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

PRINTED: 06/06/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185195		C 05/20/2011
NAME OF PROVIDER OR SUPPLIER OAKVIEW NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 10456 US HWY 62 CALVERT CITY, KY 42029	

RECEIVED JUN 2011 OFFICE OF INSPECTOR GENERAL

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F 000	INITIAL COMMENTS An abbreviated survey (KY #16049 and KY #16402) was conducted on 05/11-20/11 to determine compliance with Federal requirements. KY#16049 was substantiated with no regulatory violations. KY #16402 was substantiated with deficiencies cited.	F 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined the facility failed to identify the activity interests and needs of one resident (#1), in the selected sample of three, in order to provide activities designed to meet the interests and the physical, mental and psychosocial well-being of the resident. Resident #1 was admitted to the facility on 04/14/11 and activities staff failed to identify the resident's activity interests and provide activities to the resident. Findings include: A review of the facility's Activity Programs policy and procedure, dated 06/30/06, revealed a resident's interests and needs should be identified and a recreation (Activity) program should be designed to appeal to his or her interests and to enhance the resident's highest	F 248	The affected resident no longer resides in the facility. All residents in the facility have the potential to be affected by the deficient practice. Reviews were conducted on all residents in the facility to ensure assessments had been completed on each resident which addressed their specific interests related to activities. This was completed by the Activities Director on 06/13/11. All new residents will be reviewed in the morning meeting to ensure activities assessments have been completed by the Activities Director. This will be conducted on an on-going basis with attendees which include the Director of Nursing, Administrator, Unit Managers, Activities Director, Social Services Director, Therapy Director, and Case Manager. An audit form has been completed by the Activities Director and given to the Director of Nursing and Administrator to ensure facility wide reviews have been conducted. This was completed on 06/13/11. Additionally, an audit will be conducted weekly by the Activities Director on new residents to ensure completion of activities	06/24/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 6/21/2011

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 248	Continued From page 1 practicable level of physical, mental, and psychosocial well being. The recreation program should occur within the context of each resident's comprehensive assessment and care plan and reflects each individual resident's needs and preferences. A closed record review revealed Resident #1 was admitted to the facility on 04/14/11 with diagnoses to include Post fall with right hip fracture, Acute Renal Failure and Weakness. A review of the Activities Care Area Assessment (CAA), dated 04/21/11, revealed activity staff failed to assess the resident's activity preferences prior to admission and the resident's current activity pursuits. They failed to complete the analysis of the findings and document any reasons as to why a care plan would or would not be developed. There was no signature or date. A review of the Interim Care Plan, dated 04/14/11, and Comprehensive Care Plan, dated 04/27/11, revealed there was no care plan to address the residents activity needs. Further record review revealed there was no evidence Resident #1 was offered or participated in any activities while a resident at the facility (04/14-29/11). An interview with the Activity Director and Activity Assistant, on 05/19/11 at 10:00 AM and 10:15 AM respectively, revealed Resident #1 was never assessed to determine the resident's interests and a care plan was never developed for activities. The Activity Director stated she went to do an assessment with Resident #1 on 04/21/11,	F 248	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* assessments is accomplished. Care plans will be audited along with the assessments to ensure completion related to resident specific activity preferences. This will also be completed by the Activities Director. All of these audits will be given to the Director of Nursing services and the Administrator. An ad hoc PI meeting was held on 06/10/11 to discuss the activities program. In attendance were the Director of Nursing Services, Administrator, Medical Records, Nutritional Services, Therapy, Admissions Coordinator, Maintenance, Accounts Payable, Activities Director and Case Manager. The Medical Director was not present but was made aware of the information by phone on 06/10/11. In-servicing was conducted for all staff regarding their role in provision of activities on 06/13/11. This was conducted by the Staff Development Coordinator and the Activities Director. Additionally, a "recipe card" box will be placed at each nurse's station with activities which the resident enjoys which will be used for educational purposes for all staff to provide appropriate interventions for the residents.	

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F 248	Continued From page 2 but the resident was asleep and no further attempts to complete the assessment were made. She stated the CAA and care plan were not completed due to not completing the assessment. They revealed Resident #1 never attended any activities.	F 248	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
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 interviews and record review it was determined the facility failed to provide adequate supervision to prevent accidents for one resident (#1), in the selected sample of three. Resident #1 was attempting to get up without assistance and staff left the resident in a wheelchair on the hall with no supervision. The resident stood up from his/her wheelchair and fell, sustaining a skin tear to the hand, multiple bruising on the right arm and a cut lip. Findings include: A review of the facility's Accidents and Supervision to Prevent Accidents policy and procedure, dated 04/28/11, revealed the facility should provide supervision and assistive devices to each resident to prevent avoidable accidents. The Center should implement interventions correctly and consistently, including adequate	F 323	This will be completed by the Activities Director and put into place on 06/20/11. The results of the audits will be taken to Quality Assurance Meeting on a monthly basis until compliance is achieved. The results of the audits will be presented to the QA committee by the Activities Director and/or Administrator. The QA committee consists of the Medical Director, Administrator, and Director of Nursing, Unit Managers, Case Manager, Dietary, Social Services, Medical Records and Activities Director. Completion date: 06/24/11	

