

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

PRINTED: 03/03/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 03/02/2016
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS An onsite re-visit was concluded on 03/02/16 and found the facility in compliance on 01/31/16 as alleged in their PoC.	{F 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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.

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 185381	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 3/2/2016	Y3
NAME OF FACILITY SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0280	Correction	ID Prefix F0282	Correction	ID Prefix F0323	Correction
Reg. # 483.20(d)(3), 483.10(k)(2)	Completed	Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(h)	Completed
LSC	01/31/2016	LSC	01/31/2016	LSC	01/31/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input checked="" type="checkbox"/>	REVIEWED BY (INITIALS) <i>VH</i>	DATE <i>03/03/16</i>	SIGNATURE OF SURVEYOR <i>Melanie Zymala</i>	DATE <i>3/3/16</i>
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 12/30/2015

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? YES NO

RECEIVED

No. 743 P. 7/83

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION SPECTOR GENERAL A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>An Abbreviated Survey was initiated on 12/15/15 and concluded on 12/30/15 to investigate complaint KY24148. The Division of Health Care substantiated the allegation with Immediate Jeopardy identified on 12/16/15 and determined to exist on 11/06/15 at 42 CFR 483.20 Resident Assessment (F280 and F282) at a scope and severity of a "J"; and, 42 CFR 483.25 Quality of Care (F323) at a scope and severity of a "J". Substandard Quality of Care was also identified at 42 CFR 483.25 Quality of Care (F323). The facility was notified of the Immediate Jeopardy on 12/16/15.</p> <p>On 11/06/15 at 2:30 PM, Resident #1 sustained a fall during the process of being transferred from the wheelchair to a shower chair. It was determined Certified Nursing Assistant (CNA) #4 failed to utilize a Gait belt (a device used to transfer people from one position to another, from one thing to another or while ambulating people that have problems with balance) as care planned and the facility failed to revise the resident care plan to two person assist with transfers per the Minimum Data Set assessment. Resident #1 sustained a head injury and a skin tear that required the immediate transfer to a hospital for evaluation and treatment. Review of the Emergency Room Physician and Nursing note documentation, dated 11/06/15, revealed Resident #1 was diagnosed with a large hematoma (collection of blood under the skin due to ruptured blood vessels) to the right side of the head and multiple areas of bleeding within the brain. The resident was placed on comfort measures only; due to the significant bleeding in the brain and was returned to the nursing facility</p>	F 000	<p>Disclaimer:</p> <p>Signature Healthcare of Hart County does not believe and does not admit that any deficiencies existed either before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.</p>	

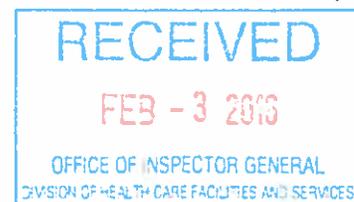
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator DATE X 3 Feb 2016

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.

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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 at 5:30 PM on 11/06/15 from the Emergency Room. On 11/07/15 at 2:00 AM, Resident #1 was without respiration and heart rate and was pronounced deceased; eleven and one-half (11 ½) hours after falling in the shower room. The facility provided an acceptable Allegation of Compliance (AOC) on 12/22/15 which alleged removal of the Immediate Jeopardy on 12/22/15. The State Survey Agency verified Immediate Jeopardy was abated on 12/22/15 as alleged prior to exit on 12/30/15. The scope and severity was lowered to a "D" at F280, F282, and F323 while the facility implements and monitors the Plan of Correction for the effectiveness of systemic changes and quality assurance.	F 000	F-280 <u>Residents Affected:</u> Due to the expiration of Resident #1, no corrective action could be made. <u>Residents Potentially Affected:</u> Residents who have the potential to be affected by the same deficient practice were identified in the following manner: On December 31, 2015 and ongoing Monday through Friday, audits were conducted by the Unit Coordinators and Director of Nursing comparing the documented transfer status of each resident in the facility with staff interviews to ensure consistency between the resident assessment, the Care Plan and the CNA Care Plan related to the resident's actual need. Based on these audits, changes will be made as needed in residents' Care Plans and CNA Care Plans by the Unit Coordinators. The results of these tests will be reviewed at the Monthly QAPI meetings for three (3) months, then quarterly for three (3) quarters, unless the QAPI Committee makes changes to the frequency and/or continuation of the testing. Daily, the "Stop and Watch" program is reviewed by the Charge Nurses and Unit Coordinators to identify residents who may have had a change in level of assistance with transfers. Daily, Monday through Friday, falls are reviewed by the Interdisciplinary Team in the morning meeting for root cause	1/31/2016
F 280 SS=J	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.	F 280		



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

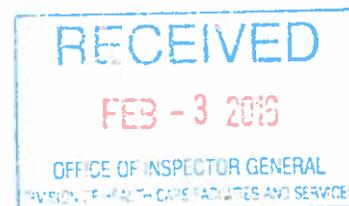
PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 280	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy and the Resident Assessment Instrument (RAI) Minimum Data Set (MDS) Manual, it was determined the facility failed to ensure resident care plans were revised after assessments determined residents needed additional assistance with transfers for one (1) of six (6) sampled residents (Resident #1). (Refer to F323)</p> <p>Resident #1 fell, on 11/06/15 at 2:30 PM, during the process of being transferred from the wheelchair to a shower chair by Certified Nursing Assistant (CNA) #4. Resident #1 sustained a head injury requiring the immediate transfer to a hospital. Review of the Emergency Room Physician and Nursing note documentation, dated 11/06/15, revealed Resident #1 was diagnosed with a large hematoma (collection of blood under the skin due to ruptured blood vessels) to the right side of the head and multiple areas of bleeding within the brain. The resident was placed on comfort measures only; due to the significant bleeding in the brain and was returned to the facility at 5:30 PM on 11/06/15. On 11/07/15, Nursing documentation revealed Resident #1 was without respiration and heart rate at 2:00 AM and was pronounced deceased; eleven and one-half (11 1/2) hours after falling in the shower room.</p> <p>Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment, completed on 10/07/15</p>	F 280	<p>analysis. This team includes the Administrator, Director of Nursing, Asst. Director of Nursing, Unit Managers, MDS Coordinator, Staff Development Coordinator and others at the request of this team. By performing this task, the facility can help to identify which residents may have the potential to be affected by the same deficient practice.</p> <p><u>Systemic Measures:</u> Audits were conducted on December 31, 2015 and daily Monday through Friday by the Unit Coordinators and Assistant Director of Nursing, comparing the documented transfer status of each resident in the facility with staff interviews to ensure consistency between the resident assessment, Care Plan and the CNA Care Plan related to the resident's actual need. Based on these audits, changes will be made if needed in residents' Care Plans and CNA Care Plans by the Unit Coordinators. These audits will be ongoing and reviewed at the Monthly QAPI meetings for three (3) months, , then quarterly for three (3) quarters, unless the QAPI Committee makes changes to the frequency and/or continuation of the observations. Daily, Monday through Friday, falls are reviewed by the Interdisciplinary Team in the morning meeting for root cause analysis. This team includes the Administrator, Director of Nursing, Asst. Director of Nursing, Unit</p>	
-------	---	-------	---	--



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 280

Continued From page 3 and review of Resident #1's Activities of Daily Living needs documentation, completed by the nursing assistants, dated 10/29/15-11/04/15 and 11/01/15-11/07/15 revealed Resident #1 required the extensive assistance of two during transfers. However, review of the resident's plan of care revealed the care plan had not been revised and indicated one person assist.

The facility's failure to have an effective system in place, to ensure care plans were revised for residents with a history of falls has caused or is likely to cause serious injury, harm, impairment or death. Immediate Jeopardy was identified on 12/16/15 and determined to exist on 11/06/15. The facility was notified of the Immediate Jeopardy on 12/16/15.

The facility provided an acceptable Allegation of Compliance (AOC) on 12/22/15 which alleged removal of the Immediate Jeopardy on 12/22/15. The State Survey Agency verified Immediate Jeopardy was abated on 12/22/15 as alleged prior to exit on 12/30/15. The scope and severity was lowered to a "D" while the facility implements and monitors the Plan of Correction for the effectiveness of systemic changes and quality assurance.

The findings include:

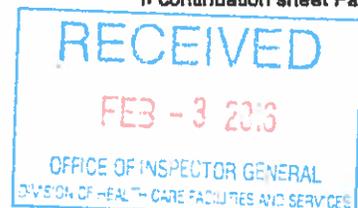
Review of the facility's policy regarding Falls Management, dated January 2010, revealed it was the policy of the facility to screen all residents to identify possible risk factors that may place a resident at risk for falls, to evaluate those risks, implement interventions to reduce those risks and monitor those interventions and modify when necessary.

F 280

Managers, MDS Coordinator, Staff Development Coordinator and others at the request of this team. During this meeting, the CNA Care Plans and Comprehensive Care Plans are reviewed and updated as needed by Licensed Nursing Staff. Newly hired staff receive competency skills evaluation during orientation by the Staff Development Coordinator, which includes use of gait belt for transfers. A 100% score must be attained by each staff member.

Monitoring Measures:
QAPI meetings were held on January 5, 2016, January 7, 2016, January 14, 2016, January 19, 2016 and January 27, 2016. These QAPI meetings have included and will include evaluation of each audit or process to determine the frequency of an audit or process or, if it might need to be changed or discontinued by the QAPI Committee. The Monthly QAPI Committee will include at a minimum, the Director of Nursing, a physician, and three other staff.

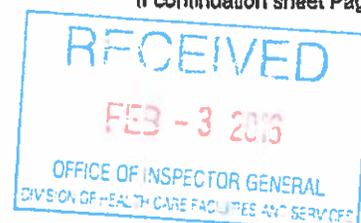
Daily, Monday through Friday, falls are reviewed in morning meeting by the Interdisciplinary Team and updates made to the CNA and Comprehensive Care Plans by Licensed Nursing Staff. The Interdisciplinary Team includes the Administrator, Director of Nursing, Asst. Director of Nursing, Unit Managers, MDS Coordinator, Staff



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 4 The facility did not provide a policy regarding the revision of care plans interventions; however, interview with the Administrator, on 12/15/15 at 9:30 AM, revealed the facility staff used the Centers for Medicare and Medicaid Services Resident Assessment Instrument (RAI) Minimum Data Set (MDS) to direct them in the revision of care plan interventions. Review of the RAI, MDS Manual 3.0, dated 10/09/15, Chapter 4, page 4-8 through 4-12, revealed the comprehensive care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care. The intermediate goals and objectives must be pertinent to the resident's condition and situation. The effectiveness of the care plan must be evaluated from its initiation and modified as necessary. Changes to the care plan should occur as needed in accordance with professional standards or practice and documentation (signing and dating entries to the care plan). The Interdisciplinary Team members should communicate as needed about care plan changes. Review of the closed clinical record for Resident #1 revealed the facility admitted the resident with diagnoses of Difficulty Walking, Abnormal Gait, Muscle Weakness, Abnormal Posture, Sprain Rotator Cuff, Joint Pain, Shortness of Breath and Osteoporosis. The facility assessed the resident as being at risk for falls on admission. Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment, completed on 10/07/15, revealed the facility assessed the resident	F 280	Development Coordinator and others at the request of this team. Findings of the above stated audits will be reviewed by the QAPI committee monthly for three (3) months, then quarterly for three (3) quarters, for frequency of ongoing audits or further recommendations and follow-up as indicated. The Monthly QAPI Committee will include at a minimum, the Director of Nursing, a physician, and three other staff.	



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 280	<p>Continued From page 5</p> <p>utilizing the Brief Interview for Mental Status with a score of thirteen (13) meaning the resident was cognitively intact and determined to be interviewable. The facility also assessed the resident as needing the extensive assistance of two with transfers, personal hygiene, and toileting. The facility assessed the resident as not steady on their feet and only able to stabilize with staff assistance with moving from a seated to standing position, walking, moving on and off the toilet and surface to surface, such as between the bed and chair or chair to wheelchair.</p> <p>Review of the resident's care plan developed on 05/06/15, with a review date of 08/04/15 and 10/27/15, revealed Resident #1 was at risk for falls due to decreased mobility, history of falls, generalized weakness and antidepressant medication revealed updated goals and target dates for 01/27/16. The goal stated the resident would be free of falls within the next ninety-days. The approaches directed staff to assist the resident with activities of daily living, keep call light and personal items within reach at all times, wheelchair mobility per staff in facility, and keep walkways free from clutter.</p> <p>Further review of the care plan, developed on 05/06/15, revealed the resident was at risk for decline of activities of daily living due to generalized weakness, depression and failure to thrive. The goal stated the resident would have improvement of activities of daily living within the next ninety days. Review of the plan of care revealed the assistance of two (2) with transfers and toileting, bed mobility and ambulation. The approach for two assist was revised to one assist on 07/15/15, with transfers, toileting, bed mobility and ambulation. Additional approaches listed,</p>	F 280		
-------	--	-------	--	--



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 280	<p>Continued From page 6</p> <p>directed staff to provide the assistance of one (1), with bathing, personal hygiene and dressing. However, review of Resident #1's Quarterly Minimum Data Set, data 10/07/15, assessed the resident as needing the extensive assistance of two (2).</p> <p>Review of Certified Nursing Assistant (CNA) ADL documentation, dated 10/01/15 through 10/07/15, used to formulate the MDS assessment, revealed under the ADL Self-Performance activity portion of the assessment the resident was assessed to need extensive assistance with transfers on 10/02/15, 10/03/15, 10/04/15, 10/06/15, and 10/07/15. Continued review revealed staff documented the resident required limited assistance on 10/01/15 and 10/05/15. Further review of the ADL Support-Provided by staff documentation revealed, the most support provided during transferring, over all shifts for the period of 10/01/15 through 10/07/15, was the assistance of two staff. However, the resident's plan of care had not been revised.</p> <p>Interview with the Assistant Minimum Data Set (MDS) Nurse, on 12/16/15 at 4:00 PM, revealed she attended weekly care plan meetings and if she identified a change in resident needs she would revise the residents' plan of care. She stated she did not input information into the MDS assessment form; however, she did review the documentation made by nursing staff that helped to formulate the assessment findings. She stated as part of her MDS responsibility she reviewed documentation completed by the nursing assistants regarding the amount and type of assistance provided to the resident during transfers. She stated the ADL documentation, dated 10/29/15-11/04/15 and 11/01/15-11/07/15,</p>	F 280		
-------	--	-------	--	--



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 280 Continued From page 7

revealed Resident #1 required the extensive assistance of two during transfers. However, her interpretation of the aides' documentation of the assistance provided and coding done by the MDS system for the ADL Self-Performance activity and the ADL Support-Provided by staff did not follow the rule of three (when an activity occurred more than three times at any one given level, the facility should code the most dependent level assessed). She further stated the CNA documentation was isolated events, in which Resident #1 needed the extensive assistance of two. Per interview, her review of the documentation helped to formulate her decision to not change the resident's plan of care to direct staff to provide the extensive assistance of two, even though the MDS assessment stated the resident required the extensive assistance of two with transfers.

