



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

PRINTED: 06/20/2014  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185402 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                      | (X3) DATE SURVEY COMPLETED<br><br>C<br>06/06/2014 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>HENDERSON NURSING AND REHABILITATION CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2500 NORTH ELM ST.<br>HENDERSON, KY 42420                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                      |                                                   |
| (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 1 changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on interview, record review and review of the facility's policy and procedure it was determined the facility failed to revise the care plan for pain due to increased pain symptoms related to injuries sustained from a fall on 05/08/14 for one (1) of five (5) sampled residents (Resident #1). On 05/08/14, Certified Nurse Aide #1 attempted to transfer Resident #1 with a mechanical lift by herself which resulted in the resident being lowered to the floor. Resident #1 was sent to the hospital due to complaints of pain in the ribs, head, chest, and legs. The resident was diagnosed with a ninth (9th) rib fracture and contusions to the right shoulder, right hip and head.</p> <p>The findings include:</p> | F 280                                                            | <ol style="list-style-type: none"> <li>1. Resident #1 Pain care plan was updated on 06/10/2014 by the Director of Nursing ensure that the resident has all pain needs being met and pain interventions were being followed. Any interventions not in place were implemented at that time.</li> <li>2. A review of all current residents Comprehensive Care Plans was completed by the Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Coordinator, MDS assistant, Social Service Director, Dietary Manager, and Activities Director on 06/25/2014 to ensure that care plans meet the needs of the resident and care plan interventions were followed. Any resident whose care plan was not up to date to meet the needs of the resident had the care plan updated. Any interventions not in place had those interventions implemented.</li> <li>3. On 06/19/2014, the IDT team consisting of the Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Coordinator, MDS assistant, Social Service Director, Dietary Manager, and Activities Director were re-educated by Regional Nurse Consultant and Regional Reimbursement Coordinator regarding development of the Comprehensive Care Plan and Care Plan Revisions related to change of resident condition.</li> </ol> |                      |                                                   |

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| F 280                                                                           | <p>Continued From page 2</p> <p>Review of the facility's policy and procedure titled "Resident Comprehensive Care Plan" dated 09/2008, revealed "The Comprehensive Care Plan should always have realistic goals and approaches/interventions to address the resident's needs. Review of the "Quality Assurance Policy" revised 03/2013, revealed "Any change of condition noted by review of the Interdisciplinary Team (IDT), medical record, and Quality Assurance discussion, will follow the adopted Change of Condition (COC) system for assessment, care planning, notification, and reimbursement."</p> <p>Record review revealed the facility admitted Resident #1 on 10/17/12 with diagnoses which included Malignant Neoplasm Breast, Anxiety, Dementia, Gastroesophageal Reflux, End Stage Renal Disease, and Trigeminal Neuralgia.</p> <p>Review of the facility's investigation, dated 05/09/14, revealed Resident #1 experienced a fall with injuries, on 05/08/14, which included a ninth rib fracture and head injury with increased complaints of pain in the ribs, legs, chest, and head. The resident was evaluated in the Emergency Room on 05/09/14 where x-rays of the ribs revealed a right ninth (9th) rib fracture and soft tissue injury to the skull.</p> <p>Review of the Comprehensive Care Plan, dated 02/11/14 for "Experiences Alteration in Comfort related to Cancer and Trigeminal Neuralgia", revealed no documented evidence on the care plan that it was revised to include interventions to address the increased complaints of pain in the ribs, chest, legs and head related to the injuries from the fall.</p> | F 280                                                            | <p>4. The Director of Nursing or Assistant Director of Nursing will audit five (5) resident records weekly for twelve (12) weeks to ensure that care plans have been revised as needed to meet the needs of the resident and care plan interventions are being followed. All monitoring will be reviewed by the Quality Assurance Committee monthly for further recommendations if needed. The Quality Assurance Committee will consist of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Coordinator, Social Service Director, Dietary Services Manager, and the Activities Director and the Medical Director attending at least quarterly.</p> | 06/28/2014           |                                                   |

