RECEIVED MAY 2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185306	A. BUILDING _____ B. WING _____	C 04/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD TERRACE NURSING HOME	425 ISLAND FORD ROAD MADISONVILLE, KY 42431

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F 000	INITIAL COMMENTS An abbreviated survey (KY #20021) was conducted on 04/23/13 through 04/26/13 to determine the facility's compliance with Federal requirements. KY #20021 was substantiated with deficiencies cited at the highest scope/severity of a "D."	F 000	**Preparation and execution of this plan of Correction does not constitute an admission of 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 solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge deficiencies below is not an admission that the alleged facts occurred as presented in the statements.**	
F 280 SS=D	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 interview, record review, and review of the facility's policy/procedure, it was determined	F 280	**F 280 (D) RIGHT TO REVISE CARE PLAN** ***Residents Found to Have Been Affected*** The care plan for Resident #1 was reviewed by the Interdisciplinary Team and responsible party and revised to denote interventions to aid in the prevention of falling out of bed due to leaning, scooting, and throwing the legs off of the bed on May 13, 2013.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Angela R Head — TITLE: Administrator — (X6) DATE: 5/14/2013

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 280	Continued From page 1 the facility failed to ensure the comprehensive care plan was revised for one resident (#1), in the selected sampled of three residents. The resident had a history of "leaning, scooting, and throwing his/her legs off the bed" which was not addressed on the care plan. On 04/05/13 at approximately 1:00 AM, Resident #1 fell from his/her bed to the floor, unwitnessed by staff, and sustained an injury to his/her forehead and bruising to the right shoulder. Findings include: A review of the facility's Nurse Aide Care Plan policy/procedure, revised 02/10/10, revealed the purpose of this form to document how each residents' daily care needs are provided by the nursing staff as outlined in the Comprehensive Care Plan in accordance with the guidelines of the RAI process. A record review revealed the facility admitted Resident #1 on 04/10/06 with diagnoses to include Chronic Airway Obstruction, Difficulty Walking, General Muscle Weakness, Vitamin D Deficiency, Muscle Spasm, Hemorrhage GI Tract, Intestinal Obstruction, Aortic Valve Disorder, and Esophageal Reflux. A review of the annual Minimum Data Set (MDS), dated 01/22/13, revealed the facility assessed Resident #1's cognition as severely impaired. A review of the Fall Assessment Screening Tool (FAST), dated 01/22/13, revealed a score of 85, which indicated the resident was at high risk for falls. A review of the nurse's notes, as well as the	F 280	***Identification of Other Residents with the Potential to be Affected*** All residents have the potential to be affected by F 280. Systemic and Monitoring actions listed below will include all residents who have the potential to be affected. Care Plans of all residents were reviewed/revised by the Interdisciplinary Team to include those residents who have been assessed to be at risk for falls on April 24, 2013 – May 13, 2013. ***Systemic Changes*** An experienced skilled nursing facility consulting team provided a site visit on April 25-26, 2013 to assist the Administrator in the revision of policies as they relate to falls management that included revision of care plans. A newly revised Falls Management Program was developed and implemented on May 3, 2013. The QAA Committee approved the revised policies for Falls Management on April 26, 2012. The Director of Nursing conducted training on April 27, 2013 and on May 3, 2013 to educate all licensed nurses on the newly revised Fall Management policies that includes a Falls Risk Assessment, Post Fall Assessment, and Individual Resident Fall Report.	