Interview with the MDS Registered Nurse, on 12/16/15 at 10:25 AM, revealed Resident #1's documented assessed need, according to the 10/27/15 MDS quarterly assessment, was for the extensive assistance of two (2). He stated this should have been reflected on the plan of care; however, the MDS team did not revise the plan of care routinely after a quarterly assessment had been completed. He revealed the MDS team members only aided in the formulation of the admission and an annual plan of care for residents. He stated an MDS nurse attended weekly care plan meetings to add input; however, nursing staff was responsible for revising resident care plans if changes were noted during the MDS quarterly assessment periods. He stated resident care plans should be revised immediately after a change in care needs had been assessed. He stated if care plans were not revised immediately staff would not have the most current

F 280



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 280	<p>Continued From page 8 information/interventions to meet the needs of the resident.</p> <p>Interview with Licensed Practical Nurse #1, on 12/15/15 at 2:15 PM, revealed Resident #1 at times, due to not feeling well, required the extensive assistance of two staff with transfers. She stated she had not reviewed the MDS assessment findings that stated the resident required the extensive assistance of two with transfers and had not reviewed the care plan to determine the assistance level documented had not been revised to instruct staff to provide the assistance of two during transfers. She revealed nursing staff could revise resident care plans when their needs changed. Per interview, the CNAs were provided resident care sheets that directed them in the care of the residents. The care sheets were also revised when resident care needs changed and again monthly when a new sheet was developed. However, she stated Resident #1's care sheet had not been revised to direct staff to provide the assistance of two per the MDS assessment. Per interview, when resident needs change the care plan and the nurse aide care sheet should be revised immediately in order for all staff to have the most up to date care information. If care plans were not revised then resident care needs would not be met.</p> <p>Interview with CNA #2, on 12/16/15 at 9:14 AM, revealed at times when Resident #1 would not feel good or was weaker than usual; it would take two people to get the resident up and to transfer to another chair or to the bed. However, she stated according to Resident #1's nurse aide care sheet, the resident only required the assistance of one with transfers. She stated if the care sheet</p>	F 280		
-------	--	-------	--	--



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/30/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 280	<p>Continued From page 9</p> <p>did not have the most up to date information staff would not know the specific intervention needed to care for the resident.</p> <p>Review of the Nursing documentation, dated 11/06/15, revealed Resident #1 fell in the shower room at approximately 2:30 PM and sustained a head injury and a skin tear to the right elbow. Interview revealed the fall occurred during a one person transfer.</p> <p>Interview with the Director of Nursing (DON), on 12/15/15 at 3:15 PM, revealed Resident #1 fell during the process of being transferred from the wheelchair to a shower chair, on 11/06/15 at 2:30 PM. The DON stated she had not reviewed the resident's medical record after the event and had not determined if the resident had been assessed to need the extensive assistance of two during transfers. She stated all nursing staff could revise a resident care plan after an assessment determined the residents' care needs had changed. She revealed the nursing aides care sheet would also be updated immediately after resident care needs were determined to have changed. Per interview, if the plan of care was not updated immediately the staff would not know the required needs of the resident and the appropriate interventions would not be implemented; which could lead to harm.</p> <p>The facility took the following actions to remove the Immediate Jeopardy as follows:</p> <p>1. On 11/06/15 Resident #1 had a fall in the facility shower room. The Restorative Nurse hearing a call for help went to the shower room, found the resident on the floor, took the resident's vital signs, and placed pressure to a laceration on</p>	F 280			



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 280	<p>Continued From page 10</p> <p>the resident's arm. The resident's vital signs were taken, neurological status was assessed, and an ice pack was applied to the resident's head. The attending physician and daughter-in-law were notified. Emergency Medical Services (EMS) was called for transport and the resident returned from the hospital the same day.</p> <p>2. An investigation was initiated by the Administrator and the Director of Nursing (DON) on 11/06/15. The shower room on the Dogwood Unit was inspected and a sign was placed on the shower room door to not use the shower room until further notice.</p> <p>3. On 11/06/15 following shift change the DON educated all day and night shift staff that two (2) staff would be required in shower rooms for transfers. There were twenty-seven (27) nursing staff on on duty on 11/06/15 of the sixty-seven(67) total staff.</p> <p>4. On 11/07/15 the Administrator called the House Supervisor and instructed her to educate the nursing staff, (28) who worked the weekend, that going forward two (2) people would be required in the shower rooms for transfers. Eleven (11) weekend staff remained to be trained. There was no agency staff at this time.</p> <p>5. On 12/17/15 the Administrator reviewed ninety-five (95) falls from 06/01/15 to present to determine if falls occurred in the shower rooms. Only one (1) fall occurred in a shower room related to a wheelchair moving. There were no falls related to resident transfer or gait belt use.</p> <p>6. On 11/13/15 education was given to nursing staff by the Staff Development Coordinator (SDC)</p>	F 280		
-------	---	-------	--	--



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	<p>Continued From page 11</p> <p>on safety devices, transfers, use of gait belts. The Charge Nurse, CNA Preceptor, Unit Managers, DON, and Assistant Director of Nursing (ADON) were included in the thirty-four (34) nurses educated by the SDC. New nursing staff receives competency skills evaluations that includes gait belt use.</p> <p>7. After the fall on 11/06/15 the facility started reviewing falls in the morning meeting Monday through Friday for root cause analysis and that the CNA and comprehensive care plans are updated. The comprehensive care plans are updated by nurses. The DON then checks that the CNA and comprehensive care plans are updated Monday through Friday. Falls on the weekend with injury are called to the DON by a licensed nurse and reviewed. The licensed nurse updates the care plan and the fall is placed on the 24 hour report. A shift to shift report is given between nurses.</p> <p>8. On 11/24/15 the Quality Assurance Performance Improvement (QAPI) committee met with the Administrator, DON, ADON, Unit Managers, Maintenance Director, Social Services Director, Human Resource Director, and Restorative Nurse Manager. The number, location, shift of falls were discussed along with monitoring of transfers to be ongoing. Transfer assistance documentation was reviewed for discrepancies. In addition, falls for 10/01/15 through 10/31/15 were reviewed to look for further trends.</p> <p>9. On 12/15/15 ninety-six (96) current CNA care plans were audited to determine gait belt needs and transfer assistance by the DON, Unit Manager, SDC, ADOC, Signature Care</p>	F 280		

RECEIVED
FEB - 3 2016
 OFFICE OF INSPECTOR GENERAL
 DIVISION OF HEALTH CARE LICENSING AND SERVICES

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

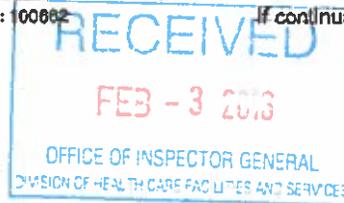
PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

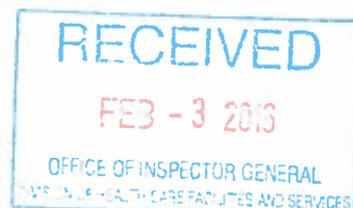
F 280	<p>Continued From page 12</p> <p>Consultant (SCC), Administrator or Director of Program Development (DPD). The team found and corrected twenty (20) discrepancies. All ninety-six (96) CNA care plans were then compared to the comprehensive care plans to ensure the CNA care plan matched for level of assistance, transfers and use of a gait belt. There were (43) discrepancies identified at that time and corrected.</p> <p>10. On 12/15/15 thirty-nine (39) of thirty-nine (39) evening and night shift nurses and therapy staff were educated by the SDC, DON, and SCC to use gait belts for transfers, checking the CNA care plans, and two (2) staff members to be in the shower rooms for assistance with transfers except for Hoyer Lift residents or independent residents.</p> <p>11. On 12/17/15 the DPD educated seventeen (17) interdisciplinary team (IDT) management team members which included the Administrator, DON, Unit Managers, Rehab Manager, Business Office Manager, Medical Records Director, SDC, MDS Coordinator, Human Resources, Maintenance Director, Human Resources, Environmental Services Director, and Activities Director on root cause analysis, Gait Belt Policy, Stop and Watch Process, two (2) persons for transfers and in the shower room at all times, updating care plans, and following the care plan. This was a face to face training. A post-test on gait belt use was administered and a score of 100% had to be reached.</p> <p>12. On 12/17/15 the staff was retrained by the management staff, who had been educated by the DPD. Any staff not trained as of 12/18/15 could not return to work until educated and they</p>	F 280		
-------	---	-------	--	--



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/30/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 280	<p>Continued From page 13</p> <p>received 100% on the post-test. If 100% was not obtained they would be re-educated and re-tested until they scored 100%. Staff on Family Medical Leave (FMLA), Medical leave, PRN, or vacation would not be allowed to return to work until trained and they received 100% on the post-test.</p> <p>Beginning 12/18/15 every shift a licensed nurse or the Regional Rehab Services Manager will observed three (3) showers on Magnolia and Dogwood daily for gait belt use for transfer. Five (5) nursing or therapy staff will be administered the gait belt post-test by the Administrator, DON, Unit Manager, Business Office Manager, Medical Records Director, MDS Coordinator, Human Resource Director, Activities Director, or Environmental Services Director. The post-test and re-education will be given until a 100% score is achieved.</p> <p>The Administrator and DON will review post-test daily.</p> <p>13. On 12/16/15 the SDC, DON, Unit Managers, ADON, and or the SCC began gait belt competencies. As of 12/21/15 sixty-one (61) staff had completed the competencies. The facility has sixty-seven (67) staff members.</p> <p>14. On 12/16/15 the Minimum Data Set (MDS) Coordinator reviewed the last MDS assessments for all ninety-seven (97) residents for their level of assistance to ensure the CNA and the comprehensive care plans matched the MDS assessment. On 12/17/15 the DON, Unit Manager, SCC, and SDC conducted a second audit and interviewed various staff members to determine the amount of assistance the ninety-seven (97) residents needed. This</p>	F 280			



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

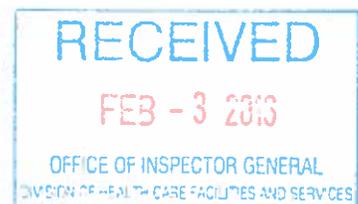
PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 280	<p>Continued From page 14</p> <p>information was compared to the MDS coding, the CNA and comprehensive care plans. Fifty-three (53) comprehensive care plans and thirty-four (34) CNA care plans were updated.</p> <p>15. A QAPI meeting was held on 12/15/15 via telephone with the Medical Director, Administrator, DON, Unit Manager, SCC and DPD to review the fall of Resident #1, the steps to put in place, incident reports, placing grab bars in the shower rooms, and staff education.</p> <p>16. On 12/17/15 the Administrator notified the staffing agency that their staff would receive gait belt education before working at the facility.</p> <p>17. On 12/21/15 three gait belts were placed in the medication room on the Magnolia and Dogwood Units.</p> <p>18. On 12/17/15 a QAPI meeting was held with the Medical Director, Special Projects Administrator (SPA), Unit managers, (3) SCC's, and the DPD to review cited deficiencies. Care plans would be audited daily Monday through Friday, Stop and Watch Process audits, fall interventions audits, continue gait belt competencies and use, shower room transfer audits with two (2) staff, gait belt post-test, and root cause analysis audits daily.</p> <p>19. Beginning 12/18/15 care plans will be audited for transfer assistance needed by the DON, ADON, Unit manager, SCC, and Charge Nurse and discussed in morning meeting if a discrepancy is noted an investigation will be initiated by the DON, Administrator, or Unit Manager. The interdisciplinary team (IDT) will update the care plan and notify the MDS</p>	F 280		
-------	--	-------	--	--



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

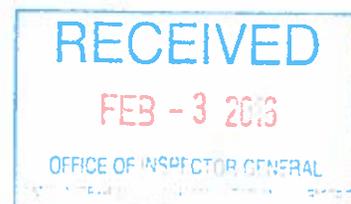
PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 280	<p>Continued From page 15</p> <p>Coordinator of the change, and falls will be reviewed for root cause analysis.</p> <p>20. A nurse from the regional team or corporate office, Regional Vice-President of Operations or Special Projects Administrator has been on site daily since 12/14/15 reviewing audits and assisting as needed. The Chief Nurse Executive, Clinical Compliance Nurse, Director of Program Development is in daily contact with the SCC or Regional Vice president of Operations and is reviewing audits.</p> <p>21. A QAPI meeting was held on 12/22/15 to determine further need for education or plan revision. Results of audits, post-test, and gait belt observations during showers were discussed and reported weekly. Concerns identified will be corrected immediately and reported to the Administrator or DON. The IDT team are auditing with audit tools daily. These audits are reviewed by the Administrator, DON, or regional staff member daily.</p> <p>22. Administrative oversight of the facility will be completed by the Special Projects Administrator, Regional Vice President of Operations, or a member of the regional staff weekly on site and daily by telephone beginning 12/16/15, then every other week for four (4) weeks, then monthly. Oversight will include, but not limited to, daily review of the audits, QAPI committee meetings and review of all audits to ensure additional education is not needed.</p> <p>23. QAPI meetings will be held weekly beginning 12/15/15 for four (4) weeks, then monthly for recommendations and further follow-up and determine what frequency any ongoing audits will</p>	F 280		
-------	--	-------	--	--



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

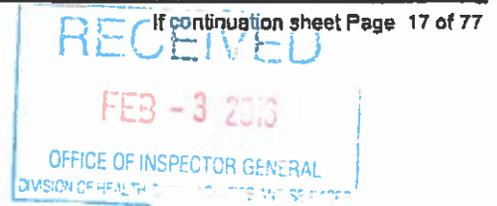
PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 280	<p>Continued From page 16</p> <p>need to continued. The Administrator has the oversight to ensure an effective plan is in place to meet the resident's well-being, identify facility concerns, and implement a corrective plan to involve all staff. Audits will be reviewed, but not limited to, gait belt competency, and two (2) person transfers for showers, gait belts on nursing and therapy staff, care plan audits for transfer assistance, MDS coding for transfers, and root causes for falls.</p> <p>The State Survey Agency validated the removal of the Immediate Jeopardy on 12/30/15 prior to exit as follows:</p> <p>1. Interview, on 12/30/15 at 7:20 AM, with LPN #1 (the Restorative Nurse) revealed on 11/06/15 she responded to a call for help from the shower room on the Dogwood Unit. When she entered the shower room, Resident #1 was laying on his/her right side on the shower room floor. Resident #1 was non-responsive to verbal stimuli for one (1) to two (2) minutes. She took the resident's vital signs, placed a pressure dressing on a laceration on the resident's right arm, and an ice pack was placed on a hematoma on the right side of the resident's forehead. Review of the nursing notes and incident report on 12/30/15 revealed, on 11/06/15 at 2:30 PM Resident #1's attending physician and daughter-in-law were notified of Resident #1's fall. The attending physician gave orders to send Resident #1 to a local hospital for assessment. Emergency Medical Services (EMS) was called to transport the resident to a local hospital for evaluation. Resident #1 was returned to the facility from the local hospital, on 11/06/15 at 3:30 PM, with a diagnosis of Subdural Hematoma and he/she was not a surgical candidate.</p>	F 280		
-------	--	-------	--	--



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

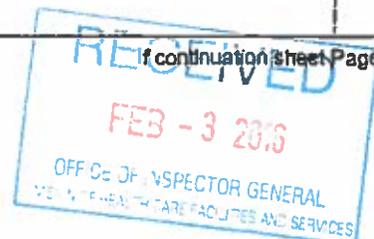
PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 280	<p>Continued From page 17</p> <p>2. Interview with the Administrator, on 12/29/15 at 9:06 AM, revealed after he was notified Resident #1 had fallen on 11/06/15 he and the Director of Nursing (DON) investigated all the shower rooms. He had a sign placed on the Dogwood Unit shower door to not use the shower room until Monday, 11/09/15 and he then purchased grab bars to be installed in all the shower rooms.</p> <p>Interview with the Plant Director, on 12/29/15 at 2:45 PM, revealed he and his Assistant installed new grab bars in all four (4) facility shower rooms; two (2) shower rooms on Dogwood and two (2) shower rooms on Magnolia on 11/09/15.</p> <p>Review of the purchase order for grab bars revealed grab bars were purchased 11/08/15 at a local store.</p> <p>Observations of two (2) shower rooms on the Dogwood and Magnolia Units, on 12/29/15 at 11:31 AM, revealed all shower rooms had new grab bars.</p> <p>3. Interview with the DON, on 12/29/15 at 3:15 PM, revealed she educated all staff working 11/06/15 that effective immediately there were to be two (2) staff always present in the shower rooms for transfers. There were twenty-seven (27) nursing staff on duty on 11/06/15 of the sixty-seven (67) total staff.</p> <p>Review of the staff schedule for 11/06/15 and staff name check offs by the DON revealed twenty-seven (27) staff were educated that two (2) staff must be present at all times in the shower rooms.</p>	F 280		
-------	---	-------	--	--



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	<p>Continued From page 18</p> <p>Observations of the shower room on the Dogwood Unit, on 12/29/15 at 9:00 AM, and the Magnolia Unit, on 12/29/15 at 9:16 AM, revealed two (2) CNAs with a resident using a gait belt to transfer the resident.</p> <p>Interview with CNA #2, on 12/29/15 at 9:12 AM and CNA #3, on 12/29/15 at 9:40 AM, revealed they were educated on 11/06/15 by the DON that two (2) staff were to always be in the shower room with a resident.</p> <p>4. Interview with the Administrator, on 12/29/15 at 3:15 PM, revealed he called the Nursing Supervisor on 11/07/15 and instructed her to educate all working staff that showers were to only be given with two (2) staff present at all times in the shower room.</p> <p>Interview with the House Supervisor, on 12/29/15 at 3:00 PM, revealed she had trained twenty-eight (28) staff on 11/07/15 that two (2) staff had to be present for all showers.</p> <p>Interview with CNA #2 on 12/29/15 at 9:30 AM; CNA #3 on 12/29/15 at 9:40 AM; CNA #4 on 12/29/15 at 2:50 PM; Registered Nurse (RN) #1 on 12/29/15 at 2:30 PM; CNA # 5 (agency staff) on 12/29/15 at 2:43 PM; and, Licensed Practical Nurse (LPN) #1 on 12/29/15 at 3:07 PM, revealed they were educated on 11/07/15 by the House Supervisor to always have two (2) staff present in the shower rooms with residents.</p> <p>Review of the staffing schedule for 11/07/15 revealed twenty-eight (28) nursing staff were trained.</p>	F 280		



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	<p>Continued From page 19</p> <p>5. Interview with the Administrator, on 12/29/15 at 3:15 PM, revealed on 12/17/15 he reviewed all falls in the facility from 06/01/15 through 12/17/15 to determine a root cause. Ninety-five (95) falls were reviewed. Only one (1) occurred in a shower room due to a wheelchair wheels not being locked. There were no falls related to resident transfers.</p> <p>6. Interview with the Staff Development Coordinator (SDC), on 12/29/15 at 9:15 AM, revealed on 11/13/15 she educated nursing staff on gait belt use. Thirty-four (34) nursing staff including the Assistant Director of Nursing (ADON), Charge Nurse, CNA Preceptor, and DON were told to always have their gait belt and to use it for all transfers. In addition she stated all direct nursing staff and therapy staff were provided a gait belt by the facility upon hire. Each unit has extra gait belts in the medication rooms for agency staff to use.</p> <p>Interview with the Unit Manager on 12/29/15 at 9:12 AM; CNA #2 on 12/29/15 at 9:30 AM; CNA #3 on 12/29/15 at 9:40 AM; CNA #1 on 12/29/15 at 12:33 PM; the Magnolia Unit Charge Nurse on 12/29/15 at 12:45 PM; RN #1 on 12/29/15 at 2:30 PM; CNA #4 on 12/29/15 at 2:50 PM; and, LPN # 1 on 12/29/15 at 3:07 PM, revealed they were educated on 11/13/15 by the SDC on gait belt use for resident transfers.</p> <p>7. Interview with the Director of Clinical Programs (DCP), on 12/29/15 at 9:15 AM, revealed the morning meetings are Monday through Friday and comprehensive care plans are reviewed and updated when needed. The DON reviews the CNA care plans to ensure it matches the comprehensive care plan.</p>	F 280		



