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

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185148	A. BUILDING B. WING	C 02/29/2012

RECEIVED
MAR 21 2012
Division of Health Care
Southern Enforcement Branch

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSBURG HEALTH AND REHABILITATION CENTER	287 N ELEVENTH ST, P O BOX 719 WILLIAMSBURG, KY 40769

(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 abbreviated standard survey (KY17914) was initiated on 02/28/12 and concluded on 02/29/12. The allegation was substantiated and deficient practice was identified with the highest scope and severity at "D" level.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of policies it was determined the facility failed to ensure services were provided in accordance with the resident's plan of care for one of three sampled residents (Resident #1). The facility developed a care plan for Resident #1 that required two staff persons to assist the resident with transfers because the resident was unable to perform activities of daily living independently. On 02/22/12, State Registered Nurse Aide (SRNA) #1 attempted to transfer Resident #1 unassisted from the resident's bed to a chair. The resident's knees weakened and the SRNA lowered the resident to the floor. (Refer to F323.) The findings include: A review of the facility policy entitled Comprehensive Care Plan Policy (undated) revealed comprehensive care plans ensured that	F 282	See Attached	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Michelle Jacboe, Administrator 3/19/12

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

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F 282	Continued From page 1 staff was applying current standards of practice and allowed the nursing facility to make every reasonable attempt at preventing avoidable decline in resident functioning/functional levels. The policy stated the care plan would contain all problems that pertained to the resident, a stated goal related to the problem, as well as approaches to assist staff and the resident in meeting the stated goal. An interview with SRNA #4 on 02/28/12, at 4:45 PM, with SRNA #6 on 02/28/12, at 4:55 PM, with SRNA #3 on 02/29/12, at 10:15 AM, and with SRNA #2 on 02/29/12, at 2:45 PM, revealed residents' Kardexes were kept at the nurses' station in the care plan book and were readily available for staff to use as a reference on how to provide care for residents. An observation of Resident #1 on 02/29/12, at 2:15 PM, revealed the resident required the assistance of two staff persons when transferring from a wheelchair to recliner and required assistance and verbal cues when being assisted with ambulation. A review of Resident #1's medical record revealed the facility admitted Resident #1 on 09/26/10, with the following diagnoses: Alzheimer's Dementia, Insomnia, Osteoporosis, and Chronic Arthralgia. A review of Resident #1's care plan, dated 11/25/11, revealed the facility identified that the resident was unable to perform activities of daily living independently secondary to physical limitations of osteoporosis and "mental errors" of Alzheimer's Dementia. According to the care	F 282		

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F 282	Continued From page 2 plan, Resident #1 required extensive assistance with transfers and ambulation. A review of the Kardex for Resident #1 revealed the resident required the assistance of two staff persons for transfers and ambulation. A review of the nurse's notes revealed on 02/22/12, at 2:00 PM, while Resident #1 was being transferred from bed to a recliner, the resident's knees became weak, and the resident was lowered to the floor on his/her knees. A review of the facility's investigation of the incident revealed on 02/22/12, SRNA #1 transferred Resident #1 from bed to a recliner chair without the assistance of another staff member. During the transfer, the resident's knees became weak and the SRNA lowered the resident to the floor. The investigation revealed the SRNA stated she knew she was required to follow the resident's Kardex, but she did not have time to look at the Kardex. Resident #1's care plan also revealed the resident was lowered to his/her knees in a kneeling position in front of the resident's recliner. An interview on 02/29/12, at 10:00 AM, with Licensed Practical Nurse (LPN) #1 revealed the incident was reported to her on 02/22/12, and she reported the incident to the Director of Nursing. The LPN further stated Resident #1 required two persons to assist with transfers and it was reported that SRNA #1 transferred the resident without assistance. During an interview on 02/29/12, at 11:15 AM, SRNA #1 revealed she was aware Resident #1	F 282		