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| F 280                                                                           | Continued From page 3<br>Interview with Registered Nurse (RN) #1, on 06/06/14 at 1:30 PM, revealed the floor nurses were responsible for updating/revising the care plans as new orders were received or as changes in the resident's condition occurred.<br><br>Interview with the Director of Nursing (DON), on 06/06/14 at 2:41 PM, revealed morning meetings were held daily and care plans were discussed and revised as needed during the meetings. The DON stated anything that needed to be changed was done and ongoing monitoring was done to ensure the care plans were correct. The DON revealed she was unsure why the care plan was not revised for Resident #1 but it should have been.                                                                       | F 280                                                            |                                                                                                                                                                                                                                                                                                                                           |                      |                                                   |
| F 282<br>SS=G                                                                   | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, and review of the facility's policy and procedure it was determined the facility failed to ensure the plan of care was followed for one (1) of five (5) sampled residents (Resident #1) related to transfers.<br><br>Resident #1 was care planned for the assistance of two (2) staff with a mechanical lift with transfers. However, on 05/08/14, Certified Nursing Assistant (CNA) #1 failed to follow the care plan and attempted to transfer the resident | F 282                                                            | 1. An observation of Resident #1 with the use of Mechanical lift was made by the Director of Nursing on 06/10/2014 to ensure that the resident was transferred according to the plan of care and with the assist of two (2) for the transfer, no concerns were identified. All interventions were followed according to the plan of care. |                      |                                                   |

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| F 282                                                                           | <p>Continued From page 4</p> <p>with a mechanical lift unassisted, which resulted in the resident being lowered to the floor causing injury. Resident #1 was sent to the hospital due to complaints of pain to the ribs, head, chest and legs and it was determined the resident sustained a right ninth (9th) rib fracture and contusions to the right shoulder, right hip and head. Naproxen (anti-inflammatory) 550 milligrams (mg) was ordered twice a day for seven (7) days after the fall for increased pain management and soft tissue swelling to the posterior skull area. In addition, prior to the fall, Resident #1 was receiving Hospice Care and had an order for Roxanol (opiate narcotic pain reliever) 20 mg/1 milliliter (ml) sublingual every two (2) hours for pain. However, Resident #1 did not require the pain medication until after the fall. Resident #1 complained of pain to the ribs, head, legs and chest. Resident #1 received eighteen (18) doses of the Roxanol between 05/09/14 and 05/17/14.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled "Resident Comprehensive Care Plan" dated 09/2008, revealed "The residents comprehensive care plan should be viewed as an Interdisciplinary approach to managing the acute and chronic needs of the resident living in the facility.</p> <p>Record review revealed the facility admitted Resident #1 on 10/17/12 with diagnoses which included Malignant Neoplasm Breast, Anxiety, Dementia, Gastroesophageal Reflux, End Stage Renal Disease, and Trigeminal Neuralgia.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment, dated 04/02/14, revealed the facility assessed Resident #1's cognition as</p> | F 282                                                            | <p>2. A review of all current residents Comprehensive Care Plan was completed by the Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Coordinator, MDS assistant, Social Service Director, Dietary Manager, and Activities Director on 06/25/2014 to ensure that care plans meet the needs of the resident and care plan interventions were followed. Any resident whose care plan was not up to date to meet the needs of the resident had the care plan updated. Any interventions not in place were immediately implemented.</p> <p>3. All nursing staff was re-educated by the Assistant Director of Nursing regarding following the resident plan of care and if unable to follow the plan of care it is to be reported the nurse. This education was completed on 06/27/2014 by the Assistant Director of Nursing with no staff working after 06/27/2014 without this education.</p> |                      |                                                   |

