

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

PRINTED: 08/26/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/12/2011
NAME OF PROVIDER OR SUPPLIER MORGANTOWN CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTH WARREN STREET MORGANTOWN, KY 42261		
(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 survey (KY #16876) was conducted on 08/10/11 through 08/12/11 to determine the facility's compliance with Federal requirements. The facility was not in compliance with Federal regulations with deficiencies cited at the highest S/S of "G." KY #16876 was substantiated with deficiencies cited related to the allegation.	F 000	Morgantown Care and Rehab Center does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves the right 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 right 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 wavier 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 or compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

J. J. Clark

TITLE

NHA

(X6) DATE

9/23/11

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 157	<p>Continued From page 1</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy/procedure and interviews, it was determined the facility failed to notify the physician for one resident (#2), in the selected sample of three (3), related to the need to alter treatment. On 08/10/11 at 1:30 PM, Resident #2 was observed to be in his/her bed crying, moaning and groaning with leg pain. The resident stated he/she was scheduled to receive pain medication at 12:00 PM (noon) and did not receive it. The physician was not notified to obtain an order for administration of the medication, and Resident #2 did not receive his/her pain medication until 2:12 PM on 08/10/11.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure, "Medication Administration," dated 12/20/10, revealed "if the resident refused medication, indicate the failure to administer medication on the administration record and in the nurse's clinical notes. Counsel the resident on the potential danger to himself/herself if medication was refused. In the nurse's clinical notes, document the refusal, the reason and the counseling. Notify the physician timely of the refusal as the medication indicated."</p>	F 157	<ol style="list-style-type: none"> 1. Resident #2's physician was notified of resident receiving Lortab and Ativan after scheduled time on 8/10/11. No new orders were received at this time. The Director of Nursing was notified of the medication administration on 8/10/11 and LPN in question was suspended pending investigation. Resident was assessed for pain following administration of his/her pain medication with no further complaints of pain reported. On 8/11/11 resident was seen by physician with no new orders at that time. On 8/12/11, LPN in question was terminated based on falsification of documentation. 2. A 100% resident audit was completed by the DON, ADON, and Charge Nurse on 08/12/11 to ensure that current pain regimen was effective for residents. No other concerns were identified. 	09/16/11	

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F 157	<p>Continued From page 2</p> <p>A record review revealed Resident #2 was admitted to the facility on 06/18/10 with diagnoses to include Diabetes Mellitus, Polyneuropathy, Anxiety and Neck Pain.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 05/17/11, revealed the resident received a Brief Interview of Mental Status (BIMS) score of "15". Resident #2 was cognitively intact. The resident was assessed with severe pain daily and received scheduled pain medication.</p> <p>A review of the physician's order, dated 08/11, revealed an order for "Hydrocodone Bit/Acetaminophen 10/325 milligrams (mg) one tablet by mouth (po) at bedtime (HS) as needed (prn), Fentanyl 12 microgram (mcg)/hour (hr) patch one every three days with 25 mcg to equal 37 mcg, Fentanyl 25 mcg/hr one patch every three days with 12 mcg to equal 37 mcg, Lidoderm 5% patch - apply three (3) patches topically to back/hips daily for pain, and Hydrocodone/Acetaminophen 10/325 mg one tablet po every six hours for pain."</p> <p>An observation of Resident #2, on 08/10/11 at 1:30 PM, revealed Resident #2 was lying on his/her right side in the bed tearful, moaning, groaning and complaining about his/her legs hurting. The resident stated "I've asked for something for my legs. I told the nurse around 1:00 PM that I needed my Ativan and my pain pill. My pain pill is due at 12:00 PM (noon) and she did not bring it to me." At 1:32 PM, it was reported to Licensed Practical Nurse (LPN) #3, by the surveyor, that the resident complained about pain in his/her legs and requested his/her "nerve</p>	F 157	<p>3. An in-service was provided to licensed staff on 08/12/11 by the Staff Development Coordinator and the Evening Supervisor in regards to pain management, physician notification and medication administration. A 100% monthly pain audit will be conducted by DON and/or designee to ensure that each resident's pain regimen is effective.</p> <p>4. Director of Nursing and/or designee will report findings of above stated audits to the Administrator and Quality Assurance committee monthly X 3 months. A performance improvement plan and education will be initiated as indicated.</p>		

