

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

PRINTED: 03/12/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185382	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2014
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 47 MARGO AVENUE BARDWELL, KY 42023		
(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)	(X6) COMPLETION DATE	
F 000	INITIAL COMMENTS An Abbreviated Survey investigating complaint #KY21339 was conducted on 02/26/14 through 02/27/14 to determine the facility's compliance with Federal requirements. #KY21339 was substantiated with past non-compliance deficiencies cited at the highest S/S of a "G". On 08/23/13, an order was obtained for Resident #1 to have bilateral leg rests with a leg cradle (foot buddy) on the wheelchair to improve positioning and to reduce the risk of injury. On 02/11/14, the facility failed to ensure the leg cradle was in place while the resident was sitting in the wheelchair. At approximately 8:15 AM, Licensed Practical Nurse (LPN) #1 attempted to transport the resident, by wheelchair, out of the dining room. The resident's feet were caught under the wheelchair, causing the resident to fall forward onto the floor. Resident #1 was transported to the hospital and was diagnosed to have a laceration with facial trauma and hematoma, and nasal fracture as a result of the facility's failure to provide assistance devices to prevent accidents.	F 000			
F 282 SS=G	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 interview, record review, and review of the facility's Care Plans policy/procedure and the	F 282	Past noncompliance; no plan of correction required.		

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

TITLE

(X6) DATE

D Sharon Cagle

Administrator

3/18/14

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	<p>Continued From page 1</p> <p>Hospital Discharge Summary, it was determined the facility failed to ensure services were provided by qualified persons in accordance with each resident's written plan of care for one (1) of three (3) sampled residents (Resident #1).</p> <p>On 08/23/13, an order was obtained and placed on the Comprehensive Care Plan for Resident #1 to have bilateral leg rests with a leg cradle (foot buddy) on the wheelchair to improve positioning and to reduce the risk of injury. On 02/11/14, the facility failed to ensure the leg cradle was in place while the resident was sitting in the wheelchair. At approximately 8:15 AM, Licensed Practical Nurse (LPN) #1 attempted to transport the resident, by wheelchair, out of the dining room. The resident's feet were caught under the wheelchair, causing the resident to fall forward onto the floor. Resident #1 was transported to the hospital and was diagnosed to have laceration with facial trauma and hematoma, and nasal fracture.</p> <p>The findings include:</p> <p>Review of the facility's "Care Plans" policy/procedure, last revised 01/02/14, revealed the purpose of the policy was to provide necessary care and services to attain or maintain the patient's highest practicable physical, mental, and psychosocial well being.</p> <p>Record review revealed the facility admitted Resident #1 on 01/25/08 with diagnoses which included Alzheimer's Disease, Osteoporosis, and Muscle Weakness. Review of the Significant Change Minimum Data Set (MDS) assessment, dated 02/05/14, revealed the facility assessed the resident as totally dependent on one (1) staff for locomotion on and off the unit, with impaired</p>	F 282			

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F 282	<p>Continued From page 2</p> <p>range of motion on both of his/her upper extremities.</p> <p>Review of the Comprehensive Care Plan, dated 01/14/10, revealed the resident was at risk for falls due to poor safety awareness and was totally dependent on staff for all activities of daily living (ADL). Further review of the Care Plan revealed the resident had impaired ADL abilities related to the diagnosis of Alzheimer's Dementia. The Care Plan included an intervention, initiated 08/23/13, for bilateral leg rests with leg cradle to the wheelchair.</p> <p>Review of a Change of Condition Documentation for Resident #1, dated 02/11/14 at 8:15 AM, revealed the resident was being pushed in the wheelchair away from the breakfast table when his/her feet were caught under the wheelchair, causing the resident to go forward and fall out of the chair onto the floor. The resident hit his/her head, causing an eight (8) centimeter (cm) cut to the forehead. Resident #1 was transported to the hospital after the fall. Review of the hospital's Discharge Summary, dated 02/13/14, revealed the resident was diagnosed with laceration with facial trauma and hematoma, and nasal fracture.</p> <p>Interview with the Occupational Therapy Assistant, on 02/26/14 at 1:00 PM, revealed the leg cradle or "foot buddy" was recommended for the resident back in August 2013. She stated in January 2014, the resident was assessed to need a wider wheelchair with a pressure reduction cushion. The leg cradle still fit the wider wheelchair; however, it was a "tight fit." She stated a new one was ordered; however, staff was instructed to use the old one until the new one arrived. She stated the resident's plan of care</p>	F 282			

