the fall. The facility evaluation of findings and documentation of conclusion was stated as "Resident did not have foot pedals on," and included an immediate facility response to reiterate the importance of foot rests.</p> <p>Interview by telephone with CNA #1, on 11/27/12 at 11:20 AM, revealed on 11/15/12 at 5:15 AM she transferred Resident #1 without assist of another staff member to a wheelchair. CNA #1 stated she did not remember to place the foot rests on the wheelchair before she transported Resident #1 to the shower room for toileting. CNA #1 stated as she pushed the wheelchair in the hallway, Resident #1 lunged forward from the wheelchair and fell face down on the floor and began to bleed from the head and nose. CNA #1 stated she was not aware Resident #1 required an assist of two (2) staff for transfers, however she was aware the resident required foot rests on the wheelchair at all times.</p> <p>Interview by telephone with LPN #1, on 11/26/12 at 3:30 PM, revealed when she assessed Resident #1 after the fall on 11/15/12 the resident did not respond to verbal stimulus and would only move to withdraw to painful stimulus. LPN #1</p>	F 280	<p>be made any time there is a change in the care needs of the resident. It is the responsibility of each nurse to update the assignment sheet for each resident when there is a change. Changes may be initiated by a fall, an incident, a resident request, a change in condition, etc. When a change in the assignment sheet is initiated it is also made on the master assignment sheet and placed on a communication sheet in front of the assignment sheets. Assignment sheets are printed at the end of each shift for the oncoming shift by the Nurse Supervisor or a Nurse in Charge. It is the responsibility of the Nurse Supervisor or Nurse in Charge to compare the communication sheet changes with the master assignment sheet to ensure all changes are made. No less than weekly, the Director of Staff Development will review the master assignment sheet and the communication sheet to ensure</p>		

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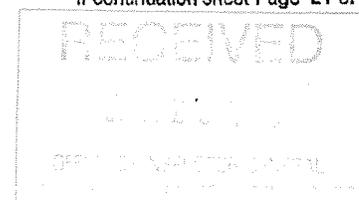
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F 280	<p>Continued From page 19</p> <p>detailed the injuries to Resident #1 as lacerations to the left eyebrow, face, nose. LPN #1 said Resident #1 continued to bleed from the lacerations until the resident was transported via Emergency Medical Services that morning.</p> <p>Interview, on 11/27/12 at 12:29 PM, with the Director of Therapy (DOT) revealed that Resident #1 was last treated in June, 2012 and did not meet the Therapy Goals, as the resident still required an assist of two (2) staff with mechanical lift for transfers. The DOT recalled that Resident #1 had lots of pain, which was osteoarthritic (joint/bone pain as a result of aging) in nature. The DOT was not sure where in the chart staff would locate information related to whether a resident required foot rests on the wheelchair for staff assisted transfers. The DOT stated if a resident was evaluated by Physical Therapy to be dependent with the use of the wheelchair, she would assume the resident would also require foot rests on the wheelchair. The DOT stated the facility did not have a policy used to determine the need for a resident to have foot rests on the wheelchairs. The DOT stated that Physical Therapy did not evaluate all residents for the need of foot rests, because not all residents were referred for Physical Therapy Treatment at the facility.</p> <p>Interview, on 11/27/12 at 2:37 PM, with LPN #3 revealed that CNAs carry a copy of the CNA Care Plan with them during their shift, and said copies of the CNA Care Plans were maintained on each nursing station for staff to review. LPN #3 said the CNA Care Plan included individual resident care needs, to assist the CNA to provide appropriate care for each resident. LPN #3 said</p>	F 280	<p>all changes were made. The master assignment sheet is also reviewed with each care plan to ensure consistency with care plan interventions. Nursing staff were educated on the process and responsibility to update nurse aide assignment sheets by the Director of Nursing, Nurse Manager and the Director of Staff Development. This was completed on Dec.6, 2012. Following the review of the care plans, a list was developed for placement in front of each book of MAR's, TAR's, Care Plans and Nurse Aide Assignment sheets listing residents requiring: Foot Pedals, Foot Pedals for staff assisted transport and residents requiring handheld assisted transport. This is a quick reference for nurses, aides and other staff.. This list is manually updated whenever there is a change and could be updated by a nurse, Nurse Supervisor, Restorative Nurse, or Director of Nursing. This list is to be reviewed in the weekly falls management</p>		