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F 157	<p>Continued From page 3</p> <p>pill." LPN #3 stated the resident's nurse was made aware he/she needed pain medication and a nerve pill. At 1:52 PM, Resident #2 continued to moan and groan about the pain in his/her legs. The resident moved his/her legs in the bed underneath the sheet and his/her legs were observed to move in a jerking motion. At 1:56 PM, the resident pushed his/her call light and continued to moan and cry. At 1:56 PM, Certified Nurse Aide (CNA) #8 answered the resident's call light. The resident informed the CNA he/she needed to get up to go to the desk and get his/her pain pill. CNA #8 informed Resident #2 she needed to get another CNA to assist her to get him/her up to the wheelchair. At 2:00 PM, CNA #8 and CNA #9 transferred the resident with a gait belt to his/her wheelchair, then took him/her to the bathroom. At 2:08 PM, LPN #4 was informed, by the surveyor, about the resident's request for pain medication. At 2:11 PM, the CNAs assisted the resident to the nurses' desk. LPN #4 revealed she was the nurse who provided care for the resident, and she administered Lorlab and Ativan to the resident at 2:12 PM.</p> <p>An interview with LPN #4, on 08/12/11 at 10:10 AM, revealed she administered medication on 08/10/11. She stated she attempted to administer medication to the resident earlier when he/she was on the way to the dining room for lunch. LPN #4 stated the resident asked her to wait awhile to administer his/her medication. She further stated, "the other nurse told me when I sat down, that Resident #2 wanted his/her pain medication. I did not notify his/her physician to get an order to administer pain medication and I should have done that. I realize, now, I gave the medication one hour and ten minutes late."</p>	F 157			

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F 157	Continued From page 4	F 157		
F 281 SS=D	<p>An interview with the Director of Nursing (DON), on 08/12/11 at 8:28 AM, revealed nurses have one hour before or after the scheduled time to administer the resident's medication. The nurse should have notified the physician when she administered Resident #2's pain medication outside the scheduled time frame.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy/procedure and interviews, it was determined the facility failed to ensure one resident (#2), in the selected sample of three (3), was provided services which meet professional standards of quality. On 08/10/11 at 2:10 PM, Hydrocodone/Acetaminophen (pain medication) 10/325 milligram (mg) one tablet was administered to Resident #2; however, the medication was scheduled to be administered at 12:00 PM (noon).</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure, "Medication Administration," dated 12/10, revealed "medications were administered only as ordered by the physician."</p> <p>A record review revealed Resident #2 was admitted to the facility on 06/18/10 with diagnoses</p>	F 281	<ol style="list-style-type: none"> 1. Resident #2's physician was notified of resident receiving Lortab and Ativan after scheduled time on 8/10/11. No new orders were received at this time. The Director of Nursing was notified of the medication administration on 8/10/11 and LPN in question was suspended pending investigation. Resident was assessed for pain following administration of his/her pain medication with no further complaints of pain reported. On 8/11/11 resident was seen by physician with no new orders at that time. On 8/12/11, LPN in question was terminated based on falsification of documentation. 2. A 100% resident audit was completed by the DON, ADON, and Charge Nurse on 08/12/11 to ensure that current pain regimen was effective for residents. No other concerns were identified. 	09/16/11

