

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

PRINTED: 11/03/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/20/2010
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NAME OF PROVIDER OR SUPPLIER WESLEY MANOR NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5012 EAST MANSLICK RD LOUISVILLE, KY 40219
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F 000	<p>INITIAL COMMENTS</p> <p>An abbreviated and partial extended survey was conducted 10/12/10-10/20/10 in response to KY#15433. Immediate Jeopardy was determined to exist on 10/07/10 in 42 CFR 483.25 (F323 S/S "J") resulting in substandard quality of care, for failure to provide appropriate training for the use of assistive devices as directed by the manufacturers recommendation for Rolator walkers. The Immediate Jeopardy was determined removed and all corrective action was completed on 10/11/10, prior to the entrance of the state agency's investigation making the deficient practice past noncompliance, Past Jeopardy. In addition; KY 14949 was investigated and substantiated with no regulatory violations identified and KY 15172 was unsubstantiated.</p>	F 000		
F 323 SS=J	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure that staff were trained on the appropriate use of assistive devices, per manufacturer's recommendations, to prevent accidents for one resident (#1) out of five sampled residents. The facility's failure to ensure adequate training of their staff resulted in an avoidable accident for</p>	F 323	<p>Past noncompliance: no plan of correction required.</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 323	<p>Continued From page 1</p> <p>Resident #1. On 10/07/10, staff transported Resident #1 using a Rollator walker, when the Rollator walker flipped over causing the resident to sustain a head injury. Resident #1 required hospitalization with diagnoses of coma secondary to intracranial hemorrhage (bleeding within the skull).</p> <p>The facility's failure to ensure staff were appropriately trained regarding the safe use of assistive devices placed residents at risk for serious injury, harm, impairment or death.</p> <p>The findings include:</p> <p>Review of the facility Job Description and Orientation revealed staff were to demonstrate competency in providing restorative functions to encourage residents to maintain independence by safe use of walkers. The Job Description and Orientation form was to be completed by the person responsible to train new staff.</p> <p>Record review of Resident #1's medical record revealed the resident was admitted on 09/30/10, with diagnoses that included; Alzheimer's, Dementia with behaviors, Episodic mood, Anxiety, Impulse control, Interim explosive disorder, Congestive heart failure, Hypertension, and Diabetes Melitis. The physical therapy assessment dated 09/30/10 revealed the resident was independent with ambulation in the facility with the Rollator walker. No deficit was identified by the Physical Therapist regarding bed mobility, wheelchair mobility, skin integrity, ambulation, transfers, and positioning.</p> <p>Review of the facility investigation, dated 10/07/10, and interview on 10/13/10 at 1:15pm</p>	F 323			

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F 323	<p>Continued From page 2</p> <p>with CNA #1 revealed the CNA had asked LPN #1 to assist with a transfer for Resident #1 to the Rollator walker. LPN#1 returned to the nurse's station and CNA #1 transported Resident #1 on the Rollator walker by pushing the resident so that the resident was facing the CNA, (backwards) down the hallway towards the dining room. The Rollator walker flipped backwards and the resident's head hit the floor. LPN #1 heard CNA #1 scream and ran to the area to assess the cause. The resident was unconscious for several minutes but when aroused, responded "no" to questions. Due to changes and fluctuations in the resident's neurological status, the facility transferred the resident to the hospital, where he/she was diagnosed with a large brain bleed and was admitted to ICU (intensive care unit). Review of the readmission orders and plan of care revealed the resident was diagnosed on 10/12/10 as being in a coma (state of prolonged unconsciousness that can be caused by a variety of problems, including traumatic head injury), secondary to intracranial hemorrhage. Continued interview with CNA#1 revealed he had been in orientation for three (3) weeks; however, he did not recall receiving the orientation sign-off forms nor did he recall receiving instructions for the safe use of walkers. He stated he did not know staff was not to use the Rollator walker for transport at the time of the incident. He stated he had not seen other staff use the walker inappropriately. He stated he did not think to get a wheelchair to transport the resident. Review of CNA #1's personnel record revealed there was no documented evidence that the job description and orientation form had been completed to ensure the CNA's completion and competency of training. Review of the facility's investigation follow-up</p>	F 323		

