

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

PRINTED: 03/19/2012  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185316	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  02/27/2012
NAME OF PROVIDER OR SUPPLIER  PRINCETON HEALTH & REHAB CENTER, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1333 WEST MAIN ST. PRINCETON, KY 42445	

(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
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F 000 INITIAL COMMENTS

AMENDED #2  
F520 on 03/13/12  
F280 and F282 - per CMS and State Agency quality review, increased scope and severity from "D" to "J" on 03/19/12

An abbreviated survey (KY #17832) was conducted on 02/13/12 through 02/17/12. Immediate Jeopardy was identified on 02/16/12 at 483.13 Resident Behavior and Facility Practices, at 483.20 Resident Assessment, at 483.25 Quality of Care and at 483.75 Administration. An extended survey was conducted on 02/21/12 through 02/27/12. Substandard Quality of Care was identified at 483.13 Resident Behavior and Facility Practices and at 483.25 Quality of Care. KY #17832 was substantiated with deficiencies cited.

The facility failed to implement their policy/procedure to prevent neglect for Resident #1. The facility failed to provide services to meet professional standards of quality in accordance with care planning, and failed to ensure the resident received adequate supervision and assistance devices to prevent accidents. The facility assessed Resident #1 as at risk for falls and placed the resident on the Falling Star Program. Interviews with staff revealed the resident required extensive assistance, having poor sitting balance, stating the resident should not be left unattended. On 05/14/11, at approximately 2:00 AM, a PRN (as needed) dose of Lortab (pain medication) was administered to Resident #1. At 4:00 AM, the staff assisted Resident #1 up to the side of the bed to a sitting position, then left him/her alone in the room

F 000

DISCLAIMER: THE COMPLETION AND SUBMISSION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION THAT THE FACILITY AGREES WITH THE DEFICIENCIES AS STATED IN THE 2567. THE FACILITY IS COMPLETING THE PLAN OF CORRECTION BECAUSE IT IS REQUIRED BY STATE AND FEDERAL LAW. THE FACILITY DISAGREES AND DISPUTES THE DEFICIENCIES STATED IN THE 2567. FURTHER, THE FACILITY DISPUTES AND DISAGREES WITH THE ACCURACY OF STATEMENTS AND OTHER INFORMATION RELIED UPON IN THE 2567 IN SUPPORT OF THE DEFECIENCIES. THIS INCLUDES, BUT IS NOT LIMITED TO, THE ALLEGED CONTENT/SUMMARY OF MULTIPLE INTERVIEWS, THE CHRONOLOGICAL/TIMING SEQUENCE OF EVENTS AND CONTACT WITH HEALTH CARE PROFESSIONALS, THE SCOPE OF PRACTICE OF APRNS UNDER KENTUCKY LAW, AND THE CARE AND SUPREVISION PROVIDED TO THE RESIDENTS. THE FACILITY PRESENTED CONTRARY EVIDENCE DURING THE SURVEY ITSELF AND IN THE DISPUTE RESOLUTION MEETING WHICH WAS NOT ACKNOWLEDGED BY THE CABINET.

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

*Kelly Solder*

TITLE

NHA

(X6) DATE

3/28/12

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 000	Continued From page 1 unattended. The resident fell from the bed and sustained an intracranial hemorrhage (bleeding within the skull), and subsequently expired on 05/19/11. Intracranial hemorrhage was listed as the underlying cause of death on a certified copy of Resident #1's death certificate. Furthermore, the facility's investigation failed to identify neglect occurred which prevented the facility from initiating action to prevent future neglect.  This failure caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/16/12 and determined to exist on 05/14/11. An acceptable Allegation of Compliance (AoC) was received on 02/22/12. Immediate Jeopardy was removed, effective 02/19/12, as alleged in the AoC with the scope and severity lowered to a "D" based on the need of the facility to continue to evaluate the implementation of changes and quality assurance activities.	F 000			
F 224 SS=J	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to implement their policy and procedure to prevent neglect for one	F 224	<u>F224</u> <u>483.13(c) Prohibit Mistreatment/ Neglect/ Misappropriation</u> It is the practice of Princeton Health and Rehab Center to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents.  <u>Corrective Measures for Resident Identified in the deficiency:</u>  <u>Resident #1</u> was discharged from the facility on 5/14/11 to the hospital and expired on 05/19/11, so no additional measures were possible for this resident.  <u>How Other Residents Were Identified Who May Have Been Impacted by the Practice:</u>	04/06/12	

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F 224	Continued From page 2 resident (#1), in the selected sample of four residents. The facility assessed Resident #1 as at risk for falls and placed the resident on the Falling Star Program. Interviews with staff revealed the resident required extensive assistance, having poor sitting balance, stating the resident should not be left unattended. On 05/14/11, at approximately 2:00 AM, a PRN (as needed) dose of Lortab (pain medication) was administered to Resident #1. At 4:00 AM, the staff assisted Resident #1 up to the side of the bed to a sitting position, then left him/her alone in the room, which resulted in Resident #1's fall from the bed to the floor. The resident sustained an intracranial hemorrhage (bleeding within the skull), and subsequently expired on 05/19/11. Intracranial hemorrhage was listed as the underlying cause of death on a certified copy of Resident #1's death certificate. Furthermore, the facility's investigation failed to identify neglect occurred which prevented the facility from initiating action to prevent future neglect.  This failure caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/16/12 and determined to exist on 05/14/11. An acceptable Allegation of Compliance (AoC) was received on 02/22/12. Immediate Jeopardy was removed, effective 02/19/12, as alleged in the AoC with the scope and severity lowered to a "D" as the facility had not completed the QA initiative related to staff monitoring, analysis of monitoring audit results and the development and implementation of the POC to ensure interventions are effective and will prevent recurrence, in order to achieve and maintain compliance. Substandard Quality of Care was	F 224	(continued) A Fall Risk Analysis was completed on each resident currently residing in the facility by the MDS Coordinator, Unit Charge Nurses or licensed Nurse designee and was completed by 02/18/12 and was verified as completed within this statement of deficiency on 02/23/12.  Residents who scored a 10 or higher on the Fall Risk Analysis were identified as high risk for falls and are provided supervision by staff while sitting on the side of the bed or toilet. This was placed on the nurse aide data sheet and comprehensive care plan for these identified residents. This was completed on 02/18/12 by the unit Charge Nurses, licensed staff and MDS Coordinator and was verified as completed within this statement of deficiency on 02/23/12.  <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u>  All facility staff including the Nursing Assistants, Medication Aides, Administrative and Licensed Nurses, Administrator, Social Services, Activities, Dietary, Environmental Service, Housekeeping, and Laundry have been re-educated on the facility's Abuse/ Neglect Policy by the Staff Development Coordinator / designee and Quality Management Specialist and was completed on 02/23/12 and was verified as initiated on 02/17/12 continuing until completed within this statement of deficiency on 02/23/12. Education for any inactive staff will be completed prior to returning to active status by the DON/ designee prior to their first shift. A post test was given to employees to verify understanding of the training provided. The administrator was provided re-education by the Regional Vice President of Operations on 02/17/12 on establishing and overseeing policies and practices to avoid instances of abuse or neglect.		

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F 224	Continued From page 3 Identified at 483.13 Resident Behavior and Facility Practices and 483.25 Quality of Care. (Refer to F279, F323, F490, and F520)  Findings include:  A review of the facility's policy/procedure, "Alleged Abuse Reporting/Investigation," revised 06/17/11, revealed the facility defined neglect as a failure or omission on the part of the care giver to provide the care, supervision, and services necessary to maintain the physical and mental health of the disabled adult or elderly person, including, but not limited to providing food, clothing, medicine, shelter, supervision and medical services that a prudent person would consider essential for the well being of the disabled adult or elderly person. Neglect can also mean the failure of care givers to make a reasonable effort to protect a disabled adult or elderly person from abuse, neglect or exploitation by others. Neglect can be either repeated conduct or a single incident of carelessness which produces or could be reasonably expected to result in serious physical or psychological injury or a substantial risk of death.  A review of the document, "Falling Star Program," undated, revealed the purpose was to promote recognition of residents who have been identified as being at risk for falls. Residents who were identified through the Falls Risk Analysis as being at risk for falls would be included in the Falling Star Program. Falling Star residents would have a large star placed beside their name plate outside their room. Upon a resident's transfer or room change, the designated staff member would remove or move the star to the appropriate room	F 224	F224 (continued) All facility licensed nurses were educated in the revised process to provide a consistent methodical process for determining the level of supervision to be provided for resident's care while sitting on side of bed or on the toilet. In addition they were re-educated in falls, fall prevention, supervision, conducting an investigation, interventions, implementing and updating care plans and nurse aide data sheets by the Quality Management Nurse, Director of Nurses, Assistant Director of Nurses, and the Staff Development Coordinator and was completed on 02/23/12 and was verified as initiated on 02/17/12 continuing until completed within this statement of deficiency on 02/23/12.  <u>Monitoring Measures to Maintain On-going Compliance:</u>  A specially called Quality Assurance (QAA) Assessment meeting including the Administrator, Director of Nurses, Assistant Director of Nurses, Clinical Nurse Supervisor, MDS Coordinator, Unit Nurses, Rehab Director, Activities, Business Office, Admission Office, Dietary manager, Medical Records, and Social Services was conducted on 02/17/12 that validated the completion of the fall risk analysis updates to the comprehensive plans of care and nurse aide data sheets for all residents currently residing in the facility and was validated as completed within this statement of deficiency on 02/23/12.  The Director of Nurses / designee will review the Fall Risk Analysis for completion with corresponding updates to the comprehensive plan of care and nurse aide data sheets, upon admission, readmission, quarterly, annual, significant change, and following a fall event through the daily AQA process using an investigation checklist and the revised daily AQA form to validate that interventions are		

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F 224	<p>Continued From page 4 and the resident Falling Star Program would be reviewed quarterly.</p> <p>Staff was alerted to a resident being on the Falling Star Program with a green star by the resident's name outside their door. Residents on the Falling Star Program had alarms, floor mats, required assistance with bed mobility, transfer, ambulation and required two staff assistance at all times.</p> <p>A record review revealed the facility admitted Resident #1 on 04/26/11 with diagnoses to include Status-post Cerebral Vascular Accident (Stroke), Paralysis of the left side, Traumatic fracture of the left Clavicle (collar bone), Hypertension, Fatigue and Weakness. The resident also received Coumadin Therapy (a blood thinner).</p> <p>A review of the Falls Risk Analysis, dated 04/26/11, revealed the facility assessed the resident as high risk for falls related to having three or more falls in the past three months prior to admission to the facility. The document detailed the resident had balance problems, decreased muscular coordination, and was on four medications (Antihypertensive, Diuretic, Hypoglycemic, and a Narcotic), with side effects to include dizziness and unsteadiness. Predisposing factors for Resident #1 included Stroke, Fractures, Diabetes, and Anemia.</p> <p>A review of the admission Minimum Data Set (MDS), dated 05/03/11, revealed the facility assessed Resident #1 as cognitively intact. He/she required extensive assistance of two staff for bed mobility, transfers, ambulation and</p>	F 224	<p>(continued) implemented. On weekends the charge nurse will be responsible to validate the Fall Risk Analysis for completion with corresponding updates to the comprehensive plan of care and nurse aide data sheets following any fall event or new admission with validation that the interventions are implemented. Any issues identified with the above process will have re-education provided to the individual staff member by the Staff Development Coordinator / designee.</p> <p>Additional re-education on the facility's Abuse / Neglect policy will be conducted monthly times three months then quarterly for one year by the Staff Development Coordinator / designee. Follow up post tests on abuse policy and supervision will be utilized to validate ongoing understanding of training received. The results of the reviews and post tests will be reported to the monthly QA&amp;A committee. If any findings indicate a concern the frequency of monitoring may be increased to validate ongoing compliance and re-education will be provided on an individual basis if indicated.</p>