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F 281	<p>Continued From page 5 to include Diabetes Mellitus, Polyneuropathy, Anxiety and Neck Pain.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 05/17/11, revealed the resident received a Brief Interview of Mental Status (BIMS) score of "15". Resident #2 was cognitively intact. The resident was assessed with severe pain daily and received a scheduled pain medication.</p> <p>A review of the physician's orders, dated 08/11, revealed "Hydrocodone/Acetaminophen 10/325 milligrams (mg) one tablet by mouth (po) every six hours for pain." Scheduled times were at 12:00 AM, 6:00 AM, 12:00 PM and 6:00 PM.</p> <p>An observation of Resident #2, on 08/10/11 at 1:30 PM, revealed he/she was in bed on his/her right side. The resident was tearful, moaning, groaning and complaining about his/her legs hurting. He/she stated "I've asked for something for my legs and told the nurse, around 1:00 PM, that I needed my Ativan and my pain pill. My pain pill was due at 12:00 PM (noon) and she did not bring it to me." At 2:11 PM, Certified Nurse Aides (CNAs) #8 and #9 assisted the resident to the nurses' desk.</p> <p>An interview with LPN #3, on 08/12/11 at 9:49 AM, revealed she was informed by the CNAs about the resident's request for pain medication. She stated she informed the resident's nurse (LPN #4) after the CNAs told her about Resident #2's complaint of pain.</p> <p>An interview with LPN #4, on 08/12/11 at 10:10 AM, revealed she administered medications on</p>	F 281	<p>3. An in-service was provided to licensed staff on 08/12/11 by the Staff Development Coordinator and the Evening Supervisor in regards to pain management, physician notification and medication administration. A 100% monthly pain audit will be conducted by DON and/or designee to ensure that each resident's pain regimen is effective.</p> <p>4. Director of Nursing and/or designee will report findings of above stated audits to the Administrator and Quality Assurance committee monthly X 3 months. A performance improvement plan and education will be initiated as indicated.</p>	

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F 281	Continued From page 6 08/10/11. She stated she attempted to administer the resident's medication around lunchtime; however, the resident asked her to wait awhile to give him/her the medication. LPN #4 continued the medication pass and intended to administer Resident #2's medication as the resident returned from lunch; however, the LPN revealed she was in another resident's room and had problems with a flush. She completed paperwork to send that resident to the hospital, and that was when she realized she did not administer Resident #2's medication. She stated, "The other nurse told me when I sat down that Resident #2 requested his/her medication. I realize, now, I administered the resident's Lortab and Ativan at 2:12 PM, one hour and ten minutes late. I did not assess the resident's pain or notify the physician for an order to administer pain medication. There should be documentation on the Medication Administration Record (MAR) related to the actual time the medication was administered and not just initial the box." An interview with the Director of Nursing (DON), on 08/12/11 at 8:28 AM, revealed nurses have one hour before or after the scheduled time to administer the resident's medication. The nurse should have notified the physician when she administered Resident #2's pain medication outside the scheduled time frame.	F 281			
F 323 SS=G	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.	F 323	1. Upon return from hospital, Resident #1 was assessed by Director of Nursing on 8/11/11 for the safe use of the mechanical lift and determined the risks and benefits for the resident.	09/16/11	

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F 323	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interview, review of facility policy, manufacturer instructions, and record review, it was determined the facility failed to ensure the resident's environment remained as free of accident hazards as possible and failed to ensure adequate supervision was provided to prevent accidents for one resident (#1), in the selected sample of three (3) residents. The facility utilized sit to stand and full body mechanical lifts for resident transfers. The facility failed to assess the resident for the safe use of the mechanical lift and determine the risk and benefits for the resident. This failure resulted in Resident #1 sustaining a fractured right femur (thigh bone), during an assisted transfer using the sit-to-stand lift, on 08/01/11. The findings include: A review of the facility's policy and procedure, entitled "Incident Reporting," dated 12/10, revealed "It is the intent of this facility to provide a safe and healthful work environment. This facility shall ensure the resident's environment shall remain as free of accident hazards as possible, and each resident shall receive adequate supervision and assistive devices which shall reduce accidents. An incident report is to be completed for all falls, bruises and skin tears of known or unknown origin, resident-to-resident altercations, resident to employee altercations,	F 323	2. On 8/11/11, assessments of residents utilizing lifts were initiated and completed by the Director of Nursing to ensure the residents safety and to determine the risks and benefits for each resident. 3. An in-service regarding the safety and use of a sit-to-stand lift was provided to the nursing staff on 08/01/11, 08/08/11, 08/09/11, 08/10/11, 08/11/11, 08/20/11, 08/21/11, 08/22/11 and 08/23/11 by the Staff Development Coordinator and the Evening Supervisor. The lift safety audit was added to the monthly maintenance checklist and will be completed by Maintenance Director and/or Central Supply Director. Findings will be forwarded to the Administrator for follow-up as needed. Residents who require the use of a mechanical lift will be assessed by a licensed nurse regarding lift safety upon admission and/or with a significant change in functional status. Findings will be documented in nursing progress notes. 4. Director of Nursing and/or designee will report findings of above stated audits to the Administrator and Quality Assurance committee monthly X 3 months. A performance improvement plan and education will be initiated as indicated.	09/16/11	