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F 282	Continued From page 3 required the assistance of two individuals when transferring but on 02/22/12, had attempted to transfer the resident unassisted. The SRNA stated she was providing incontinence care for Resident #1 and had assisted the resident to a sitting position on the side of the bed. However, according to SRNA #1, when the resident would not lie back down in bed the SRNA attempted to transfer the resident to a chair. An interview with the Director of Nursing on 02/29/12, at 4:30 PM, revealed SRNA #1 reported she attempted to transfer Resident #1 by herself from the resident's bed to a chair. The DON stated the SRNA was aware Resident #1 required two persons to assist the resident with transfers.	F 282		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of facility policies, and a review of the facility's investigation it was determined the facility failed to ensure one of three residents (Resident #1) received adequate supervision to prevent accidents. Resident #1 was assessed by the facility to require the assistance of two staff	F 323	See Attached	

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F 323	Continued From page 4 persons for transfer. The facility developed a care plan that also stated the resident required the assistance of two staff persons for transfer. On 02/22/12, State Registered Nurse Aide (SRNA) #1 attempted to transfer Resident #1 without the assistance of another staff member. Resident #1's knees became weak and the SRNA lowered the resident to the floor. The findings include: A review of the facility policy entitled Comprehensive Care Plan (CCP) Policy (undated) revealed comprehensive care plans ensured that staff was applying current standards of practice and allowed the nursing facility to make every reasonable attempt at preventing avoidable decline in resident functioning/functional levels. A review of the Falls Prevention Program Policy (undated) revealed the purpose of the policy was to identify all residents who were at high risk for falls and to put interventions in place to limit or eliminate risks for residents who were identified as high risk. An interview with SRNA #4 on 02/28/12, at 4:45 PM, with SRNA #6 on 02/28/12, at 4:55 PM, with SRNA #3 on 02/29/12, at 10:15 AM, and with SRNA #2 on 02/29/12, at 2:45 PM, revealed residents' Kardexes were kept readily available in a care plan book at the nurses' station. The SRNAs stated the Kardex contained information on the care needs each resident required. An observation on 02/29/12, at 2:15 PM, of Resident #1 revealed the resident required the	F 323		

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F 323	Continued From page 5 assistance of two staff persons when transferring from the wheelchair to a recliner with verbal cues and assistance of two for ambulation. A review of Resident #1's medical record revealed the facility admitted the resident on 09/26/10, with the following diagnoses: Alzheimer's Dementia, Insomnia, Osteoporosis, and Chronic Arthralgia. A review of the comprehensive assessment for Resident #1, dated 08/25/11, revealed the resident required extensive assistance of two staff persons for all transfers. Additional review revealed Resident #1 required two staff persons to assist the resident with ambulation related to being at risk for falls. On the Quarterly Minimum Data Set Assessment, dated 02/20/12, the resident was assessed to require the total assistance of two staff persons for transfers and the extensive assistance of two staff persons for ambulation. Resident #1's care plan, dated 11/25/11, revealed the facility identified the resident was unable to perform activities of daily living independently secondary to physical limitations of osteoporosis and "mental errors" of Alzheimer's Dementia. According to the care plan, Resident #1 required extensive assistance with transfers and ambulation. Resident #1's Kardex revealed the resident required two staff persons to assist with transfers and with ambulation. A review of the nurse's notes revealed on 02/22/12, at 2:00 PM, while Resident #1 was being transferred from the bed to a recliner, the resident's knees weakened and the resident was	F 323		

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F 323	Continued From page 6 lowered to the floor. A review of the facility's investigation of the incident revealed on 02/22/12, SRNA #1 transferred Resident #1 from bed to a recliner chair without the assistance of another staff member. During the transfer, the resident's knees became weak and the SRNA lowered the resident to the floor. The investigation revealed the SRNA knew she was required to follow the resident's Kardex but she did not have time to look at the Kardex. Resident #1's care plan also revealed the resident was lowered to his/her knees in a kneeling position in front of the resident's recliner. An interview with SRNA #1 on 02/29/12, at 11:15 AM, revealed on 02/22/12, she attempted to transfer Resident #1 unassisted. SRNA #1 stated she was aware the resident required the assistance of two individuals when transferring and "knew better" than to transfer the resident unassisted. The SRNA stated she was providing incontinence care for Resident #1 and had assisted the resident to the side of the bed. When the resident would not lie back down in bed the SRNA attempted to assist the resident to a chair. An interview on 02/29/12, at 10:00 AM, with Licensed Practical Nurse (LPN) #1 revealed Resident #1 required the assistance of two staff persons for transferring. The LPN stated she was notified SRNA #1 transferred Resident #1 without assistance on 02/22/12. The LPN stated she notified the Director of Nursing of the incident.	F 323		