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F 224	<p>Continued From page 5</p> <p>toileting. A review of the Comprehensive Care Plan for "Falls," dated 05/12/11, revealed Resident #1 was at risk for falls related to weakness, clavicle fracture, and impaired mobility; however, there was no evidence the facility addressed the resident's condition related to balance, or the potential for dizziness and unsteadiness associated with his/her medication.</p> <p>An interview with the Unit Nurse (UN), Registered Nurse (RN) #1, on 02/14/12 at 10:20 AM, revealed, on 04/26/11, she completed Resident #1's admission assessment. She recalled the resident required much assistance. She stated the resident was weak and it was not safe for the resident to sit up alone on the side of his/her bed.</p> <p>Interviews with State Registered Nurse Aide (SRNA) #2, on 02/15/12 at 12:10 PM, SRNA#3, on 02/15/12 at 11:55 AM, SRNA #4, on 02/13/12 at 10:43 AM, SRNA #5, on 02/15/12 at 12:45 PM, SRNA #6, on 02/15/12 at 10:55 AM, and SRNA #7 on 02/14/12 at 10:00 AM, revealed Resident #1 had periods of weakness and was only able to maintain balance while sitting on the side of the bed for a maximum of ten minutes with assistance because the resident swayed and was "wobbly." Each of the SRNA interviews revealed it was not safe to leave Resident#1 alone sitting on the side of the bed.</p> <p>An interview with SRNA #1, on 02/13/12 at 10:30 AM, revealed, on the morning of 05/14/11, at approximately 4:00 AM, Resident #1 requested to sit up on the side of his/her bed. She stated the resident was restless during the the night and was up and down. Often, he/she sat up on the side of the bed to dangle his/her legs when</p>	F 224	

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F 224	Continued From page 6 having leg cramps. She stated she assisted the resident to sit up in the bed, propped a pillow under his/her left arm, then left the room to go answer other call lights. She stated Resident #1 was able to brace himself/herself with the right hand while sitting on the side of the bed. There was a personal clip alarm attached to the right side of the resident's gown when she left the room. She stated she was in a room down the hall when she heard a loud noise, like a chair moving, and ran back down the hall to Resident #1's room to find the resident on the floor mat. Resident #1 was bleeding from his/her knees and from an area on his/her head. She stated the alarm did not sound. When she entered the room, the alarm was not attached to Resident #1. The alarm was on the left side of the bed attached to the alarm box. She stated the resident could have taken the alarm off. Further interview with SRNA #1, on 02/15/12 at 1:00 PM, revealed she was aware Resident #1 was on the Falling Star Program, which meant the resident was at high falls risk. She revealed she was alone while providing care for Resident #1 because SRNA #4, who was working with her that night, was down the hall answering lights. She stated she was aware Resident #1 was paralyzed on the left side, and required extensive assistance with all care. She stated Resident #1 would only want to sit up 5-10 minutes at a time, then would ask to lay back down. She stated she should not have left the resident alone sitting on the side of the bed, but it was a busy night and she "had to do what she had to do." Additional interview with SRNA #1, on 02/27/12 at 9:27 AM, revealed Resident #1 constantly asked for pain medication. She stated she let the nurse know that the resident requested medication for leg pain and	F 224	

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F 224	<p>Continued From page 7</p> <p>the nurse gave pain medication to Resident #1 an hour prior to the fall.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 02/14/12 at 9:40 AM, revealed Resident #1 complained of leg cramps and Lortab was administered for pain. She stated that the resident had frequent leg cramps, and the request was not unusual. She stated Resident #1 requested to sit up on the side of the bed due to his/her leg cramps, as he/she had requested to do so in the past. She stated the SRNA assisted the resident up on the side of the bed, then left the room to go check on another resident. The SRNA returned to Resident #1's room after hearing a noise and found the resident on the floor. LPN #1 stated she went back to the room and observed Resident #1 face down on the floor mat at the bedside. Resident #1 told LPN #1 that he/she lost his/her balance and fell forward onto the floor mat. She stated Lortab was administered prior to the resident's fall and may have caused the resident to be "light-headed." She stated they should not have left the resident alone sitting up on the side of the bed.</p> <p>An interview with the attending Physician, on 02/13/12 at 9:10 AM, whose signature appeared on the certified copy of Resident #1's death certificate, revealed the Intracranial Hemorrhage listed as the underlying cause of death on Resident #1's death certificate was the result of the fall the resident sustained while at the nursing facility and was the cause of Resident #1's death.</p> <p>An interview with the Administrator and the Director of Nursing (DON), on 02/14/12 at 3:00 PM, revealed Resident #1 was on the Falling Star</p>	F 224	

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F 224	<p>Continued From page 8</p> <p>Program which meant the resident was a high risk for falls and it should have been "common knowledge" that the resident should not be left sitting on the side of the bed. On 02/15/12, the Administrator stated no further investigation was conducted related to the resident's fall from the bed because the resident said he/she lost his/her balance and fell; therefore, that was thought to be the cause of the fall. Any further investigation would only be completed if abuse, neglect or exploitation were involved. Thus the facility did not identify through their investigation that neglect had occurred as staff left a resident unsupervised who the facility assessed as requiring extensive assistance due to a "wobbly" balance, and at high risk for falls. This failure prevented the facility from taking action to prevent neglect recurrence.</p> <p>An acceptable Allegation of Compliance was received on 02/22/12 and detailed the following:</p> <p>All facility staff including the Nursing Assistants, Medication Aides, Administrative and Licensed Nurses, Administrator, Social Services, Activities, Dietary, Environmental Service, Housekeeping, and Laundry have been or will be re-educated on the facility's Abuse /Neglect policy by the Staff Development Coordinator and the Quality Management Specialist starting 02/17/12 and will continue with each oncoming shift until completed.</p> <p>Verification of removal of Immediate Jeopardy was completed as follows:</p> <p>The Quality Management Nurse trained the DON, Assistant Director of Nursing (ADON), and Staff Development, who educated licensed nurses in</p>	F 224		

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<p>F 224</p>	<p>Continued From page 9</p> <p>the process related to falls, falls prevention, supervision, conducting an investigation, interventions, implementing and updating the care plans, was initiated on 02/17/12 and verified by a sign-in sheet.</p> <p>Interview with RN #2, on 02/23/12 at 9:20 AM, revealed she was inserviced on falls and fall prevention, supervision, investigation, updating the care plan and abuse/neglect.</p> <p>Interviews with LPN #1 on 02/23/12 at 9:50 AM, LPN #2 on 02/23/12 at 9:10 AM, LPN #3 on 02/23/12 at 3:00 PM, and LPN #4 on 02/23/12 at 1:40 PM, revealed they were inserviced on falls and fall prevention, supervision, investigation, updating the care plan and abuse/neglect.</p> <p>Training on supervision was initiated on 02/17/12 by the Staff Development and verified by a sign-in sheet.</p> <p>Interviews with SRNA #7 on 02/23/12 at 1:15 PM, SRNA #8 on 02/23/12 at 2:07 PM, SRNA #9 on 02/23/12 at 1:35 PM, and SRNA #10 on 02/23/12 at 9:30 AM, revealed they were inserviced about not leaving the residents sitting on bed or toilet alone, unless they were independent. They were to keep dependent residents within arms' reach and to ensure all alarms were in place and in working order.</p> <p>Housekeeping, laundry and dietary staff was educated on 02/17/12, and was verified on 02/23/12, by a sign-in sheet and by interviews with Housekeeper #1, Dietary staff #1 and Dietary staff #2 on 02/23/12 at 1:50 PM, as well as the Beautician on 02/23/12 at 2:05 PM.</p>	<p>F 224</p>		
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F 224	Continued From page 10  A Falls Risk Analysis will be completed for all current residents by the Unit Managers, or other Licensed Nurse designee, and was verified by observation, on 02/23/12. The analysis completed on all current residents, care plans and nurse aide data sheets were updated as indicated and verified.  A Quality assurance and Assessment meeting was conducted, on 02/17/12, to validate that the analyses were complete and that the interventions based on the scores were added to the Interdisciplinary Care plans and the corresponding Nurse Aide Data Sheet. Verified by a sign-in sheet and observation of the updated Falls Analysis Forms and Care Plans on all residents in the facility on 02/23/12 .  Based on the above interviews and record reviews, it was determined the Immediate Jeopardy was removed , effective 02/19/12 , as alleged in the AoC with the scope and severity lowered to a "D" as the facility had not completed the QA initiative related to staff monitoring, analysis of monitoring audit results and the development and implementation of the POC to ensure interventions are effective and will prevent recurrence, in order to achieve and maintain compliance.	F 224	
F 279 SS=J	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results,of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care	F 279	F279 <u>483.20(d), 483.20(k)(1) Develop Comprehensive Care Plans</u> It is the practice of Princeton Health and Rehab Center to use the results of assessments to develop, review and revise the resident's

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F 279	Continued From page 11 plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).  This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy and procedure, it was determined the facility failed to provide services to meet professional standards of quality for one resident (#1), in the selected sample of four residents, in accordance with care planning. The facility assessed Resident #1 as a falls risk, upon admission on 04/26/11, related to balance problems, decreased muscular coordination, receiving four medications (Antihypertensive, Diuretic, Hypoglycemic, and a Narcotic), which have side effects, to include dizziness and unsteadiness; however, these risk factors were not addressed in Resident #1's "Falls" Plan of Care. On 05/14/11, at approximately 2:00 AM, the facility administered a PRN (as needed) dose of Lortab (pain medication) to Resident #1. At 4:00 AM, the staff assisted Resident #1 up to a sitting	F 279	F279 (continued) comprehensive plan of care and provide services to meet professional standards of quality.  <u>Corrective Measures for Resident Identified in the deficiency:</u>  <u>Resident #1</u> was discharged from the facility on 5/14/11 to the hospital and expired on 05/19/11, so no additional measures were possible for this resident.  <u>How Other Residents Were Identified Who May Have Been Impacted by the Practice:</u>  All residents comprehensive care plans were reviewed. Those residents identified as receiving anti-hypertensive and pain medication have had side effects of the medication added to their comprehensive plan of care by the MDS coordinator. In addition resident's who scored a 10 or higher on the Fall Risk Analysis were identified as high risk for falls and are provided supervision by staff while sitting on the side of the bed or toilet. This was placed on the nurse aide data sheet and comprehensive care plan for these identified residents. This was completed on 02/18/12 by the unit Charge Nurses, licensed staff and MDS Coordinator and was verified as completed within this statement of deficiency on 02/23/12.  <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u>  The MDS Coordinator and care plan team to include DON/ ADON/ and Unit Charge Nurses were educated on including side effects of anti-hypertensives and pain medications on the resident fall comprehensive plan of care by the Quality Management Nurse on 02/17/12 with return verbal understanding of the training provided. This was verified as completed within this statement of deficiency on 2/23/12.		

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F 279	<p>Continued From page 12</p> <p>position on the side of the bed and left him/her alone without supervision. Resident #1 fell forward from the bed and sustained an intracranial hemorrhage (bleeding within the skull). Resident #1 subsequently expired on 05/19/11. Intracranial Hemorrhage was listed as the underlying cause of death on a certified copy of Resident #1's death certificate.</p> <p>This failure caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/16/12 and determined to exist on 05/14/11. An acceptable Allegation of Compliance (AoC) was received on 02/22/12. Immediate Jeopardy was removed, effective 02/19/12, as alleged in the AoC with the scope and severity lowered to a "D" as the facility had not completed the QA initiative related to staff monitoring, analysis of monitoring audit results and the development and implementation of the POC to ensure interventions are effective and will prevent recurrence, in order to achieve and maintain compliance. Substandard Quality of Care was identified at 483.13 Resident Behavior and Facility Practices and 483.25 Quality of Care. (Refer to F224, F323, F490, and F520)</p> <p>Findings include:</p> <p>A review of the facility's policy and procedure, "Comprehensive Care Plans," revised 06/14/11, revealed it was the facility's policy that residents would have a plan of care for assessed needs. A written plan of care would be initiated at the time of admission and would be incorporated into a comprehensive plan of care following the comprehensive assessment and Minimum Data</p>	F 279	<p>F279 (continued)</p> <p>Education for any inactive staff will be completed prior to returning to active status by the DON / designee prior to their first shift. The MDS Coordinator will continue to place side effects of the medications on the falls comprehensive plan of care for admissions, readmission's, quarterly, annually and with any significant change in status.</p> <p><b>Monitoring Measures to Maintain On-going Compliance:</b></p> <p>A specially called Quality Assurance (QAA) Assessment meeting including the Administrator, Director of Nurses, Assistant Director of Nurses, Clinical Nurse Supervisor, MDS Coordinator, Unit Nurses, Rehab Director, Activities, Business Office, Admission Office, Dietary manager, Medical Records, and Social Services was conducted on 02/17/12 that validated the completion of the fall risk analysis, updates to the comprehensive plans of care and nurse aide data sheets for all residents currently residing in the facility and was validated as completed within this statement of deficiency on 02/23/12.</p> <p>The DON or designee will randomly audit three residents care plan from each unit weekly (approximately) 10% to verify that the comprehensive care plan includes the side effects of pain and anti-hypertensive medications. The audits will continue weekly times 8 weeks then monthly times 6 months. The results of the reviews will be reported to the monthly QA&amp;A committee. If any findings indicate a concern the frequency of monitoring may be increased to validate ongoing compliance and re-education will be provided on an individual basis if indicated.</p>