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F 323	<p>Continued From page 8</p> <p>medication errors or any other atypical occurrence. Incident and occurrence will be reported to the department supervisor."</p> <p>A review of the manufacturer's "Operating and Product Care Instructions," dated 06/03, revealed the need to attach and tighten the (calf) strap around the lower legs, just below the knees. Further review of the guide revealed a "caution" statement, which stated, "Only use after a satisfactory professional assessment has been carried out on the individual resident. An assessment must be made as to whether the resident required the lower leg straps. Apply these if necessary."</p> <p>A review of the "Fall/Change in Functional Status" note, dated 08/01/11, no time listed, revealed Resident #1 was assisted up by the staff and a mechanical lift (sit to stand). The resident slid out of the lift pad and fell onto the floor. The resident complained of right leg pain and stated it popped twice. The right leg exhibited external rotation. After the fall, the resident was transported to the hospital and returned to the facility, on 08/10/11, with diagnoses of a "Right Femur fracture" and severe Osteoporosis. Proximal and distal fixations screws were used for internal fixation of the previously described spiral fracture in the distal third of the right femur with minimal comminution.</p> <p>An interview with Resident #1, on 08/11/11 at 9:22 AM, revealed the staff put the strap behind the resident and pulled the resident to the edge of the bed. The resident held onto the bar once the strap was in place. The resident stated he/she could bear a little weight on the right leg. The</p>	F 323			

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F 323	<p>Continued From page 9</p> <p>resident stated staff had never used the leg strap before and the resident told them to push his/her leg in the knee support. Per interview, the resident got too close to the edge of the bed and slid down to the floor. The resident's leg went to the right and he/she heard a "pop." The resident stated he/she did not remember anything else, and "blacked out."</p> <p>An interview with Certified Nurse Aide (CNA) #1, on 08/10/11 at 4:09 PM, revealed she and CNA #2 were in Resident #1's room to get him/her out of bed. She stated they got the resident up with the sit to stand mechanical lift and the resident told them his/her catheter was not in the right position. She stated when they raised the resident in the mechanical lift, Resident #1's leg slipped out of the bottom leg holder. CNA #1 stated she did not use a leg strap on the resident at the time. She realized they were not able to get his/her leg back in the support and the resident had to be lowered to the floor. The resident stated his/her leg popped, but nothing was heard. She stated they reviewed the resident's care plan to know how they were supposed to lift the resident, and they used the sit to stand mechanical lift with the resident as indicated on the plan of care.</p> <p>An interview with CNA #2, on 08/10/11 at 4:27 PM, revealed she was in the room with CNA #1, on 08/01/11 at 5:30 AM, to get Resident #1 out of bed. She stated they assisted the resident up in the sit to stand mechanical lift and tried to adjust the position of his/her catheter. CNA #2 stated the sit to stand lift had knee supports and when she looked down, one of the resident's legs was out of the support. The resident told the CNAs</p>	F 323			