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| F 282                                                                           | <p>Continued From page 5</p> <p>moderately impaired with a Brief Interview of Mental Status (BIMS) score of eight (8). The facility assessed the resident to require two (2) person assist for transfers.</p> <p>Review of the Comprehensive Care Plan titled "Risk for Injury related to Falls", dated 02/11/14, revealed an intervention to transfer with the assistance of two (2) staff with a mechanical lift. Review of the CNA Care Plan titled "Activities of Daily Living (ADL) Plan of Care" dated 04/18/14, revealed Resident #1 required two (2) or more person physical assist and total dependence with a sling lift and wheelchair for transfers.</p> <p>Review of the facility's investigation, dated 05/09/14, revealed on 05/08/14 at approximately 7:55 PM, CNA #1 attempted to transfer Resident #1 from a wheel chair to the bed unassisted with a mechanical lift when the sling began to shift which resulted in Resident #1 being caught and lowered to the floor. Resident #1 sustained injuries to the head and ribs.</p> <p>Review of the Emergency Room Patient Record and Radiology Reports for x-rays of the ribs and review of the CT Scan (Computed Tomography Scan) of the head, dated 05/09/14, revealed the resident sustained a fracture to the right 9th rib and contusions to the head, right shoulder and right hip.</p> <p>Review of the May 2014 Medication Administration Record (MAR) revealed Resident #1 had an order for Roxanol 20 mg/1 ml sublingual every two (2) hours for pain, prior to the fall. Further review of the MAR revealed after the fall on 05/08/14, Resident #1 received eighteen (18) doses of the "as needed" Roxanol</p> | F 282                                                            | <p>4. The Director of Nursing or Assistant Director of Nursing will audit five (5) resident records weekly for twelve (12) weeks to ensure that care plans meet the needs of the resident and care plan interventions are followed. All monitoring will be reviewed by the Quality Assurance Committee monthly for further recommendations if needed. The Quality Assurance Committee will consist of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Coordinator, Social Service Director, Dietary Services Manager, and the Activities Director and the Medical Director attending at least quarterly.</p> | 06/28/2014           |                                                   |

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| F 282                                                                           | <p>Continued From page 6</p> <p>between 05/09/14 through 05/17/14 for complaints of pain in the ribs, chest, head and leg. He/She had not received any as needed Roxanol prior to the fall. In addition, the resident was ordered Naproxen (anti-inflammatory) 550 milligrams (mg) twice a day for seven (7) days after the fall for increased pain management and soft tissue swelling to the posterior skull area.</p> <p>Interview with CNA #1, on 06/04/14 at 11:05 AM and on 06/05/14 at 8:09 AM, revealed she was caring for Resident #1 on 05/08/14 when the incident occurred. She stated she was aware of the need to follow the Accu-Nurse Care Plan (the CNA ADL Care Plan is the care plan in Accu-Nurse {computer system} in which the CNAs listen to a headset to know what care needs to be provided). She stated CNA #2 was in the room to assist her with the mechanical lift but did not provide any assistance; however, interview with Licensed Practical Nurse (LPN)/Charge Nurse #1, on 06/05/14 at 7:45 AM, revealed CNA #1 had to have been in the resident's room alone because CNA #2 was up the hallway caring for other residents when CNA #1 came to get her to assess the resident.</p> <p>Interview with CNA #2, on 06/04/14 at 10:49 AM, revealed she was not in the room when Resident #1 fell on 05/08/14. She stated there was three (3) CNAs on duty on Hall 1 that night and she had rooms nine (9) through fifteen (15). She stated CNA #1 never asked her for assistance with the lift. CNA #2 stated CNA #1 told her that she had attempted to transfer Resident #1 to the bed and the lift gave and the resident began to fall but never hit the floor because she had grabbed the resident.</p> | F 282                                                            |                                                                                                                 |                      |                                                   |