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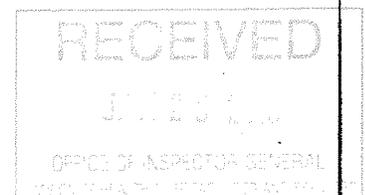
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F 280	<p>Continued From page 20</p> <p>after review of the CNA Care Plan, updated 10/23/12, there was no documentation to ensure CNA staff were aware of the need for Resident #1 to maintain foot rests on the wheelchair at all times to maintain resident safety. LPN #3 stated if the information was not available on the CNA Care Plan, the staff would have no other way to determine the need for foot rests on the wheelchairs, and said the Director of Nursing (DON) was responsible for updating the CNA Care Plans.</p> <p>Interview, on 11/28/12 at 9:00 AM, with LPN #4 revealed that all CNAs should have been aware that Resident #1 required foot rests on the wheelchair at all times because it was documented on the CNA Care Plan. Upon review of the CNA Care Plan, last updated, 10/23/12, LPN #4 stated there was no documentation to state that Resident #1 required the foot rests and did not know why the information was not included on the CNA Care Plan. LPN #4 stated the CNAs relied on the information on the CNA Care Plan to provide the appropriate care to the residents. LPN #4 stated the Director of Nursing (DON) was responsible for updating the CNA Care Plans.</p> <p>Interview, on 11/27/12 at 1:25 PM, with CNA #2 revealed documentation of a resident need for foot rests on the wheelchair at all times should be documented on the CNA Care Plan. Upon review of the CNA Care Plan, last updated 10/23/12, CNA #2 found there was no documentation of the need for foot rests on the wheelchair for Resident #1. CNA #2 said staff understand when a resident was not able to lift and hold their feet for a staff assisted transfer in the wheelchair, the</p>	F 280	<p>meeting to ensure all updates are made. Staff was educated on the use of this list by the Director of Staff development on Dec. 5, 2012.</p> <p>Re-education provided to staff beginning Nov. 16, 2012 and completed on Dec. 3, 2012 on 1. Following nurse aide care plans</p> <p>2. Transporting residents in wheelchairs and 3. Use of foot pedals for wheelchair transport. This was completed by the Director of Staff Development. This in service will be repeated monthly for 3 months beginning Jan.2013 then quarterly for 3 quarters then include in an annual in-service. All newly hired staff will be educated during orientation. This will be completed by the Director of Staff Development.</p> <p>Re-education provided by Corporate Consultant to all licensed staff beginning on Nov 30, 2012 and completed on Dec. 3, 2012 on Care Plans, including reviewing and revising, setting measurable goals and utilizing the care Plan as a</p>		



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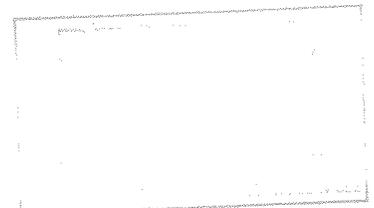
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F 280	<p>Continued From page 21</p> <p>resident required the use of foot rests to maintain resident safety.</p> <p>Interview, on 11/28/12 at 6:01 AM, with CNA #8 revealed all CNAs use the CNA Care Plan as a guide to provide the appropriate care for residents. CNA #8 said if a resident required foot rests on the wheelchair at all times, it should be documented on the CNA Care Plan. Upon review of the CNA Care Plan, last updated 10/23/12, CNA #8 found there was no documentation of the need for Resident #1 to have the foot rests on the wheelchair. CNA #8 stated that some of the new CNA staff had complained a couple of months ago that the CNA Care Plans did not include the most current information, and said some necessary changes had been discussed before at a staff meeting.</p> <p>Interview, on 11/27/12 at 3:35 PM, with the Director of Nursing (DON) revealed that she was responsible for updating the CNA Care Plans and was aware there was no documentation of the need for the foot rests on the wheelchair at all times for Resident #1, but was not sure why the information was not current on the CNA Care Plan, last updated 10/23/12. The DON stated she did not believe the facility's failure to ensure the foot rests were on the wheelchair for Resident #1 contributed to the fall on 11/15/12 because residents fall all of the time. However, the DON stated the failure to document the need for foot rests on the wheelchair on the CNA Care Plan could increase the risk of a fall for a resident. The DON stated no Falls Care Plan was initiated for Resident #1 because the resident never had any prior falls at the facility.</p>	F 280	<p>communication tool.</p> <p>Opportunity for questions was provided and prior to end of each presentation understanding was evaluated by participants answering questions related to the material. All newly hired licensed nursing staff will be educated on the above during orientation by the Director of Staff Development. Re-education on Care Plans including revision of care plans, provided to the Care Plan Team (MDS Coordinator, Director of Social Service, Dietary manager and Activities Director) by Corporate Consultant on Dec. 3, 2012.</p> <p>Opportunity for questions was provided and prior to end of each presentation understanding was evaluated by participants answering questions related to the material.</p> <p>Therapy Manager instructed on facility practice to have foot pedals on all wheelchairs unless car planned otherwise, ie. self-mobile with feet, at risk for</p>		