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F 279	Continued From page 13 Set (MDS) process. The care plan established would be individualized to the resident and their identified risk factors and problems. The care plan would be easily followed by designated staff members. The care plan would be accessible to staff and some interventions would be provided through methods such as the Nurse Aide Data Sheet, assignment sheet or other communication tools.  An interview with Unit Nurse (UN), Registered Nurse (RN) #1, on 02/14/12 at 10:20 AM, revealed the admission assessment was completed within 24 hours of admission and the MDS staff formulated a care plan after the assessment was completed.  An interview with Unit Manager #1, on 02/14/12 at 12:00 PM, revealed she signed off on the comprehensive admission assessment and the MDS staff formulated the initial care plan within 24 hours of a resident's admission.  The facility admitted Resident #1 on 04/26/11 with diagnoses to include Status-post Cerebral Vascular Accident (Stroke), Paralysis of the left side, Traumatic Fracture of the left Clavicle (collar bone), Hypertension, Fatigue and Weakness. The resident also received Coumadin Therapy (a blood thinner).  On 04/26/11, the facility completed a Falls Risk Analysis which determined the resident was at high risk for falls related to three or more falls in the past three months prior to admission to the facility, balance problems, decreased muscular coordination, receiving four medications (Antihypertensive, Diuretic, Hypoglycemic, and a	F 279	

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F 279	Continued From page 14 Narcotic) which have side effects to include dizziness and unsteadiness. The document detailed Resident #1 had three or more predisposing conditions to include Stroke, Fractures, Diabetes and Anemia.  The admission Minimum Data Set (MDS), dated 05/03/11, revealed the facility assessed Resident #1's cognition as intact. He/she required extensive assistance of two staff for bed mobility, transfers, ambulation and toileting. The Comprehensive Care Plan for "Falls," dated 05/12/11, detailed Resident #1 was at risk for falls related to weakness, clavicle fracture, impaired mobility; however, there was no documented evidence the facility addressed the resident's problems with balance or the potential for dizziness and unsteadiness associated with his/her medications. On 05/14/12 the resident was administer Lorlab at 2:00 AM and at 4:00 AM sustained a fall when he/she was left alone sitting on the side of the bed.  An interview with Unit Nurse (UN), Registered Nurse (RN) #1, on 02/14/12 at 10:20 AM, revealed, on 04/26/12, she completed the admission comprehensive assessment on Resident #1 and recalled the resident required much assistance. She stated the resident was weak and would not be safe to be left alone sitting on the side of the bed.  An interview with the MDS Coordinator, on 02/14/12 at 1:35 PM, revealed she was ultimately responsible for the accuracy of the individual care plans. Further interview, on 02/15/12 at 4:40 PM, revealed she did not address the issue of dizziness or unsteadiness on the falls care plan,	F 279			

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F 279	Continued From page 15  She stated side effects from narcotic use were addressed on the care plan for pain, and included monitoring for signs and symptoms of dizziness, unsteadiness, blurred vision and oversedation, however review of the care plan for "Pain" did not monitor for the side effects. She offered no explanation as to why no interventions, that addressed Resident #1 having balance problems, decreased muscular coordination, being on four medications (Antihypertensive, Diuretic, Hypoglycemic, and a Narcotic) with side effects to include dizziness and unsteadiness, were noted on the initial or the comprehensive care plans.  An interview with the Administrator, on 02/14/12 at 3:00 PM, revealed Resident #1 was on the falling star program which designated a resident was at high risk for falls, and a green star was placed outside the resident's door to alert the staff. She stated if a resident was at risk for falls, it should be common knowledge that a resident should not be left sitting on the side of the bed unsupervised, and it was not necessary to document all the risk factors related to balance.  An acceptable Allegation of Compliance was received on 02/22/12 and detailed the following:  The facility's system for screening was reviewed to establish the amount of supervision a resident required to avoid preventable falls. The process was modified to provide a consistent methodical process for determining whether or not a resident may sit on the bed or the toilet unsupervised. The modification enhanced the communication of this information to the facility staff. The revised process required a resident be evaluated for his/her fall risk using the facility's fall risk analysis	F 279	

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F 279	<p>Continued From page 16</p> <p>tool. The falls analysis will be completed by the MDS Coordinator, Unit Charge Nurses and Licensed Nurses. This will be completed on admission, re-admission, quarterly, significant change, and after each fall. Upon completion of this screening tool, a resident who scored a ten or higher on the analysis should not be seated on the side of the bed or toilet by staff and left unsupervised. Supervision means the resident must be within arms' reach of the staff member. Even if a resident scored less than ten, there may be instances where the interdisciplinary team determined that a resident should be supervised. The determination as to whether or not the resident may be unattended on the bedside or toilet, based on the Falls Risk Analysis, will be placed on the resident's interdisciplinary plan of care by the Unit Charge Nurse/Licensed Nurse and updated after admission and readmission, quarterly, annually, significant change, and after each fall. It will be recorded on the resident's Nurse Aide Data Sheet, which is the instruction guide Nursing Assistants utilize to provide care to assigned residents.</p> <p>The Quality Management Nurse trained the Director of Nursing (DON), Assistant Director of Nursing (ADON), and the Staff Development in the process, on 02/17/12, and they were responsible for providing training to all other nursing staff to include Nursing Assistants (NA), Medication Aides (MA), Licensed Nurses (LN), MDS/Care Plan Coordinators, Administrative Nurses and the Administrator, and to continue with nurses and nurses assistants on each oncoming shift until training is completed.</p> <p>A Falls Risk Analysis will be completed for all</p>	F 279	

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F 279	<p>Continued From page 17</p> <p>current residents by the Unit Managers, or other Licensed Nurse designee. The nurse who completed the analysis will be responsible for updating the care plan and the nurse aide data sheet. The Falls Risk Analysis for all current residents were reviewed and revised, if indicated, on 02/16/12 and 02/17/12. The Care Plans and Nurse Aide Data Sheets for those residents were reviewed and/or revised to reflect their need for supervision while sitting unattended on the bedside or toilet.</p> <p>A Quality Assurance and Assessment meeting was conducted, on 02/17/12, to validate that the analysis were completed and the interventions based on the scores were added to the Interdisciplinary Care plans and the corresponding Nurse Aide Data Sheet.</p> <p>The nurse who completed the the falls risk analysis will be responsible for the revision of the care plan and the nurse aide data sheet. The DON or her designee will review for completion of this task through the admission audit process.</p> <p>The UM and/or DON or designee will review for completion after a fall through the Daily AQA process.</p> <p>The Quarterly Fall Risk Analysis will be checked by the designated MDS nurse responsible for the quarterly MDS.</p> <p>On weekends, the CN will be responsible to validate that all falls risk analysis were completed and the care plan and nurse aide data sheet are revise with the proper information.</p>	F 279		

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F 279	<p>Continued From page 18</p> <p>Verification of removal of Immediate Jeopardy was completed as follows:</p> <p>The Quality Management Nurse trained the DON, ADON, and the Staff Development on the process on 02/17/12, and they were responsible for providing training to all other nursing staff including Nursing Assistants (NA), Medication Aides (MA), Licensed Nurses (LN), MDS/Care Plan Coordinators, and Administrative Nurses and the Administrator, and to continue with nurses and nurses assistants on each oncoming shift until training was completed, and verified by sign-in sheets initiated on 02/17/12.</p> <p>A Falls Risk Analysis will be completed by the Unit Managers or other Licensed Nurse designee for all current residents verified as completed on each unit.</p> <p>The nurse completing the analysis will be responsible for updating the care plan and the nurse aide data sheet. The Falls Risk Analysis for all current residents were reviewed and revised, if indicated, on 02/16/12 and 02/17/12, and was verified by the care plan and the nurse aide data sheet for each resident on each unit.</p> <p>The Care Plans and Nurse Aide Data Sheets for those residents were reviewed and/or revised to reflect the need for supervision with sitting unattended when placed on the bedside or toilet by staff, was verified as completed by review of the care plan and the nurse aide data sheet for each resident on each unit.</p> <p>Based on the above interviews and record reviews, it was determined the Immediate</p>	F 279		

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F 279 Continued From page 19  
Jeopardy was removed , effective 02/19/12 , as alleged in the AoC with the scope and severity lowered to a "D" as the facility had not completed the QA initiative related to staff monitoring, analysis of monitoring audit results and the development and implementation of the POC to ensure interventions are effective and will prevent recurrence, in order to achieve and maintain compliance.

F 279

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  
SS=J

F 280

**F280 483.20(d)(3), 483.10(k)(2) Right to Participate in Care Planning Care-Revise CP**

04/06/12

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

It is the practice of Princeton Health and Rehab Center to honor the residents right to participate in planning care and treatment. develop a comprehensive plan of care within seven days of the comprehensive assessment. prepared by an interdisciplinary team and to the extent possible involve the resident, resident's family or legal representative; and periodically review and revise the plan of care after each assessment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

**Corrective Measures for Resident Identified in the deficiency:**

**Resident #4** care plan has been reviewed and revised by the Director of Nurses to reflect the bruising potential related to lung term steroid use related to Rheumatoid Arthritis and refusal of the padding intervention to decrease risk of bruising.

**How Other Residents Were Identified Who May Have Been Impacted by the Practice:**

All resident's comprehensive care plans and nurse aide data sheets were reviewed and revised to reflect current interventions. This was completed by the MDS Coordinator, Unit Charge Nurses and licensed nurses.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview and record review, it was determined the facility failed to

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NAME OF PROVIDER OR SUPPLIER  PRINCETON HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1333 WEST MAIN ST. PRINCETON, KY 42445		
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F 280	<p>Continued From page 20</p> <p>ensure the comprehensive care plan is periodically reviewed and revised by a team of qualified persons after each assessment for one resident (#4), in the selected sample of four residents. A review of the resident's care plan, dated 11/17/11, revealed no documented evidence the facility updated the falls care plan to reflect the padding added to the resident's bedside table.</p> <p>This failure caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/16/12 and determined to exist on 05/14/11. An acceptable Allegation of Compliance (AoC) was received on 02/22/12. Immediate Jeopardy was removed, effective 02/19/12, as alleged in the AoC with the scope and severity lowered to a "D" as the facility had not completed the QA initiative related to staff monitoring, analysis of monitoring audit results and the development and implementation of the POC to ensure interventions are effective and will prevent recurrence, in order to achieve and maintain compliance. Substandard Quality of Care was identified at 483.13 Resident Behavior and Facility Practices and 483.25 Quality of Care. (Refer to F323, F490, and F520)</p> <p>Findings include:</p> <p>A record review revealed the facility admitted Resident #4 on 12/08/09 with diagnoses to include Rheumatoid Arthritis, Osteoarthritis, Degenerative Joint Disease, Diabetes Type II, Malaise and Fatigue.</p> <p>A review of the Comprehensive Care Plan for</p>	F 280	<p>F280 (continued)</p> <p>In addition resident's who scored a 10 or higher on the Fall Risk Analysis were identified as high risk for falls and are provided supervision by staff while sitting on the side of the bed or toilet. This was placed on the nurse aide data sheet and comprehensive care plan for these identified residents. This was completed on 02/18/12 by the unit Charge Nurses, licensed staff and MDS Coordinator and was verified as completed within this statement of deficiency on 02/22/12.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>The MDS Coordinator, Unit Charge Nurses, and licensed staff have been re-educated by the Staff Development Coordinator / designee on updating the comprehensive plan of care with new interventions when indicated and implementation of interventions. This was completed on 02/18/12 and was validated as completed within this statement of deficiency on 02/22/12 with verbal understanding of the training provided. Education for any inactive staff will be completed prior to returning to active status by the DON / designee prior to their first shift worked.</p> <p><u>Monitoring Measures to Maintain On-going Compliance:</u></p> <p>A specially called Quality Assurance (QAA) Assessment meeting including the Administrator, Director of Nurses, Assistant Director of Nurses, Clinical Nurse Supervisor, MDS Coordinator, Unit Nurses, Rehab Director, Activities, Business Office, Admission Office, Dietary manager, Medical Records, and Social Services was conducted on 02/17/12 that validated the completion of the fall risk analysis, updates to the comprehensive plans of care and nurse aide data sheets for all residents currently residing in the facility and was validated as</p>		