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| F 282                                                                           | Continued From page 7<br>Interview with Registered Nurse (RN) #1, on 06/06/14 at 1:30 PM, revealed she monitored the CNAs on the hall to ensure they were following the care plan. She further stated when she was not present, the Charge Nurses were responsible to oversee the CNAs and ensure the resident's care plan was being followed.<br><br>Interview with the Assistant Director of Nursing (ADON), on 06/05/14 at 12:22 PM, revealed she would have expected CNA #1 to have followed Resident #1's care plan and to ask for assistance prior to using a mechanical lift. Additional interview, on 06/06/14 at 1:07 PM, revealed every staff member had been inservice related to following the resident's plan of care. There was no competency testing completed with the inservice and the CNAs were instructed to report to licensed staff if they were unable to follow the plan of care for any reason.<br><br>Interview with the Director of Nursing (DON), on 06/06/14 at 2:41 PM, revealed when she interviewed CNA #1 regarding the use of the mechanical lift unassisted, CNA #1 admitted she was trying to save time and therefore did not follow the care plan to have two (2) staff for the transfer. | F 282                                                            |                                                                                                                 |                      |                                                   |
| F 309<br>SS=D                                                                   | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | F 309                                                            |                                                                                                                 |                      |                                                   |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185402 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                      | (X3) DATE SURVEY COMPLETED<br><br>C<br>06/06/2014 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>HENDERSON NURSING AND REHABILITATION CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2600 NORTH ELM ST.<br>HENDERSON, KY 42420                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                      |                                                   |
| (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 309                                                                           | Continued From page 8<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, and review of the facility's policy and procedure it was determined the facility failed to provide one (1) of five (5) sampled residents (Resident #1) the necessary care and services related to pain. The facility failed to conduct a pain assessment and update the care plan for pain for Resident #1 after the resident sustained a fall with injury and increased pain.<br><br>The findings include:<br><br>Review of the facility's policy and procedure titled "Pain Management Process" revised 09/2013, revealed the "Interact III" system was to be followed for use of all forms and tools for accurate assessment, transfer information, and notification when needed and assessments to include a Pain Assessment. These assessments were to be completed annually, quarterly, and with any change in a resident's condition.<br><br>Record review revealed the facility admitted Resident #1 on 10/17/12 with diagnoses which included Malignant Neoplasm Breast, Anxiety, Dementia, Gastroesophageal Reflux, End Stage Renal Disease, and Trigeminal Neuralgia.<br><br>Review of the "Resident Transfer" form dated 05/09/14 (no time) revealed Resident #1 was sent to the emergency room for evaluation after he/she sustained a fall on 05/08/14 resulting in an injury to the head and ribs leading to the increased need for pain medication. However, | F 309                                                            | 1. A complete review of resident #1 record was completed on 06/10/2014 by the Director of Nursing to ensure that all pain needs of resident #1 were being met. Resident #1 had a comprehensive pain assessment completed on 06/10/2014 by the Director of Nursing. The resident pain care plan was updated to ensure that all pain needs were being met on 06/10/2014 by the Director of Nursing. Any interventions not in place were implemented.<br><br>2. All current residents had a comprehensive pain assessment completed by 06/15/2014 by the Director of Nursing, Assistant Director of Nursing, and Unit Manager to identify any resident with pain control needs unmet. Any resident who had pain control needs unmet had further intervention implemented to address pain control needs. In addition all current resident's pain care plans were reviewed by the Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Coordinator, MDS assistant, Social Service Director, Dietary Manager, and Activities Director on 06/25/2014 to assure that their pain care plan was up to date and met the needs of the resident any needed changes to the plan of care were reflected on the plan of care. |                      |                                                   |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185402 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                      | (X3) DATE SURVEY COMPLETED<br><br>C<br>06/06/2014 |
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| F 309                                                                           | Continued From page 9<br>review of the Supplemental Assessments for pain revealed the last Pain Data Set Assessment was completed on 02/11/14.<br><br>Review of the facility's investigation, dated 05/09/14, revealed Resident #1 experienced a fall with injuries which included a ninth rib fracture and a head injury on 05/08/14 with increased complaints of pain in the ribs, legs, chest, and head. The resident was evaluated in the emergency room on 05/09/14 where x-rays of the ribs revealed a right ninth (9th) rib fracture and a soft tissue injury to the skull. However, review of the Comprehensive Care Plan titled "Experiences Alteration in Comfort" dated 02/11/14, revealed there were no revisions to the care plan to address the resident's pain related to the fall with injuries.<br><br>Interview with Registered Nurse (RN) #1, Unit Manager, on 06/06/14 at 1:30 PM, revealed she did not, nor did the Charge Nurse, update the pain assessments after the incident on 05/08/14 related to a lack of communication. She could not account for the reason a new pain assessment was not completed related to the increased complaints of pain to the head and ribs by Resident #1.<br><br>Interview with the Assistant Director of Nursing (ADON), on 06/05/14 at 12:22 PM, revealed a communication failure was the cause of the assessments not being updated. She stated they implemented a new communication book a couple of weeks ago for nursing staff to use to communicate changes in resident's conditions. | F 309                                                            | 3. Beginning 06/13/2014, all licensed staff were re-educated by the Director of Nursing and the Assistant Director of Nursing on the completion of the comprehensive pain assessment and reassessment including notification of the physician as needed. No licensed staff will work after 06/27/2014 without having received this education. On 06/19/2014, the IDT team consisting of the Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Coordinator, MDS assistant, Social Service Director, Dietary Manager, and Activities Director were re-educated by Regional Nurse Consultant and Regional Reimbursement Coordinator regarding development of the Comprehensive Care Plan and Care Plan Revisions related to change of resident condition.<br><br>4. The Director of Nursing or Assistant Director of Nursing will audit five (5) resident records weekly for twelve (12) weeks to ensure that pain assessments are completed as needed and that pain care plans are updated to reflect the current needs of the resident. All monitoring will be reviewed by the Quality Assurance Committee monthly for further recommendations if needed. The Quality Assurance Committee will consist of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Coordinator, Social Service Director, Dietary Services Manager, and the Activities Director and the Medical Director attending at least quarterly. | 06/28/2014           |                                                   |
| F 323<br>SS=G                                                                   | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | F 323                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                      |                                                   |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185402 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X3) DATE SURVEY COMPLETED<br><br>C<br>06/06/2014 |
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| F 323                                                                           | Continued From page 10<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, and review of the facility's policy and procedure it was determined the facility failed to provide adequate supervision to prevent accidents for one (1) of five (5) sampled residents (Resident #1) during a transfer with a mechanical lift which resulted in a fall with injury to the resident's ribs and head.<br><br>On 05/08/14, Certified Nurse Aide #1 attempted to transfer Resident #1 with a mechanical lift by herself, when the sling gave and she had to lower the resident to the floor. The CNA failed to obtain assistance from another staff member to ensure adequate supervision was provided during the mechanical lift transfer. Resident #1 had complaints of pain in the ribs, head, chest, and legs after the fall and was sent to the hospital and diagnosed with a ninth (9th) rib fracture and contusions to the right shoulder, right hip and head. The resident returned to the facility with an order for Naproxen (anti-inflammatory) 550 mg twice a day for seven (7) days for increased pain management and soft tissue swelling to the posterior skull area. In addition, Resident #1 was receiving Hospice Care and had an order for Roxanol (opiate narcotic pain medication) 20 mg/1 ml sublingual every two (2) hours for pain | F 323                                                            | 1. An observation of Resident #1 with the use of Mechanical lift was made by the Director of Nursing on 06/10/2014 to ensure that the resident was transferred according to the plan of care and with the assist of two (2) for the transfer. All procedures were followed correctly.<br><br>2. An observation of all residents requiring the use of a mechanical lift was made by the Director of Nursing and the Assistant Director of Nursing on 06/10/2014 to ensure that all residents requiring the use of a mechanical lift were done so with the assist of two (2) staff members. All procedures were followed correctly.<br><br>3. Beginning 05/14/2014 and ongoing all nursing staff completed re-education by the Assistant Director of Nursing on the use of mechanical lifts including use of two persons and completing the competency of a return demonstration with no staff working after 06/27/2014 without this re-education. |                                                   |