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 280	<p>Continued From page 20</p> <p>Interview with the Administrator, on 12/29/15 at 3:15 PM, revealed the morning meetings are Monday through Friday. After the fall on 11/06/15 the facility started reviewing the comprehensive and CNA care plans for transfer and assistance needs to ensure they were reviewed and updated as needed. Falls are reviewed for root cause analysis. If a fall with injury occurs on the weekend the DON is notified.</p> <p>Interview with the DON, on 12/29/15 at 3:23 PM, revealed morning meetings are held Monday through Friday. In the meeting the resident comprehensive care plans are reviewed and she checks that the comprehensive care plan matches the CNA care plan. Any fall that occurred is placed on the 24 hour report and the shift to shift report. The fall is reviewed in the morning meeting the next morning for a possible root cause. She is notified if a fall with injury occurs on the weekend.</p> <p>Interview with the ADON, on 12/30/15 at 8:50 AM, revealed she attends morning meetings Monday through Friday. All ninety-six (96) resident comprehensive care plans are reviewed and updated as needed. The DON compares the CNA care plan to the comprehensive for transfer and assistance needs.</p> <p>8. Interview with the Administrator, on 12/30/15 at 9:57 AM, revealed the QAPI committee is an interdisciplinary team (IDT) that consists of the DON, ADON, Unit Managers, Social Services, Office Manager, Medical Records, Human Resources, Activity Director, two (2) Unit Coordinators, Environmental Services Director, MDS Coordinators, Therapy Director, Staff</p>	F 280		
-------	--	-------	--	--



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 280	<p>Continued From page 21</p> <p>Development, and the Medical Director. The committee meets monthly. On 11/24/15 the committee met to discuss monitoring transfer assistance needs. Falls data was reviewed from 10/01/15 through 10/31/15 to identify if there was a trend.</p> <p>Interviews with the DON, two (2) Unit Managers, SDC, SCC, and DPD on 12/30/15 at 3:23 PM, revealed they attended the 11/24/15 QAPI meeting and discrepancies identified for transfer assistance were reviewed.</p> <p>Review of the QAPI committee sign in sheet for 11/24/15 on 12/30/15, revealed the DON, ADON, Unit Managers, Social Services, Office Manager, Medical Records, Human Resources, Activity Director, two (2) Unit Coordinators, Environmental Services Director, MDS Coordinators, Therapy Director, and SDC were present at the meeting.</p> <p>9. Review of the facility's audits for needed care plan updates of transfer and assistance needed, dated 12/13/15; 12/15/15; 12/16/15; 12/17/15; 12/18/15; 12/20/15; 12/21/15; and 12/22/15 revealed the audits had been completed with changes identified that needed to be made to the care plans.</p> <p>Review of Resident #7's and Resident #10's comprehensive and CNA care plans revealed, revealed their care plans had been updated for transfer and assistive needs on 12/18/15.</p> <p>Review of Unsampld Resident's A and B's comprehensive and CNA care plans revealed their care plans had been updated for transfer and assistive needs on 12/19/15.</p>	F 280		
-------	---	-------	--	--



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

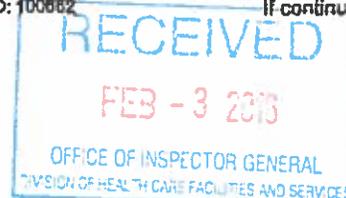
PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 280	<p>Continued From page 22</p> <p>10. Review of the education sign in sheets revealed on 12/15/15 thirty-two (32) nursing staff and seven (7) therapy staff were trained on two (2) staff in the shower rooms for assistance except for Hoyer Lifts and independent residents.</p> <p>Interview with the Dogwood Unit Manager, on 12/29/15 at 9:12 AM, revealed she assisted with the training of the nursing and therapy staff 12/15/15 and 12/16/16.</p> <p>Interview with, CNA #2 on 12/29/15 at 9:30 AM; CNA #3 on 12/29/15 at 9:40 AM; an Occupational Therapist (OT) on 12/29/15 at 11:53 AM; a Physical Therapist Assistant (PTA) on 12/29/15 at 12:10 PM; CNA #5 on 12/29/15 at 2:43 PM; LPN #1 on 12/29/15 at 3:07 PM; and, CNA #10 on 12/29/15 at 3:15 PM, revealed on 12/15/15 and 12/16/15 they had been educated that two (2) staff members were to be in the shower rooms for resident transfers, gait belts were to be used for transfers according to the care plan and that staff was to check the care plan for fall interventions and needed changes.</p> <p>11. Interview with the Director of Clinical Programs (DCP), on 12/29/15 at 9:15 PM, revealed on 12/17/15 she educated the IDT team on Root Cause Analysis in a power point presentation in the morning meeting. The (IDT) consisted of the DON, ADON, Unit Managers, Social Services, Office Manager, Medical Records, Human Resources, Activity Director, two (2) Unit Coordinators, Environmental Services Director, MDS Coordinators, Therapy Director, Staff Development, and Maintenance Director. The Gait Belt Policy was reviewed with no changes needed. A Stop and WatchProcess</p>	F 280		
-------	--	-------	--	--



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 280

Continued From page 23

form was presented, two (2) person transfers and staff being in the shower rooms were to be permanent changes. Care plan reviews, updating care plans, and face to face training were discussed. She administered a post gait belt test to the IDT team and each had to obtain a score of 100%. If 100% was not reached re-education was done immediately and the person was retested.

Interviews, on 12/29/15 with the SDC at 9:45 AM; Director of Social Services at 11:10 AM; the Office Manager at 11:20 AM; Human Resource Director at 11:30 AM; MDS Coordinator at 11:55 AM; and, the Therapy Director at 12:10 PM, revealed they attended the training on 12/15/15 presented by the DCP.

12. Interview with CNA #2 on 12/29/15 and 9:30 AM; CNA #3 on 12/29/15 at 9:40 AM; an Occupational Therapist (OT) on 12/29/15 at 11:53 AM; a Physical Therapist Assistant (PTA) on 12/29/15 at 12:10 PM; CNA #5 on 12/29/15 at 2:43 PM; LPN #1 on 12/29/15 at 3:07 PM; and, CNA # 10 on 12/29/15 at 3:15 PM, revealed they all stated they had received education on gait belt use, obtained 100% on the post test, could explain when and how the use the Stop and Watch form, and were aware two (2) persons must always be in the shower rooms for resident transfers.

Review of the daily gait belt post-tests revealed since 12/18/15 five random staff from nursing and therapy had been administered the gait belt post-test and obtained a score of 100%.

Interview with the Administrator, on 12/30/15 at 11:49 AM, revealed he or the DON reviewed all gait belt post-test daily for the five (5) random

F 280



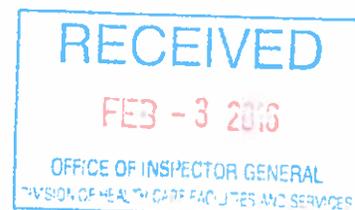
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	<p>Continued From page 24 staff test.</p> <p>In addition, interview with the DON, on 12/30/15 at 11: 50 AM, revealed she follows-up with the Administrator to assess if staff had to be re-educated and were re-tested.</p> <p>Review of the staff post-test revealed sixty-five (65) of sixty-seven (67) facility staff were trained. One (1) untrained staff member was on FMLA and the other was a PRN staff.</p> <p>13. Review of staff post-test revealed between 12/16/15 and 12/21/15 sixty-one (61) of the facility's sixty-seven staff members were administered a gait belt competency which was part of the gait belt training. The staff member had to demonstrate correct use of the gait belt.</p> <p>Review of post-test after 12/21/16 revealed three (3) PRN staff and one (1) staff from vacation completed the gait belt testing with 100% and were able to demonstrate appropriate use of the gait belt.</p> <p>14. Interviews on 12/29/16 with the SDC at 9:45 AM and the DON at 3:23 PM, revealed they interviewed various nurses and CNAs on 12/17/15 to determine the amount of assistance a resident needed for bed mobility, eating, transfers and toileting. This information was compared to the MDS coding, CNA care plans and the comprehensive care plan. Eight (8) assessments required modification. Follow up on 12/18/15 revealed fifty-three (53) comprehensive care plans and thirty-four (34) CNA care plans were updated by the DON, Unit Managers, SCC, ADON, SDC, and the DPD.</p>	F 280		



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

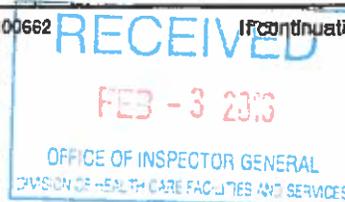
PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 280	<p>Continued From page 25</p> <p>15. Interview with the DON, on 12/30/15 at 8:50 AM; the Administrator at 9:57 AM; the Medical Director at 10:40 AM; and, the Signature Care Consultant for Nursing (SCC) at 12:06 PM, revealed all were present on 12/15/15 for a QAPI meeting to discuss the fall of Resident #1 and an action plan. (Grab bars, staff education, and incident reports)</p> <p>16. Interview with the owner of the Staffing Agency, on 12/29/15 at 12:35 PM, revealed she was notified by the Administrator on 12/17/15 that all agency staff would be gait belt trained and tested before working at the facility.</p> <p>17. Observations, on 12/29/15 at 11:31 AM, of the medication rooms on the Dogwood and Magnolia Units revealed there were three (3) gait belts in the room.</p> <p>18. Interview with the Administrator, on 12/30/15 at 9:57 AM, revealed a QAPI meeting was held on 12/17/15 by phone with the Medical Director.</p> <p>Interview with the Medical Director, on 12/30/15 at 10:40 AM, revealed he was called into a QAPI meeting on 12/17/15.</p> <p>Interview, on 12/30/15 with the DON at 8:00 AM; Special Projects Administrator at 10:20 AM; SDC at 9:30 AM; and, the ADON at 11:07 AM, revealed they were present for the QAPI conference call with the Medical Director on 12/17/15.</p> <p>Review of the QAPI sign in sheet for the 12/17/15 meeting revealed seven (7) persons were present for the meeting.</p> <p>19. Interview with the SDC, on 12/29/15 at 9:45</p>	F 280		
-------	--	-------	--	--



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 280	<p>Continued From page 26</p> <p>AM, revealed she assisted with the audits, beginning 12/18/15, of the care plans and if discrepancies are identified they are discussed in the morning meetings.</p> <p>Interview with the DON, on 12/29/15 at 3:15 PM, revealed prior to 12/18/15 the facility had reviewed and updated all resident care plans for assistance and transfer needs. Beginning 12/18/15 through ongoing care plan audits if a discrepancy was identified in a resident's care plan for transfer or assistance needs it was to be reported in morning meeting and would be investigated. All falls would be reviewed for root cause and if a care plan was updated MDS would be notified of the change.</p> <p>Review of the facility falls since 11/06/15 revealed there had been no resident falls from 12/15/15 to 12/30/15.</p> <p>20. Interviews, on 12/29/15 with the DPD at 9:15 AM; and, the Special Project Administrator at 10:20 AM, revealed the corporate team assigned to assist the facility since 12/14/15 were present on site and reviewing audits. The Corporate team consisted of the Special Project Administrator, the Director of Program Development, and the Signature Care Consultant.</p> <p>21. Interview with the Administrator, on 12/30/15 at 9:57 AM, revealed QAPI meetings were held 12/15/15, 12/17/15, 12/22/15, and 12/29/15.</p> <p>Review of the QAPI sign in sheets on 12/30/15, revealed QAPI meetings were held 12/15/15, 12/17/15, 12/22/15, and 12/29/15.</p> <p>22. Interview with the Special Project</p>	F 280		
-------	--	-------	--	--



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

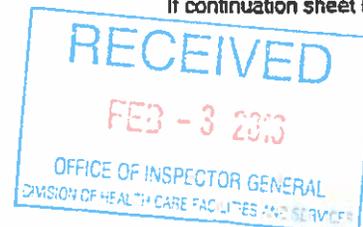
PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 280	<p>Continued From page 27</p> <p>Administrator, on 12/29/15 at 10:20 AM, revealed he was the Corporate Administrator assigned to oversight with the facility. He stated he would be at the facility weekly and was available to the facility by phone seven (7) days a week. He further stated he would review audits, attend QAPI meetings and ensure additional staff education was not needed.</p> <p>23. Interview with the Administrator, on 12/30/15 at 9:37 AM, revealed QAPI meetings had been weekly since 12/05/15.</p> <p>Review of the QAPI meeting sign in sheets revealed QAPI meetings had been held 12/15/15, 12/17/15, 12/22/15, and 12/29/15.</p>	F 280	<p>F-282</p> <p><u>Residents Affected:</u> Due to the expiration of Resident #1, no corrective action could be made.</p> <p><u>Residents Potentially Affected:</u> Residents who have the potential to be affected by the same deficient practice were identified in the following manner:</p> <p>On December 31, 2015 and daily Monday through Friday, audits were conducted by the Unit Coordinators and Director of Nursing comparing the documented transfer status of each resident in the facility with staff interviews to ensure consistency between the resident assessment, the Care Plan and the CNA Care Plan as it relates to the resident's actual need. This includes the need or lack of need for a gait belt during transfer. These audits will be ongoing and reviewed at the Monthly QAPI meetings for three (3) months, then quarterly for three (3) quarters, unless the QAPI Committee makes changes to the frequency and/or continuation of the audits.</p> <p>Daily, the "Stop and Watch" program is reviewed by the Charge Nurses and Unit Coordinators to identify residents who may have had a change in level of assistance with transfers.</p> <p>Daily, Monday through Friday, falls are reviewed by the Interdisciplinary Team in the morning meeting for root cause analysis. This team includes the Administrator, Director of Nursing,</p>	1/31/2016
F 282 SS=J	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS) Manual it was determined the facility failed to have an effective system to ensure resident care plans were followed related to the use of a gait belt when providing transfer assistance for one (1) of six (6) sampled residents, (Resident #1). (Refer to F323)</p> <p>On 11/06/15 at 2:30 PM, Resident #1 sustained a</p>	F 282		



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 SOUTH DIXIE STREET HORSE CAVE, KY 42749	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	<p>Continued From page 28</p> <p>fall during a transfer from the wheelchair to a shower chair by Certified Nursing Assistant (CNA) #4. Interview with the Director of Nursing (DON) revealed she determined the CNA did not use a gait belt (a device used to transfer people from one position to another, from one thing to another or while ambulating people that have problems with balance) per the plan of care. Resident #1 sustained a head injury and a skin tear requiring the immediate transfer to a hospital. Review of the Emergency Room Physician and Nursing note documentation, dated 11/06/15, revealed Resident #1 was diagnosed with a large hematoma (collection of blood under the skin due to ruptured blood vessels) to the right side of the head and multiple areas of bleeding within the brain. The resident was placed on comfort measures only due to the significant bleeding in the brain and was returned to the facility at 5:30 PM on 11/06/15 from the Emergency Room. Eleven and one-half (11 1/2) hours, after falling in the shower room, Nursing noted at 2:00 AM on 11/07/15, Resident #1 was without respiration and heart rate and pronounced the resident deceased.</p> <p>The facility's failure to have an effective system in place, to ensure care plans were followed for residents with a history of falls has caused or is likely to cause serious injury, harm, impairment or death. Immediate Jeopardy was identified on 12/16/15 and determined to exist on 11/06/15.</p> <p>The facility provided an acceptable Allegation of Compliance (AOC) on 12/22/15 which alleged removal of the Immediate Jeopardy on 12/22/15. The State Survey Agency verified Immediate Jeopardy was abated on 12/22/15 as alleged prior to exit on 12/30/15. The scope and severity</p>	F 282	<p>Asst. Director of Nursing, Unit Managers, MDS Coordinator, Staff Development Coordinator and others at the request of this team. By performing these tasks, the facility can help to identify which residents may have the potential to be affected by the same deficient practice.</p> <p><u>Systemic Measures:</u> On December 31, 2015 through January 5, 2016, daily – Monday through Friday, five (5) staff members daily were given Post Tests by the Unit Coordinators to complete regarding proper gait belt use. From January 14, 2016, Monday, Wednesday and Friday, three (3) staff members daily were given Post Tests by the Unit Coordinators to complete regarding proper gait belt use. For each test, a 100% score is required. If the score is less than 100%, the staff member is re-educated and re-tested until they score 100%. The results of these tests will be reviewed at the Monthly QAPI meetings for three (3) months, then quarterly for three (3) quarters, unless the QAPI Committee makes changes made to the frequency and/or continuation of the testing. Newly-hired staff receive competency skills evaluation by the Staff Development Coordinator, which includes use of gait belt for transfers. Daily, the "Stop and Watch" program is reviewed by the Charge Nurses and Unit Coordinators to identify residents</p>	