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F 282	<p>Continued From page 3</p> <p>had not changed and the purpose of the leg cradle was to keep the resident's legs from sliding off or behind the foot rests.</p> <p>Interview with LPN #1, on 02/26/14 at 12:55 PM, revealed she fed Resident #1 breakfast in the dining room, on 02/11/14. She stated afterwards, she backed the resident away from the table, ensuring the resident's feet were on the foot rests. She started to push Resident #1 out of the dining room when the resident started to fall forward out of the wheelchair. LPN #1 stated the resident's foot "apparently" had fallen off the footrest. She stated she was aware the leg cradle was supposed to be on the wheelchair for positioning, per therapy's recommendation. She stated she realized it was not on the wheelchair; however, she continued to transport the resident.</p> <p>Interview with the Director of Nursing (DON), on 02/26/14 at 3:00 PM and on 02/27/14 at 10:40 AM, revealed the resident fell out of the wheelchair because the leg cradle was not in use. She further stated she expected staff to ensure care was being provided, per the resident's plan of care.</p> <p>Interview with the Administrator, on 02/26/14 at 3:00 PM and on 02/27/14 at 10:20 AM, revealed an investigation into the fall was conducted, on 02/12/14. Other residents were interviewed to ensure there were no concerns with their care in the facility. Staff education was initiated immediately. Nursing staff was inserviced, on 02/11/14 and 02/13/14, ensuring assistive devices were in place and functioning properly with review of the policy/procedure for accidents/incidents and adverse events.</p>	F 282			

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F 282	Continued From page 4 Inservice records revealed inservices were conducted with all staff on Abuse/Neglect on 02/13/14 and on assistive devices/accidents on 02/11/14 and 02/13/14. In addition, the Supervisor issued a Record of Counseling and the staff signed it, indicating they were re-educated on following the care plan and the Certified Nursing Assistant (CNA) Care Card for the protection of the residents. Interviews with State Registered Nurse Aides (SRNAs) #1, #2, #3 and #4, on 02/26/14 at 12:20 PM, 12:27 PM, 12:37 PM, and 12:45 PM, respectively, and LPN #1, on 12/26/14 at 12:55 PM, revealed they were reeducated on following the care plans and CNA care cards. Interview with the DON, on 02/27/14 at 10:40 AM and 2:10 PM, revealed the facility initiated a Performance Improvement (PI) audit, to ensure staff was following the care plan and assistive devices were in place/functioning. Audits would be completed by one of the members of the PI committee; every shift for seven (7) days, daily for fourteen (14) days, three (3) times a week for five (5) weeks, and monthly for two (2) months, to ensure compliance. ** Audits were verified per facility documentation as completed, per the above schedule. The facility is currently on the daily schedule for fourteen (14) days.	F 282			
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			

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F 323	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's Falls Management policy/procedure and Hospital Discharge Summary, it was determined the facility failed to ensure each resident received adequate assistance devices to prevent accidents for one (1) of three (3) sampled residents (Resident #1). On 08/23/13, an order was obtained for Resident #1 to have bilateral leg rests with a leg cradle (foot buddy) on the wheelchair to improve positioning and to reduce the risk of injury. On 02/11/14, the facility failed to ensure the leg cradle was in place while the resident was sitting in the wheelchair. At approximately 8:15 AM, Licensed Practical Nurse (LPN) #1 attempted to transport the resident, by wheelchair, out of the dining room. The resident's feet were caught under the wheelchair, causing the resident to fall forward onto the floor. Resident #1 was transported to the hospital and diagnosed with laceration with facial trauma and hematoma, and nasal fracture. Refer F282 The findings include: Review of the facility's "Falls Management" policy/procedure, last revised 06/01/13, revealed patients would be assessed for fall risks as part of the nursing assessment process. Those determined to be at risk would receive appropriate interventions to reduce risk and minimize injury.	F 323	Past noncompliance: no plan of correction required.		