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F 280 Continued From page 21  Falls, dated 11/17/11, revealed Resident #4 was at risk for falls related to an unsteady gait and impaired mobility. Interventions included assistance should be provided before the resident attempted to transfer or ambulate, updated 02/01/12. A personal clip alarm was to be used in the bed and wheelchair and staff were to observe for placement. Low bed with a mat placed on the floor and one helper rail, updated 02/15/12. High-sided mattress was placed on the bed, and dycem in the wheelchair. Call light and frequently used items were to be in reach of the resident. The resident removed the alarm at times; remind the resident of the importance of the personal clip alarm. Anti-rollback on the wheelchair and his/her bed against the wall, was added on 02/15/12.  A review of the Fall Risk Analysis, dated 01/18/12, revealed the resident was assessed at high risk for falls. A review of the quarterly Minimum Data Set (MDS), dated 01/24/12, revealed the facility assessed Resident #4 as moderately cognitively impaired and required extensive assistance of two staff for bed mobility and toileting. The resident required extensive assistance of one staff for ambulation, dressing, hygiene and bathing.  A review of the Nurses' Note, dated 01/29/12 at 3:30 AM, revealed documentation of two quarter-sized purple discolorations to the left cheek from lying on the left side with his/her hand under his/her head. A review of the physician's progress notes, dated 01/29/12, revealed documentation by the Advance Practice Registered Nurse (APRN), who noted two quarter-sized dark bluish bruises on the resident's	F 280	F280 (continued) completed within this statement of deficiency on 02/23/12. The Director of Nurses / designee will review the Fall Risk Analysis for completion with corresponding updates to the comprehensive plan of care and nurse aide data sheets, upon admission, readmission, quarterly, annual, significant change, and following a fall event through the daily AQA process using an investigation checklist and the revised daily AQA form to validate that interventions are implemented. On weekends the charge nurse will be responsible to validate the Fall Risk Analysis for completion with corresponding updates to the comprehensive plan of care and nurse aide data sheets following any fall event or new admission with validation that the interventions are implemented. Any issues identified with the above process will have re-education provided to the individual staff member by the Staff Development Coordinator / designee.  In addition the DON / designee will audit 3 residents comprehensive care plans from each unit weekly times 8 weeks then monthly times 6 months to verify that the care plan reflects current interventions. The results of the reviews will be reported to the monthly QA&A committee. If any findings indicate a concern the frequency of monitoring may be increased to validate ongoing compliance and re-education will be provided on an individual basis if indicated.		

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F 280	<p>Continued From page 22</p> <p>left cheek and forehead, and the resident stating he/she bumped that area trying to get out of the bed.</p> <p>A review of an Incident/Accident report, dated 01/29/12, identified two quarter-sized bruises on the left cheek and stated the cause was related to the resident lying on the left side with his/her hand under his/her head. For action to be taken, it was noted that the bruising would be monitored for ten days and then reassessed. Further review of the Incident /Accident report revealed to pad the bedside table, monitor bruising and start on anti-inflammatory medication in the morning. An interview with the Assistant Director of Nursing (ADON), on 02/16/12 at 3:55 PM, revealed Resident #4 mentioned that he/she fell and hit the table, so she added an intervention to pad the bedside table as a precautionary measure.</p> <p>A review of the care plan, dated 11/17/11, revealed no documented evidence the facility updated the resident's falls care plan to reflect the padding added to the bedside table.</p> <p>An observation of Resident #4, on 02/13/12 at 7:10 AM, revealed the resident was sitting in a wheelchair in his/her room. The resident was noted with a large pink and purple bruise on the left cheek. When questioned about what happened to his/her cheek, the resident stated he/she fell off the bed and hit his/her face on the table. Observation of the resident's room revealed no bedside table having padding. Interviews with Certified Medication Technician #1, on 02/16/12 at 11:10 AM, and State Registered Nurse Aida (SRNA) #11 and #12, on 02/16/12 at 12:20 PM, revealed that the facility</p>	F 280		

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F 280	Continued From page 23  had not padded the resident's bedside table prior to 02/16/12. The resident's Power of Attorney, on 02/16/12 at 12:30 PM, stated that she visits the resident weekly and had never witnessed the bedside table padded since the incident on 01/29/12.  An interview with the Administrator, on 02/22/12 at 9:30 AM, revealed whenever there was an accident or incident, the licensed nurse was notified and that person initiated an investigation by utilization of the Incident/Accident Form, and also completed an investigative analysis which indicated the what, when, how, and why the incident occurred. When a determination was made, the physician and the family were notified. Every incident was addressed in the Abbreviated Quality Assurance (AQA) meeting held Monday through Friday. If the incident occurred on the weekend, the Staff Development/Week-end Supervisor reviewed it. In the AQA meeting, interventions are discussed. The licensed nurse is contacted with any questions. The resident's record is reviewed. The care plan and the the Nurse Aide Data Sheet are updated. A care plan progress note was documented in the care plan section of the resident's record.  An acceptable Allegation of Compliance was received on 02/22/12 and detailed the following:  The facility's system for screening was reviewed to establish the amount of supervision a resident required to avoid preventable falls. The process was modified to provide a consistent methodical process for determining whether or not a resident may sit on the bed or the toilet unsupervised. The modification enhanced the communication of this	F 280	

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F 280	<p>Continued From page 24</p> <p>information to the facility staff. The revised process required a resident be evaluated for his/her fall risk using the facility's fall risk analysis tool. The falls analysis will be completed by the MDS Coordinator, Unit Charge Nurses and Licensed Nurses. This will be completed on admission, re-admission, quarterly, significant change, and after each fall. Upon completion of this screening tool, a resident who scored a ten or higher on the analysis should not be seated on the side of the bed or toilet by staff and left unsupervised. Supervision means the resident must be within arms' reach of the staff member. Even if a resident scored less than ten, there may be instances where the interdisciplinary team determined that a resident should be supervised. The determination as to whether or not the resident may be unattended on the bedside or toilet, based on the Falls Risk Analysis, will be placed on the resident's interdisciplinary plan of care by the Unit Charge Nurse/Licensed Nurse and updated after admission and readmission, quarterly, annually, significant change, and after each fall. It will be recorded on the resident's Nurse Aide Data Sheet, which is the instruction guide Nursing Assistants utilize to provide care to assigned residents.</p> <p>The Quality Management Nurse trained the Director of Nursing (DON), Assistant Director of Nursing (ADON), and the Staff Development in the process, on 02/17/12, and they were responsible for providing training to all other nursing staff to include Nursing Assistants (NA), Medication Aides (MA), Licensed Nurses (LN), MDS/Care Plan Coordinators, Administrative Nurses and the Administrator, and to continue with nurses and nurses assistants on each</p>	F 280		

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F 280	<p>Continued From page 25</p> <p>oncoming shift until training is completed.</p> <p>A Falls Risk Analysis will be completed for all current residents by the Unit Managers, or other Licensed Nurse designee. The nurse who completed the analysis will be responsible for updating the care plan and the nurse aide data sheet. The Falls Risk Analysis for all current residents were reviewed and revised, if indicated, on 02/16/12 and 02/17/12. The Care Plans and Nurse Aide Data Sheets for those residents were reviewed and/or revised to reflect their need for supervision while sitting unattended on the bedside or toilet.</p> <p>A Quality Assurance and Assessment meeting was conducted, on 02/17/12, to validate that the analysis were completed and the interventions based on the scores were added to the Interdisciplinary Care plans and the corresponding Nurse Aide Data Sheet.</p> <p>The nurse who completed the the falls risk analysis will be responsible for the revision of the care plan and the nurse aide data sheet. The DON or her designee will review for completion of this task through the admission audit process.</p> <p>The UM and/or DON or designee will review for completion after a fall through the Daily AQA process.</p> <p>The Quarterly Fall Risk Analysis will be checked by the designated MDS nurse responsible for the quarterly MDS.</p> <p>On weekends, the CN will be responsible to validate that all falls risk analysis were completed</p>	F 280		

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F 280	<p>Continued From page 26</p> <p>and the care plan and nurse aide data sheet are revise with the proper information.</p> <p>Verification of removal of Immediate Jeopardy was completed as follows:</p> <p>The Quality Management Nurse trained the DON, ADON, and the Staff Development on the process on 02/17/12, and they were responsible for providing training to all other nursing staff including Nursing Assistants (NA), Medication Aides (MA), Licensed Nurses (LN), MDS/Care Plan Coordinators, and Administrative Nurses and the Administrator, and to continue with nurses and nurses assistants on each oncoming shift until training was completed, and verified by sign-in sheets initiated on 02/17/12.</p> <p>A Falls Risk Analysis will be completed by the Unit Managers or other Licensed Nurse designee for all current residents verified as completed on each unit.</p> <p>The nurse completing the analysis will be responsible for updating the care plan and the nurse aide data sheet. The Falls Risk Analysis for all current residents were reviewed and revised, if indicated, on 02/16/12 and 02/17/12, and was verified by the care plan and the nurse aide data sheet for each resident on each unit.</p> <p>The Care Plans and Nurse Aide Data Sheets for those residents were reviewed and/or revised to reflect the need for supervision with sitting unattended when placed on the bedside or toilet by staff, was verified as completed by rewlav of the care plan and the nurse aide data sheet for each resident on each unit.</p>	F 280		

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F 280	Continued From page 27  Based on the above interviews and record reviews, it was determined the Immediate Jeopardy was removed, effective 02/19/12, as alleged in the AoC with the scope and severity lowered to a "D" as the facility had not completed the QA initiative related to staff monitoring, analysis of monitoring audit results and the development and implementation of the POC to ensure interventions are effective and will prevent recurrence, in order to achieve and maintain compliance.	F 280		
F 282 SS=J	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 and record review, it was determined the facility failed to ensure services provided or arranged by the facility were provided by qualified persons in accordance with each resident's plan of care for one resident (#3), in the selected sample of four residents. A review of the Comprehensive Care Plan for falls, dated 05/17/11, included an intervention for non-skid socks to be on at bedtime as the resident allowed. Further review of a Fall Risk Analysis, dated 01/03/12, revealed the resident was assessed as high risk for falls. On 02/14/12, the resident experienced a fall while using the toilet during which time the staff was assisting him/her.	F 282	F282 <u>483.20(k)(3)(ii) Services by Qualified Persons / Per Care Plan</u> It is the practice of Princeton Health and Rehab Center to provide services by qualified persons in accordance with each resident's written plan of care.  <u>Corrective Measures for Resident Identified in the deficiency:</u>  <u>Resident #3</u> fall risk analysis was updated on 02/16/12, was screened by Physical Therapy on 02/18/12 and placed on caseload with the following recommendations: will transfer to bedside commode only at this time with assist of 1 with rolling walker. Resident's plan of care and nurse aide data sheet were updated to reflect these changes by the Unit Charge Nurse. This was completed on 02/18/12. Resident was seen by an orthopedic surgeon on 02/28/12 with only recommendation to keep a knee immobilizer or brace to keep knee while out of bed. All non skid socks identified by the resident as worn out were validated to ensure non skid grips were intact.	04/06/12

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F 282	Continued From page 28  This failure caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/16/12 and determined to exist on 05/14/11. An acceptable Allegation of Compliance (AoC) was received on 02/22/12. Immediate Jeopardy was removed, effective 02/19/12, as alleged in the AoC with the scope and severity lowered to a "D" as the facility had not completed the QA initiative related to staff monitoring, analysis of monitoring audit results and the development and implementation of the POC to ensure interventions are effective and will prevent recurrence, in order to achieve and maintain compliance. Substandard Quality of Care was identified at 483.13 Resident Behavior and Facility Practices and 483.25 Quality of Care. (Refer to F323, F490, and F520)  Findings include:  A record review revealed the facility admitted Resident #3 on 04/27/11 with diagnoses to include Osteoarthritis, Anticoagulation use, Hypertension, Anxiety, Depressive Disorder and Anemia.  A review of the Comprehensive Care Plan, "At Risk for Falls," dated 05/17/11, included an intervention for non-skid socks to be on at bedtime as the resident allowed. A review of a Fall Risk Analysis, dated 01/03/12, revealed Resident #3 was at high risk for falls.  A review of the quarterly Minimum Data Set (MDS), dated 01/18/12, revealed the facility assessed Resident #3 as cognitively intact, requires extensive assistance of two staff for bed	F 282	F282 (continued) <u>How Other Residents Were Identified Who May Have Been Impacted by the Practice:</u>  The comprehensive care plans and nurse aide data sheets were reviewed and updated as indicated with all current interventions to validate identified interventions are care planned and implemented on each resident currently residing in the facility by the MDS Coordinator, Unit Charge Nurses or Licensed Nurse designee. This was completed by 02/18/12 and was validated as complete within this statement of deficiency on 02/22/12.  In addition resident's who scored a 10 or higher on the Fall Risk Analysis were identified as high risk for falls and are provided supervision by staff during care provided while sitting on the side of the bed or toilet. This was placed on the nurse aide data sheet and comprehensive care plan for these identified residents. This was completed on 02/18/12 by the unit Charge Nurses, licensed staff and MDS Coordinator and was verified as completed within this statement of deficiency on 02/22/12.  <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u>  All facility licensed nurses and administrative staff were educated in the process related to conducting an investigation, interventions, implementing and updating care plans and nurse aide data sheets by the Quality Management Nurse, Director of Nurses, Assistant Director of Nurses, and the Staff Development Coordinator. This was completed by 02/18/12 and validated as complete within this statement of deficiency on 02/22/12 with verbal understanding of the training provided. Education for any inactive staff will be completed prior to returning to active status by the DON / designee prior to their first shift.		