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

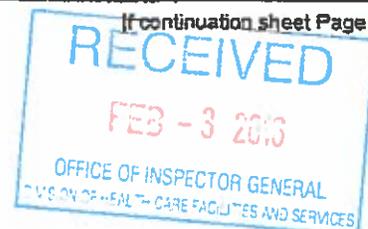
PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 282	<p>Continued From page 29</p> <p>was lowered to a "D" while the facility implements and monitors the Plan of Correction for the effectiveness of systemic changes and quality assurance.</p> <p>The findings include:</p> <p>The facility did not provide a policy regarding following care plan interventions; however, interview with the Administrator, on 12/15/15 at 9:30 AM, revealed the facility staff used the Centers for Medicare and Medicaid Services Resident Assessment Instrument (RAI) Minimum Data Set (MDS) to direct them in the implementation of care plan interventions.</p> <p>Review of the RAI, MDS manual, dated 10/09/15, Chapter 4, page 4-8 through page 4-11, revealed the care plan was a communication tool and the services provided must be consistent with each resident's written plan of care. The approaches serve as instructions for resident care and provide for the continuity of care by all staff. Precise and concise instructions help staff understand and implement interventions.</p> <p>Review of the facility's policy regarding Falls Management, dated January 2010, revealed it was the policy of the facility to screen all residents to identify possible risk factors that may place a resident at risk for falls, to evaluate those risks, implement interventions to reduce those risks and monitor those interventions and modify when necessary.</p> <p>Review of the closed clinical record for Resident #1 revealed the facility admitted the resident on 04/27/15 with diagnoses of Difficulty Walking, Abnormal Gait, Muscle Weakness, Abnormal</p>	F 282	<p>who may have had a change in level of assistance needed with transfers. Daily interviews with Licensed Nursing Staff and CNAs are done by the Unit Managers and Asst. Directors of Nursing to identify any changes in transfer status to include the need or lack of need for a gait belt during transfers. These interviews will be ongoing and reviewed at the Monthly QAPI meetings for three (3) months, then quarterly for three (3) quarters, unless the QAPI Committee makes changes to the frequency and/or continuation of the interviews. On December 31, 2015 and daily, showers are monitored by the Charge Nurses on each Unit, to identify if staff is utilizing two assist and gait belts during transfer of residents except for those who are independent or use a Hoyer Lift for transfer. These observations will be ongoing and reviewed at the Monthly QAPI meetings for three (3) months, then quarterly for three (3) quarters, unless the QAPI Committee makes changes to the frequency and/or continuation of the observations.</p> <p><u>Monitoring Measures:</u> QAPI meetings were held on January 5, 2016, January 7, 2016, January 14, 2016, January 19, 2016 and January 27, 2016. These QAPI meetings have included and will include evaluation of each audit or process and determining the frequency of an audit or process or,</p>	
-------	--	-------	--	--



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	<p>Continued From page 30</p> <p>Posture, Sprain Rotator Cuff, Joint Pain, Shortness of Breath and Osteoporosis. The facility assessed the resident as being at risk for falls on admission.</p> <p>Review of Resident #1's Quarterly MDS assessment, completed on 10/07/15, revealed the facility assessed the resident utilizing the Brief Interview for Mental Status with a score of thirteen (13) meaning the resident was cognitively intact and determined to be interviewable. The facility also assessed the resident as needing the extensive assistance of two with transfers, personal hygiene, and toileting. The facility assessed the resident as not steady on their feet and only able to stabilize with staff assistance with moving from a seated to standing position, walking, moving on and off the toilet and surface to surface, such as between the bed and chair or chair to wheelchair.</p> <p>Review of the Comprehensive Care Plan for Resident #1 revealed the facility revised a plan of care for impaired physical mobility due to decreased strength, endurance and arthritic pain to the shoulder on 10/27/15 with updated goals and target dates for 01/27/15. The goal stated the resident would show no decline in ambulation ability and would maintain the current level of ability. The interventions listed directed staff to use a gait belt with ambulation, and to monitor and observe for signs and symptoms of pain and shortness of breath/exertion. If noted, stop the procedure and notify the licensed nurse of the occurrence.</p> <p>Interview with the Director of Nursing, on 12/15/15 at 3:15 PM, revealed CNA #4 attempted</p>	F 282	<p>if it might need to be changed or discontinued by the QAPI Committee. The Monthly QAPI Committee will include at a minimum, the Director of Nursing, a physician, and three other staff.</p> <p>Shower audits, post tests and daily audits are reviewed by the Director of Nursing to identify if there are issues with staff following care plans for two assist and gait belts during transfer of residents. These audits, tests and observations will be ongoing and reviewed at the Monthly QAPI meetings for three (3) months, then quarterly for three (3) quarters, unless the QAPI Committee makes changes to the frequency and/or continuation of the audits, tests and observations.</p> <p>Daily interviews with Licensed Nursing Staff and CNAs are done by the Unit Coordinators and Asst. Director of Nursing to identify any changes in transfer status. This includes monitoring the need or lack of need for a gait belt during transfer. If resident assistance for transfers needs to be updated, updates will be made to the CNA and Comprehensive Care Plans by Licensed Nursing Staff. MDS Coordinators will be notified by the Unit Coordinators, of any changes in transfer status to determine if significant change of MDS needs to be completed. These audits and observations will be ongoing and reviewed at the Monthly QAPI meetings for three (3) months, then quarterly for three (3) quarters, unless</p>	



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

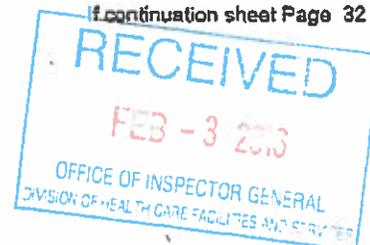
PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 282	<p>Continued From page 31</p> <p>to transfer Resident #1 from the wheelchair to a shower chair when the resident lost their balance, fell and sustained a head injury with a skin tear to the right elbow.</p> <p>Attempts were made via telephone to contact Certified Nursing Assistant #4, on 12/16/15 at 11:00 AM, 12/17/15 at 9:10 AM and 12/18/15 at 10:50 AM; and they were unsuccessful.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 12/15/15 at 2:15 PM, revealed she heard CNA #4 yelling for help from the shower room on 11/06/15 and witnessed Resident #1 laying on the floor with a large hematoma to the right side of the head and a skin tear to the right elbow. CNA #4 told her she was attempting to transfer the resident from the wheel chair to the shower chair when the resident lost their balance and fell to the floor, hitting their head. LPN #1 stated the resident did not have a gait belt applied at the time she entered the shower room and witnessed the resident on the floor. She stated the gait belt was listed as an intervention on the resident's plan of care and the expectation was for all staff to use one when transferring residents. Per interview, the plan of care directed the staff in the care of the resident and if not followed resident care needs would not be met.</p> <p>Interview with the Director of Nursing (DON), on 12/15/15 at 3:15 PM, revealed she was informed of Resident #1's fall on, 11/06/15 around 2:30 PM, and immediately went to the shower room and attended to the resident's needs. The DON stated when she arrived at the shower room and assessed the resident she determined the resident did not have a gait belt around the waist. Per interview, it was her expectation that staff</p>	F 282	<p>the QAPI Committee makes changes to the frequency and/or continuation of the audits.</p> <p>Falls are reviewed by the QAPI Committee each month. Care Plans and CNA Care Plans will be updated as needed.</p> <p>Findings of the above stated audits will be reviewed by the QAPI committee monthly for three (3) months, then quarterly for three (3) quarters, for frequency of ongoing audits or further recommendations and follow-up as indicated. The Monthly QAPI Committee will include at a minimum, the Director of Nursing, a physician, and three other staff.</p>	
-------	---	-------	---	--



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

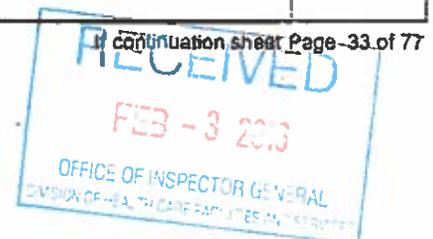
PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 282	<p>Continued From page 32</p> <p>follow care plan interventions and if they did not, resident care needs would not be met and harm could occur.</p> <p>Interview with the Administrator, on 12/16/15 at 5:50 PM, revealed upon hire all staff was educated regarding the use of a gait belt and it was his expectation that staff use a gait belt during all resident transfers and ambulation. He stated after the fall it was determined the CNA did not use a gait belt during the transfer process. However, per interview after determining the gait belt was not used, an action plan was not developed to determine the contributing factors for its non-use or for audits to be conducted to ensure staff implemented its use during transfers.</p> <p>The facility took the following actions to remove the Immediate Jeopardy as follows:</p> <ol style="list-style-type: none"> 1. On 11/06/15 Resident #1 had a fall in the facility shower room. The Restorative Nurse hearing a call for help went to the shower room, found the resident on the floor, took the resident's vital signs, and placed pressure to a laceration on the resident's arm. The resident's vital signs were taken, neurological status was assessed, and an ice pack was applied to the resident's head. The attending physician and daughter-in-law were notified. Emergency Medical Services (EMS) was called for transport and the resident returned from the hospital the same day. 2. An investigation was initiated by the Administrator and the Director of Nursing (DON) on 11/06/15. The shower room on the Dogwood Unit was inspected and a sign was placed on the shower room door to not use the shower room until further notice. 	F 282		
-------	--	-------	--	--



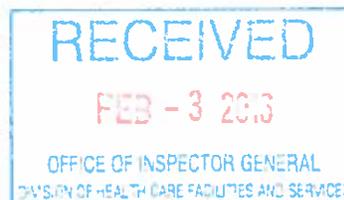
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/16/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	<p>Continued From page 33</p> <p>3. On 11/06/15 following shift change the DON educated all day and night shift staff that two (2) staff would be required in shower rooms for transfers. There were twenty-seven (27) nursing staff on on duty on 11/06/15 of the sixty-seven(67) total staff.</p> <p>4. On 11/07/15 the Administrator called the House Supervisor and instructed her to educate the nursing staff, (28) who worked the weekend, that going forward two (2) people would be required in the shower rooms for transfers. Eleven (11) weekend staff remained to be trained. There was no agency staff at this time.</p> <p>5. On 12/17/15 the Administrator reviewed ninety-five (95) falls from 06/01/15 to present to determine if falls occurred in the shower rooms. Only one (1) fall occurred in a shower room related to a wheelchair moving. There were no falls related to resident transfer or gait belt use.</p> <p>6. On 11/13/15 education was given to nursing staff by the Staff Development Coordinator (SDC) on safety devices, transfers, use of gait belts. The Charge Nurse, CNA Preceptor, Unit Managers, DON, and Assistant Director of Nursing (ADON) were included in the thirty-four (34) nurses educated by the SDC. New nursing staff receives competency skills evaluations that includes gait belt use.</p> <p>7. After the fall on 11/06/15 the facility started reviewing falls in the morning meeting Monday through Friday for root cause analysis and that the CNA and comprehensive care plans are updated. The comprehensive care plans are updated by nurses. The DON then checks that</p>	F 282		



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

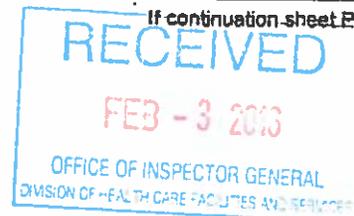
PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 282	<p>Continued From page 34</p> <p>the CNA and comprehensive care plans are updated Monday through Friday. Falls on the weekend with injury are called to the DON by a licensed nurse and reviewed. The licensed nurse updates the care plan and the fall is placed on the 24 hour report. A shift to shift report is given between nurses.</p> <p>8. On 11/24/15 the Quality Assurance Performance Improvement (QAPI) committee met with the Administrator, DON, ADON, Unit Managers, Maintenance Director, Social Services Director, Human Resource Director, and Restorative Nurse Manager. The number, location, shift of falls were discussed along with monitoring of transfers to be ongoing. Transfer assistance documentation was reviewed for discrepancies. In addition, falls for 10/01/15 through 10/31/15 were reviewed to look for further trends.</p> <p>9. On 12/15/15 ninety-six (96) current CNA care plans were audited to determine gait belt needs and transfer assistance by the DON, Unit Manager, SDC, ADOC, Signature Care Consultant (SCC), Administrator or Director of Program Development (DPD). The team found and corrected twenty (20) discrepancies. All ninety-six (96) CNA care plans were then compared to the comprehensive care plans to ensure the CNA care plan matched for level of assistance, transfers and use of a gait belt. There were (43) discrepancies identified at that time and corrected.</p> <p>10. On 12/15/15 thirty-nine (39) of thirty-nine (39) evening and night shift nurses and therapy staff were educated by the SDC, DON, and SCC to use gait belts for transfers, checking the CNA</p>	F 282		
-------	--	-------	--	--



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 282 Continued From page 35
care plans, and two (2) staff members to be in the shower rooms for assistance with transfers except for Hoyer Lift residents or independent residents.

11. On 12/17/15 the DPD educated seventeen (17) interdisciplinary team (IDT) management team members which included the Administrator, DON, Unit Managers, Rehab Manager, Business Office Manager, Medical Records Director, SDC, MDS Coordinator, Human Resources, Maintenance Director, Human Resources, Environmental Services Director, and Activities Director on root cause analysis, Gait Belt Policy, Stop and Watch Process, two (2) persons for transfers and in the shower room at all times, updating care plans, and following the care plan. This was a face to face training. A post-test on gait belt use was administered and a score of 100% had to be reached.

12. On 12/17/15 the staff was retrained by the management staff, who had been educated by the DPD. Any staff not trained as of 12/18/15 could not return to work until educated and they received 100% on the post-test. If 100% was not obtained they would be re-educated and re-tested until they scored 100%. Staff on Family Medical Leave (FMLA), Medical leave, PRN, or vacation would not be allowed to return to work until trained and they received 100% on the post-test.

Beginning 12/18/15 every shift a licensed nurse or the Regional Rehab Services Manager will observed three (3) showers on Magnolia and Dogwood daily for gait belt use for transfer. Five (5) nursing or therapy staff will be administered the gait belt post-test by the Administrator, DON, Unit Manager, Business Office Manager, Medical

F 282

RECEIVED
If continuation sheet Page 36 of 77
FEB - 3 2016
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

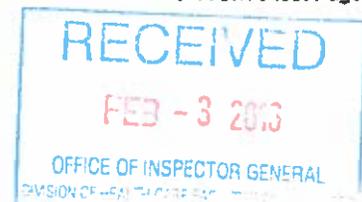
PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 282	<p>Continued From page 36</p> <p>Records Director, MDS Coordinator, Human Resource Director, Activities Director, or Environmental Services Director. The post-test and re-education will be given until a 100% score is achieved.</p> <p>The Administrator and DON will review post-test daily.</p> <p>13. On 12/16/15 the SDC, DON, Unit Managers, ADON, and or the SCC began gait belt competencies. As of 12/21/15 sixty-one (61) staff had completed the competencies. The facility has sixty-seven (67) staff members.</p> <p>14. On 12/16/15 the Minimum Data Set (MDS) Coordinator reviewed the last MDS assessments for all ninety-seven (97) residents for their level of assistance to ensure the CNA and the comprehensive care plans matched the MDS assessment. On 12/17/15 the DON, Unit Manager, SCC, and SDC conducted a second audit and interviewed various staff members to determine the amount of assistance the ninety-seven (97) residents needed. This information was compared to the MDS coding, the CNA and comprehensive care plans. Fifty-three (53) comprehensive care plans and thirty-four (34) CNA care plans were updated.</p> <p>15. A QAPI meeting was held on 12/15/15 via telephone with the Medical Director, Administrator, DON, Unit Manager, SCC and DPD to review the fall of Resident #1, the steps to put in place, incident reports, placing grab bars in the shower rooms, and staff education.</p> <p>16. On 12/17/15 the Administrator notified the staffing agency that their staff would receive gait</p>	F 282		
-------	---	-------	--	--



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	<p>Continued From page 37 belt education before working at the facility.</p> <p>17. On 12/21/15 three gait belts were placed in the medication room on the Magnolia and Dogwood Units.</p> <p>18. On 12/17/15 a QAPI meeting was held with the Medical Director, Special Projects Administrator (SPA), Unit managers, (3) SCC's, and the DPD to review cited deficiencies. Care plans would be audited daily Monday through Friday, Stop and Watch Process audits, fall interventions audits, continue gait belt competencies and use, shower room transfer audits with two (2) staff, gait belt post-test, and root cause analysis audits daily.</p> <p>19. Beginning 12/18/15 care plans will be audited for transfer assistance needed by the DON, ADON, Unit manager, SCC, and Charge Nurse and discussed in morning meeting if a discrepancy is noted an investigation will be initiated by the DON, Administrator, or Unit Manager. The interdisciplinary team (IDT) will update the care plan and notify the MDS Coordinator of the change, and falls will be reviewed for root cause analysis.</p> <p>20. A nurse from the regional team or corporate office, Regional Vice-President of Operations or Special Projects Administrator has been on site daily since 12/14/15 reviewing audits and assisting as needed. The Chief Nurse Executive, Clinical Compliance Nurse, Director of Program Development is in daily contact with the SCC or Regional Vice president of Operations and is reviewing audits.</p> <p>21. A QAPI meeting was held on 12/22/15 to</p>	F 282		