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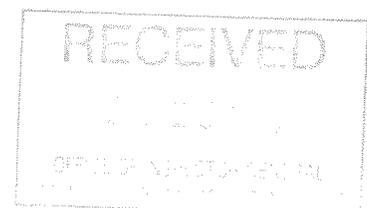
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F 280	<p>Continued From page 22</p> <p>Interview, on 12/04/12 at 12:13 PM, with the MDS Coordinator revealed she was responsible to develop care plans for residents who were triggered for a focused area and the care plan was reviewed with the Interdepartmental Team quarterly to determine effectiveness and necessary updates. The MDS Coordinator stated she was aware Resident #1 fell in the shower room and had another fall previously, but was not sure why the falls were not addressed on the Nursing Care Plan with appropriate interventions. The MDS Coordinator stated the Falls Care Plan was last reviewed for Resident #1 on 09/27/12.</p> <p>2. Review of the clinical record for Resident #4, revealed an admission date of 09/25/12 with diagnoses Metabolic Encephalopathy, and Dementia. Review of the MDS dated 10/02/12, for Resident #4, revealed in Section C the resident scored 04 on the Brief Interview for Mental Status (BIMS) testing, and the Care Area Assessment Summary triggered Cognitive Loss and the facility documented intention to Care Plan the Focus of Cognition to reduce further cognitive loss. Review of the Comprehensive Care Plan at the Nurse's Station, revealed no plan for Cognitive loss for Resident #4.</p> <p>Review of the clinical record for Resident #5, revealed an admission date of 10/27/12, with diagnoses History of falls with hip fracture, Urinary Tract Infection, Chronic Airway Obstruction, Anemia, and Pulmonary Hypertension. Review of the MDS dated 11/03/12, for Resident #5, revealed the Care Area Assessment (CAA) Summary identified Pressure Ulcer as a focus for the resident. The facility documented intention to address the focus of</p>	F 280	<p>injury related to foot rests, etc.by Corporate Consultant prior to providing education to therapy staff. Re-education provided to therapy staff by therapy manager on use of wheelchairs and facility practice on use of foot pedals on Dec. 3, 2012.</p> <p>3. Administrative Staff (Director of Nursing, Nursing Supervisor, Administrator, Administrative Nurses, Medical records) completed audits no less than 2 times per day beginning Nov. 30, 2012 and continuing through December 21, 2012. Audits were then completed no less than daily through January 11, 2013. To ensure residents requiring foot pedals have them during transport. Beginning January 12, 2013 audits will be completed 3 times per week for 4 weeks then weekly for 4 weeks then will be assigned to the MDS Coordiantor as a quarterly review by the facility QA Committee. Audits are</p>	



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F 280	<p>Continued From page 23</p> <p>Pressure Ulcer for Resident #5 based on the resident taking anti-depressants, recent hip fracture, and confinement to the bed or chair most of the time. Review of the Comprehensive Care Plan at the Nurse's Station revealed no plan for Pressure Ulcer for Resident #5.</p> <p>Review of the clinical record for Resident #6, revealed an admission date of 08/16/09, with diagnoses Progressive Idiopathic Scoliosis, Congestive Heart Failure, Anxiety, Cataract, and Irritable Bowel Syndrome. Review of the MDS, dated 10/19/12, for Resident #6, revealed the resident was on a toileting program and was occasionally incontinent of urine (less than seven episodes of incontinence in a week) and the Care Area Assessment (CAA) Summary identified Urinary Incontinence as a focus for Resident #6. The facility documented intention to care plan for Urinary Incontinence due to functional incontinence and Congestive Heart Failure with the use of Lasix for medical management. Review of the Comprehensive Care Plan at the Nurse's Station revealed no plan for Urinary Incontinence for Resident #6.</p> <p>Interview, on 12/04/12 at 2:55 PM, with the MDS Coordinator revealed she was not sure why the Comprehensive Care Plans stored in binders on the Nursing Unit was not complete for Resident #4, Resident #5, or Resident #6 and said the Care Plans could have been lost if a resident changed rooms, or maybe the Care Plan was developed, but failed to print and was not placed in the binder. The MDS Coordinator said the Nurse was responsible to ensure that the Comprehensive Care Plans in the binder were complete for each resident, and the Care Plan</p>	F 280	<p>reviewed by Administrator and direction for re-education given as indicated. Corporate Consultant to review 25% of CAA's monthly for 3 months then 25% quarterly to ensure they are completed appropriately and timely and that if indicated a Care Plan is developed related to the CAA. Director of Nursing to review Nurse Aide Assignment sheets weekly for 12 weeks, then monthly to ensure all changes have been made and that assignment sheets are reflective of care and services to be provided to the residents. Director of Nursing to review the quick reference related to use of foot pedals located in front of the MAR, TAR, Care Plan and Nurse Aide assignment sheet weekly for 12 weeks then monthly to ensure it is updated appropriately and present in all designated locations. Facility has established a QA sub-committee that will meet monthly to review the</p>		