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F 282	<p>Continued From page 29</p> <p>mobility, transfers, ambulation, toileting, and extensive assistance of one staff for personal hygiene and bathing.</p> <p>An interview with Resident #3, on 02/14/12 at 12:00 PM, revealed he/she experienced a fall "last night while I was using the toilet." Resident #3 stated while a State Registered Nurse Aide (SRNA) assisted him/her to pull up his/her pants, his/her feet slipped out from under him/her, and caused him/her to fall back onto the toilet. Resident #3 was not able to recall the staff who assisted him/her. The resident stated he/she required the staff's assistance to the toilet, on and off the toilet, and to pull his/her pants up and down due to hand weakness. On 02/15/12 at 9:20 AM, Resident #3 voiced complaints of hip pain, and was not sure the pain was associated with the recent fall on 02/14/12. On 02/15/12 at 11:30 AM, the resident stated the hip pain was "better." On 02/16/12 at 3:25 PM, Resident #3 stated the hip pain was worse and he/she could hardly sit on the commode. When asked if he/she wore non-skid socks the night of the fall, Resident #3 stated the non-skid socks he/she wore when the fall occurred, on 02/14/12, were worn out and did not prevent his/her feet from sliding. The resident stated the staff had been made aware of the need for new socks; however, the facility had not provided new socks until 02/15/12.</p> <p>The facility presented an Incident/Accident report, on 02/16/12 at 9:45 AM, which included three staff statements that did not address the incident as was reported by the resident. Licensed Practical (LPN) #1 was the charge nurse and her statement stated no fall was reported to her on the night of 02/13/12. SRNA #8's statement</p>	F 282	<p>F282 (continued) <u>Monitoring Measures to Maintain On-going Compliance:</u></p> <p>A specially called Quality Assurance (QAA) Assessment meeting including the Administrator, Director of Nurses, Assistant Director of Nurses, Clinical Nurse Supervisor, MDS Coordinator, Unit Nurses, Rehab Director, Activities, Business Office, Admission Office, Dietary manager, Medical Records, and Social Services was conducted on 02/17/12 that validated the completion of the fall risk analysis, updates to the comprehensive plans of care and nurse aide data sheets for all residents currently residing in the facility and was validated as completed within this statement of deficiency on 02/23/12.</p> <p>The Director of Nurses / designee will review the Fall Risk Analysis for completion with corresponding updates to the comprehensive plan of care and nurse aide data sheets, upon admission, readmission, quarterly, annual, significant change, and following a fall event through the daily AQA process using an investigation checklist and the revised daily AQA form to validate that interventions are implemented. On weekends the charge nurse will be responsible to validate the Fall Risk Analysis for completion with corresponding updates to the comprehensive plan of care and nurse aide data sheets following any fall event or new admission with validation that the interventions are implemented. Any issues identified with the above process will have re-education provided to the individual staff member by the Staff Development Coordinator / designee.</p> <p>DON / designee will audit 3 residents comprehensive care plans from each unit weekly times 8 weeks then monthly times 6 months to verify that the care plan reflects current</p>

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F 282	Continued From page 30  revealed she took Resident #3 to the toilet and the resident always "plops" down hard on the toilet and this was usual behavior for the resident so she did not feel the need to report it to the nurse. She stated the resident refused help with sitting down on the toilet and did not complain of pain. SRNA #9 denied any knowledge of the incident. The facility did not present evidence of an investigation which determined a root cause of the fall, identified the resident's non-skid socks were worn out or replaced the non-skid socks were implemented to prevent the fall.  An interview with the Administrator, on 02/22/12 at 9:30 AM, revealed when there was an accident or incident, the licensed nurse was notified and that person was to initiate an investigation by utilization of the incident/Accident Form. The nurse also filled out an investigative analysis which indicated the what, when, how, and why the incident occurred. When a determination was made, the physician and the family were notified. If it was an emergent situation, care was provided before this took place and the Administrator and the Director of Nursing (DON) were notified.  An acceptable Allegation of Compliance was received on 02/22/12 and detailed the following:  The facility's system for screening was reviewed to establish the amount of supervision a resident required to avoid preventable falls. The process was modified to provide a consistent methodical process for determining whether or not a resident may sit on the bed or the toilet unsupervised. The modification enhanced the communication of this information to the facility staff. The revised process required a resident be evaluated for	F 282	F282 (continued) interventions. The results of the reviews will be reported to the monthly QA&A committee. If any findings indicate a concern the frequency of monitoring may be increased to validate ongoing compliance and re-education will be provided on an individual basis if indicated.		

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F 282	<p>Continued From page 31</p> <p>his/her fall risk using the facility's fall risk analysis tool. The falls analysis will be completed by the MDS Coordinator, Unit Charge Nurses and Licensed Nurses. This will be completed on admission, re-admission, quarterly, significant change, and after each fall. Upon completion of this screening tool, a resident who scored a ten or higher on the analysis should not be seated on the side of the bed or toilet by staff and left unsupervised. Supervision means the resident must be within arms' reach of the staff member. Even if a resident scored less than ten, there may be instances where the interdisciplinary team determined that a resident should be supervised. The determination as to whether or not the resident may be unattended on the bedside or toilet, based on the Falls Risk Analysis, will be placed on the resident's interdisciplinary plan of care by the Unit Charge Nurse/Licensed Nurse and updated after admission and readmission, quarterly, annually, significant change, and after each fall. It will be recorded on the resident's Nurse Aide Data Sheet, which is the instruction guide Nursing Assistants utilize to provide care to assigned residents.</p> <p>The Quality Management Nurse trained the Director of Nursing (DON), Assistant Director of Nursing (ADON), and the Staff Development in the process, on 02/17/12, and they were responsible for providing training to all other nursing staff to include Nursing Assistants (NA), Medication Aides (MA), Licensed Nurses (LN), MDS/Care Plan Coordinators, Administrative Nurses and the Administrator, and to continue with nurses and nurses assistants on each oncoming shift until training is completed.</p>	F 282		

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F 282	<p>Continued From page 32</p> <p>A Falls Risk Analysis will be completed for all current residents by the Unit Managers, or other Licensed Nurse designee. The nurse who completed the analysis will be responsible for updating the care plan and the nurse aide data sheet. The Falls Risk Analysis for all current residents were reviewed and revised, if indicated, on 02/16/12 and 02/17/12. The Care Plans and Nurse Aide Data Sheets for those residents were reviewed and/or revised to reflect their need for supervision while sitting unattended on the bedside or toilet.</p> <p>A Quality Assurance and Assessment meeting was conducted, on 02/17/12, to validate that the analysis were completed and the interventions based on the scores were added to the Interdisciplinary Care plans and the corresponding Nurse Aide Data Sheet.</p> <p>The nurse who completed the the falls risk analysis will be responsible for the revision of the care plan and the nurse aide data sheet. The DON or her designee will review for completion of this task through the admission audit process.</p> <p>The UM and/or DON or designee will review for completion after a fall through the Daily AQA process.</p> <p>The Quarterly Fall Risk Analysis will be checked by the designated MDS nurse responsible for the quarterly MDS.</p> <p>On weekends, the CN will be responsible to validate that all falls risk analysis were completed and the care plan and nurse aide data sheet are revise with the proper information.</p>	F 282		

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F 282	<p>Continued From page 33</p> <p>Verification of removal of immediate Jeopardy was completed as follows:</p> <p>The Quality Management Nurse trained the DON, ADON, and the Staff Development on the process on 02/17/12, and they were responsible for providing training to all other nursing staff including Nursing Assistants (NA), Medication Aides (MA), Licensed Nurses (LN), MDS/Care Plan Coordinators, and Administrative Nurses and the Administrator, and to continue with nurses and nurses assistants on each oncoming shift until training was completed, and verified by sign-in sheets initiated on 02/17/12.</p> <p>A Falls Risk Analysis will be completed by the Unit Managers or other Licensed Nurse designee for all current residents verified as completed on each unit.</p> <p>The nurse completing the analysis will be responsible for updating the care plan and the nurse aide data sheet. The Falls Risk Analysis for all current residents were reviewed and revised, if indicated, on 02/16/12 and 02/17/12, and was verified by the care plan and the nurse aide data sheet for each resident on each unit.</p> <p>The Care Plans and Nurse Aide Data Sheets for those residents were reviewed and/or revised to reflect the need for supervision with sitting unattended when placed on the bedside or toilet by staff, was verified as completed by review of the care plan and the nurse aide data sheet for each resident on each unit.</p> <p>Based on the above interviews and record</p>	F 282	

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F 282	Continued From page 34 reviews, it was determined the Immediate Jeopardy was removed, effective 02/19/12, as alleged in the AoC with the scope and severity lowered to a "D" as the facility had not completed the QA initiative related to staff monitoring, analysis of monitoring audit results and the development and implementation of the POC to ensure interventions are effective and will prevent recurrence, in order to achieve and maintain compliance.	F 282			
F 323 SS=J	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, and review of the facility's policies and procedures, it was determined the facility failed to ensure three residents (#1, #3, and #4), in the selected sample of four residents, received adequate supervision and assistance devices to prevent accidents. The facility failed to follow their "Falls" and "Incident/Accident" policies and procedures. The facility's staff failed to provide necessary supervision to prevent accidents, failed to ensure interventions were implemented to prevent fall occurrence, and failed to thoroughly investigate to identify causal factors of falls in	F 323	F323 <u>483.25(h) Free of Accident Hazards / Supervision / Devices</u> It is the practice of Princeton Health and Rehab Center to 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.  <u>Corrective Measures for Resident Identified in the deficiency:</u>  <u>Resident #1</u> was discharged from the facility on 5/14/11 to the hospital and expired on 05/19/11, so no additional measures were possible for this resident. <u>Resident #3</u> fall risk analysis was updated on 02/16/12, was screened by Physical Therapy on 02/18/12 and placed on caseload with the following recommendations: will transfer to bedside commode only at this time with assist of 1 with rolling walker. Resident's plan of care and nurse aide data sheet were updated to reflect these changes by the Unit Charge Nurse. This was completed on 02/18/12. Resident was seen by an orthopedic surgeon on 02/28/12 with only recommendation to keep a knee immobilizer or brace to knee while out of bed. All non skid socks identified by the resident as worn out were validated to ensure non skid grips were intact.	04/06/12	