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F 323	<p>Continued From page 10</p> <p>his/her leg popped and asked them if they heard it. They each stated, "we did not hear anything." Afterwards, Resident #1 became weak and he/she let go of the mechanical lift handles and his/her arms went up. She stated, at that point, she realized they needed to get the resident back on the bed, but they were not able to do so. The resident was too heavy and was lowered to the floor. The resident's leg was out in the front of the lift and did not go to the side. CNA #2 stated she went to the door and called for the nurse.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 08/11/11 at 10:10 AM, revealed she was the nurse on duty, at the time of the fall. She stated she entered the resident's room and observed Resident #1 in the floor, with the lift out in front of him/her. Resident #1's back was against the bed. The CNAs stated the resident complained the catheter tubing was twisted or something was not right with it. They tried to get it straight and the resident's leg popped out of the knee support. The CNAs were not able to get him/her back in the bed and they lowered Resident #1 to the floor. Resident #1 complained of real bad pain in his/her leg and swelling was noted in his/her right ankle. His/her right leg was turned outward and LPN #1 notified the physician and family of the incident. Additional staff were called to the floor to assist the resident to bed. There were 4 or 5 staff on the unit to assist the resident to bed while the ambulance was notified. She stated physical therapy usually completed an assessment on the resident to determine if a mechanical lift needed to be used. The therapist put the intervention on the care plan and obtained a physician's order.</p>	F 323		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/26/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/12/2011
NAME OF PROVIDER OR SUPPLIER MORGANTOWN CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTH WARREN STREET MORGANTOWN, KY 42261		
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F 323	<p>Continued From page 11</p> <p>An interview with Resident #1's Power of Attorney (POA), on 08/12/11 at 11:39 AM, revealed she was contacted by the facility staff, on 08/01/11, between 5:30 AM and 6:00 AM. She was told Resident #1 fell out of the lift, and when she arrived to the facility, the resident was already in the ambulance. The POA revealed Resident #1 told her they let him/her fall and also revealed the resident did not have any previous falls. She stated "if the staff positioned the lift right up against his/her right leg, then the resident should not have any problems." She felt the staff were in a hurry to use the lift and stated, "that lift was used between the three floors."</p> <p>A record review revealed Resident #1 was admitted to the facility on 07/13/06, and readmitted on 10/27/08, with diagnoses to include Status Post Left Above the Knee Amputation, Status Post Cerebrovascular Accident with Left Sided Deficit (left sided weakness) and Diabetes Mellitus Type II.</p> <p>A review of the resident's quarterly Minimum Data Set (MDS), dated 06/29/11, revealed the facility assessed the resident to require extensive assistance of two plus persons for bed mobility and total assistance of two plus persons for transfers.</p> <p>A review of the Comprehensive Care Plan, revision date of 02/11/11, and last updated on 06/29/11, revealed the facility identified the resident was at risk for a fall related injury with interventions which included the use of the mechanical lift (sit-to-stand lift) with all transfers. The comprehensive care plan indicated to use the mechanical lift with all transfers; however, it</p>	F 323			

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F 323	<p>Continued From page 12</p> <p>did not indicate the amount of staff required to assist the resident with transfers.</p> <p>Further review of the record revealed there was no evidence of an assessment to determine if the resident was safe in the use of the sit to stand mechanical lift, prior to or after the 08/01/11 incident.</p> <p>An interview with the Assistant Director of Nursing (ADON), on 08/10/11 at 5:09 PM, revealed there was no policy to evaluate residents for the safe use of a mechanical lift. She stated if a resident was able to bear 20% of his/her weight, then the sit to stand mechanical lift was used with the resident, if he/she wanted to do so. Additionally, she stated if a resident was bed bound or could not do anything for himself/herself, then the full body mechanical lift was used. She stated Resident #1 was evaluated by therapy and he/she only used a particular sit to stand mechanical lift.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 08/11/11 at 10:10 AM, revealed physical therapy usually completed an assessment on the resident to determine if a mechanical lift needed to be used. The therapist put the intervention on the care plan and obtained a physician's order.</p> <p>However, an interview with the Physical Therapy Assistant (PTA), on 08/11/11 at 1:02 PM, revealed therapy evaluated residents and if there was a need for a lift, then the issue was suggested and discussed with the MDS Coordinator. The MDS Coordinator worked to get that intervention on the resident's care plan. She stated the therapy did not assess the resident for</p>	F 323			