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F 280	<p>Continued From page 24</p> <p>addressed the individual needs of each resident. The MDS Coordinator was able to provide a copy of the Care Plan for Resident #4 to address Impaired Cognition, dated 10/03/12, and a copy of the Care Plan for Resident #5 for Pressure Ulcers, dated 11/10/12, and stated the facility neglected to initiate a Care Plan for Resident #6 for Urinary Incontinence.</p> <p>Interview, on 12/07/12 at 12:30 PM, with the DON revealed the MDS Coordinator was responsible to initiate the care plan and staff were responsible to provide updates to the care plan as needed. The DON was not aware the care plans for Resident #4, #5, and #6 were not complete as posted in the Care Plan Books on the Nursing Station. The DON stated the failure to ensure the care plans posted were complete for each resident could impact the ability of staff to provide appropriate interventions and result in a failure to meet residents needs.</p> <p>Review of the acceptable Allegation of Compliance (AOC), on 12/07/12, revealed the facility took the following immediate actions:</p> <ol style="list-style-type: none"> <li>1. The Medical Director was advlsed of Immediate Jeopardy on 11/29/12 by the Administrator and Corporate Consultant.</li> <li>2. A multidisciplinary team, including the Director of Nursing (DON), Director of Physical Therapy, and others met on 12/03/12 and reviewed all resident care plans and CNA care plans on 12/03/12 to ensure completeness and inclusion of appropriate information to reflect the use of foot rests for residents determined to be in need of them on wheelchairs to maintain safety.</li> </ol>	F 280	<p>implementation of the POC and monitor compliance. This sub-committee is comprised of the Administrator, Director of Nursing, Director of Staff Development, Nurse Supervisor, MDS Coordinator, a staff nurse, a nursing assistant and corporate consultant.</p> <p>Results of all audits, reviews and interviews will be reported to the facility QA Sub-Committee who will then report to the facility QA Committee no less than quarterly for one year.</p> <p>Date of completion 1-7-13</p>	

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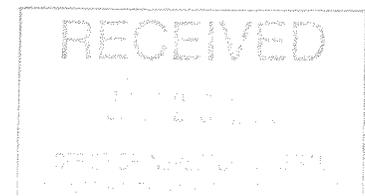
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F 280	Continued From page 25  3. CNA care plans were updated on 12/04/12 by the DON to reflect the use of foot rests on wheelchairs based on reviews completed 12/03/12. The Director of Staff Development was assigned to update the master CNA care plans weekly. CNA care plans were reviewed during the Resident Care Plan meeting to ensure the Nursing care plan and CNA care plan were consistent.  4. Staff in-services were provided by the Corporate Consultant on 12/03/12 to ensure staff were aware of the facility changes to the resident Care Plan regarding reviewing, revising, and the use of the care plan as a communication tool. All future hired staff would be educated about Care Plans by the Director of Staff Development during orientation.  5. The Care Plan Team was provided an in-service by the Corporate Consultant on 12/03/12 to detail the process and responsibilities of care plan revision  The State Agency validated the AOC on 12/07/12 prior to exit as follows:  1. The State Agency validated by interview with the Medical Director on 12/05/12 at 12:55 PM revealed he was contacted by the facility Administrator and Corporate Consultant and advised of the Immediate Jeopardy, but was not certain of the date of notification.  2. The State Agency validated the facility actions to identify residents who required the use of foot rests on the wheelchair to maintain resident	F 280		