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F 323	<p>Continued From page 35</p> <p>order to prevent recurrence. The facility had assessed Resident #1 as high risk for falls upon admission and facility staff was knowledgeable that Resident #1 required extensive assistance, having poor sitting balance and was identified on the falling star program. On 05/14/11, at approximately 2:00 AM, the facility administered a PRN (as needed) dose of Lorlab to Resident #1. At 4:00 AM, the staff assisted Resident #1 to the side of the bed to a sitting position, then left him/her alone in the room unsupervised. Resident #1 fell forward from the bed landing on the floor, sustaining an Intracranial hemorrhage (bleeding within the skull) and subsequently expired on 05/19/11. Intracranial Hemorrhage was listed as the underlying cause of death on a certified copy of Resident #1's death certificate. The facility's investigation failed to identify staff had not provided supervision to the resident, nor developed a care plan which identified all the falls risk factors. Resident #3 sustained a fall, on 02/14/12, when his/her feet slipped from under him/her as staff as staff assisted him/her to stand up from the toilet. The facility's investigation failed to identify the causal factor of the fall and failed to identify that facility staff did not ensure Interventions were effective. Resident #4 who sustained a fall from bed which resulted in a bruise to the left cheek. The facility's investigation failed to address and investigate that resident's statements that he/she had fallen, failed to identify the causal factors and failed to ensure that preventive measures detailed on the investigation were care planned and implemented to prevent further occurrence.</p> <p>This failure caused or is likely to cause serious injury, harm, impairment, or death to a resident.</p>	F 323	<p>F323 (continued) <b>Resident #4</b> fall risk analysis was updated on 02/16/12, had the care plan reviewed and revised by the Director of Nurses to reflect the bruising potential related to long term steroid use related to Rheumatoid Arthritis and refusal of padding to table to decrease risk of bruising.</p> <p><b>How Other Residents Were Identified Who May Have Been Impacted by the Practice:</b></p> <p>A Fall Risk Analysis was completed on each resident currently residing in the facility by the MDS Coordinator, Unit Charge Nurses or licensed Nurse designee and was completed by 02/17/12. Resident's who scored a 10 or higher on the Fall Risk Analysis were identified as high risk for falls and are provided supervision by staff while sitting on the side of the bed or when on the toilet. This was placed on the nurse aide data sheet and comprehensive care plan for these identified residents. This was completed by 02/18/12 by the unit Charge Nurses, licensed staff and MDS Coordinator. These items were verified as completed within this statement of deficiency on 02/23/12.</p> <p>The comprehensive care plans and nurse aide data sheets were reviewed and revised as indicated to validate all residents have current interventions identified for those residents currently residing in the facility. This was completed by the MDS Coordinator, Unit charge nurses or Licensed Nurse designee by 02/17/12. These items were verified as completed within this statement of deficiency on 02/23/12.</p> <p><b>Measures Implemented or Systems Altered to Prevent Re-occurrence:</b></p> <p>All facility staff including the Nursing Assistants, Medication Aides, Administrative and Licensed Nurses, Administrator, Social Services, Activities, Dietary, Environmental Services, Housekeeping, and Laundry have been</p>

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F 323	Continued From page 36  Immediate Jeopardy was identified on 02/16/12 and determined to exist on 05/14/11. An acceptable Allegation of Compliance (AoC) was received on 02/22/12. Immediate Jeopardy was removed, effective 02/19/12, as alleged in the AoC with the scope and severity lowered to a "D" as the facility had not completed the QA initiative related to staff monitoring, analysis of monitoring audit results and the development and implementation of the POC to ensure interventions are effective and will prevent recurrence, in order to achieve and maintain compliance. Substandard Quality of Care was identified at 483.13 Resident Behavior and Facility Practices and 483.25 Quality of Care. (Refer to F224, F279, F280, F282, F490, and F520)  Findings include:  A review of the facility's policy and procedure, "Falls," dated 04/28/11, revealed upon admission, the facility would identify residents at risk for fall by utilization of the "Falls Risk Analysis" form. Based on the falls analysis, preventive/safety measures would be implemented as appropriate, for residents identified at risk for falls. In the event of a fall, a post fall analysis was to be conducted to aid in identifying contributing factors.  A review of the facility's policy and procedure, "Incident/Accident," dated 06/09/11, revealed residents were reviewed routinely and through the care planning process for factors that may place them at risk for incidents or accidents. Interventions would be implemented based on the analysis findings. The facility would investigate	F 323	F323(continued) re-educated on the facility's Abuse/ Neglect Policy by the Staff Development Coordinator / designee and the Quality Management Specialist. A post test was used to validate understanding of the education provided. Education for any inactive staff will be completed prior to returning to active status by the DON / designee prior to their first shift. This education was completed on 02/23/12 and was verified as completed through in-service sign in sheets and interviews within this statement of deficiency on 02/23/12.  All facility licensed nurses were educated in the process related to falls, fall prevention, supervision, conducting an investigation, interventions, implementing and updating care plans and nurse aide data sheets by the Quality Management Nurse, Director of Nurses, Assistant Director of Nurses, and the Staff Development Coordinator / designee and was completed on 02/23/12. A post test and or return verbal understanding was used to validate understanding of the education provided. Education for any inactive staff will be completed prior to returning to active status by the DON / designee prior to their first shift. This was verified as completed through in-service sign in sheets and interviews within this statement of deficiency on 02/23/12.  <u>Monitoring Measures to Maintain On-going Compliance:</u>  A specially called Quality Assurance (QAA) Assessment meeting including the Administrator, Director of Nurses, Assistant Director of Nurses, Clinical Nurse Supervisor, MDS Coordinator, Unit Nurses, Rehab Director, Activities, Business Office, Admission Office, Dietary manager, Medical Records, and Social Services was conducted on 02/17/12 that validated the completion of the fall risk analysis.		

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F 323	Continued From page 37  incidents, accidents and injuries to identify the potential contributing factors. Based on the findings of the investigation the care plan would be reviewed and revised if needed to include preventative interventions to decrease the potential of recurrence.  1. A record review revealed, on 04/26/11, the facility admitted Resident #1 with diagnoses to include Status post Cerebral Vascular Accident (Stroke), Paralysis of the left side, Traumatic Fracture of the left Clavicle (collar bone), Hypertension, Fatigue and Weakness. The resident also received Coumadin Therapy (a blood thinner). A review of the Falls Risk Analysis, dated 04/26/11, revealed upon admission the facility assessed the resident as high risk for falls related to having three or more falls in the past three months prior to admission to the facility. Further record review revealed the resident had balance problems, decreased muscular coordination, and was on four medications (Antihypertensive, Diuretic, Hypoglycemic, and a Narcotic) with side effects to include dizziness and unsteadiness. Predisposing factors for Resident #1 included Stoke, Fractures, Diabetes, and Anemia.  A review of the admission Minimum Data Set (MDS), dated 05/03/11, revealed the facility assessed Resident #1 as cognitively intact. The assessment detailed that he/she required extensive assistance of two staff for bed mobility, transfers, ambulation and toileting. A review of the Comprehensive Care Plan for "Falls," dated 05/12/11, revealed Resident #1 was at risk for falls related to weakness, clavicle fracture, and impaired mobility; however, there was no	F 323	F323 (continued) updates to the comprehensive plans of care and nurse aide data sheets for all residents currently residing in the facility and was validated as completed within this statement of deficiency on 02/23/12.  In the event a resident refuses supervision, assistance or other fall safety interventions, they will be informed of the risks associated with refusal, offered alternatives. If they continue to refuse supervision, attendance or other interventions they will be asked to sign a Refusal of Treatment Form if they are alert and oriented. A Non-Compliance Form is utilized for residents with cognitive impairment and is discussed and reviewed with the responsible person. The facility will continue to develop/implement interventions to meet the resident's safety needs while respecting the resident's rights. The resident's choice to decline the recommended intervention will be included in the resident's plan of care and Nurse Aide Data Sheet, but resident will still be encouraged to accept the planned interventions and alternatives to meet the resident's needs will be offered to the resident and or decision maker. This will be documented on the resident's plan of care.  The Director of Nurses / designee will review the Fall Risk Analysis for completion with corresponding updates to the comprehensive plan of care and nurse aide data sheets, upon admission, readmission, quarterly, annual, significant change, and following a fall event through the daily AQA process using an investigation checklist and the revised daily AQA form to validate that interventions are implemented. On weekends the charge nurse will be responsible to validate the Fall Risk Analysis for completion with corresponding updates to the comprehensive plan of care and nurse aide data sheets following any fall event of	

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F 323 Continued From page 38  
evidence the facility addressed the resident's condition related to balance or the potential for dizziness and unsteadiness associated with his/her medication.

An interview with Unit Nurse (UN), Registered Nurse (RN) #1, on 02/14/12 at 10:20 AM revealed on 04/26/12, she completed Resident #1's admission assessment. She stated the resident required much assistance, was weak, and not safe to sit up alone on the side of the bed. Interviews with SRNA #2 on 02/15/12 at 12:10 PM, SRNA #3 on 02/15/12 at 11:55 AM, SRNA #4 on 02/13/12 at 10:43 AM, SRNA #5 on 02/15/12 at 12:45 PM, SRNA #6 on 02/15/12 at 10:55 AM, and SRNA #7 on 02/14/12 at 10:00 AM, revealed Resident #1 had periods of weakness and was only able to maintain balance while sitting on the side of the bed for a maximum of ten minutes with assistance because the resident swayed and was "wobbly". Each of the SRNA interviews revealed it was not safe to leave Resident #1 alone sitting on the side of the bed.

Interview with SRNA #1, on 02/27/12 at 9:27 AM, revealed SRNA #1 stated Resident #1 constantly asked for pain medication. She stated she let the nurse know on 02/14/12 that the resident requested medication for leg pain and the nurse gave pain medication to Resident #1. An interview with LPN #1, on 02/14/12 at 9:40 AM, revealed, on 05/14/11 at 2:00 AM, Resident #1 complained of leg cramps and Lortab was administered. She stated this was not unusual behavior as the resident frequently complained of leg cramps.

Further interview with LPN #1 and interview with

F 323 (continued)  
new admission with validation that the interventions are implemented. Any issues identified with the above process will have re-education provided to the individual staff member by the Staff Development Coordinator / designee.

Additional re-education on the facility's Abuse / Neglect policy, process related to falls, fall prevention, supervision, for all staff, conducting an investigation, interventions, implementing and updating care plans and nurse aide data sheets, for all nursing staff, will be conducted monthly times three months then quarterly for one year by the Staff Development Coordinator / designee. A post test and or return verbal understanding will be utilized to validate understanding of training received. The DON will audit 3 charts per wing (approximately 10%) weekly times 8 weeks then monthly times 6 months to validate that the fall risk analysis has been completed, and interventions and level of supervision have been placed on the comprehensive plan of care and nurse aide data sheets.

The audit results will be reported to the monthly QAA meeting by the Director of Nurses / designee for the next six months to ensure interventions are effective to achieve and maintain compliance. If any findings indicate a concern the frequency of monitoring may be increased to validate ongoing compliance.

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NAME OF PROVIDER OR SUPPLIER  PRINCETON HEALTH & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1333 WEST MAIN ST. PRINCETON, KY 42445
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F 323 Continued From page 39  
SRNA #1, on 02/13/12 at 10:30 AM, revealed that Resident #1 requested to sit up on the side of the bed due to leg cramps and the SRNA assisted the resident up on the side of the bed. Further interview with SRNA #1 revealed she assisted the resident to sit up on the side of the bed, propped a pillow under his/her left arm then left the room to go answer other call lights, leaving the resident unsupervised. She stated Resident #1 was able to brace himself/herself with the right hand while sitting on the side of the bed. There was Personal Clip (PC) alarm attached to the right (Rt) side of the resident's gown when she left the room. She stated she was in a room down the hall when she heard a loud noise, like a chair moving, and ran back down the hall to Resident #1's room to find the resident on the floor on the floor mat. Resident #1 was bleeding from his/her knees and from an area on his/her head. Both SRNA #1 and LPN #1 revealed the resident was found face down on the floor mat at the bedside.