If continuation sheet Page 38 of 77

RECEIVED

FEB - 3 2016

OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 282	<p>Continued From page 38</p> <p>determine further need for education or plan revision. Results of audits, post-test, and gait belt observations during showers were discussed and reported weekly. Concerns identified will be corrected immediately and reported to the Administrator or DON. The IDT team are auditing with audit tools daily. These audits are reviewed by the Administrator, DON, or regional staff member daily.</p> <p>22. Administrative oversight of the facility will be completed by the Special Projects Administrator, Regional Vice President of Operations, or a member of the regional staff weekly on site and daily by telephone beginning 12/16/15, then every other week for four (4) weeks, then monthly. Oversight will include, but not limited to, daily review of the audits, QAPI committee meetings and review of all audits to ensure additional education is not needed.</p> <p>23. QAPI meetings will be held weekly beginning 12/15/15 for four (4) weeks, then monthly for recommendations and further follow-up and determine what frequency any ongoing audits will need to continued. The Administrator has the oversight to ensure an effective plan is in place to meet the resident's well-being, identify facility concerns, and implement a corrective plan to involve all staff. Audits will be reviewed, but not limited to, gait belt competency, and two (2) person transfers for showers, gait belts on nursing and therapy staff, care plan audits for transfer assistance, MDS coding for transfers, and root causes for falls.</p> <p>The State Survey Agency validated the removal of the Immediate Jeopardy on 12/30/15 prior to exit as follows:</p>	F 282		
-------	---	-------	--	--



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

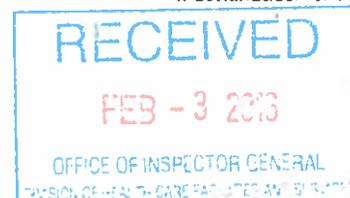
PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 282	<p>Continued From page 39</p> <p>1. Interview, on 12/30/15 at 7:20 AM, with LPN #1 (the Restorative Nurse) revealed on 11/06/15 she responded to a call for help from the shower room on the Dogwood Unit. When she entered the shower room, Resident #1 was laying on his/her right side on the shower room floor. Resident #1 was non-responsive to verbal stimuli for one (1) to two (2) minutes. She took the resident's vital signs, placed a pressure dressing on a laceration on the resident's right arm, and an ice pack was placed on a hematoma on the right side of the resident's forehead. Review of the nursing notes and incident report on 12/30/15 revealed, on 11/06/15 at 2:30 PM Resident #1's attending physician and daughter-in-law were notified of Resident #1's fall. The attending physician gave orders to send Resident #1 to a local hospital for assessment. Emergency Medical Services (EMS) was called to transport the resident to a local hospital for evaluation. Resident #1 was returned to the facility from the local hospital, on 11/06/15 at 3:30 PM, with a diagnosis of Subdural Hematoma and he/she was not a surgical candidate.</p> <p>2. Interview with the Administrator, on 12/29/15 at 9:06 AM, revealed after he was notified Resident #1 had fallen on 11/06/15 he and the Director of Nursing (DON) investigated all the shower rooms. He had a sign placed on the Dogwood Unit shower door to not use the shower room until Monday, 11/09/15 and he then purchased grab bars to be installed in all the shower rooms.</p> <p>Interview with the Plant Director, on 12/29/15 at 2:45 PM, revealed he and his Assistant installed new grab bars in all four (4) facility shower rooms;</p>	F 282		
-------	--	-------	--	--



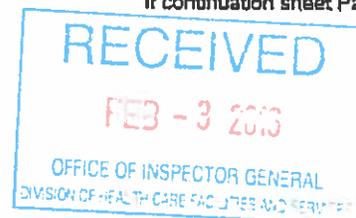
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	<p>Continued From page 40</p> <p>two (2) shower rooms on Dogwood and two (2) shower rooms on Magnolia on 11/09/15.</p> <p>Review of the purchase order for grab bars revealed grab bars were purchased 11/08/15 at a local store.</p> <p>Observations of two (2) shower rooms on the Dogwood and Magnolia Units, on 12/29/15 at 11:31 AM, revealed all shower rooms had new grab bars.</p> <p>3. Interview with the DON, on 12/29/15 at 3:15 PM, revealed she educated all staff working 11/06/15 that effective immediately there were to be two (2) staff always present in the shower rooms for transfers. There were twenty-seven (27) nursing staff on duty on 11/06/15 of the sixty-seven (67) total staff.</p> <p>Review of the staff schedule for 11/06/15 and staff name check offs by the DON revealed twenty-seven (27) staff were educated that two (2) staff must be present at all times in the shower rooms.</p> <p>Observations of the shower room on the Dogwood Unit, on 12/29/15 at 9:00 AM, and the Magnolia Unit, on 12/29/15 at 9:16 AM, revealed two (2) CNAs with a resident using a gait belt to transfer the resident.</p> <p>Interview with CNA #2, on 12/29/15 at 9:12 AM and CNA #3, on 12/29/15 at 9:40 AM, revealed they were educated on 11/06/15 by the DON that two (2) staff were to always be in the shower room with a resident.</p> <p>4. Interview with the Administrator, on 12/29/15 at</p>	F 282		



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/30/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	<p>Continued From page 41</p> <p>3:15 PM, revealed he called the Nursing Supervisor on 11/07/15 and instructed her to educate all working staff that showers were to only be given with two (2) staff present at all times in the shower room.</p> <p>Interview with the House Supervisor, on 12/29/15 at 3:00 PM, revealed she had trained twenty-eight (28) staff on 11/07/15 that two (2) staff had to be present for all showers.</p> <p>Interview with CNA #2 on 12/29/15 at 9:30 AM; CNA #3 on 12/29/15 at 9:40 AM; CNA #4 on 12/29/15 at 2:50 PM; Registered Nurse (RN) #1 on 12/29/15 at 2:30 PM; CNA # 5 (agency staff) on 12/29/15 at 2:43 PM; and, Licensed Practical Nurse (LPN) #1 on 12/29/15 at 3:07 PM, revealed they were educated on 11/07/15 by the House Supervisor to always have two (2) staff present in the shower rooms with residents.</p> <p>Review of the staffing schedule for 11/07/15 revealed twenty-eight (28) nursing staff were trained.</p> <p>5. Interview with the Administrator, on 12/29/15 at 3:15 PM, revealed on 12/17/15 he reviewed all falls in the facility from 06/01/15 through 12/17/15 to determine a root cause. Ninety-five (95) falls were reviewed. Only one (1) occurred in a shower room due to a wheelchair wheels not being locked. There were no falls related to resident transfers.</p> <p>6. Interview with the Staff Development Coordinator (SDC), on 12/29/15 at 9:15 AM, revealed on 11/13/15 she educated nursing staff on gait belt use. Thirty-four (34) nursing staff including the Assistant Director of Nursing</p>	F 282			



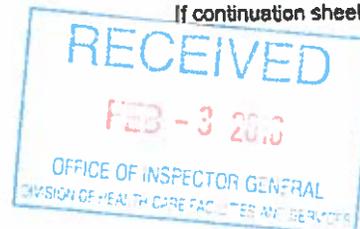
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

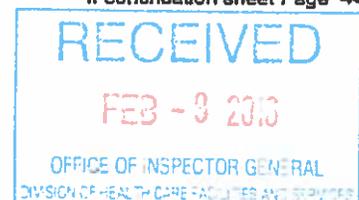
F 282	<p>Continued From page 42</p> <p>(ADON), Charge Nurse, CNA Preceptor, and DON were told to always have their gait belt and to use it for all transfers. In addition she stated all direct nursing staff and therapy staff were provided a gait belt by the facility upon hire. Each unit has extra gait belts in the medication rooms for agency staff to use.</p> <p>Interview with the Unit Manager on 12/29/15 at 9:12 AM; CNA #2 on 12/29/15 at 9:30 AM; CNA #3 on 12/29/15 at 9:40 AM; CNA #1 on 12/29/15 at 12:33 PM; the Magnolia Unit Charge Nurse on 12/29/15 at 12:45 PM; RN #1 on 12/29/15 at 2:30 PM; CNA #4 on 12/29/15 at 2:50 PM; and, LPN # 1 on 12/29/15 at 3:07 PM, revealed they were educated on 11/13/15 by the SDC on gait belt use for resident transfers.</p> <p>7. Interview with the Director of Clinical Programs (DCP), on 12/29/15 at 9:15 AM, revealed the morning meetings are Monday through Friday and comprehensive care plans are reviewed and updated when needed. The DON reviews the CNA care plans to ensure it matches the comprehensive care plan.</p> <p>Interview with the Administrator, on 12/29/15 at 3:15 PM, revealed the morning meetings are Monday through Friday. After the fall on 11/06/15 the facility started reviewing the comprehensive and CNA care plans for transfer and assistance needs to ensure they were reviewed and updated as needed. Falls are reviewed for root cause analysis. If a fall with injury occurs on the weekend the DON is notified.</p> <p>Interview with the DON, on 12/29/15 at 3:23 PM, revealed morning meetings are held Monday through Friday. In the meeting the resident</p>	F 282		
-------	--	-------	--	--



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/30/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	<p>Continued From page 43</p> <p>comprehensive care plans are reviewed and she checks that the comprehensive care plan matches the CNA care plan. Any fall that occurred is placed on the 24 hour report and the shift to shift report. The fall is reviewed in the morning meeting the next morning for a possible root cause. She is notified if a fall with injury occurs on the weekend.</p> <p>Interview with the ADON, on 12/30/15 at 8:50 AM, revealed she attends morning meetings Monday through Friday. All ninety-six (96) resident comprehensive care plans are reviewed and updated as needed. The DON compares the CNA care plan to the comprehensive for transfer and assistance needs.</p> <p>8. Interview with the Administrator, on 12/30/15 at 9:57 AM, revealed the QAPI committee is an interdisciplinary team (IDT) that consists of the DON, ADON, Unit Managers, Social Services, Office Manager, Medical Records, Human Resources, Activity Director, two (2) Unit Coordinators, Environmental Services Director, MDS Coordinators, Therapy Director, Staff Development, and the Medical Director. The committee meets monthly. On 11/24/15 the committee met to discuss monitoring transfer assistance needs. Falls data was reviewed from 10/01/15 through 10/31/15 to identify if there was a trend.</p> <p>Interviews with the DON, two (2) Unit Managers, SDC, SCC, and DPD on 12/30/15 at 3:23 PM, revealed they attended the 11/24/15 QAPI meeting and discrepancies identified for transfer assistance were reviewed.</p> <p>Review of the QAPI committee sign in sheet for</p>	F 282			



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 282	<p>Continued From page 44</p> <p>11/24/15 on 12/30/15, revealed the DON, ADON, Unit Managers, Social Services, Office Manager, Medical Records, Human Resources, Activity Director, two (2) Unit Coordinators, Environmental Services Director, MDS Coordinators, Therapy Director, and SDC were present at the meeting.</p> <p>9. Review of the facility's audits for needed care plan updates of transfer and assistance needed, dated 12/13/15; 12/15/15; 12/16/15; 12/17/15; 12/18/15; 12/20/15; 12/21/15; and 12/22/15 revealed the audits had been completed with changes identified that needed to be made to the care plans.</p> <p>Review of Resident #7's and Resident #10's comprehensive and CNA care plans revealed, revealed their care plans had been updated for transfer and assistive needs on 12/18/15.</p> <p>Review of Unsampled Resident's A and B's comprehensive and CNA care plans revealed their care plans had been updated for transfer and assistive needs on 12/19/15.</p> <p>10. Review of the education sign in sheets revealed on 12/15/15 thirty-two (32) nursing staff and seven (7) therapy staff were trained on two (2) staff in the shower rooms for assistance except for Hoyer Lifts and independent residents.</p> <p>Interview with the Dogwood Unit Manager, on 12/29/15 at 9:12 AM, revealed she assisted with the training of the nursing and therapy staff 12/15/15 and 12/16/16.</p> <p>Interview with, CNA #2 on 12/29/15 at 9:30 AM; CNA #3 on 12/29/15 at 9:40 AM; an Occupational</p>	F 282		
-------	---	-------	--	--



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

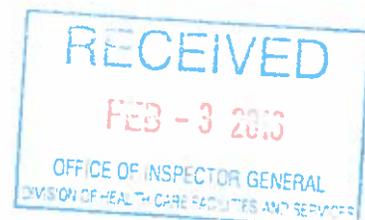
PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 282	<p>Continued From page 45</p> <p>Therapist (OT) on 12/29/15 at 11:53 AM; a Physical Therapist Assistant (PTA) on 12/29/15 at 12:10 PM; CNA #5 on 12/29/15 at 2:43 PM; LPN #1 on 12/29/15 at 3:07 PM; and, CNA #10 on 12/29/15 at 3:15 PM, revealed on 12/15/15 and 12/16/15 they had been educated that two (2) staff members were to be in the shower rooms for resident transfers, gait belts were to be used for transfers according to the care plan and that staff was to check the care plan for fall interventions and needed changes.</p> <p>11. Interview with the Director of Clinical Programs (DCP), on 12/29/15 at 9:15 PM, revealed on 12/17/15 she educated the IDT team on Root Cause Analysis in a power point presentation in the morning meeting. The (IDT) consisted of the DON, ADON, Unit Managers, Social Services, Office Manager, Medical Records, Human Resources, Activity Director, two (2) Unit Coordinators, Environmental Services Director, MDS Coordinators, Therapy Director, Staff Development, and Maintenance Director. The Gait Belt Policy was reviewed with no changes needed. A Stop and Watch Process form was presented, two (2) person transfers and staff being in the shower rooms were to be permanent changes. Care plan reviews, updating care plans, and face to face training were discussed. She administered a post gait belt test to the IDT team and each had to obtain a score of 100%. If 100% was not reached re-education was done immediately and the person was retested.</p> <p>Interviews, on 12/29/15 with the SDC at 9:45 AM; Director of Social Services at 11:10 AM; the Office Manager at 11:20 AM; Human Resource Director at 11:30 AM; MDS Coordinator at 11:55 AM; and, the Therapy Director at 12:10 PM,</p>	F 282		
-------	--	-------	--	--



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

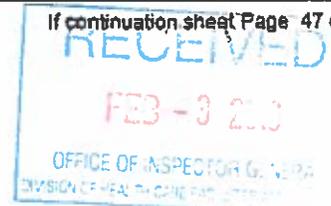
PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 282	<p>Continued From page 46 revealed they attended the training on 12/15/15 presented by the DCP.</p> <p>12. Interview with CNA #2 on 12/29/15 and 9:30 AM; CNA #3 on 12/29/15 at 9:40 AM; an Occupational Therapist (OT) on 12/29/15 at 11:53 AM; a Physical Therapist Assistant (PTA) on 12/29/15 at 12:10 PM; CNA #5 on 12/29/15 at 2:43 PM; LPN #1 on 12/29/15 at 3:07 PM; and, CNA # 10 on 12/29/15 at 3:15 PM, revealed they all stated they had received education on gait belt use, obtained 100% on the post test, could explain when and how the use the Stop and Watch form, and were aware two (2) persons must always be in the shower rooms for resident transfers.</p> <p>Review of the daily gait belt post-tests revealed since 12/18/15 five random staff from nursing and therapy had been administered the gait belt post-test and obtained a score of 100%.</p> <p>Interview with the Administrator, on 12/30/15 at 11:49 AM, revealed he or the DON reviewed all gait belt post-test daily for the five (5) random staff test.</p> <p>In addition, interview with the DON, on 12/30/15 at 11: 50 AM, revealed she follows-up with the Administrator to assess if staff had to be re-educated and were re-tested.</p> <p>Review of the staff post-test revealed sixty-five (65) of sixty-seven (67) facility staff were trained. One (1) untrained staff member was on FMLA and the other was a PRN staff.</p> <p>13. Review of staff post-test revealed between 12/16/15 and 12/21/15 sixty-one (61) of the</p>	F 282		
-------	---	-------	--	--



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

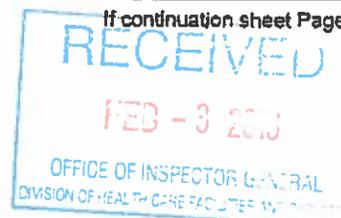
PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 282	<p>Continued From page 47</p> <p>facility's sixty-seven staff members were administered a gait belt competency which was part of the gait belt training. The staff member had to demonstrate correct use of the gait belt.</p> <p>Review of post-test after 12/21/15 revealed three (3) PRN staff and one (1) staff from vacation completed the gait belt testing with 100% and were able to demonstrate appropriate use of the gait belt.</p> <p>14. Interviews on 12/29/15 with the SDC at 9:45 AM and the DON at 3:23 PM, revealed they interviewed various nurses and CNAs on 12/17/15 to determine the amount of assistance a resident needed for bed mobility, eating, transfers and toileting. This information was compared to the MDS coding, CNA care plans and the comprehensive care plan. Eight (8) assessments required modification. Follow up on 12/18/15 revealed fifty-three (53) comprehensive care plans and thirty-four (34) CNA care plans were updated by the DON, Unit Managers, SCC, ADON, SDC, and the DPD.</p> <p>15. Interview with the DON, on 12/30/15 at 8:50 AM; the Administrator at 9:57 AM; the Medical Director at 10:40 AM; and, the Signature Care Consultant for Nursing (SCC) at 12:06 PM, revealed all were present on 12/15/15 for a QAPI meeting to discuss the fall of Resident #1 and an action plan. (Grab bars, staff education, and incident reports)</p> <p>16. Interview with the owner of the Staffing Agency, on 12/29/15 at 12:35 PM, revealed she was notified by the Administrator on 12/17/15 that all agency staff would be gait belt trained and tested before working at the facility.</p>	F 282		
-------	---	-------	--	--