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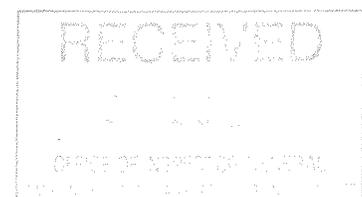
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F 280	Continued From page 25  3. CNA care plans were updated on 12/04/12 by the DON to reflect the use of foot rests on wheelchairs based on reviews completed 12/03/12. The Director of Staff Development was assigned to update the master CNA care plans weekly. CNA care plans were reviewed during the Resident Care Plan meeting to ensure the Nursing care plan and CNA care plan were consistent.  4. Staff in-services were provided by the Corporate Consultant on 12/03/12 to ensure staff were aware of the facility changes to the resident Care Plan regarding reviewing, revising, and the use of the care plan as a communication tool. All future hired staff would be educated about Care Plans by the Director of Staff Development during orientation.  5. The Care Plan Team was provided an in-service by the Corporate Consultant on 12/03/12 to detail the process and responsibilities of care plan revision  The State Agency validated the AOC on 12/07/12 prior to exit as follows:  1. The State Agency validated by interview with the Medical Director on 12/05/12 at 12:55 PM revealed he was contacted by the facility Administrator and Corporate Consultant and advised of the Immediate Jeopardy, but was not certain of the date of notification.  2. The State Agency validated the facility actions to identify residents who required the use of foot rests on the wheelchair to maintain resident	F 280			



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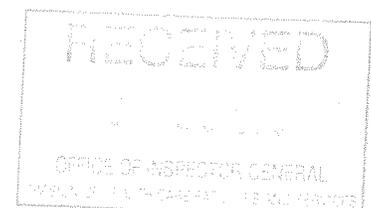
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F 280	<p>Continued From page 26</p> <p>safety, by interview, on 12/07/12 at 6:30 PM, with the DON who also provided documentation of notes, which included discussions with the IDT to identify residents who required foot rests from the larger group of residents who used wheelchairs for mobility in the facility. Observations of residents in the facility who were determined to require the use of foot rests on the wheelchair were validated on 12/07/12 at 5:30 PM and at 5:45 PM in the facility hallways and dining areas.</p> <p>3. The State Agency validated CNA Care Plans were updated by record review of the CNA Care Plans available at the East and West Nursing Stations, documented as last updated 12/06/12. Interview with the Director of Staff Development on 12/07/12 at 6:00 PM, revealed she would be responsible to ensure the master CNA Care Plans were updated weekly, and that the CNA Care Plan was reviewed at the Resident Care Plan meeting to ensure both the Resident Care Plan and the CNA Care Plan included consistent information.</p> <p>4. The State Agency validated an in-service was provided by the Corporate Consultant on 12/03/12 regarding Resident Care Plans by review of the content of the in-service and review of the attendance logs for the in-service. Interview, on 12/07/12 at 6:40 PM, with RN #3 revealed staff were trained to understand the responsibility to review and revise the Care Plan, and understood the Director of Staff Development was responsible to update the CNA Care Plan weekly. Interview, on 12/07/12 at 6:40 PM, with RN #3 regarding Care Plan in-service, revealed she did attend the in-service and verbalized understanding of the need for the CNA Care Plan</p>	F 280			



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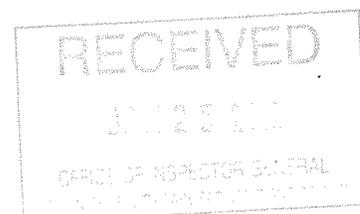
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F 280	Continued From page 27 to include resident care interventions that were consistent with the Nursing Care plan, and her responsibility to review the Resident and CNA Care Plan to ensure completeness.  5. The State Agency validated an in-service was provided by the Corporate Consultant on 12/03/12 by review of the facility documentation of the content of the In-service and the attendance log for the in-service. Interview, on 12/07/12 at 6:30 PM with the DON and on 12/07/12 at 7:00 PM with the Administrator revealed the Care Plan Team would be reviewing and revising the Resident Care Plan quarterly, and comparing the CNA Care Plan to determine both care plans contained consistent information with regard to individualized and safe resident care.	F 280		
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's policy, and Nursing Job Descriptions, it was determined the facility failed to ensure the necessary care and services to attain or maintain the highest practicable physical,	F 309	F-309  1. Resident #1 is no longer a resident of the facility.  2. Director of Nursing, Director of Staff Development, Restorative Nurse, and MDS Coordinator conducted interviews and/or reviewed caretracker reports for each resident to assess for	