F 323:

A review of the Skilled Assessment, dated 05/14/11 at 4:00 AM, revealed documentation by LPN #1. The documentation revealed Resident #1 was sitting on the side of the bed, fell forward and was found on the floor in his/her room. Additional documentation revealed the resident complained of severe pain to the left shoulder and left leg and a laceration was noted to the corner of Resident #1's left eye, which was swollen. Further interview with LPN #1 revealed Resident #1 told her that he/she lost his/her balance and fell forward on to the floor mat. LPN #1 stated the Lortab was administered prior to the resident's fall and may have caused the resident to be "light headed." She stated they should not have left the resident alone sitting up on the side

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F 323	Continued From page 40 of the bed.  A review of the Post Fall Analysis, dated 05/14/11 at 4:00 AM, revealed Resident #1 was in his/her room, sitting on the side of the bed with a floor mat in place. The Personal Clip (PC) alarm was in place and sounded at the time of the fall. Detailed under "Environmental factors that may be related to the fall," was, "Resident was sitting on the side of the bed, lost his/her balance and fell forward." While the facility had assessed the resident as high risk related to left sided paralysis, balance problems, decreased muscular coordination requiring extensive assistance and had administered a narcotic two hours prior to the fall with side effects to include dizziness and unsteadiness; there was no documented evidence the facility's investigation had identified that staff had left the resident alone sitting on the side of the bed, unsupervised, prior to the fall.  A second interview with SRNA #1 on 02/15/12 at 1:00 PM, revealed she was aware Resident #1 was on the Falling Star Program and detailed that meant the resident was a high falls risk. She stated residents on the Falling Star Program had alarms, floor mats, required assistance with bed mobility, transfer, ambulation and required two staff assistance at all times. She revealed she was alone while providing care for Resident #1 because SRNA #4, who was working with her that night, was down the hall answering lights. She stated she was aware Resident #1 was paralyzed on the left side, required extensive assistance all care. She stated Resident #1 would only want to sit up 5-10 minutes at a time, then would ask to lay back down. She stated she should not have left the resident alone sitting on the side of the	F 323		

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F 323	<p>Continued From page 41</p> <p>bed, but it was a busy night and she "had to do what she had to do." An interview with SRNA#4 on 02/13/12 at 10:43 AM revealed at the time Resident #1 fell from the bed, she was in the shower room with another resident. When she entered Resident #1's room she observed the resident face down on the mat with blood under his/her head.</p> <p>Record review revealed the facility transferred the resident to the hospital where the resident was diagnosed with Intracranial Hemorrhage and subsequently expired on 05/19/12. Interview with the Attending Physician on 02/13/12 at 9:10 AM, whose signature appeared on the certified copy of Resident #1's death certificate, revealed the Intracranial Hemorrhage listed as the underlying cause of death on Resident #1's death certificate was the result of the fall the resident sustained while at the nursing facility and was the cause of Resident #1's death.</p> <p>An interview with the MDS Coordinator, on 02/14/12 at 1:35 PM, end on 02/15/12 at 4:40 PM, revealed she was ultimately responsible for the accuracy of the individual care plans. She stated she did not address the issue of dizziness or unsteadiness on the falls care plan. She revealed side effects from narcotic use were addressed on the care plan for pain, and included monitoring for signs and symptoms of dizziness, unsteadiness, blurred vision and oversedation. She offered no explanation as to why no interventions were noted on either the initial care plan or the comprehensive care plan.</p> <p>An interview with the Administrator and the Director of Nursing (DON), on 02/14/12 at 3:00</p>	F 323		

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F 323	<p>Continued From page 42</p> <p>PM, revealed Resident #1 was on the Falling Star Program which meant the resident was a high risk for falls and it should have been "common knowledge" that the resident should not be left sitting on the side of the bed. On 02/15/12 at 9:52 AM, the Administrator stated no further investigation was conducted related to the resident's fall from the bed because the resident said he/she lost his/her balance and fell; therefore that was thought to be the cause of the fall. Any further investigation would only be completed if abuse, neglect or exploitation were involved. Review of the facility's investigation revealed no evidence the facility considered this accident as possible neglect.</p> <p>2. A record review revealed the facility admitted Resident #3 on 04/27/11 with diagnoses to include Osteoarthritis, Anticoagulation use, Hypertension, Anxiety, Depressive Disorder and Anemia. A review of the Comprehensive Care Plan, dated 05/17/11, included Risk for falls revealed an intervention for non-skid socks to be on at bedtime as the resident allows. A Fall Risk Analysis, dated 01/03/12, revealed Resident # 3 was high risk for falls. A review of the quarterly MDS, dated 01/18/12, revealed the facility assessed Resident #3 to be cognitively intact, required extensive assistance of two staff for bed mobility, transfers, ambulation, and toileting. Extensive assistance of one staff was required for personal hygiene and bathing.</p> <p>An interview with Resident #3, on 02/14/12 at 12:00 PM, revealed he/she experienced a fall "last night while I was using the toilet." Resident #3 stated while an SRNA was assisting him/her to pull up his/her pants, his/her feet out slipped from</p>	F 323		

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F 323	<p>Continued From page 43</p> <p>under him/her causing him/her to fall back onto the toilet. Resident #3 was not able to recall the staff who was assisted her. The resident stated he/she required staff assistance to the toilet, on and off the toilet, and to pull his/her pant up and down due to hand weakness. On 02/15/12 at 9:20 AM, Resident #3 voiced complaints of hip pain, and was not sure the pain was associated with the recent fall on 02/14/12. On 02/15/12 at 11:30 AM, the resident stated the hip pain was better. On 02/16/12 at 3:25 PM, Resident #3 stated hip pain was worst and he/she could hardly sit on the commode. When asked if he/she wore non-skid socks the night of the fall, Resident #3 stated the non-skid socks he/she wore when the fall occurred on 02/14/12 were worn out and did not prevent his/her feet from sliding. The resident stated staff as aware of the need for new socks.</p> <p>An interview with the Assistant Director of Nursing (ADON) and Unit Manager (UM) #1, on 02/15/12 at 6:00 PM, revealed they were unaware of an incident involving Resident #3 related to a fall in the bathroom. The ADON presented an Incident/Accident report on 02/16/12 at 9:45 AM which included three staff statements which did not address the incident as reported by the resident. LPN #1 was the charge nurse and her statement revealed no fall was reported to her on the night of 02/13/12. SRNA #8's statement revealed she took Resident #3 to the toilet and the resident always "plops down hard" on the toilet and this was usual behavior for the resident so she did not feel it was necessary to report it to the nurse. She stated the resident refused assistance to sit down on the toilet and did not complain of pain. SRNA #9 denied any knowledge of the incident. The facility did not present documented</p>	F 323	

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F 323	<p>Continued From page 44</p> <p>evidence of an investigation establishing the root cause of the fall nor did it identify that the resident's non-skid socks were no longer embellished with the non-skid application to prevent falls.</p> <p>3. A record review revealed the facility admitted Resident #4 on 12/08/09 with diagnoses to include Rheumatoid Arthritis and Osteoarthritis, Degenerative Joint Disease, Diabetes Type II, Malaise and Fatigue. A review of the Fall Risk Analysis, dated 04/26/11, revealed the facility assessed the resident as high risk for falls. A review of the Comprehensive Care Plan for Falls dated 11/17/11, revealed Resident #4 was at risk for falls related to an unsteady gait, and impaired mobility.</p> <p>A review of the quarterly MDS, dated 01/24/12, revealed the facility assessed Resident #4 as moderately cognitively impaired and required extensive assistance of two staff for bed mobility, and toileting. Further review revealed the resident required extensive assistance of one staff for ambulation, dressing, hygiene and bathing.</p> <p>A review of the Nurses' Notes, dated 01/29/12 at 3:30 AM, revealed documentation of two quarter-sized purple discolorations to the left cheek from lying on the left side with his/her hand under his/her head. A review of a Physician's Progress Note, dated 01/29/12, revealed documentation by the Advance Practice Registered Nurse (APRN), who noted two quarter-sized dark bluish bruises to the left cheek and forehead, and the resident stating he/she bumped that area trying to get out of the bed.</p>	F 323		

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F 323	Continued From page 45  A review of an Incident/Accident report, dated 01/29/12 identified two quarter-sized bruises on the left cheek and stated the cause was related to resident lying on the left side with his/her hand under his/her head. It was noted that the bruising would be monitored for ten days and then reassessed. Further review of the Incident/accident report revealed interventions to pad the bedside table, monitor bruising and the resident was to receive anti-inflammatory medication in the mornings. An interview with the ADON, on 02/16/12 at 3:55 PM, revealed the next day Resident #4 mentioned that he/she hit his/her head on the table, so she added an intervention to pad the bedside table as a precautionary measure. The occurrence of a fall from the bed was not mentioned in the report nor were causal factors identified related to the injury. Further interview with the ADON revealed she did not know why an investigation was not completed.  An observation of Resident #4, on 02/13/12 at 7:10 AM, revealed the resident was sitting in a wheelchair in his/her room. The resident was noted with a large pink and purple bruise on the left cheek. When questioned about what happened to his/her cheek the resident stated he/she had fallen from the bed and hit his/her face on the table. Observation of the resident's room revealed no bedside table having padding. Furthermore, interviews with Certified Medication Technician #1, on 02/16/12 at 11:10 AM, and SRNA #11 and #12, on 02/16/12 at 12:20 PM, revealed that the facility had not padded the resident's bedside table prior to 02/16/12. Interview with the resident's Power of Attorney, on	F 323			

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F 323	<p>Continued From page 46</p> <p>02/16/12 at 12:30 PM, revealed that she visits the resident weekly and had never witnessed the bedside table padded since the incident on 01/29/12.</p> <p>The facility was unable to provide evidence of an investigation which determined causal factor to the injury despite the resident's continued statements to the APRN and the ADON that he/she bumped the area while trying to get out of the bed. Furthermore, there was no evidence that the facility implemented the intervention of padding the bedside table as detailed on the incident/accident report. Additionally, review of the resident's falls care plan revealed the facility had not revised the care plan to include the padded bedside table.</p> <p>An interview with the Administrator, on 02/22/12 at 9:30 AM, revealed whenever there was an accident or incident, the licensed nurse was notified and that person initiated an investigation by utilization of the Incident/Accident Form and filled out the investigative analysis which indicated the what, when, how, and why the incident occurred. When a determination was made, the physician and the family were notified. If it was an emergent situation, the resident was provided care before this took place and the Administrator and the DON were notified. Every incident was addressed in the Abbreviated Quality Assurance (AQA) meeting held Monday through Friday. If the incident occurred on the weekend, the Staff Development/Week-end Supervisor reviewed it. In the AQA meeting, interventions were discussed. The licensed nurse was contacted with any questions. The resident's record was reviewed. The care plan and the the Nurse Aide</p>	F 323		

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F 323	<p>Continued From page 47</p> <p>Data Sheet were updated. A care plan progress note was documented on the care plan section of the resident's record. If the resident was sent to the hospital they were to be reassessed upon return from the hospital.</p> <p>An acceptable Allegation of Compliance was received on 02/22/12 and detailed the following.</p> <p>Resident #1 was discharged from the facility on 05/14/11 to the hospital and expired on 05/19/11, so no additional measures were possible for him/her.</p> <p>The Fall Incident Reports of Resident #3 and Resident #4 were reviewed to identify additional factors that may have contributed to the falls. The care plans were reviewed and revised, and the Nurse Aide Data Sheets was revised to reflect new interventions as of 02/18/12.</p> <p>Resident #3 was screened by Physical Therapy for evaluation and treatment. An order was obtained and the evaluation was completed on 02/18/12. The resident's care plan was updated with the following interventions on 02/17/12 and 02/18/12: the resident was unsafe to be seated on the side of the bed or toilet without supervision; the resident refused the recommendation of a PC alarm. Staff continued to encourage and advised the resident to follow the recommendations of the care plan team; restorative ambulation was discontinued; for toileting, transfer to the bedside commode only with assistance of one staff at this time and with resident's rolling walker; place the gait belt above the resident's chest level secondary to rib fractures; do not leave the resident alone on the</p>	F 323		

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F 323	<p>Continued From page 48</p> <p>bedside commode; and remove the bedside commode from the room when not in use per the resident's request.</p> <p>Resident #4 was reviewed for falls and for bruising concerns. The resident's care plan was revised, on 02/17/12 and 02/18/12, with the following interventions: the resident may have dizziness from psychoactive medication use and have increased risk for falls; Falls risk analysis indicated resident maybe unsafe to be seated on the side of the bed or on the toilet unsupervised; the resident refused to follow the facility's recommended interventions; PC alarms to the bed and the wheelchair; continue to encourage and advise to follow recommendations of care; non-skid footwear at bedtime; and bruises easily related to long-term steroid use for Rheumatoid Arthritis.</p> <p>The facility's system for screening for establishing the amount of supervision a resident required to avoid preventable falls was reviewed. The process was modified to provide a consistent methodical process to determine whether or not a resident may sit on a bed or toilet unsupervised. The modification enhanced the communication of this information to the facility staff. The revised process required that a resident be evaluated for his/her fall risk using the facility's fall risk analysis tool. The falls analysis will be completed by the MDS Coordinator, Unit Charge Nurses and Licensed Nurses. This will be completed on admission, or re-admission, quarterly, significant change, and after each fall. Upon completion of this screening tool, a resident who scored a ten (10) or higher on the analysis should not be seated on the side of the bed or toilet by staff and</p>	F 323	