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 282	<p>Continued From page 48</p> <p>17. Observations, on 12/29/15 at 11:31 AM, of the medication rooms on the Dogwood and Magnolia Units revealed there were three (3) gait belts in the room.</p> <p>18. Interview with the Administrator, on 12/30/15 at 9:57 AM, revealed a QAPI meeting was held on 12/17/15 by phone with the Medical Director.</p> <p>Interview with the Medical Director, on 12/30/15 at 10:40 AM, revealed he was called into a QAPI meeting on 12/17/15.</p> <p>Interview, on 12/30/15 with the DON at 8:00 AM; Special Projects Administrator at 10:20 AM; SDC at 9:30 AM; and, the ADON at 11:07 AM, revealed they were present for the QAPI conference call with the Medical Director on 12/17/15.</p> <p>Review of the QAPI sign in sheet for the 12/17/15 meeting revealed seven (7) persons were present for the meeting.</p> <p>19. Interview with the SDC, on 12/29/15 at 9:45 AM, revealed she assisted with the audits, beginning 12/18/15, of the care plans and if discrepancies are identified they are discussed in the morning meetings.</p> <p>Interview with the DON, on 12/29/15 at 3:15 PM, revealed prior to 12/18/15 the facility had reviewed and updated all resident care plans for assistance and transfer needs. Beginning 12/18/15 through ongoing care plan audits if a discrepancy was identified in a resident's care plan for transfer or assistance needs it was to be reported in morning meeting and would be investigated. All falls would be reviewed for root</p>	F 282		
-------	--	-------	--	--



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

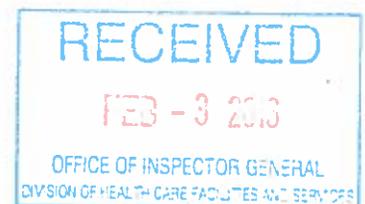
PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 282	<p>Continued From page 49 cause and if a care plan was updated MDS would be notified of the change.</p> <p>Review of the facility falls since 11/06/15 revealed there had been no resident falls from 12/15/15 to 12/30/15.</p> <p>20. Interviews, on 12/29/15 with the DPD at 9:15 AM; and, the Special Project Administrator at 10:20 AM, revealed the corporate team assigned to assist the facility since 12/14/15 were present on site and reviewing audits. The Corporate team consisted of the Special Project Administrator, the Director of Program Development, and the Signature Care Consultant.</p> <p>21. Interview with the Administrator, on 12/30/15 at 9:57 AM, revealed QAPI meetings were held 12/15/15, 12/17/15, 12/22/15, and 12/29/15.</p> <p>Review of the QAPI sign in sheets on 12/30/15, revealed QAPI meetings were held 12/15/15, 12/17/15, 12/22/15, and 12/29/15.</p> <p>22. Interview with the Special Project Administrator, on 12/29/15 at 10:20 AM, revealed he was the Corporate Administrator assigned to oversight with the facility. He stated he would be at the facility weekly and was available to the facility by phone seven (7) days a week. He further stated he would review audits, attend QAPI meetings and ensure additional staff education was not needed.</p> <p>23. Interview with the Administrator, on 12/30/15 at 9:37 AM, revealed QAPI meetings had been weekly since 12/05/15.</p> <p>Review of the QAPI meeting sign in sheets</p>	F 282		
-------	---	-------	--	--



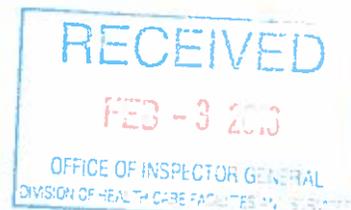
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282 F 323 SS=J	<p>Continued From page 50 revealed QAPI meetings had been held 12/15/15, 12/17/15, 12/22/15, and 12/29/15.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system in place to ensure staff used a gait belt (a device used to transfer people from one position to another, from one thing to another or while ambulating people that have problems with balance) during a transfer of a resident, as directed by the plan of care, and failed to provide the assistance of two (2) during the transfer, as assessed to be needed by the residents' Quarterly Minimum Data Set. The facility failed to investigate and analyze all identified contributing factors after a fall and failed to determine the root cause of the fall in order to develop a corrective action plan to prevent a similar event from occurring to other residents. This failure effected (1) of six (6) sampled residents (Resident #1).</p> <p>Resident #1 sustained a fall on, 11/08/15 at 2:30 PM, during the process of being transferred from the wheelchair to a shower chair in the shower</p>	F 282 F 323	<p>F-323 <u>Residents Affected:</u> Due to the expiration of Resident #1, no further corrective action could be made.</p> <p><u>Residents Potentially Affected:</u> Residents who have the potential to be affected by the same deficient practice were identified in the following manner:</p> <p>On December 31, 2015 and daily, Monday through Friday, falls occurring in the facility are reviewed during Clinical Morning Meeting. The Clinical Team includes, but is not limited to, the Director of Nursing, Assistant Director of Nursing, Unit Coordinators, Staff Development Coordinator, Restorative Nurse, Activities Coordinator, Social Services Director and others as deemed necessary by the Clinical Team. This review includes a discussion regarding the root cause and contributing factors for each fall. This review helps the facility to identify residents having the potential to be affected by the deficient practice.</p> <p>Daily, the "Stop and Watch" program is reviewed by the Charge Nurses and Unit Coordinators to identify residents who may have had a change in level of assistance with transfers.</p> <p>On December 31, 2015 and daily Monday through Friday, audits were conducted by the Unit Coordinators and Director of Nursing comparing the documented transfer status of each resident in the facility with staff interviews to ensure consistency</p>	1/31/2016



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323	<p>Continued From page 51</p> <p>room with the assist of one staff and no gait belt. The resident sustained a head injury and skin tear requiring the immediate transfer to a hospital. Review of the Emergency Room Physician and Nursing note documentation, dated 11/06/15, revealed Resident #1 was diagnosed with a large hematoma (collection of blood under the skin due to ruptured blood vessels) to the right side of the head and multiple areas of bleeding within the brain. The resident was placed on comfort measures only, due to the significant bleeding in the brain, and was returned to the facility at 5:30 PM on 11/06/15. On 11/07/15, Nursing documentation revealed Resident #1 was without respiration and heart rate at 2:00 AM and was pronounced deceased; eleven and one-half (11 ½) hours, after falling in the shower room.</p> <p>Interview with the Director of Nursing (DON) revealed she had not reviewed the resident's medical record after the event and had not determined if the resident had been assessed to need the extensive assistance of two (2) during transfers. She also stated she had not reviewed Resident #1's Activities of Daily Living needs documentation, made by the nursing assistants, dated, 10/29/15-11/04/15 and 11/01/15-11/07/15; which stated Resident #1 required the extensive assistance of two (2) during transfers.</p> <p>The facility's failure to have an effective system in place, to ensure staff provided adequate supervision and utilized assistive devices to prevent falls has caused or is likely to cause serious injury, harm, impairment or death. Immediate Jeopardy was identified on 12/16/15 and determined to exist on 11/06/15.</p>	F 323	<p>between the resident assessment, the Care Plan and the CNA Care Plan as it relates to the resident's actual need. This includes the need or lack of need for a gait belt during transfer. These audits will be ongoing and reviewed at the Monthly QAPI meetings for three (3) months, then quarterly for three (3) quarters, unless the QAPI Committee makes changes to the frequency and/or continuation of the audits.</p> <p>Daily interviews with Licensed Nursing Staff and CNAs are done by the Unit Managers and Asst. Directors of Nursing to identify any changes in transfer status or need for assistance. These interviews will be ongoing and reviewed at the Monthly QAPI meetings for three (3) months, then quarterly for three (3) quarters, unless the QAPI Committee makes changes to the frequency and/or continuation of the interviews.</p> <p>The Care Plan review by the Unit Coordinators as well as the daily, Monday through Friday falls review by the Clinical Team, also assist the facility in identifying residents who may have the potential to be affected by the deficient practice. The Clinical Team includes, but is not limited to, the Director of Nursing, Assistant Director of Nursing, Unit Coordinators, Staff Development Coordinator, Restorative Nurse, Activities Coordinator, Social Services Director and others as deemed necessary by the Clinical Team.</p>	
-------	--	-------	--	--

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323

Continued From page 52

The facility provided an acceptable Allegation of Compliance (AOC) on 12/22/15 which alleged removal of the Immediate Jeopardy on 12/22/15. The State Survey Agency verified Immediate Jeopardy was removed on 12/22/15 as alleged prior to exit on 12/30/15. The scope and severity was lowered to a "D" while the facility implements and monitors the Plan of Correction for the effectiveness of systemic changes and quality assurance.

The findings include:

Review of the facility's policy regarding Falls Management, dated January 2010, revealed it was the policy of the facility to screen all residents to identify possible risk factors that may place a resident at risk for falls, to evaluate those risks, implement interventions to reduce those risks and monitor those interventions and modify when necessary. Also the facility would investigate any resident fall to determine appropriate interventions to put in place to reduce the likelihood that a fall would reoccur and/or to minimize the risk of injury related to a fall.

Review of the closed clinical record for Resident #1 revealed the facility admitted the resident on 04/27/15 with diagnoses of Difficulty Walking, Abnormal Gait, Muscle Weakness, Abnormal Posture, Sprain Rotator Cuff, Joint Pain, Shortness of Breath and Osteoporosis. The facility assessed the resident as being at risk for falls on admission (04/27/15).

Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment, completed on 10/07/15, revealed the facility assessed the resident utilizing the Brief Interview for Mental Status with

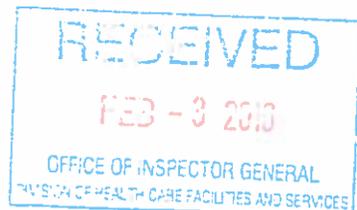
F 323

Systemic Measures:

On January 5, 2016, the newly-hired staff received competency skills evaluations by the Staff Development Coordinator, which included use of gait belt for transfers as well as two person transfers in showers with the exception of those who are independent or who use a Hoyer Lift for transfers. This training by the Staff Development Coordinator is now part of all new staff orientation.

Additionally, investigation of incidents utilizing root cause analysis, care plan revision, ADL Coding, Care Plan (Following and updating), two-person assist for transfers in showers except for those who are independent or who use a Hoyer Lift for transfer, gait belt competency and post-test are included in this orientation by the Staff Development Coordinator.

Daily, Monday through Friday, audits are conducted by the Director of Nursing, Unit Managers, Staff Development Coordinator, Asst. Directors of Nursing, Signature Clinical Coordinator, and/or the Director of Program Development to verify that Care Plans and CNA Care Plans match for level of assistance necessary for transfers as well as potential need for a gait belt. These audits will be ongoing and reviewed at the Monthly QAPI meetings for three (3) months, then quarterly for three (3) quarters, unless the QAPI Committee makes changes to the frequency and/or continuation of the interviews.

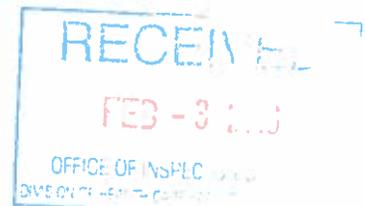


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 53</p> <p>a score of thirteen (13) meaning the resident was cognitively intact and determined to be interviewable. The facility also assessed the resident as needing the extensive assistance of two (2) with transfers, personal hygiene, and toileting. The facility assessed the resident as not steady on their feet and only able to stabilize with staff assistance with moving from a seated to standing position, walking, moving on and off the toilet and surface to surface, such as between the bed and chair or chair to wheelchair.</p> <p>Review of the Comprehensive Care Plan for Resident #1, revealed the facility developed updated a plan of care on, 10/27/15, for impaired physical mobility, due to decreased strength, endurance, and arthritic pain to the shoulder, with updated goals and target dates for 01/27/16. The goal stated the resident would show no decline in ambulation ability and would maintain the current level of ability. The interventions listed directed staff to use a gait belt with ambulation and to monitor and observe for signs and symptoms of pain and shortness of breath/exertion. If noted, they were to stop the procedure and notify the licensed nurse with occurrence.</p> <p>Review of the resident's care plan developed on 05/06/15, with a review date of 08/04/15 and 10/27/15, revealed Resident #1 was at risk for falls due to decreased mobility, history of falls, generalized weakness and antidepressant medication revealed updated goals and target dates for 01/27/16. The goal stated the resident would be free of falls within the next ninety-days. The approaches directed staff to assist the resident with activities of daily living, keep call light and personal items within reach at all times, wheelchair mobility per staff in facility, and keep</p>	F 323	<p>Daily, Monday through Friday, care plans are updated by the Unit Coordinators as needed for changes in transfer assistance needed for residents, based on audits conducted by the Unit Coordinators. These audits will be ongoing and reviewed at the Monthly QAPI meetings for three (3) months, then quarterly for three (3) quarters, unless the QAPI Committee makes changes to the frequency and/or continuation of the audits.</p> <p>Daily interviews with Licensed Nursing Staff and CNAs are done by the Unit Managers and Asst. Directors of Nursing to identify any changes in transfer status. These interviews will be ongoing and reviewed at the Monthly QAPI meetings for three (3) months, then quarterly for three (3) quarters, unless the QAPI Committee makes changes to the frequency and/or continuation of the interviews.</p> <p>Additional education to nursing staff was accomplished on January 29, 2016 to include but not limited to root cause analysis, care plan revision, ADL Coding, Care Plan (Following and updating). This education was conducted by the Staff Development Coordinator and Director of Nursing.</p> <p><u>Monitoring Measures:</u> QAPI meetings were held on January 5, 2016, January 7, 2016, January 14, 2016, January 19, 2016 and January 27, 2016. These QAPI meetings have included and will continue to include</p>	



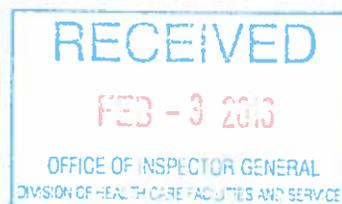
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1605 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 54 walkways free from clutter.</p> <p>Further review of the care plan, developed on 05/06/15, revealed the resident was at risk for decline of activities of daily living due to generalized weakness, depression and failure to thrive. The goal stated the resident would have improvement of activities of daily living within the next ninety days. Review of the plan of care revealed the assistance of two (2) with transfers and toileting, bed mobility and ambulation. The approach for two assist was revised to one assist on 07/15/15, with transfers, toileting, bed mobility and ambulation. Additional approaches listed, directed staff to provide the assistance of one (1), with bathing, personal hygiene and dressing. However, review of Resident #1's Quarterly Minimum Data Set, data 10/07/15, assessed the resident as needing the extensive assistance of two (2).</p> <p>Review of the Nursing Assistants' activities of daily living needs documentation dated, 10/29/15-11/04/15 and 11/01/15-11/07/15, revealed Resident #1's transfer needs as requiring the extensive assistance of two (2).</p> <p>Review of the facility's incident report, dated for 11/06/15, revealed it was completed by the DON. The form specified there was a fall occurrence and a time of 2:30 PM. However, there was no falls analysis to determine the cause of the fall.</p> <p>Interview with the DON, on 12/15/15 at 3:15 PM, revealed she was informed of Resident #1's fall on, 11/06/15 at 2:30 PM, and immediately went to the shower room and attended to the resident's needs. She stated Certified Nursing Assistant (CNA) #4 informed her she was in the process of</p>	F 323	<p>evaluation of each audit or process by the QAPI Committee to determine the frequency of an audit or process, or if it might need to be changed or discontinued.</p> <p>Daily, Monday through Friday, falls including their investigations are reviewed in morning meeting by the Clinical Team. The Clinical Team includes, but is not limited to, the Director of Nursing, Assistant Director of Nursing, Unit Coordinators, Staff Development Coordinator, Restorative Nurse, Activities Coordinator, Social Services Director and others as deemed necessary by the Clinical Team.</p> <p>Updates will be made to the CNA and Comprehensive Care Plans by Licensed Nursing Staff.</p> <p>Findings of the above stated audits will be reviewed by the QAPI committee monthly for three (3) months, then quarterly for three (3) quarters, for frequency of ongoing audits or further recommendations and follow-up as indicated. The Monthly QAPI Committee will include at a minimum, the Director of Nursing, a physician, and three other staff.</p>	