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F 280	Continued From page 2 Investigation completed by Licensed Practical Nurse (LPN) #1, dated 04/05/13 at 1:00 AM, revealed the resident was observed in the floor with injury to his/her forehead. The fall from his/her bed was unwitnessed. Further review revealed the resident was transported to the hospital via ambulance at 2:10 AM. The resident returned to the facility at 6:15 PM, on 04/05/13. An interview with LPN #1, on 04/23/13 at 9:25 PM, revealed, on 04/05/13 at approximately 1:00 AM, she was on another hall and heard a yell. She stated she was in the resident's room in a matter of seconds, and Certified Nurse Aide (CNA) #1 was already there. She stated CNA #1 informed her the resident had a fall with injury. When LPN #1 entered the room, he/she was laying in a straight position on his/her right side on the floor, and was on the right side of the bed. He/she was bleeding from his/her head and the staff tried to reposition him/her after being assessed by LPN #1. The resident did not complain of any pain other than his/her head, and was able to move his/her extremities. LPN #1 notified the physician, and the resident was sent to the emergency room via ambulance. LPN #1 revealed she thought the resident must have hit his/her head on the floor. An interview with CNA #1, on 04/24/13 at 6:00 PM, revealed the resident leaned a lot to the right side. At times, the resident's feet would hang over the side of the bed and they would straighten him/her up in the bed each time. He stated the resident does not try to get out of the bed on his/her own, and is a total assist with care, except for eating.	F 280	***Monitoring*** The Director of Nursing is reviewing all Individual Resident Fall Reports to verify that care plans are addressed immediately. The Interdisciplinary Team (IDT) is monitory assessments of residents at risk for falls, interventions, and care plans at their daily meeting. The QAA Committee will meet weekly beginning May 13, 2013 for a minimum of four weeks and until regulatory compliance is achieved. ***Completion Date:*** Completion Date: May 20, 2013	05/20/13

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F 280	Continued From page 3 An interview with CNA #2, on 04/23/13 at 10:30 PM, revealed the resident leaned toward the side of the window, and they had straightened him/her in the bed earlier in the shift, on 04/05/13. She did not notice any further leaning. The resident is total assist with all care except for eating. He/she cannot get up on his/her own at all, and stated she could not believe the resident fell out of the bed. An interview with CNA #3, on 04/24/13 at 10:05 AM, revealed they repositioned the resident in the bed, but not very frequently. The resident was able to use the grab bars to assist with turning himself/herself in the bed, but does not try to get out of bed on his/her own. He revealed they do rounds every two hours for "check and change" and do visual rounds each hour. Interview with RN #1 and LPN #3, on 04/23/13 at 4:00 PM and 4:10 PM, respectively, and interview with CNA #4 and CNA #5, on 04/24/13 at 9:51 AM and 3:00 PM, respectively, revealed Resident #1 was able to "scoot" or "wiggle" himself/herself in the bed and was also able to "throw" his/her legs, usually, to the right side of the bed. A review of the comprehensive care plan, At Risk for Falls/Injury related to Impaired Balance, Non-ambulatory, updated 04/23/13, revealed no evidence of an intervention to address the resident's leaning, scooting, or throwing his/her legs over in the bed. An interview with the MDS Coordinator, on 04/26/13 at 12:10 PM, revealed she completed updates to the care plans. She stated she was aware the resident leaned in the bed; however,	F 280		

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F 280	Continued From page 4 she did not realize it was an issue, and had not addressed the resident's leaning or scooting in the bed on the care plan. An interview with the Interim Director of Nursing (DON), on 04/24/13 at 11:18 AM, revealed the investigative information related to the fall was reviewed the following day in the facility's morning meeting with new interventions put in place; however, there was no information on the care plan which indicated the resident would "scoot" or "wiggle" himself/herself in the bed, or "throw" his/her legs over the right side of the bed.	F 280		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accidents for one resident (#1), in the selected sampled of three residents. On 04/05/13 at approximately 1:00 AM, Resident #1 fell from his/her bed to the floor, unwitnessed by staff, and sustained an injury to his/her forehead and bruising to the right	F 323	**F 323 (D) FREE OF ACCIDENT HAZARDS** ***Residents Found to Have Been Affected*** The care plan for Resident #1 was reviewed by the Interdisciplinary Team and responsible party and revised to denote interventions to aid in the prevention of falling out of bed due to leaning, scooting, and throwing the legs off of the bed on May 13, 2013. ***Identification of Other Residents with the Potential to be Affected*** All residents have the potential to be affected by F 323. Systemic and Monitoring actions listed below will include all residents who have the potential to be affected. Care Plans of all residents were reviewed/revised by the Interdisciplinary Team to include those residents who have been assessed to be at risk for falls on April 24, 2013 – May 13, 2013. ***Systemic Changes*** An experienced skilled nursing facility consulting team provided a site visit on April 25-26, 2013 to assist the Administrator in the revision of policies as they relate to falls management that included	