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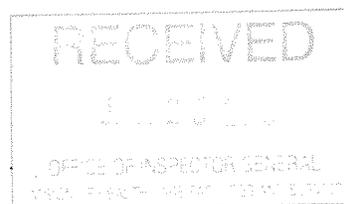
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F 309	Continued From page 28 mental, and psychosocial well-being of one (1) of six (6) sampled residents, (Resident #1). Resident #1 fell from the wheelchair, on 11/15/12 at 5:15 AM, and sustained multiple injuries with bleeding from the head. At the time of the fall, Resident #1 demonstrated verbal and non-verbal signs of pain, which were identified by multiple staff members, but the facility failed to ensure the resident received a pain assessment and pain treatment. After the Attending Physician was notified of the fall, Resident #1 was returned to bed, continued to bleed from facial injuries, and exhibited verbal and non-verbal signs of pain, which was not addressed by the facility. The facility failed to ensure Resident #1 received necessary emergency treatment in a timely manner. Resident #1 was transferred to a local hospital, on 11/15/12 at 8:30 AM, which resulted in a three (3) hour delay in the treatment of significant injuries and pain. Resident #1 was transferred to the Regional Level I Trauma Center on 11/15/12 at 2:00 PM for further treatment. The resident expired on 11/16/12 at 3:20 PM. The facility's failure to recognize the critical need for emergent treatment of Resident #1's injuries resulted in a three (3) hour delay in treatment of significant injuries and pain and placed residents at risk in a situation that was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 11/29/12 and was found to exist on 11/15/12.  The facility provided a Credible Allegation of compliance (AOC) on 12/07/12 and the state agency verified Immediate Jeopardy was removed on 12/07/12 prior to exit on 12/07/12. The scope and severity was lowered to a D at 42 CFR 483.25 (F309) Provide Services for the	F 309	current presence of pain, presence of pain recently and if applicable if resident felt like pain was/is treated appropriately. If the resident indicated they were in pain, further investigation was done to ensure the pain was reported and treatment initiated. All complaints of pain had been addressed. If resident indicated recent pain, further investigation was done to ensure pain had been properly assessed, reported and treatment provided. Only one resident indicated that pain was not addressed and upon review of the resident's pain management program, resident is on routine and PRN pain medication. Review of the resident's MAR shows resident has received all routine doses of medication and has not requested any PRN medication. Review of the resident caretracker report shows no pain reported in last 7 days. Resident states he knows to report pain and does so if he has pain. This was completed on Dec. 5, 2012	



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F 309	<p>Continued From page 29</p> <p>Highest Well-Being, while the facility develops and implements the Plan of Correction to establish an effective system to ensure residents receive appropriate and timely interventions by staff to address emergent care needs.</p> <p>The findings include:</p> <p>Review of the facility's policy for Pain, dated 06/01/09, revealed the facility was to assess each resident for the presence of and potential for the occurrence of pain with a goal to recognize when a resident experienced pain to identify circumstances when pain could be anticipated. The facility adopted the Wong-Baker Pain Scale to aide in recognition of severity of pain, and included a reference list which included Non-verbal Indicators of Pain and Non-Pharmacological Interventions. The Pain policy stated caregivers were responsible to document pain each shift if the resident verbalized or demonstrated non-verbal signs of pain.</p> <p>Review of the clinical record for Resident #1 revealed an admission date of 07/27/11 and diagnoses of Osteoarthritis, Osteoporosis, Knee Replacement, Dementia, and a history of Cervical Spine Surgery (Spinal Fusion). Review of the annual Minimum Data Set for Resident #1, dated 06/12/12, revealed the functional status for transfer was total dependence with a two person physical assist and cited physical limitations as weakness due to recent hospitalization, limited range of motion, poor coordination, poor balance, visual impairment, and pain.</p> <p>Review of the Nurse's Notes, dated 11/15/12 at</p>	F 309	<p>3. Re-education provided by Corporate Consultant to all licensed staff beginning Nov. 30 and completed Dec. 3, 2012 on Notification of Change Policy, Pain Management Policy, including assessment of pain, verbal and non-verbal indicators of pain, and that not assessing and treating pain can be considered neglect., Emergency Procedures, including response, treatment, notifications and resources. Attendees voiced understanding of material and time for questions was provided This education will be repeated no less than quarterly for 4 quarters then annually. All newly hired licensed staff will be educated on the facility Pain Management Policy during orientation. This will be the responsibility of the Nurse responsible for the Pain Management Program or the Director of Staff development. Re-education provided to all</p>		