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| F 323                                                                           | <p>Continued From page 11</p> <p>prior to the fall but did not require the pain medication. Resident #1 complained of pain to the head, chest, ribs and legs and received eighteen (18) doses between 05/09/14 and 05/17/14 after the fall.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Fall Assessment/Intervention Process" revised 09/2013, revealed "Accu-Nurse care plan updated frequently for point of care needs of the resident to ensure safety and accurate care was being delivered."</p> <p>Review of the facility's "Skills Check Off/Return Demonstration" for the Invacare 450/600 Total Lift, dated 06/23/11 revealed "Use number of staff required for the procedure."</p> <p>Record review revealed the facility admitted Resident #1 on 10/17/12 with diagnoses which included Malignant Neoplasm Breast, Anxiety, Dementia, Gastroesophageal Reflux, End Stage Renal Disease, and Trigeminal Neuralgia. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 04/02/14, revealed the facility assessed Resident #1's cognition as moderately impaired with a Brief Interview of Mental Status (BIMS) score of eight (8). The facility assessed the resident to require two (2) person assist for transfers.</p> <p>Review of a facility investigation, dated 05/09/14, revealed CNA #1 was working on second shift and was assigned care for Resident #1. The facility assessed Resident #1 to require a mechanical lift with two (2) person assist for transfers from the bed to the chair and the chair</p> | F 323                                                            | <p>4. Monitoring of the education and skills consists of five (5) resident handling observations with the use of mechanical lifts per week for twelve (12) weeks to assure staff are using the correct level of supervision thee will be completed by the Director of Nursing or Assistant Director of Nursing. All monitoring will be reviewed by the Quality Assurance Committee monthly for further recommendations if needed. The Quality Assurance Committee will consist of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Coordinator, Social Service Director, Dietary Services Manager, and the Activities Director and the Medical Director attending at least quarterly.</p> | 06/28/2014           |                                                   |