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F 323	Continued From page 5 shoulder. Findings include: A review of the facility's Fall Prevention policy/procedure, revised 10/21/10, revealed every resident will be evaluated for falls upon admission and subsequently thereafter when the resident's condition changes or at least quarterly. The care plan will state the goals, interventions, and approaches for every resident who is identified as being at risk for falls. Staff will be trained to be alert to risk and hazards for falls in the environment. The falls prevention approaches will be evaluated by the Quality Improvement Committee to determine the effectiveness of the approaches. With the recommendations of the committee, changes will be implemented to reduce falls risk in the facility. A record review revealed the facility admitted Resident #1 on 04/10/06 with diagnoses to include Chronic Airway Obstruction, Difficulty Walking, General Muscle Weakness, Vitamin D Deficiency, Muscle Spasm, Hemorrhage GI Tract, Intestinal Obstruction, Aortic Valve Disorder, and Esophageal Reflux. A review of the annual Minimum Data Set (MDS), dated 01/22/13, revealed the facility assessed Resident #1's cognition as severely impaired. A review of the Fall Assessment Screening Tool (FAST), dated 01/22/13, revealed a score of 85, which indicated the resident was at high risk for falls. A review of the comprehensive care plan, At Risk for Falls/Injury related to Impaired Balance,	F 323	revision of care plans. A newly revised Falls Management Program was developed and implemented on May 3, 2013. The QAA Committee approved the revised policies for Falls Management on April 26, 2012. The Director of Nursing conducted training on April 27, 2013 and on May 3, 2013 to educate all licensed nurses on the newly revised Fall Management policies that includes a Falls Risk Assessment, Post Fall Assessment, and Individual Resident Fall Report. ***Monitoring*** The Director of Nursing is reviewing all Individual Resident Fall Reports to verify that care plans are addressed immediately. The Interdisciplinary Team (IDT) is monitory assessments of residents at risk for falls, interventions, and care plans at their daily meeting. The QAA Committee will meet weekly beginning May 13, 2013 for a minimum of four weeks and until regulatory compliance is achieved. ***Completion Date:*** Completion Date: May 20, 2013	05/20/13

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F 323	Continued From page 6 Non-ambulatory, updated 04/23/13, revealed no evidence of an intervention to address the resident's leaning in the bed. A review of the Nursing Assistant Care Plan, dated April 2013, revealed the resident was non-ambulatory, and required assistance of two staff for positioning every two hours during the day and while awake, and as needed (prn). An observation during an abbreviated tour of the facility, on 04/23/13 at 10:30 AM, revealed the resident was laying in his/her bed, eyes closed and his/her head leaning to the right side of the perimeter defined mattress. The head of the bed was raised approximately 30 degrees. Observation revealed an area of dry skin to the center of his/her forehead. A review of the nurse's notes, as well as the investigation completed by Licensed Practical Nurse (LPN) #1, dated 04/05/13 at 1:00 AM, revealed the resident was observed in the floor with injury to his/her forehead. The fall from his/her bed was unwitnessed. Further review revealed the ambulance service was notified at 1:50 AM, and arrived to transport the resident to the hospital at 2:10 AM. The resident returned to the facility via ambulance at 6:15 PM, on 04/05/13. An interview with LPN #1, on 04/23/13 at 9:25 PM, revealed, on 04/05/13 at approximately 1:00 AM, she was on another hall and heard a yell. She stated she was in the resident's room in a matter of seconds, and Certified Nurse Aide (CNA) #1 was already there. She stated CNA #1 informed her the resident had a fall with injury. When LPN #1 entered the room, he/she was	F 323		

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F 323	Continued From page 7 laying in a straight position on his/her right side on the floor, and was on the right side of the bed. He/she was bleeding from his/her head and the staff tried to reposition him/her after being assessed by LPN #1. The resident did not complain of of any pain other than his/her head, and was able to move his/her extremities. The resident remained in the floor while LPN #1 notified the physician. An order was received to send the resident to the emergency room. The CNAs stayed with the resident until the ambulance arrived. LPN #1 revealed there were no mats beside the bed and she thought the resident must have hit his/her head on the floor. She did not recall the height of the bed at the time of the resident's fall. An interview with CNA #1, on 04/24/13 at 6:00 PM, revealed the resident leaned a lot to the right side. At times, the resident's feet would hang over the side of the bed and they would straighten him/her up in the bed each time. He stated they repositioned the resident around midnight, on 04/05/13, prior to the fall. He revealed, around 1:00 AM, on 04/05/13, he was at the nurse's station when he heard a scream. He went to investigate and found the resident on the floor, on the right side of the bed. He/she was on his/her stomach, and appeared to have fallen head first on the floor. He called for the charge nurse, and another CNA came to assist as well. He stated the resident was anxious and scared. He stayed with the resident while the nurse notified the physician and the Emergency Medical Service (EMS). He stated he applied pressure to the area on the resident's forehead, and did not notice any other injuries at that time. He stated the resident does not try to get out of the bed on his/her own,	F 323		