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 55</p> <p>transferring the resident from the wheelchair to a shower chair when the resident fell and sustained a head injury and a skin tear to the right elbow. The DON stated when she arrived at the shower room and assessed the resident she determined the resident did not have a gait belt around the waist. However, she did not investigate to determine the reason CNA #4 had not used one during the transfer, as required by the plan of care.</p> <p>Attempts were made via telephone to contact CNA #4, on 12/16/15 at 11:00 AM, 12/17/15 at 9:10 AM and 12/18/15 at 10:50 AM, but they were unsuccessful.</p> <p>Interview, on 12/15/15 at 2:15 PM, with Licensed Practical Nurse (LPN) #1, revealed Resident #1 was admitted for therapy after a fall at home. The resident had made improvements; however, had recently come down with a chest infection and had not been feeling well. The resident had very brittle bones that popped and cracked all the time, and the resident had one leg shorter than the other, causing balance problems and both hands were malformed from osteoarthritis. LPN #1 explained a few months ago the resident obtained a fracture to the right hand and believed it was caused by osteoarthritis and the resident still had some pain issues with the hand due to that fracture. At times the resident required the extensive assistance of two (2) staff with transfers; however, the plan of care directed staff to provide the assistance of one (1) with transfers. On 11/08/15, she heard a staff member yelling from the shower room and she immediately went to check to see what they needed and found Resident #1 on the floor with a head injury and a skin tear to the right elbow. The</p>	F 323		

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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/30/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 56</p> <p>resident was not responsive when she entered the shower room; however, after a few moments the resident was able to answer questions according to their baseline cognition level. The resident did not remember falling or hitting their head. The DON was notified and came to assist and an ambulance was called to transfer the resident to the hospital. The LPN did not remember seeing a gait belt on the resident when she was providing treatment for the injuries; however, a gait belt should have been used during the transfer. She did not interview the nursing assistant to determine all the possible contributing factors to the fall. Per interview, she was not directed to review the resident's medical record for missed opportunities to prevent the fall and she was not directed to conduct audits of staff to determine if they had gait belts on their person or if they routinely used them during transfers, after the event.</p> <p>Interview, on 12/16/15 at 9:14 AM, with CNA #2, revealed Resident #1 was normally wobbly and off balance due to one leg being shorter than the other. The resident would get dizzy at times when standing and could not stand for more than a couple of minutes due to weakness. The resident had shoulder pain and deformed hands. The CNA explained to begin the transfer process she had to provide the resident a boost to obtain a standing position, and due to the shoulder pain and deformed hands she had to guide the resident's arms and hands up to the grab bar in order to continue the transfer process. The resident was not able to come to a standing position on their own. The resident's transfer needs fluctuated day to day, and at times when the resident would not feel good or was weaker than usual it would take two (2) people to get the</p>	F 323			

If continuation sheet Page 57 of 77

RECEIVED
FEB - 3 2016
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

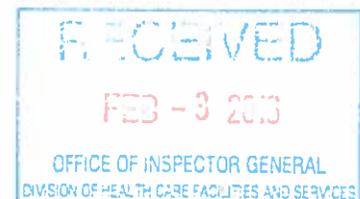
PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323	<p>Continued From page 57</p> <p>resident up and to transfer to another chair or to the bed. However, according to Resident #1's nurse aide care sheet the resident only required the assistance of one (1) with transfers same as the comprehensive care plan.</p> <p>Continued interview with the DON, on 12/15/15 at 3:15 PM, revealed her investigation had not determined Resident #1 was assessed to need the assistance of two (2) during transfers, per the resident's quarterly Minimum Data Set Assessment, dated 10/07/15. She did not review the medical record after the event or the nursing assistants, activities of daily living needs documentation dated, 10/29/15-11/04/15 and 11/01/15-11/07/15 that assessed Resident #1's transfer needs as requiring the extensive assistance of two (2). She focused her investigation on the fact the resident lost his/her balance during the fall. It was determined the shower room needed an additional grab bar for staff to use when transferring residents. The only grab bar in the shower room at the time was on the wall next to the toilet and when the wheelchair was pushed up to the grab bar there was limited room for the resident to hold on to and for the staff to move the wheelchair out from behind the resident and then move the shower chair underneath the resident. The DON continued to explain after the incident she did not direct the nursing staff to conduct audits of care plans or for the use of gait belts or the amount of assistant needed during a transfer to determine if there were other resident care concerns. Per interview, she did not interview other nursing assistants regarding Resident #1's transfer needs or if they had a gait belt to use or if they knew when to use it. The DON further stated she was new to the role of Director of Nursing and the investigation</p>	F 323		
-------	--	-------	--	--



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

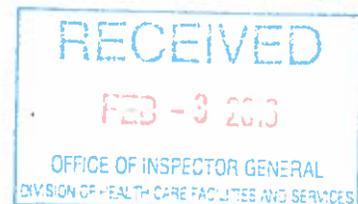
PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1606 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323	<p>Continued From page 58</p> <p>process. However, she stated it was important to identify all causes of an incident and then address them with an action plan in order to prevent another similar incident from happening. She could not provide evidence the facility investigated and addressed all the contributing factors of the fall with an action plan and completed audits to ensure compliance after Resident #1's fall with a head injury that resulted in the resident's death.</p> <p>Interview with the Administrator, on 12/16/15 at 5:50 PM, revealed he had been informed of Resident #1's fall on 11/06/15 and his investigative findings determined the root cause of the fall was the shower room lacked a bar on the long wall, across from the toilet, for residents to grab onto; which would better facilitate a transfer. However, record review revealed Resident #1 would not be able to grab the bar due to arthritic and congenital malformation of the hands. He stated it was the expectation of the facility that all staff use gait belts when assisting residents with ambulation and/or transfers. However, the facility did not have a policy directing the staff in that expectation. Per interview, he did not direct staff to determine if there were other issues regarding the use of gait belt, per facility expectation. He did not identify the resident had been assessed as needing the extensive assistance of two (2) or that the care plan did not reflect this information.</p> <p>The facility took the following actions to remove the Immediate Jeopardy as follows:</p> <p>1. On 11/06/15 Resident #1 had a fall in the facility shower room. The Restorative Nurse</p>	F 323		
-------	--	-------	--	--



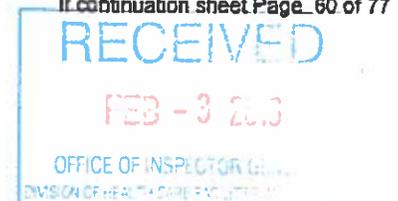
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 59</p> <p>hearing a call for help went to the shower room, found the resident on the floor, took the resident's vital signs, and placed pressure to a laceration on the resident's arm. The resident's vital signs were taken, neurological status was assessed, and an ice pack was applied to the resident's head. The attending physician and daughter-in-law were notified. Emergency Medical Services (EMS) was called for transport and the resident returned from the hospital the same day.</p> <p>2. An investigation was initiated by the Administrator and the Director of Nursing (DON) on 11/06/15. The shower room on the Dogwood Unit was inspected and a sign was placed on the shower room door to not use the shower room until further notice.</p> <p>3. On 11/06/15 following shift change the DON educated all day and night shift staff that two (2) staff would be required in shower rooms for transfers. There were twenty-seven (27) nursing staff on on duty on 11/06/15 of the sixty-seven(67) total staff.</p> <p>4. On 11/07/15 the Administrator called the House Supervisor and instructed her to educate the nursing staff, (28) who worked the weekend, that going forward two (2) people would be required in the shower rooms for transfers. Eleven (11) weekend staff remained to be trained. There was no agency staff at this time.</p> <p>5. On 12/17/15 the Administrator reviewed ninety-five (95) falls from 06/01/15 to present to determine if falls occurred in the shower rooms. Only one (1) fall occurred in a shower room related to a wheelchair moving. There were no falls related to resident transfer or gait belt use.</p>	F 323		



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323	<p>Continued From page 60</p> <p>6. On 11/13/15 education was given to nursing staff by the Staff Development Coordinator (SDC) on safety devices, transfers, use of gait belts. The Charge Nurse, CNA Preceptor, Unit Managers, DON, and Assistant Director of Nursing (ADON) were included in the thirty-four (34) nurses educated by the SDC. New nursing staff receives competency skills evaluations that includes gait belt use.</p> <p>7. After the fall on 11/06/15 the facility started reviewing falls in the morning meeting Monday through Friday for root cause analysis and that the CNA and comprehensive care plans are updated. The comprehensive care plans are updated by nurses. The DON then checks that the CNA and comprehensive care plans are updated Monday through Friday. Falls on the weekend with injury are called to the DON by a licensed nurse and reviewed. The licensed nurse updates the care plan and the fall is placed on the 24 hour report. A shift to shift report is given between nurses.</p> <p>8. On 11/24/15 the Quality Assurance Performance Improvement (QAPI) committee met with the Administrator, DON, ADON, Unit Managers, Maintenance Director, Social Services Director, Human Resource Director, and Restorative Nurse Manager. The number, location, shift of falls were discussed along with monitoring of transfers to be ongoing. Transfer assistance documentation was reviewed for discrepancies. In addition, falls for 10/01/15 through 10/31/15 were reviewed to look for further trends.</p> <p>9. On 12/15/15 ninety-six (96) current CNA care</p>	F 323		
-------	---	-------	--	--



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

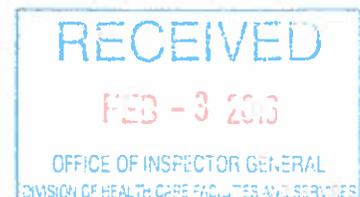
PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323	<p>Continued From page 61</p> <p>plans were audited to determine gait belt needs and transfer assistance by the DON, Unit Manager, SDC, ADOC, Signature Care Consultant (SCC), Administrator or Director of Program Development (DPD). The team found and corrected twenty (20) discrepancies. All ninety-six (96) CNA care plans were then compared to the comprehensive care plans to ensure the CNA care plan matched for level of assistance, transfers and use of a gait belt. There were (43) discrepancies identified at that time and corrected.</p> <p>10. On 12/15/15 thirty-nine (39) of thirty-nine (39) evening and night shift nurses and therapy staff were educated by the SDC, DON, and SCC to use gait belts for transfers, checking the CNA care plans, and two (2) staff members to be in the shower rooms for assistance with transfers except for Hoyer Lift residents or independent residents.</p> <p>11. On 12/17/15 the DPD educated seventeen (17) interdisciplinary team (IDT) management team members which included the Administrator, DON, Unit Managers, Rehab Manager, Business Office Manager, Medical Records Director, SDC, MDS Coordinator, Human Resources, Maintenance Director, Human Resources, Environmental Services Director, and Activities Director on root cause analysis, Gait Belt Policy, Stop and Watch Process, two (2) persons for transfers and in the shower room at all times, updating care plans, and following the care plan. This was a face to face training. A post-test on gait belt use was administered and a score of 100% had to be reached.</p> <p>12. On 12/17/15 the staff was retrained by the</p>	F 323		
-------	---	-------	--	--



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

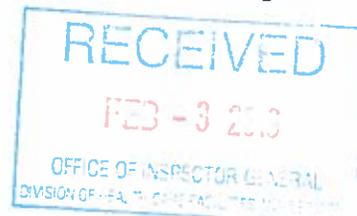
F 323	<p>Continued From page 62</p> <p>management staff, who had been educated by the DPD. Any staff not trained as of 12/18/15 could not return to work until educated and they received 100% on the post-test. If 100% was not obtained they would be re-educated and re-tested until they scored 100%. Staff on Family Medical Leave (FMLA), Medical leave, PRN, or vacation would not be allowed to return to work until trained and they received 100% on the post-test.</p> <p>Beginning 12/18/15 every shift a licensed nurse or the Regional Rehab Services Manager will observed three (3) showers on Magnolia and Dogwood daily for gait belt use for transfer. Five (5) nursing or therapy staff will be administered the gait belt post-test by the Administrator, DON, Unit Manager, Business Office Manager, Medical Records Director, MDS Coordinator, Human Resource Director, Activities Director, or Environmental Services Director. The post-test and re-education will be given until a 100% score is achieved.</p> <p>The Administrator and DON will review post-test daily.</p> <p>13. On 12/16/15 the SDC, DON, Unit Managers, ADON, and or the SCC began gait belt competencies. As of 12/21/15 sixty-one (61) staff had completed the competencies. The facility has sixty-seven (67) staff members.</p> <p>14. On 12/16/15 the Minimum Data Set (MDS) Coordinator reviewed the last MDS assessments for all ninety-seven (97) residents for their level of assistance to ensure the CNA and the comprehensive care plans matched the MDS assessment. On 12/17/15 the DON, Unit Manager, SCC, and SDC conducted a second</p>	F 323		
-------	--	-------	--	--



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/30/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 63</p> <p>audit and interviewed various staff members to determine the amount of assistance the ninety-seven (97) residents needed. This information was compared to the MDS coding, the CNA and comprehensive care plans. Fifty-three (53) comprehensive care plans and thirty-four (34) CNA care plans were updated.</p> <p>15. A QAPI meeting was held on 12/15/15 via telephone with the Medical Director, Administrator, DON, Unit Manager, SCC and DPD to review the fall of Resident #1, the steps to put in place, incident reports, placing grab bars in the shower rooms, and staff education.</p> <p>16. On 12/17/15 the Administrator notified the staffing agency that their staff would receive gait belt education before working at the facility.</p> <p>17. On 12/21/15 three gait belts were placed in the medication room on the Magnolia and Dogwood Units.</p> <p>18. On 12/17/15 a QAPI meeting was held with the Medical Director, Special Projects Administrator (SPA), Unit managers, (3) SCC's, and the DPD to review cited deficiencies. Care plans would be audited daily Monday through Friday, Stop and Watch Process audits, fall interventions audits, continue gait belt competencies and use, shower room transfer audits with two (2) staff, gait belt post-test, and root cause analysis audits daily.</p> <p>19. Beginning 12/18/15 care plans will be audited for transfer assistance needed by the DON, ADON, Unit manager, SCC, and Charge Nurse and discussed in morning meeting if a discrepancy is noted an investigation will be</p>	F 323			



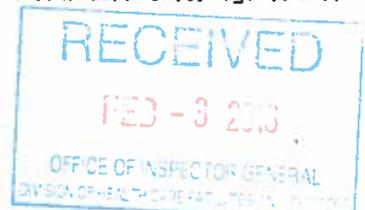
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 64</p> <p>initiated by the DON, Administrator, or Unit Manager. The interdisciplinary team (IDT) will update the care plan and notify the MDS Coordinator of the change, and falls will be reviewed for root cause analysis.</p> <p>20. A nurse from the regional team or corporate office, Regional Vice-President of Operations or Special Projects Administrator has been on site daily since 12/14/15 reviewing audits and assisting as needed. The Chief Nurse Executive, Clinical Compliance Nurse, Director of Program Development is in daily contact with the SCC or Regional Vice president of Operations and is reviewing audits.</p> <p>21. A QAPI meeting was held on 12/22/15 to determine further need for education or plan revision. Results of audits, post-test, and gait belt observations during showers were discussed and reported weekly. Concerns identified will be corrected immediately and reported to the Administrator or DON. The IDT team are auditing with audit tools daily. These audits are reviewed by the Administrator, DON, or regional staff member daily.</p> <p>22. Administrative oversight of the facility will be completed by the Special Projects Administrator, Regional Vice President of Operations, or a member of the regional staff weekly on site and daily by telephone beginning 12/16/15, then every other week for four (4) weeks, then monthly. Oversight will include, but not limited to, daily review of the audits, QAPI committee meetings and review of all audits to ensure additional education is not needed.</p> <p>23. QAPI meetings will be held weekly beginning</p>	F 323		



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

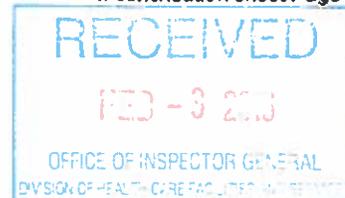
PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323	<p>Continued From page 65</p> <p>12/15/15 for four (4) weeks, then monthly for recommendations and further follow-up and determine what frequency any ongoing audits will need to continued. The Administrator has the oversight to ensure an effective plan is in place to meet the resident's well-being, identify facility concerns, and implement a corrective plan to involve all staff. Audits will be reviewed, but not limited to, gait belt competency, and two (2) person transfers for showers, gait belts on nursing and therapy staff, care plan audits for transfer assistance, MDS coding for transfers, and root causes for falls.</p> <p>The State Survey Agency validated the removal of the Immediate Jeopardy on 12/30/15 prior to exit as follows:</p> <p>1. Interview, on 12/30/15 at 7:20 AM, with LPN #1 (the Restorative Nurse) revealed on 11/06/15 she responded to a call for help from the shower room on the Dogwood Unit. When she entered the shower room, Resident #1 was laying on his/her right side on the shower room floor. Resident #1 was non-responsive to verbal stimuli for one (1) to two (2) minutes. She took the resident's vital signs, placed a pressure dressing on a laceration on the resident's right arm, and an ice pack was placed on a hematoma on the right side of the resident's forehead. Review of the nursing notes and incident report on 12/30/15 revealed, on 11/06/15 at 2:30 PM Resident #1's attending physician and daughter-in-law were notified of Resident #1's fall. The attending physician gave orders to send Resident #1 to a local hospital for assessment. Emergency Medical Services (EMS) was called to transport the resident to a local hospital for evaluation. Resident #1 was returned to the facility from the</p>	F 323		
-------	--	-------	--	--



