

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

PRINTED: 09/09/2014
FORM APPROVED
OMB NO. 0938-0391

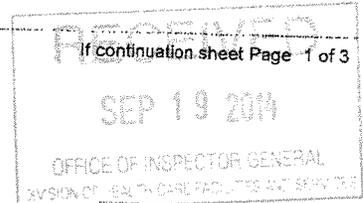
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185122	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/29/2014
NAME OF PROVIDER OR SUPPLIER PARKWAY MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1155 EASTERN PARKWAY LOUISVILLE, KY 40217		
(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	F 000	The preparation and execution of this plan of correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency.		
F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's Care Plan policy, and review of the facility's investigation report, it was determined the facility failed to ensure one (1) of four (4) sampled residents (Resident #1) received a two (2) person transfer as directed per the care plan.</p> <p>The findings include:</p> <p>Review of the facility's Care Plan policy, undated, revealed the interventions for each resident were developed using the Minimum Data Set (MDS) assessments, and followed to promote the residents' highest functional status.</p> <p>Review of the clinical record for Resident #1, revealed the facility admitted the resident with diagnoses of Dementia, Alzheimer's Disease, and Hypertension. The facility completed a quarterly MDS assessment on 06/04/14, which revealed the resident had severe cognitive impairment and</p>	F 282	<p>This plan of correction is prepared and executed solely because it is required by federal and state law. As part of the facilities' ongoing performance improvement program, all audit results will be reported to the Performance Improvement Team with additional education as necessary.</p> <p>F282 We feel this is an isolated incident. The CNA was immediately placed on administrative leave, counseled, and re-educated as to the importance of using the CNA card. When the CNA returned to the facility after administrative leave, she was assigned to a different unit and no longer cared for resident #1. The Clinical Director of Nursing re-educated the Unit Managers on 9-2-14 and 9-3-14 as to the importance of following the CNA card and making sure the CNA card is followed. All residents have the potential to be affected by the same deficient practice. On 9-2-14 the Staff Development Coordinator solicited input from Certified Nurses' Assistants (CNA's) as part of a root cause analysis (RCA) to assess some possible reasons why the CNA card would</p>		

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

TITLE

(X6) DATE

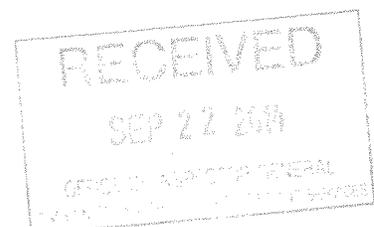
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable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



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F 282	<p>Continued From page 1</p> <p>required extensive assistance for activities of daily living. The resident was unable to ambulate.</p> <p>Review of the Nurse Aide Care Plan for Resident #1, revealed two (2) nursing staff were to be utilized during the care of the resident, and that included a stand pivot transfer of the resident from bed to chair and chair to bed.</p> <p>Review of the facility's investigation report, dated 06/09/14, revealed Certified Nurse Aide (CNA) #1 discovered Resident #1 had a bruise to the left forehead after the resident was assisted to bed at 8:00 PM on 06/09/14. The facility was unable to determine how the bruise occurred. However, the facility determined during the course of the investigation that CNA #1 did not follow the resident's care plan, and that the resident was transferred to the bed from a chair with a one (1) person assist.</p> <p>Interview with the Clinical Director of Nursing (CDON), on 08/29/14 at 11:15 AM, revealed there was bruising to Resident #1's forehead, on 06/09/14 at 8:00 PM. She stated no bruising was noticed by staff when they assisted the resident to the bathroom in the late afternoon. She indicated the resident may have been transferred back to the bed from the chair later that evening at 8:00 PM, however, the CNA who provided care denied the resident was transferred back to bed by one (1) person. The CDON stated CNA #1 admitted on 06/11/14 at 3:05 PM that she failed to follow the resident's care plan, and transferred the resident from the chair to the bed without another person for assistance. She indicated the facility suspended CNA #1 for three (3) days for failure to follow the resident's care plan. She revealed CNA #1 denied anything happened</p>	F 282	<p>Continued from page 4</p> <p>not be followed. The CNA cards were identified to be cluttered and at times confusing to follow.</p> <p>On 9-10-14 a focus group consisting of the Assistant Director of Nursing, Human Resources Director, Administrative Director of Nursing, Clinical Director of Nursing and Staff Development Coordinator met to discuss Plan of Correction for Ftag 282. The Focus group discussed the facility's CNA card policy, CNA cards, staff education, CNA/nurse orientation, and findings from CNA interviews regarding the CNA card. As a result of the focus group's meeting, the facility implemented systemic changes. The CNA card policy was revised on 9-11-14. The CNA card was revised and updated on 9-11-14 making them easier to read and understand. CNA cards were added to the nurse/CNA orientation packets on 9-15-14. On 9-17-14 and 9-18-14 mandatory CNA skills day were held and facilitated by the Staff Development Coordinator. All CNA's were required to attend. The Staff Development Coordinator will incorporate CNA cards into the CNA skills packets. During the skills days for CNA's held on 9-17-14 and 9-18-14 all CNA's were educated and instructed on the revised CNA cards which are easier to read and understand. All CNA's will also be informed that if they are found not following the CNA card they will be disciplined according to the severity of the infraction, including termination. The facility's Compliance Officer will audit random 10 CNA cards weekly x 4 weeks, monthly x 2 months, then quarterly x 3 quarters.</p>		



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F 282	<p>Continued From page 2</p> <p>during the transfer to cause the resident's face to bruise. The CDON stated she was unable to prove the bruising occurred during the transfer of the resident by CNA #1. She stated the staff were educated on following care plans, and she expected staff to follow the care plan.</p> <p>Interview with CNA #2, on 08/09/14 at 2:22 PM, revealed she assisted CNA #1 in the transfer of Resident #1 into and out of the bathroom on 06/09/14 at 4:00 PM. She stated the resident did not have a bruised face. She indicated CNA #1 requested for her to look at Resident #1's face later that evening at 8:00 PM. She stated she noticed the bruising on the resident's face, and the fact the resident was in bed and CNA #1 had not requested any assistance from her. She stated Resident #1 was weak and could hardly stand up and required a two (2) person pivot from the chair to the bed. She stated the resident's care plan, located at the nursing station, included directions for two (2) persons to transfer the resident safely and avoid falls.</p> <p>Interview with the Administrative Director of Nursing, on 08/29/14 at 2:45 PM, revealed CNA #1 received training on following the care plan and was aware Resident #1 required two (2) staff persons for care. She stated CNA #2 was suspended for failure to follow Resident #1's care plan. She stated the resident and the CNA were in danger of injury when the care plan was disregarded.</p>	F 282	<p>Continued from page 5</p> <p>The facility's Compliance Officer will audit random 10 CNA cards weekly x 4 weeks, monthly x 2 months, then quarterly x 3 quarters. The Compliance Officer will check for accuracy of CNA cards, and interview CNA's as to their knowledge of the content therein. The Compliance Officer will provide results to the Directors of Nursing. The Directors of Nursing will promptly review with the Unit Managers discrepancies noted. The Unit Managers will return the audits with actions taken regarding findings to the Director of Nursing. The results of the audits will be submitted by the facility's Compliance Officer to the Performance Improvement Committee meetings quarterly for the next 3 quarters.</p>	9-19-14	