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F 323	Continued From page 8 and is a total assist with care, except for eating. An interview with CNA #2, on 04/23/13 at 10:30 PM, revealed, on 04/05/13, she was asked to assist with Resident #1 as she walked by the resident's room. The resident was closest to the window on his/her right side, legs bent up. She stated she went to get others to get him/her off the floor. The nurse was in the room getting vital signs. She stated they used a lift pad to get the resident back in bed. He/she was alert and talking, with some complaint of pain at the time. She stated, at times, the resident leaned toward the side of the window, and they had straightened him/her in the bed earlier in the shift. She did not notice any further leaning. The resident is total assist with all care except for eating. He/she cannot get up on his/her own at all. CNA #2 was uncertain of the height of the bed at the time of the resident's fall; however, the head of the bed was up approximately 30 degrees, and no mats on the floor. CNA #2 revealed she could not believe the resident fell out of the bed. She stated they do rounds every two hours for tolleting and repositioning, and do visual rounds hourly to check if he/she needed anything. An interview with CNA #3, on 04/24/13 at 10:05 AM, revealed they repositioned the resident in the bed, but not very frequently. The resident was able to use the grab bars to assist with turning himself/herself in the bed, but does not try to get out of bed on his/her own. On the night of the fall, on 04/05/13, CNA #3 stated he worked another hall; however, he came to assist after the resident fell. He stated he/she was laying on the floor mostly on his/her back and leaning to the right. He was uncertain regarding the height of the bed;	F 323		

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F 323	Continued From page 9	F 323		

however, he thought it was 1 foot to 1-1/2 feet off the floor, in low position. There were no mats on the floor. He stated they lifted the resident back to bed using bed linen along with a lift sling. He stated she was awake and talking during this time. There was a small amount of blood on the floor. He revealed CNA #1 kept pressure on the center of the resident's forehead, and the nurse checked the resident for any further injury. He revealed they do rounds every two hours for "check and change" and do visual rounds each hour.

Interview with RN #1 and LPN #3, on 04/23/13 at 4:00 PM and 4:10 PM, respectively, and interview with CNA #4 and CNA #5, on 04/24/13 at 9:51 AM and 3:00 PM, respectively, revealed Resident #1 was able to "scoot" or "wiggle" himself/herself in the bed and was also able to "throw" his/her legs, usually, to the right side of the bed.

An interview with the MDS Coordinator, on 04/26/13 at 12:10 PM, revealed she completed updates to the care plans. She stated she was aware the resident leaned in the bed; however, she did not realize it was an issue, and had not addressed the resident's leaning or scooting in the bed on the care plan.

An attempt to interview the resident, on 04/23/13 at 2:50 PM, revealed he/she was alert/oriented to self, and speech was clear; however, he/she did not recall the fall on 04/05/13.

An observation of a skin assessment conducted by LPN #2, on 04/24/13 at 12:45 PM, revealed a healing area to the center of his/her forehead and a brownish-colored half-dollar sized area on

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F 323	Continued From page 10 his/her right shoulder. An interview with the Interim Director of Nursing (DON), on 04/24/13 at 11:18 AM, revealed the resident had no falls in over a year and was only aware of two falls since the resident's admission to the facility in 2006; however, risk factors indicated he/she was still high risk for falls. She stated, to her knowledge, the resident had never tried to get out of the bed on his/her own, and always asked for assistance. Regarding the fall on 04/05/13, it was reported that the staff heard a noise and then found him/her on the floor in his/her room. It appeared the resident rolled out of the bed, and sustained a laceration on his/her forehead with a complaint of arm pain. The CNAs moved him/her back to bed after an assessment was completed and care was provided by the nurse. Notifications were made and the resident was sent to the hospital. An investigation was completed by LPN #1 following the fall. The investigative information was reviewed the following day in the facility's morning meeting with new interventions put in place; however, there was no information on the care plan which indicated the resident would "scoot" or "wiggle" himself/herself in the bed, or "throw" his/her legs over the right side of the bed.	F 323		