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F 323	<p>Continued From page 13</p> <p>the safe use of a lift. She revealed that was the responsibility of the nurses.</p> <p>An interview with Registered Nurse (RN) #1, on 08/11/11 at 3:54 PM, revealed she thought a lift assessment was completed through the care plan process. The type of lift used was discussed with the resident and family, but was not exactly sure how the process worked.</p> <p>An interview with Director of Nursing (DON), on 08/11/11 at 12:25 PM, revealed there was no actual assessment the facility conducted for the lift and there was no device assessment policy. She stated it was a nursing judgement as to which lift was used for a resident. If there was a question about the resident's ability to participate in a transfer, if the resident was heavy or combative, then a full body lift was used. If a resident could bear weight and participated in the transfer, then they used the sit to stand lift. If a resident's status changed, then the staff would not use the sit to stand mechanical lift for a resident. She revealed Resident #1 used the sit to stand mechanical lift since she started there. The resident did not have much upper body strength and he/she was not able to transfer with two staff and a gait belt. The resident was informed the lift would be used with him/her. When the sit to stand mechanical lift was used, the resident became off balance due to his/her amputation. Resident #1 refused to use a full body mechanical lift. Therapy was involved with his/her care and worked to improve his/her transfer status. Per interview, it was determined the sit to stand lift was no longer safe for Resident #1.</p>	F 323			

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F 323	<p>Continued From page 14</p> <p>An interview with the Maintenance Assistant, on 08/12/11 at 8:08 AM, revealed he checked the mechanical lifts once the staff completed a work order. He stated after Resident #1 fell on 08/01/11, the sit to stand mechanical lift was removed from the floor because the buckle for the left leg strap was off. The part was ordered by the central supply manager and he replaced the buckle of the knee support. The Maintenance Assistant stated he put the sit to stand mechanical lift back on the floor for use on 08/04/11.</p> <p>An interview with the Quality Assurance representative of the lift manufacturer, on 08/12/11 at 10:55 AM, revealed the inservice on the product was to be completed by the sales representative. They were responsible for inservicing the facility staff on who can use the lift and who could not use the lift. The lift came equipped with leg straps when it was ordered. The straps could be used with the resident, depending on the condition of the resident.</p> <p>However, an interview with the Staff Development Coordinator (SDC), on 08/11/11 at 8:29 AM, revealed she was responsible for training the CNAs and ensured they knew how to use the lifts. She stated, during the training, she went over the manual for the specific mechanical lift and completed a demonstration with the lift. When CNAs were hired, they were to be checked off on the mechanical lifts for competency. The SDC observed the CNAs the majority of the time when using the lifts on the floor. If she observed the CNAs operate the mechanical lift incorrectly, then she immediately intervened and provided education to the CNAs at that time. She revealed</p>	F 323		
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F 323	<p>Continued From page 15</p> <p>if the resident was able to bear 20% of his/her weight, the sit to stand mechanical lift could be used with the resident. She stated if extra security was needed or desired for the residents, then the CNAs could use the leg straps.</p> <p>A review of "CNA Skills Competency," revealed CNA #1 demonstrated proficiency on the use of the "lifts" on 07/22/11, and CNA #2 demonstrated proficiency on the use of the "lifts" on 06/30/11.</p> <p>The facility provided no evidence of an investigative report for Resident #1's incident, which occurred on 08/01/11. The Administrator informed the surveyor, on 08/11/11 at 5:00 PM, the facility did investigate the incident and the incident report, as well as interviews with the staff, were attached to the incident report and they were considered a part of the facility's Quality Assurance program. The Administrator stated she was unable to determine a cause of the incident.</p>	F 323		
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