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F 323	<p>Continued From page 3</p> <p>report identified CNA #1 as being unaware of the facility policy regarding the proper transport of residents. Interview, on 10/13/10 at 4:55pm, with the DON revealed she had pulled CNA #1 from the schedule immediately on 10/07/10 and began her investigation of the incident 10/07/10. She stated CNA #1 had reported he was not aware he should not have used the Rollator walker for a transport device and did not recall if he had been trained/educated regarding the safe use of the walkers. She stated she could not find the orientation verification form for CNA #1 and could not be sure if he had been trained by the previous Staff Development Trainer. She stated the manufacture recommendations detailed the Rollator walker was not to be used as a wheelchair or transport device.</p> <p>Further review of the report, interview on 10/13/10 at 4:55pm with the Director of Nursing (DON) and further interview with CNA #1 revealed the CNA was pulled immediately to discuss the incident with the DON, and the CNA was removed from the weekend schedule and was enrolled in additional training. The DON and the Director of Staff Development conducted "on the spot" training through group meetings with staff immediately following the incident on 10/08/10, 10/09/10, and 10/10/10. Additional one to one training was provided for CNA #1. Further interview, on 10/13/10 at 1:15pm, with CNA#1 confirmed that he was immediately removed from the schedule on 10/07/10 until he had been retrained on 10/11/10. He stated the Restorative nurse (LPN #6) retrained him on 10/11/10 regarding the appropriate use of the walker, lifts, and wheelchairs before he was allowed to return to work to provide direct resident care. Interview, on 10/14/10 at 8:54am, with the Restorative nurse</p>	F 323		

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F 323	<p>Continued From page 4</p> <p>confirmed she had in-serviced CNA #1 on 10/11/10 on the appropriate use of a Rollator walker and assisted with in-service for all the staff. She stated she trains the new and "seasoned" staff on safe equipment use on a daily basis. She stated she had not witnessed any staff pushing residents on Rollator walkers and would stop staff immediately if seen. The Restorative nurse identified five (5) residents in the facility that was currently using a Rollator walker. (Residents #1, #4, #5, #6, and #22)</p> <p>Record review on 10/14/10 for Residents #1, #4, #5, #6, and #22 revealed a Physical Therapy evaluation had been completed for each resident with no deficits identified for use of the Rollator walkers. Additional review revealed the facility care planned for the use of the Rollator walkers for Residents #1, #4, #5, #6, and #22.</p> <p>Observation, on 10/12/10 at 5:05pm, revealed Resident #1 was lying in bed with his/her eyes closed. The bed was in a low position with fall pads on the floor and a tab alarm was attached to the resident, as detailed per the care plan.</p> <p>Observation, on 10/14/10 at 5:30pm, revealed Resident #1 was lying in bed with his/her eyes open, slapping at CNA #6 as she had just finished providing care for the resident. Additional observation, on 10/19/10 at 8:30am, revealed the resident was sitting up in a wheelchair with staff feeding a pureed breakfast to the resident. The resident was actively eating the food with no verbal cues observed.</p> <p>Personnel records reviewed for RN's #1, #2, and #5, LPN #4 and five unsampled CNAs revealed the facility had completed the Job Description and Orientation form as required by the facility's policy</p>	F 323		

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F 323	<p>Continued From page 5</p> <p>which included instruction and training of the use of assistive devices to include the Rollator walker.</p> <p>Further interview with the DON revealed she developed a new policy for the use of the Rollator walker and she and the Restorative nurse immediately began to in-service the staff on 10/08/10 regarding the safe use of the Rollator walker. The DON stated all incidents were reported to the Quality Assurance (QA) committee monthly and to the quarterly QA committee which included the Medical Director, Pharmacist, and two board members. She stated all incidents were reviewed to monitor and assess corrective action for prevention of accidents.</p> <p>Interviews with facility staff on 10/12/10; CNA #6 on 10/13/10; and RN #3, LPN #1, and on 10/14/10 with the Restorative Nurse, Charge Nurse, LPN #2, #3, CNA's #1, #2, #3, #4, and #7 revealed they had been in-serviced on the appropriate use of the Rollator walker and safe transport for residents. In addition the staff revealed the facility provided annual in-services and on the spot training regarding abuse/neglect and patient rights.</p> <p>Review of the facility policy dated 10/10 revealed the seated walkers were not transport devices. The seat was there for residents to use to sit and rest if they get tired when walking. The policy further detailed the appropriate transport devices and directed staff not to pull a resident in a wheelchair backwards; not to pull more than one resident at a time, and the appropriate positioning of the resident when in a wheelchair. Review of the in-service log for the "Do's and Don'ts when transporting residents" was signed by staff and verified by the DON of training completion on</p>	F 323		
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F 323	Continued From page 6 10/11/10. The Immediate Jeopardy was determined to be removed and all corrective action was completed on 10/11/10, prior to the State Agency's initiation of the investigation on 10/12/10. The facility, after having investigated the incident, immediately pulled the CNA from the schedule on 10/07/10 and retrained him on 10/11/10 prior to allowing him to return to work. The DON initiated immediate "on the spot training" for all direct care staff on appropriate transport of residents and use of assistive equipment to ensure all staff were educated regarding Rollator walkers. The policy was developed to ensure safety of residents when assisting with mobility or transportation with a mobility device and identified the seated walkers were not transport devices. Monthly QA meetings were held to identify and assess corrective action for prevention of accidents.	F 323		