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F 323	Continued From page 7 An interview with the Director of Nursing (DON) on 02/29/12, at 4:30 PM, revealed SRNA #1 reported she attempted a transfer of Resident #1 unassisted from bed to a chair. The DON stated she asked SRNA #1, "Do you not realize the resident is a two-person assist?" and the SRNA stated, "Yes."	F 323		

Williamsburg Health and Rehabilitation Center

Plan of Correction

March 19, 2012

F282

1. Resident # 1 is being transferred with the assistance of two staff members as assessed in accordance with the written plan of care. This information is readily available to all nursing staff in the care plan in resident # 1's record and in the kardex. MD and family aware.
2. All residents were reviewed and re-assessed to determine the proper amount of assistance required for transfers. The written plan of care and kardex of each resident has been reviewed to ensure accuracy. No irregularities were found.
3. An inservice was conducted by Director of Nursing and Clinical Coordinators on 2/22/12-2/27/12 with all nursing staff on following the plan of care/kardex when providing care and notifying the charge nurse or clinical coordinator if care needs have changed. The staff were also educated regarding transfer techniques, including the importance of utilizing the appropriate number of staff or devices required for transferring. Staff were also observed performing transfers to ensure proper techniques and appropriate number of staff were used for assistance.
4. The QA committee designee(clinical coordinator and in her absence the Director of Nursing) will select 6 charts at random to review care plan and kardex to ensure that the appropriate amount of assistance for transfers has been assessed appropriately. Observations will be conducted on the selected residents to ensure the appropriate number of staff are providing assistance. These audits/observations will be documented by the QA designee and will be conducted on a weekly basis for one month, then monthly for the next quarter. Any identified concern will be corrected immediately and reported to the QA committee for further follow-up and review.
5. Completion date: March 1st 2012

Williamsburg Health and Rehabilitation Center

Plan of Correction

March 19th, 2012

F323

1. Resident # 1 is receiving adequate supervision to prevent accidents. Resident # 1 is being transferred with assistance of two staff members as assessed and per the written plan of care. This information as well as that resident # 1 is a fall risk is readily available to all nursing staff in the care plan on the resident's record and in the kardex. MD and family aware.
2. All residents were reviewed and re-assessed to determine the proper amount of assistance required for transfers as well as ensuring that each was identified as fall risk as needed to ensure adequate supervision is followed through . The written plan of care and kardex of each resident has been reviewed to ensure accuracy. No irregularities were found.
3. An inservice was conducted by Director of Nursing and Clinical Coordinators on 2/22/12-2/27/12 with all nursing staff on following the plan of care/kardex as well as how to identify when a resident is a fall risk ,when providing care and ensuring adequate supervision to prevent accidents. The staff was also educated on proper transfer techniques, including using the appropriate amount of staff or devices required for transferring. Staff was also observed performing transfers to ensure proper techniques and appropriate number of staff were used for assistance.
4. The QA committee designee (clinical coordinator and in her absence Director of Nursing) will select 6 charts at random to review care plan and kardex to ensure that the appropriate amount of assistance for transfers has been assessed properly and that all have been assessed to identify any resident that is a fall risk to ensure adequate supervision to prevent accidents. Observations will be conducted on the selected residents to ensure the appropriate number of staff are providing assistance. The audits/observations will be documented by the QA designee and will be conducted on a weekly basis for one month, then monthly for the next quarter. Any identified concern will be corrected immediately an reported to the QA committee for further follow-up and review.
5. Completion date: March 1st 2012