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| F 323                                                                           | <p>Continued From page 12</p> <p>to the bed. However, on 05/08/14 at approximately 7:55 PM, CNA #1 attempted to transfer Resident #1 from a wheel chair to the bed unassisted with a mechanical lift when the sling began to shift which resulted in Resident #1 being caught by CNA #1 and lowered to the floor which resulted in injuries to the resident's head and ribs.</p> <p>Review of the Emergency Room Patient Record and Radiology Reports for x-rays of the ribs and CT Scan (Computed Tomography) of the head, dated 05/09/14, revealed the resident sustained a fracture to the right 9th rib and contusions to the head, right shoulder and right hip.</p> <p>Review of the May 2014 Medication Administration Record (MAR) revealed Resident #1 had an order for Roxanol (opiate narcotic pain) 20 mg/1 ml sublingual every two (2) hours, prior to the fall. Further review of the MAR revealed Resident #1 received eighteen (18) doses of the "as needed" Roxanol between 05/09/14 and 05/17/14 for complaints of pain to the head, ribs, chest and leg, which was after the fall on 05/08/14. He/She had not received any "as needed" Roxanol prior to the fall. In addition, the resident had an order to receive Naproxen (anti-inflammatory) 550 mg twice a day for seven (7) days for increased pain management and soft tissue swelling to the posterior skull area</p> <p>Review of the Comprehensive Care Plan titled "Risk for Injury related to Falls", dated 02/11/14, revealed an intervention for Resident #1 to require two (2) staff with a mechanical lift for transfers.</p> <p>Interview with Resident #1's roommate, on</p> | F 323                                                            |                                                                                                                 |                      |                                                   |