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F 323	Continued From page 3 supervision. A review of the facility's Patient Supervision and Monitoring policy and procedure, dated 04/28/11, revealed residents should be provided supervision when they present with conditions that may place other residents and /or themselves at risk for harm. There are three levels of supervision: 1) Periodic Checks - when a staff should be assigned to check on the resident every 15 minutes but does not need to maintain visual contact with the resident at all times. 2) Visual Supervision - when a staff member is in visual contact of the resident at all times and 3) 1:1 Supervision when a staff remains in close proximity (no more than two arms length) of the resident at all times. A record review revealed Resident #1 was admitted to the facility on 04/14/11 with diagnoses to include Post fall with right hip fracture, Acute Renal Failure and Weakness. A review of the Nursing Admission Assessment, dated 04/14/11, revealed Resident #1 required extensive assistance of two staff for transfers with walker and gait belt. Resident #1 was assessed as a high risk for falls due to the resident's history of forgetfulness, disorientation, exhibiting unsafe ambulatory transfer skills, weakness, shuffled gait and previous falls. A review of the Interim Care Plan, dated 04/14/11, revealed interventions implemented due to the resident's fall risk were bed and chair alarms, low bed and blue mats on the floor by the bed. A review of the nurse's notes and Post Fall Evaluation, dated 04/14/11 at 3:35 PM, revealed	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Resident #1 no longer resides in the facility. All residents with fall assessment scores which place them at risk for falls will be reviewed. This was conducted by the Director of Nursing Services and the Unit Managers and was completed on 06/15/11. All residents identified at risk for falls were evaluated with regard to their need for increased supervision. This was completed by the Director of Nursing Services and the Unit Managers. This was also completed on 06/15/11. In-services were conducted by the Staff Development Coordinator on 06/09/11 which addressed placing residents on the appropriate level of supervision when residents have behaviors that could put themselves or others at risk for injury. Staff was also in-serviced regarding the incorporation of activities which the resident enjoys into their daily activities to assist with prevention of falls. This was also conducted by the Staff Development Coordinator and the Activities Director on 06/09/11. All falls will continue to be discussed in the morning meeting with all disciplines to discuss falls and root cause of falls with	06/24/11

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F 323	Continued From page 4 Resident #1 was attempting a self transfer from the low bed to the blue mat by the bed. No injuries were noted. The resident was moved to a room across from the nursing station for closer supervision. A review of the nurse's notes and Post Fall Evaluation, dated 04/14/11 at 8:55 PM, revealed Resident #1 was found lying on the floor in the hall on the right side face down. Resident #1's wheelchair was beside the resident with the urinary catheter still attached. The resident was assessed and found to have a skin tear to the right hand, multiple bruises to the left arm and blood coming from the mouth. The clip alarm was not attached to the resident. Interviews with Registered Nurse (RN) #1 and Certified Nurse Aide (CNA) #1, on 05/12/11 at 11:30 AM and on 05/18/11 at 1:30 PM and at 3:05 PM, revealed they were the only staff on the hall because the other CNA was on supper break. The staff stated the resident was attempting to get out of the bed so they placed the resident in a wheelchair and wheeled the resident into the hall at the nurse's station so staff could keep an eye on him/her. The resident continued to try to get up from the wheelchair. CNA #1 stated the nurse was trying to keep an eye on the resident while she was passing medication because the she had to provide care for another resident in their room. RN #1 stated Resident #1 was sitting in the wheelchair when she entered another resident's room to administer medication. She stated when she exited the resident's room, Resident #1 was on the floor beside the wheelchair. The clip alarm had not sounded. She assessed the resident and identified the resident had a cut lip and a skin tear	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* interventions, physician and family contact review. This occurs on an on-going basis. The meeting team consists of the Director of Nursing, Administrator, Unit Managers, Activities Director, Social Services Director, Therapy Director and Case Manager. Audits will be conducted weekly times four weeks of any resident who has a fall to ensure the appropriate level of supervision was provided prior to and after the fall. The audit will also include the involvement of activities with relation to the supervision. This audit will occur times four weeks, was initiated on 06/20/11, and will be conducted by the Director of Nursing and Activities Director. Additionally, audits will be conducted monthly times four months after completion of the weekly audits of residents with falls to ensure compliance with supervision and provision of activities. This will also be conducted by the Director of Nursing and the Activities Director. An ad hoc PI meeting was held on 06/10/11 to discuss falls, supervision and interventions. In attendance were the Director of Nursing Services, Administrator, Medical Records, Nutritional Services, Therapy, Admissions	

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F 323	Continued From page 5 on his/her hand. An interview with the Director of Nursing , on 05/19/11 at 1:40 PM, revealed she was aware Resident #1 had tried to get up out of the bed but was not aware the resident had tried to get up from the wheelchair prior to the fall on 04/14/11 at 8:55 PM. She stated staff were aware of the facility's policy and procedure on providing supervision to prevent accidents and if the resident was exhibiting those behaviors the staff should have provided increased supervision.	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Coordinator, Maintenance, Accounts Payable, Activities Director and Case Manager. The Medical Director was not present but made aware by phone on 06/10/11. The results of the audits will be brought to Quality Assurance meeting monthly times four months or until compliance is achieved. The QA committee consists of the Medical Director, Administrator, Director of Nursing, Unit Managers, Case Manager, Dietary, Social Services, Medical Records, and Activities Director. Completion date: 06/24/11	