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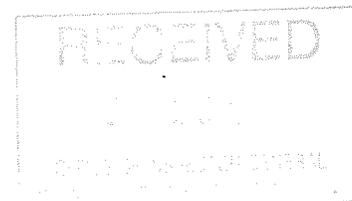
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F 309	<p>Continued From page 30</p> <p>5:15 AM, detailed Resident #1 had lacerations to the forehead and nose with abrasions to shoulder and throughout face, and was non-verbal but grimaced with movement. Nursing documentation revealed the status of Resident #1 was reported to the physician and an order was obtained to return the resident to bed and to clean lacerations and apply steri-strips. The nursing documentation included vital signs; however, there was no assessment of pain and no documentation of pain medication administration for Resident #1. Further review of the Medication Administration Record for Resident #1, detailed the resident had an order for Ibuprofen 600 milligrams to be given daily at 9:00 AM, and Acetaminophen 325 milligrams, two (2) tablets to be given every four (4) hours for pain.</p> <p>Interview by telephone with CNA #1, on 11/27/12 at 11:20 AM, revealed on 11/15/12 at 5:15 AM she transferred Resident #1 without assist of another staff member to a wheelchair. CNA #1 stated she did not remember to place the foot rests on the wheelchair before she transported Resident #1 to the shower room for toileting. CNA #1 stated Resident #1 lunged forward from the wheelchair and fell face down on the floor in the hallway and began to bleed from the head and nose. CNA #1 stated her shift ended at 6:00 AM, and she was trying to complete her routine duties, and as a result she failed to place the foot rests on the wheelchair. CNA #1 said she was told the physician advised LPN #1 to return Resident #1 to bed.</p> <p>Interview by telephone with LPN #1, on 11/26/12 at 3:30 PM, revealed on 11/15/12 after Resident</p>	F 309	<p>non-licensed nursing staff beginning Dec. 1 and completed on Dec. 3, 2012 on identifying, documenting and reporting pain, including non-verbal indicators of pain and use of CareTracker. Non-licensed staff were interviewed by MDS Coordinator, Restorative Nurse, Nurse Supervisor, DON, Corporate Consultant, Administrator, and Director of Staff Development.</p> <p>This re-education will be repeated monthly for 3 months then will be part of the annual in-service schedule. All newly hired non-licensed nursing staff will be educated during orientation. This will be completed by the Director of Staff Development. Corporate Consultant reviewed the facility Pain Management Program with the Nursing Supervisor responsible for program to ensure all components of the program are being followed,</p>	



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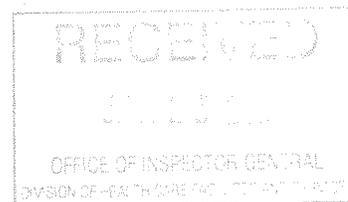
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F 309	<p>Continued From page 31</p> <p>#1 fell she was not aware she did not document a pain assessment or treat the resident for pain as she was more concerned about the injuries and bleeding.</p> <p>Interview by telephone with RN #1, on 11/26/12 at 4:03 PM revealed she was the assigned Charge Nurse on 11/15/12. RN #1 said she was not notified by LPN #1 that Resident #1 had fallen on 11/15/12, and overheard about the fall from another staff member. RN #1 said the third shift was very busy that night and she took one look at Resident #1, then went to the Nurse's Station and reported to the LPN #1 that the resident needed to go to the hospital. RN #1 stated she returned to her work, and she was aware that LPN #2 from dayshift arrived later, and assisted LPN #1 with the transfer of Resident #1 to the hospital.</p> <p>Interview, on 11/27/12 at 7:10 AM, with CNA #3 revealed she heard Resident #1 fall on 11/15/12, then saw the resident lying face forward on the floor bleeding from the face and nose in obvious pain as the resident was groaning. CNA #3 said she stayed with Resident #1 after the resident was returned to bed from 5:30 AM until 7:30 AM in an attempt to control the bleeding. CNA #3 stated that RN #1 (Charge Nurse) came into the room, looked at Resident #1 and said "Oh, My God," but never returned to the room.</p> <p>Interview, on 11/27/12 at 2:37 PM, with LPN #3 revealed she was working on 11/15/12 after Resident #1 had fallen from the wheelchair. LPN #3 stated after she obtained the shift report from LPN #2, and was told EMS (Emergency Medical Systems) was on the way, she went to see Resident #1. LPN #3 said Resident #1 was lying</p>	F 309	<p>including review of CareTracker reports, MAR's for pain medication usage and acute pain assessments. Knowledge and understanding was validated by the Corporate Consultants review of the Pain Management Program. This was completed on Dec. 3, 2012.</p> <p>4. Corporate Consultant to review the facility Pain Management Program monthly for 3 months then no less than quarterly to ensure resident pain is appropriately assessed, treated and evaluated. This review will include review of the initial pain assessment, caretracker reports, MAR's, acute pain assessments and the Pain Management Logs. Director of Staff Development to review CareTracker report related to Pain weekly for 4 weeks to ensure compliance with completing the daily assessment of pain indicators. Facility has established a QA sub-committee that will meet</p>		