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F 323	Continued From page 6 Record review revealed the facility admitted Resident #1 on 01/25/08 with diagnoses which included Alzheimer's Disease, Osteoporosis, and Muscle Weakness. Review of the Significant Change Minimum Data Set (MDS) assessment, dated 02/05/14, revealed the facility assessed the resident as totally dependent on one staff for locomotion, and impaired range of motion on both of his/her upper extremities. Review of the February 2014 Physician's Orders, signed 02/08/14, revealed an order (dated 08/23/13) for bilateral leg rests with leg cradle to improve positioning and reduce the risk of injury, per occupational therapy. Review of the Comprehensive Care Plan, dated 01/14/10, revealed an intervention, initiated 08/23/13, for bilateral leg rests with leg cradle. Review of the Change of Condition Documentation, dated 02/11/14 at 8:15 AM, revealed the resident was being pushed in the wheelchair away from the breakfast table when his/her feet were caught under the wheelchair, causing the resident to go forward and fall out of the chair onto the floor. The resident hit his/her head, causing an eight (8) centimeter (cm) cut to the forehead. Resident #1 was transported to the hospital after the fall. Review of the Hospital's Discharge Summary, dated 02/13/14, revealed discharge diagnoses included laceration with facial trauma and hematoma, and nasal fracture. Interview with the Occupational Therapy Assistant, on 02/26/14 at 1:00 PM, revealed the leg cradle or "foot buddy" was recommended for the resident back in August 2013. She stated in January 2014, the resident was assessed to need	F 323			

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F 323	<p>Continued From page 7</p> <p>a wider wheelchair with a pressure reduction cushion. The leg cradle still fit the wider wheelchair; however, it was a "tight fit." She stated a new one had been ordered; however, staff was instructed to use the old one until the new one arrived. Further interview revealed the purpose of the leg cradle was to keep the resident's legs from sliding off or behind the foot rests.</p> <p>Interview with LPN #1, on 02/26/14 at 12:55 PM, revealed on 02/11/13 she fed Resident #1 breakfast in the dining room. She stated when the resident had finished eating, she backed the resident away from the table, ensuring the resident's feet were on the foot rests. LPN #1 revealed when she started to push Resident #1 out of the dining room the resident started to fall forward out of the wheelchair. She stated the resident's foot "apparently" had fallen off the footrest. LPN #1 stated she was aware the resident was care planned to have a leg cradle on the wheelchair for positioning, per therapy's recommendation. She revealed she realized the leg cradle was not on the wheelchair; however, she continued to transport the resident.</p> <p>Interview with the Director of Nursing (DON), on 02/26/14 at 3:00 PM and 02/27/14 at 10:40 AM, revealed the resident fell out of the wheelchair because the leg cradle was not in use. She further stated her expectation was for staff to ensure residents' care was being provided, per the resident's plan of care.</p> <p>Interview with the Administrator, on 02/26/14 at 3:00 PM; and, on 02/27/14 at 10:20 AM, revealed an investigation into the fall was conducted, on 02/12/14. Other residents were interviewed to</p>	F 323			

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F 323	<p>Continued From page 8</p> <p>ensure there were no concerns with their care in the facility. Staff education was initiated immediately. All staff received an abuse/neglect inservice, on 02/13/14. Nursing staff was inserviced, on 02/11/14 and 02/13/14, ensuring assistive devices were in place and functioning properly with review of the policy/procedure for accidents/incidents and adverse events.</p> <p>Inservice records revealed inservices were conducted with all staff on Abuse/Neglect on 02/13/14 and on assistive devices/accidents on 02/11/14 and 02/13/14. In addition, the Supervisor issued a Record of Counseling and the staff signed it, indicating they were re-educated on following the care plan and the Certified Nursing Assistant (CNA) Care Card for the protection of the residents. Interviews with State Registered Nurse Aides (SRNAs) #1, #2, #3 and #4, on 02/26/14 at 12:20 PM, 12:27 PM, 12:37 PM, and 12:45 PM, respectively, and LPN #1, on 12/26/14 at 12:55 PM, revealed they were reeducated on following the care plans and CNA care cards.</p> <p>Interview with the DON, on 02/27/14 at 10:40 AM and 2:10 PM, revealed the facility initiated a Performance Improvement (PI) Audit, to ensure staff was following the care plan and assistive devices were in place/functioning. Audits would be completed by one of the members of the PI committee; every shift for seven (7) days, daily for fourteen (14) days, three (3) times a week for five (5) weeks, and monthly for two (2) months, to ensure compliance. ** Audits were verified per facility documentation as completed, per the above schedule. The facility is currently on the daily schedule for fourteen (14) days.</p>	F 323			