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

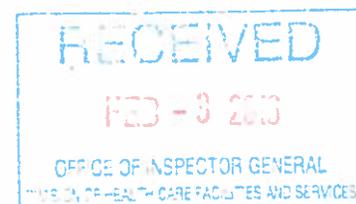
PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323	<p>Continued From page 66</p> <p>local hospital, on 11/06/15 at 3:30 PM, with a diagnosis of Subdural Hematoma and he/she was not a surgical candidate.</p> <p>2. Interview with the Administrator, on 12/29/15 at 9:08 AM, revealed after he was notified Resident #1 had fallen on 11/06/15 he and the Director of Nursing (DON) investigated all the shower rooms. He had a sign placed on the Dogwood Unit shower door to not use the shower room until Monday, 11/09/15 and he then purchased grab bars to be installed in all the shower rooms.</p> <p>Interview with the Plant Director, on 12/29/16 at 2:45 PM, revealed he and his Assistant installed new grab bars in all four (4) facility shower rooms; two (2) shower rooms on Dogwood and two (2) shower rooms on Magnolia on 11/09/15.</p> <p>Review of the purchase order for grab bars revealed grab bars were purchased 11/08/15 at a local store.</p> <p>Observations of two (2) shower rooms on the Dogwood and Magnolia Units, on 12/29/15 at 11:31 AM, revealed all shower rooms had new grab bars.</p> <p>3. Interview with the DON, on 12/29/15 at 3:15 PM, revealed she educated all staff working 11/06/15 that effective immediately there were to be two (2) staff always present in the shower rooms for transfers. There were twenty-seven (27) nursing staff on duty on 11/06/15 of the sixty-seven (67) total staff.</p> <p>Review of the staff schedule for 11/06/15 and staff name check offs by the DON revealed</p>	F 323		
-------	--	-------	--	--



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 67</p> <p>twenty-seven (27) staff were educated that two (2) staff must be present at all times in the shower rooms.</p> <p>Observations of the shower room on the Dogwood Unit, on 12/29/15 at 9:00 AM, and the Magnolia Unit, on 12/29/15 at 9:16 AM, revealed two (2) CNAs with a resident using a gait belt to transfer the resident.</p> <p>Interview with CNA #2, on 12/29/15 at 9:12 AM and CNA #3, on 12/29/15 at 9:40 AM, revealed they were educated on 11/06/15 by the DON that two (2) staff were to always be in the shower room with a resident.</p> <p>4. Interview with the Administrator, on 12/29/15 at 3:15 PM, revealed he called the Nursing Supervisor on 11/07/15 and instructed her to educate all working staff that showers were to only be given with two (2) staff present at all times in the shower room.</p> <p>Interview with the House Supervisor, on 12/29/15 at 3:00 PM, revealed she had trained twenty-eight (28) staff on 11/07/15 that two (2) staff had to be present for all showers.</p> <p>Interview with CNA #2 on 12/29/15 at 9:30 AM; CNA #3 on 12/29/15 at 9:40 AM; CNA #4 on 12/29/15 at 2:50 PM; Registered Nurse (RN) #1 on 12/29/15 at 2:30 PM; CNA # 5 (agency staff) on 12/29/15 at 2:43 PM; and, Licensed Practical Nurse (LPN) #1 on 12/29/15 at 3:07 PM, revealed they were educated on 11/07/15 by the House Supervisor to always have two (2) staff present in the shower rooms with residents.</p> <p>Review of the staffing schedule for 11/07/15</p>	F 323		



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/30/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 68</p> <p>revealed twenty-eight (28) nursing staff were trained.</p> <p>5. Interview with the Administrator, on 12/29/15 at 3:15 PM, revealed on 12/17/15 he reviewed all falls in the facility from 06/01/15 through 12/17/15 to determine a root cause. Ninety-five (95) falls were reviewed. Only one (1) occurred in a shower room due to a wheelchair wheels not being locked. There were no falls related to resident transfers.</p> <p>6. Interview with the Staff Development Coordinator (SDC), on 12/29/15 at 9:15 AM, revealed on 11/13/15 she educated nursing staff on gait belt use. Thirty-four (34) nursing staff including the Assistant Director of Nursing (ADON), Charge Nurse, CNA Preceptor, and DON were told to always have their gait belt and to use it for all transfers. In addition she stated all direct nursing staff and therapy staff were provided a gait belt by the facility upon hire. Each unit has extra gait belts in the medication rooms for agency staff to use.</p> <p>Interview with the Unit Manager on 12/29/15 at 9:12 AM; CNA #2 on 12/29/15 at 9:30 AM; CNA #3 on 12/29/15 at 9:40 AM; CNA #1 on 12/29/15 at 12:33 PM; the Magnolia Unit Charge Nurse on 12/29/15 at 12:45 PM; RN #1 on 12/29/15 at 2:30 PM; CNA #4 on 12/29/15 at 2:50 PM; and, LPN # 1 on 12/29/15 at 3:07 PM, revealed they were educated on 11/13/15 by the SDC on gait belt use for resident transfers.</p> <p>7. Interview with the Director of Clinical Programs (DCP), on 12/29/15 at 9:15 AM, revealed the morning meetings are Monday through Friday and comprehensive care plans are reviewed and</p>	F 323			



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/30/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 69</p> <p>updated when needed. The DON reviews the CNA care plans to ensure it matches the comprehensive care plan.</p> <p>Interview with the Administrator, on 12/29/15 at 3:15 PM, revealed the morning meetings are Monday through Friday. After the fall on 11/06/15 the facility started reviewing the comprehensive and CNA care plans for transfer and assistance needs to ensure they were reviewed and updated as needed. Falls are reviewed for root cause analysis. If a fall with injury occurs on the weekend the DON is notified.</p> <p>Interview with the DON, on 12/29/15 at 3:23 PM, revealed morning meetings are held Monday through Friday. In the meeting the resident comprehensive care plans are reviewed and she checks that the comprehensive care plan matches the CNA care plan. Any fall that occurred is placed on the 24 hour report and the shift to shift report. The fall is reviewed in the morning meeting the next morning for a possible root cause. She is notified if a fall with injury occurs on the weekend.</p> <p>Interview with the ADON, on 12/30/15 at 8:50 AM, revealed she attends morning meetings Monday through Friday. All ninety-six (96) resident comprehensive care plans are reviewed and updated as needed. The DON compares the CNA care plan to the comprehensive for transfer and assistance needs.</p> <p>8. Interview with the Administrator, on 12/30/15 at 9:57 AM, revealed the QAPI committee is an interdisciplinary team (IDT) that consists of the DON, ADON, Unit Managers, Social Services, Office Manager, Medical Records, Human</p>	F 323			



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323 Continued From page 70
Resources, Activity Director, two (2) Unit Coordinators, Environmental Services Director, MDS Coordinators, Therapy Director, Staff Development, and the Medical Director. The committee meets monthly. On 11/24/15 the committee met to discuss monitoring transfer assistance needs. Falls data was reviewed from 10/01/15 through 10/31/15 to identify if there was a trend.

Interviews with the DON, two (2) Unit Managers, SDC, SCC, and DPD on 12/30/15 at 3:23 PM, revealed they attended the 11/24/15 QAPI meeting and discrepancies identified for transfer assistance were reviewed.

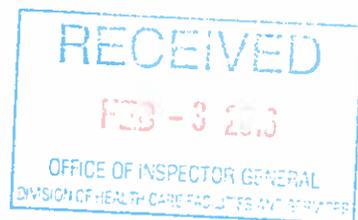
Review of the QAPI committee sign in sheet for 11/24/15 on 12/30/15, revealed the DON, ADON, Unit Managers, Social Services, Office Manager, Medical Records, Human Resources, Activity Director, two (2) Unit Coordinators, Environmental Services Director, MDS Coordinators, Therapy Director, and SDC were present at the meeting.

9. Review of the facility's audits for needed care plan updates of transfer and assistance needed, dated 12/13/15; 12/15/15; 12/16/15; 12/17/15; 12/18/15; 12/20/15; 12/21/15; and 12/22/15 revealed the audits had been completed with changes identified that needed to be made to the care plans.

Review of Resident #7's and Resident #10's comprehensive and CNA care plans revealed, revealed their care plans had been updated for transfer and assistive needs on 12/18/15.

Review of Unsampled Resident's A and B's

F 323



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323	<p>Continued From page 71</p> <p>comprehensive and CNA care plans revealed their care plans had been updated for transfer and assistive needs on 12/19/15.</p> <p>10. Review of the education sign in sheets revealed on 12/15/15 thirty-two (32) nursing staff and seven (7) therapy staff were trained on two (2) staff in the shower rooms for assistance except for Hoyer Lifts and independent residents.</p> <p>Interview with the Dogwood Unit Manager, on 12/29/15 at 9:12 AM, revealed she assisted with the training of the nursing and therapy staff 12/15/15 and 12/16/16.</p> <p>Interview with, CNA #2 on 12/29/15 at 9:30 AM; CNA #3 on 12/29/15 at 9:40 AM; an Occupational Therapist (OT) on 12/29/15 at 11:53 AM; a Physical Therapist Assistant (PTA) on 12/29/15 at 12:10 PM; CNA #5 on 12/29/15 at 2:43 PM; LPN #1 on 12/29/15 at 3:07 PM; and, CNA #10 on 12/29/15 at 3:15 PM, revealed on 12/15/15 and 12/16/15 they had been educated that two (2) staff members were to be in the shower rooms for resident transfers, gait belts were to be used for transfers according to the care plan and that staff was to check the care plan for fall interventions and needed changes.</p> <p>11. Interview with the Director of Clinical Programs (DCP), on 12/29/15 at 9:15 PM, revealed on 12/17/15 she educated the IDT team on Root Cause Analysis in a power point presentation in the morning meeting. The (IDT) consisted of the DON, ADON, Unit Managers, Social Services, Office Manager, Medical Records, Human Resources, Activity Director, two (2) Unit Coordinators, Environmental Services Director, MDS Coordinators, Therapy</p>	F 323		
-------	--	-------	--	--



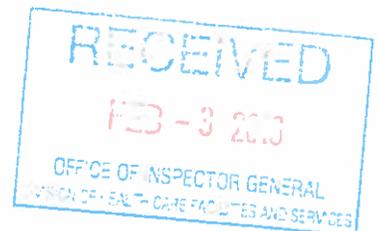
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 72</p> <p>Director, Staff Development, and Maintenance Director. The Gait Belt Policy was reviewed with no changes needed. A Stop and Watch Process form was presented, two (2) person transfers and staff being in the shower rooms were to be permanent changes. Care plan reviews, updating care plans, and face to face training were discussed. She administered a post gait belt test to the IDT team and each had to obtain a score of 100%. If 100% was not reached re-education was done immediately and the person was retested.</p> <p>Interviews, on 12/29/15 with the SDC at 9:45 AM; Director of Social Services at 11:10 AM; the Office Manager at 11:20 AM; Human Resource Director at 11:30 AM; MDS Coordinator at 11:55 AM; and, the Therapy Director at 12:10 PM, revealed they attended the training on 12/15/15 presented by the DCP.</p> <p>12. Interview with CNA #2 on 12/29/15 and 9:30 AM; CNA #3 on 12/29/15 at 9:40 AM; an Occupational Therapist (OT) on 12/29/15 at 11:53 AM; a Physical Therapist Assistant (PTA) on 12/29/15 at 12:10 PM, CNA #5 on 12/29/15 at 2:43 PM; LPN #1 on 12/29/15 at 3:07 PM; and, CNA # 10 on 12/29/15 at 3:15 PM, revealed they all stated they had received education on gait belt use, obtained 100% on the post test, could explain when and how the use the Stop and Watch form, and were aware two (2) persons must always be in the shower rooms for resident transfers.</p> <p>Review of the daily gait belt post-tests revealed since 12/18/15 five random staff from nursing and therapy had been administered the gait belt post-test and obtained a score of 100%.</p>	F 323		



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/30/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 73</p> <p>Interview with the Administrator, on 12/30/15 at 11:49 AM, revealed he or the DON reviewed all gait belt post-test daily for the five (5) random staff test.</p> <p>In addition, interview with the DON, on 12/30/15 at 11: 50 AM, revealed she follows-up with the Administrator to assess if staff had to be re-educated and were re-tested.</p> <p>Review of the staff post-test revealed sixty-five (65) of sixty-seven (67) facility staff were trained. One (1) untrained staff member was on FMLA and the other was a PRN staff.</p> <p>13. Review of staff post-test revealed between 12/16/15 and 12/21/15 sixty-one (61) of the facility's sixty-seven staff members were administered a gait belt competency which was part of the gait belt training. The staff member had to demonstrate correct use of the gait belt.</p> <p>Review of post-test after 12/21/15 revealed three (3) PRN staff and one (1) staff from vacation completed the gait belt testing with 100% and were able to demonstrate appropriate use of the gait belt.</p> <p>14. Interviews on 12/29/15 with the SDC at 9:45 AM and the DON at 3:23 PM, revealed they interviewed various nurses and CNAs on 12/17/15 to determine the amount of assistance a resident needed for bed mobility, eating, transfers and toileting. This information was compared to the MDS coding, CNA care plans and the comprehensive care plan. Eight (8) assessments required modification. Follow up on 12/18/15 revealed fifty-three (53) comprehensive care plans and thirty-four (34) CNA care plans were</p>	F 323			



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 74 updated by the DON, Unit Managers, SCC, ADON, SDC, and the DPD.</p> <p>15. Interview with the DON, on 12/30/15 at 8:50 AM; the Administrator at 9:57 AM; the Medical Director at 10:40 AM; and, the Signature Care Consultant for Nursing (SCC) at 12:06 PM, revealed all were present on 12/15/15 for a QAPI meeting to discuss the fall of Resident #1 and an action plan. (Grab bars, staff education, and incident reports)</p> <p>16. Interview with the owner of the Staffing Agency, on 12/29/15 at 12:35 PM, revealed she was notified by the Administrator on 12/17/15 that all agency staff would be gait belt trained and tested before working at the facility.</p> <p>17. Observations, on 12/29/15 at 11:31 AM, of the medication rooms on the Dogwood and Magnolia Units revealed there were three (3) gait belts in the room.</p> <p>18. Interview with the Administrator, on 12/30/15 at 9:57 AM, revealed a QAPI meeting was held on 12/17/15 by phone with the Medical Director.</p> <p>Interview with the Medical Director, on 12/30/15 at 10:40 AM, revealed he was called into a QAPI meeting on 12/17/15.</p> <p>Interview, on 12/30/15 with the DON at 8:00 AM; Special Projects Administrator at 10:20 AM; SDC at 9:30 AM; and, the ADON at 11:07 AM, revealed they were present for the QAPI conference call with the Medical Director on 12/17/15.</p> <p>Review of the QAPI sign in sheet for the 12/17/15 meeting revealed seven (7) persons were present</p>	F 323		



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

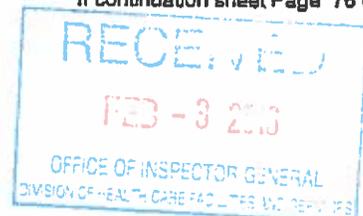
PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323	<p>Continued From page 75 for the meeting.</p> <p>19. Interview with the SDC, on 12/29/15 at 9:45 AM, revealed she assisted with the audits, beginning 12/18/15, of the care plans and if discrepancies are identified they are discussed in the morning meetings.</p> <p>Interview with the DON, on 12/29/15 at 3:15 PM, revealed prior to 12/18/15 the facility had reviewed and updated all resident care plans for assistance and transfer needs. Beginning 12/18/15 through ongoing care plan audits if a discrepancy was identified in a resident's care plan for transfer or assistance needs it was to be reported in morning meeting and would be investigated. All falls would be reviewed for root cause and if a care plan was updated MDS would be notified of the change.</p> <p>Review of the facility falls since 11/06/15 revealed there had been no resident falls from 12/15/15 to 12/30/15.</p> <p>20. Interviews, on 12/29/15 with the DPD at 9:15 AM; and, the Special Project Administrator at 10:20 AM, revealed the corporate team assigned to assist the facility since 12/14/15 were present on site and reviewing audits. The Corporate team consisted of the Special Project Administrator, the Director of Program Development, and the Signature Care Consultant.</p> <p>21. Interview with the Administrator, on 12/30/15 at 9:57 AM, revealed QAPI meetings were held 12/15/15, 12/17/15, 12/22/15, and 12/29/15.</p> <p>Review of the QAPI sign in sheets on 12/30/15, revealed QAPI meetings were held 12/15/15,</p>	F 323		
-------	---	-------	--	--



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

PRINTED: 01/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 76 12/17/15, 12/22/15, and 12/29/15.</p> <p>22. Interview with the Special Project Administrator, on 12/29/15 at 10:20 AM, revealed he was the Corporate Administrator assigned to oversight with the facility. He stated he would be at the facility weekly and was available to the facility by phone seven (7) days a week. He further stated he would review audits, attend QAPI meetings and ensure additional staff education was not needed.</p> <p>23. Interview with the Administrator, on 12/30/15 at 9:37 AM, revealed QAPI meetings had been weekly since 12/05/15.</p> <p>Review of the QAPI meeting sign in sheets revealed QAPI meetings had been held 12/15/15, 12/17/15, 12/22/15, and 12/29/15.</p>	F 323		