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F 309	<p>Continued From page 32</p> <p>in the bed and thought it obvious the resident had a broken nose, had lacerations to the face, and was bleeding from both nares. LPN #3 said she talked to Resident #1, who responded and told her "I hurt all over."</p> <p>Interview, on 11/28/12 at 9:00 AM, with LPN #4 revealed she was working on 11/15/12 and was told that Resident #1 had fallen on third shift. LPN #4 said she had taken care of Resident #1 since the resident was admitted to the facility, and she went into the room of Resident #1 to say good-bye before the resident went to the hospital. LPN #4 said Resident #1 was bleeding from the nose and eyes, with multiple lacerations and it was apparent to her that the bleeding continued and the resident was experiencing pain, because of grimacing facial expressions.</p> <p>Interview, on 12/05/12 at 2:28 PM, with LPN #2 revealed that due to the extent of injuries to Resident #1 on 11/15/12, LPN #2 thought the resident was experiencing pain. LPN #2 stated because of the extent of Resident #1's injuries, she did not ask LPN #1 if the resident was assessed or treated for pain because she was more concerned to get the resident transferred to the hospital.</p> <p>Interview, on 12/06/12 at 6:30 AM, with CNA #8 revealed when she saw Resident #1 after the fall on 11/15/12, the resident had an uncomfortable look on her face and she knew the resident was in pain. CNA #8 said the way Resident #1 looked, "that just had to hurt."</p> <p>Interview, on 12/07/12 at 12:30 PM, with the Director of Nursing (DON) revealed that she</p>	F 309	<p>monthly to review the implementation of the POC and monitor compliance. This sub-committee is comprised of the Administrator, Director of Nursing, Director of Staff Development, Nurse Supervisor, MDS Coordinator, a staff nurse, a nursing assistant and corporate consultant. Results of all audits, reviews and interviews will be reported to the facility QA Sub-Committee who will then report to the facility QA Committee no less than quarterly for one year.</p> <p>Date of completion 1-7-13</p>		



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F 309	<p>Continued From page 33</p> <p>Interviewed LPN #1 about Resident #1's fall on 11/15/12. The DON stated that LPN #1 never mentioned that Resident #1 complained of pain; however, the DON did find that LPN #1 documented in the Nurse's Notes that the resident grimaced with movement. The DON stated grimacing would be considered a non-verbal sign of pain, and stated a pain assessment should have been completed and documented for Resident #1 and the resident should have been treated for pain when the non-verbal signs of pain were observed by staff.</p> <p>Review of the acceptable Allegation of Compliance (AOC), on 12/07/12, revealed the facility took the following immediate actions:</p> <ol style="list-style-type: none"> <li>1. The Medical Director was advised of Immediate jeopardy notification on 11/29/12 by the Administrator and Corporate Consultant.</li> <li>2. The Director of Staff Development provided an in-service to all non-licensed nursing staff on 12/01/12 and completed on 12/03/12 regarding pain, which included identification of pain, reporting of pain, and update to the facility's Standard of Care. All future hired staff would receive this education during facility orientation.</li> <li>3. The Corporate Consultant provided in-service to all licensed staff on 11/30/12 and was completed on 12/03/12 to educate staff on the facility Pain Management Policy to include verbal and non-verbal indicators of pain with focus on failure to assess and treat pain as an indication of resident neglect.</li> <li>4. The Corporate Consultant reviewed the Pain</li> </ol>	F 309			



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F 309	<p>Continued From page 34</p> <p>Management Program with the Nurse Supervisor to ensure program implementation and effectiveness, on 12/03/12.</p> <p>5. All residents in the facility were individually assessed on 12/05/12 for pain by an Administrative Core Group to identify any residents who had experienced pain without treatment or ineffective treatment of pain.</p> <p>The State Agency validated the AOC on 12/07/12 prior to exit as follows:</p> <p>1. The State Agency validated by interview with the Medical Director, on 12/05/12 at 12:55 PM, revealed he was contacted by the facility Administrator and Corporate Consultant and advised of the Immediate Jeopardy, but was not certain of the date of notification.</p> <p>2. The State Agency validated by review of the information provided to staff during the in-service on 12/03/12 which included hand-outs with non-verbal indicators of pain and an updated facility Standard of Care to include assessment and treatment of resident pain. Review of the attendance log for the In-service on 12/03/12 revealed all non-licensed staff were included in the in-service. Interview, on 12/07/12 at 6:20 PM with CNA #9, and on 12/07/12 at 6:25 PM, with CNA #10 revealed both participated in the in-service and were able to correctly verbalize non-verbal signs of pain, and stated the responsibility of the CNA was to document pain on the Care Tracker system and advised the nurse. CNA #10 stated the CNA was further responsible to follow-up with the resident to ensure that the pain had been treated, and</p>	F 309		