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| F 323                                                                           | <p>Continued From page 13</p> <p>06/04/14 at 9:55 AM, revealed he/she recalled Resident #1 lying on the floor after the lift was used to get him/her up.</p> <p>Interview with CNA #1, on 06/04/14 at 11:05 AM and on 06/05/14 at 8:09 AM, revealed she was caring for Resident #1 on 05/08/14 when the incident occurred. She stated CNA #2 was in the room to assist her with the mechanical lift but did not provide any assistance. She stated the lift she used had a sling that fit between the resident's legs and when she started to move the lift back something gave with the sling and the resident began to fall. She stated she caught him/her and lowered the resident to the floor but the resident hit his/her head on the dresser on the way down. CNA #1 revealed after the resident was on the floor, she and CNA #2 assessed the lift to see if they could see anything wrong with it and found nothing to be in non-working order. CNA #1 stated she then proceeded to place Resident #1 back on the lift and transferred him/her to the bed prior to getting the Charge Nurse, (Licensed Practical Nurse (LPN) #1), to assess the resident. CNA #1 revealed after the resident was back in the bed, CNA #1 went to get LPN #1 and told her the resident was complaining of head and chest/rib pain but did not tell the Charge Nurse the resident had fallen. CNA #1 stated LPN #1 assessed the resident and gave the resident some pain medication but did not send the resident to the emergency room for evaluation because she was unaware of the fall and the resident had chronic pain related to malignant breast cancer.</p> <p>Interview with CNA #2, on 06/04/14 at 10:49 AM, revealed she was not in the room when Resident #1 fell on 05/08/14. She stated CNA #1 never</p> | F 323                                                            |                                                                                                                 |                      |                                                   |

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| NAME OF PROVIDER OR SUPPLIER<br><br>HENDERSON NURSING AND REHABILITATION CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2500 NORTH ELM ST.<br>HENDERSON, KY 42420                              |                      |                                                   |
| (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 14</p> <p>asked her for assistance and CNA #1 told her that she had attempted to transfer Resident #1 to the bed when the lift gave and the resident began to fall. CNA #2 revealed CNA #1 said the resident never hit the floor because she had grabbed him/her when he/she began to fall. CNA #2 stated staff was taught to never use a mechanical lift unassisted and to always follow the resident's plan of care.</p> <p>Interview with LPN #1, on 06/04/14 at 2:08 PM, revealed she was unaware of Resident #1 experiencing a fall on 05/08/14 and she did not find out about the fall until 05/09/14. LPN #1 stated CNA #1 had come to her and asked her to come and assess the resident because he/she was complaining of pain in the ribs and in the head. She stated CNA #1 began to question her about the rib and head pain and was wondering if the pain could have been the result of a fall but she never told her the resident had fallen. Additionally, she revealed the resident was in the bed when she went in to assess him/her, so there was no reason for her to suspect the resident had fallen. Further interview, on 06/05/14 at 7:45 AM, revealed CNA #1 had to have been in the resident's room alone because CNA #2 was up the hallway caring for other residents when CNA #1 came to get her to assess the resident.</p> <p>Interview with the Staff Development Coordinator (SDC), on 06/05/14 at 8:23 AM, revealed she had inserviced staff related to the use of a mechanical lift with two (2) staff members and she did not know why CNA #1 would use the lift unassisted to transfer a resident. She stated she had educated staff related to waiting for assistance or asking the resident to wait to be transferred until staff was available to assist with the transfer.</p> | F-323                                                            |                                                                                                                 |                      |                                                   |

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

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FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185402 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                            |                      | (X3) DATE SURVEY COMPLETED<br><br>C<br>06/06/2014 |
|---------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>HENDERSON NURSING AND REHABILITATION CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2500 NORTH ELM ST.<br>HENDERSON, KY 42420                              |                      |                                                   |
| (X4) ID PREFIX TAG                                                              | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID PREFIX TAG                                                    | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |                                                   |
| F 323                                                                           | Continued From page 15<br><br>Interview with Assistant Director of Nursing, on 06/06/14 at 1:07 PM, revealed every staff member was inserviced related to following the resident's plan of care and the proper use of the mechanical lift. She was unable to explain why CNA #1 attempted to transfer Resident #1 with a mechanical lift unassisted.<br><br>Interview with the Director of Nursing (DON), on 06/06/14 at 2:41 PM, revealed CNA #1 told her she was trying to save time when she used the mechanical lift unassisted for Resident #1 and the CNA did not provide adequate supervision for the transfer. | F 323                                                            |                                                                                                                 |                      |                                                   |