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F 323	<p>Continuod From page 49</p> <p>left unsupervised. Supervision meant the resident must be within arms' reach of the staff member. Even if a resident scored less than ten (10), there may be some instances where the interdisciplinary team determined that a resident should be supervised. The determination as to whether or not the resident may be unattended on the bedside or toilet, based on the Falls Risk Analysis, will be placed on the resident's interdisciplinary plan of care by the Unit Charge Nurse/Licensed Nurse, and updated after admission and readmission, quarterly, annually, significant change and after each fall. It will also be recorded on the resident's Nurse Aide Data Sheet, and the instruction guide Nursing Assistants utilized to provide care to each of the assigned residents.</p> <p>The Quality Management Nurse trained the DON, ADON, and the Staff Development on the process, on 02/17/12, and they were responsible for providing training to all other nursing staff to include Nursing Assistants (NA), Medication Aides (MA), Licensed Nurses, MDS/Care Plan Coordinators, and Administrative Nurses and the Administrator, to begin on 02/17/12, and to continue with nurses and NAs on each oncoming shift until training was completed.</p> <p>A Falls Risk Analysis will be completed for all current residents by the Unit Managers, or other Licensed Nurse designee. The nurse completing the analysis will be responsible for updating the care plan and the nurse aide data sheet. The Falls Risk Analysis for all current residents were reviewed and revised on 02/16/12 and 02/17/12. The Care Plans and Nurse Aide Data Sheets were reviewed and/or revised to reflect the need</p>	F 323		

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F 323	<p>Continued From page 50</p> <p>for supervision with sitting unattended when placed on the bedside or toilet by staff.</p> <p>A Quality assurance and Assessment meeting was conducted, on 02/17/12, to validate that the analyses were completed and the interventions based on the scores were added to the Interdisciplinary Care plans and the corresponding Nurse Aide Data Sheet.</p> <p>The nurse completing the the fall risk analysis will be responsible for the revision of the care plan and the nurse aide data sheet.</p> <p>The DON or her designee will review for completion of this task, on admission through the admission audit process.</p> <p>The UM and/or DON or designee will review for completion after a fall through the Daily AQA process.</p> <p>The Quarterly Fall Risk Analysis will be checked by the designated MDS nurse responsible for the quarterly MDS.</p> <p>On weekends, the CN will be responsible to validate that all falls risk analysis were completed and the care plan and nurse aide data sheet were revised with the proper information.</p> <p>Observations to monitor residents who have been identified as high risk began, on 02/16/12, to validate placement of interventions for these residents and will be completed by the charge nurses and licensed nurses every shift.</p> <p>In the event a resident refused supervision,</p>	F 323		

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F 323	<p>Continued From page 51</p> <p>attendance or other fall safety interventions, they will be informed of the risks associated with the refusal and offered alternatives. If they continued not to accept supervision, attendance, or other interventions, they will be asked to sign a Refusal of Treatment Form if alert and oriented. A Non-Compliance Form will be utilized for the resident with cognitive impairment and was discussed and reviewed with the responsible person. The facility will continue to develop /implement interventions to meet the residents safety needs while respecting the residents rights. The resident's choice to decline the recommended intervention will be on both the resident's plan of care and the nurse aide data sheet. The resident will be encouraged to accept the planned interventions, and alternatives to meet the residents' needs will be offered to the resident and or decision maker. This will be documented on the resident's plan of care.</p> <p>The Quality Management Nurse trained the DON, ADON, and the Staff Development in this process, on 02/17/12, and they were responsible for all other staff beginning 02/17/12 and continuing until completed.</p> <p>Housekeeping , laundry and dietary staff were educated, on 02/17/12, by the Development Coordinator, that if they observed a resident sitting independently on the side of the bed, they should alert the staff and continue to monitor the resident until such time as a nursing staff representative arrived to assist. The education will continue with on-coming shifts until completed.</p> <p>On 02/17/12, a training conducted by the Quality</p>	F 323		

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F 323	Continued From page 52  Management Nurse re-educated the Administrative Nurses, Licensed Nurses, and the MDS/Care Coordinator on the facility's Falls policy and procedure, including the completion of a prompt, through investigation that assisted in identifying contributing factors to the falls. The goal of the investigation was to identify what happened, when it happened, how it happened, where it occurred, who it happened to, what caused it, who might have information about what happened, and what can be done to prevent it from happening again. The same group was provided education on Falls Prevention, including numerous but not all inclusive, common factors that contribute to falls. Nurses that were not educated on 02/17/12 by the Quality Management Nurse, the DON, ADON, or the Staff Development, will be provided training on or before their next shift worked.  The DON or her designee in her absence will monitor the investigation process for thoroughness, accuracy and appropriateness of interventions. A second review will be conducted by the Administrator. A check-list will be utilized to validate that all tasks were completed. The check list will be reviewed in the AQA meeting and findings reviewed in the Quality Assurance and Assessment (QAA) Committee meeting.  Verification of removal of Immediate Jeopardy was completed as follows:  Review of Resident #3's record revealed all modifications were in place.  Review of Resident #4's record revealed all modifications were in place.	F 323			

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F 323	<p>Continued From page 53</p> <p>The Quality Management Nurse trained the DON, ADON, and the Staff Development, who educated licensed nurses about the process of falls, falls prevention, supervision conducting an investigation, interventions, implementing and updating the care plans, was initiated on 02/17/12 and verified by a sign in-sheet.</p> <p>Interview with RN #2, on 02/23/12 at 9:20 AM, revealed she was inserviced on falls and falls prevention, supervision, investigation, updating the care plan and abuse/neglect.</p> <p>Interviews with LPN #1 on 02/23/12 at 9:50 AM, LPN #2 on 02/23/12 at 9:10 AM, LPN #3 on 02/23/12 at 3:00 PM, and LPN #4 on 02/23/12 at 1:40 PM, revealed they were inserviced on falls and falls prevention, supervision, investigation, updating the care plan and abuse/neglect.</p> <p>Training on supervision by the Staff Development was initiated on 02/17/12 and verified by a sign-in sheet.</p> <p>Interview with SRNA #7 on 02/23/12 at 1:15 PM, SRNA #8 on 02/23/12 at 2:07 PM, SRNA #9 on 02/23/12 at 1:35 PM, and SRNA #10 on 02/23/12 at 9:30 AM, revealed they were inserviced about not leaving the resident sitting on the bed or the toilet unless they were independent and to keep dependent residents within arms' reach and to ensure all alarms were in place and in working order.</p> <p>Housekeeping, laundry and dietary staff were educated, on 02/17/12, and was verified, on 02/23/12, by a sign-in sheet and interviews with</p>	F 323	

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F 323	Continued From page 54 Housekeeper #1, Dietary staff #1 and Dietary staff #2, on 02/23/12 at 1:50 PM, and the Beautician on 02/23/12 at 2:05 PM.  A Falls Risk Analysis will be completed for all current residents by the Unit Managers, or other Licensed Nurse designee verified by observation, on 02/23/12, of the analysis completed on all current residents and care plans and nurse aide data sheet that were updated as indicated.  A Quality assurance and Assessment meeting, conducted on 02/17/12, validated that the analyses were completed and that the interventions based on the scores were added to the Interdisciplinary Care plans and the corresponding Nurse Aide Data Sheet. Verified by a sign-in sheet on 02/23/12.  Based on the above interviews and record reviews it was determined the Immediate Jeopardy was removed, effective 02/19/12, as alleged in the AoC with the scope and severity lowered to a "D" as the facility had not completed the QA initiative related to staff monitoring, analysis of monitoring audit results and the development and implementation of the POC to ensure interventions are effective and will prevent recurrence, in order to achieve and maintain compliance.	F 323			
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING  A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 490	F490 <u>483.75 Effective Administration / Resident Well-Being</u> It is the practice of Princeton Health and Rehab Center to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.	04/06/12	

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F 490	<p>Continued From page 55</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's policy and procedure, and review of the Administrator's job description, it was determined the facility failed to administer in a manner which enabled it to use its resources effectively and efficiently to attain or maintain the highest practical, physical, mental, and psychosocial well-being for three residents (#1, #3 and #4), in the selected sample of four residents. The facility failed to have an effective system in place to ensure risk factors were properly identified and communicated, and to ensure adequate supervision was provided to prevent accidents for Resident #1. The facility failed to have an effective system in place to ensure Incident/Accidents were thoroughly investigated to identify the causal factors for Residents #1, #3 and #4. (Refer to F224, F279, F280, F282, F323, and F520)</p> <p>The facility assessed Resident #1 as a high risk for fall, and staff was knowledgeable regarding the resident's need for supervision due to balance concerns. On 05/14/11, at approximately 2:00 AM, the facility administered a PRN (as needed) dose of Lortab (pain medication) to Resident #1. At 4:00 AM, the staff assisted Resident #1 upon the side of the bed to a sitting position and then left him/her alone in the room unsupervised. Resident #1 fell forward from the bed, sustaining an intracranial hemorrhage (bleeding within the skull). Resident #1 subsequently expired on 05/19/11. Intracranial Hemorrhage was listed as</p>	F 490	<p>F490 (continued) <u>Corrective Measures for Resident Identified in the deficiency:</u></p> <p><b>Resident #1</b> was discharged from the facility on 5/14/11 to the hospital and expired on 05/19/11; so no additional measures were possible for this resident.</p> <p><b>Resident #3</b> fall risk analysis was updated on 02/16/12, was screened by Physical Therapy on 02/18/12 and placed on caseload with the following recommendations: will transfer to bedside commode only at this time with assist of 1 with rolling walker. Resident's plan of care and nurse aide data sheet were updated to reflect these changes by the Unit Charge Nurse. This was completed on 02/18/12. Resident was seen by an orthopedic surgeon on 02/28/12 with only recommendation to keep a knee immobilizer or brace to knee while out of bed. All non skid socks identified by the resident as worn out were validated to ensure non skid grips were intact.</p> <p><b>Resident #4</b> fall risk analysis was updated on 02/16/12, has had the care plan reviewed and revised by the Director of Nurses to reflect the bruising problem related to long term steroid use related to Rheumatoid Arthritis and refusal of padding the table to decrease risk of bruising.</p> <p><u>How Other Residents Were Identified Who May Have Been Impacted by the Practice:</u></p> <p>A Fall Risk Analysis was completed on each resident currently residing in the facility by the MDS Coordinator, Unit Charge Nurses or licensed Nurse designee and was verified as completed within this statement of deficiency on 02/23/12. The comprehensive plan of care and nurse aide data sheet were reviewed and revised based on the results of the falls risk analysis on each resident currently residing in the facility. This was completed by the Unit charge nurses or licensed Nurse designee and was verified as</p>

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F 490	<p>Continued From page 56</p> <p>the underlying cause of death on a certified copy of Resident #1's death certificate. The facility's investigation failed to identify staff left the resident without supervision despite their knowledge of the resident's needs and falls risk. Furthermore, the facility failed to identify through their investigation that neglect occurred which prevented the facility from taking necessary action to prevent recurrence associated with Resident #1's fall, related to no evidence the facility determined the resident, who was assessed as high risk for falls related to left sided paralysis, balance problems, decreased muscular coordination, and having received a narcotic two hours prior to the fall, which had side effects to include dizziness and unsteadiness, was left alone sitting on the side of the bed prior to the fall. Resident #3, on 02/14/12, and Resident #4, on 01/29/12, both experienced falls; however, the facility's investigation failed to identify causal factors which prevented the facility from implementing corrective action to prevent recurrence.</p> <p>This failure caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/16/12 and determined to exist on 05/14/11. An acceptable Allegation of Compliance (AoC) was received on 02/22/12. Immediate Jeopardy was removed, effective 02/19/12, as alleged in the AoC with the scope and severity lowered to a "D" based on the need to ensure the facility was administered effectively and efficiently. Substandard Quality of Care was identified at 483.13 Resident Behavior and Facility Practices and 483.25 Quality of Care. (Refer to F224, F279, F280, F282, F323, and F520)</p>	F 490	<p>F490 (continued) completed within this statement of deficiency on 02/23/12.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>All facility staff including the Nursing Assistants, Medication Aides, Administrative and Licensed Nurses, Administrator, Social Services, Activities, Dietary, Environmental Service, Housekeeping, and Laundry have been re-educated on the facility's Abuse/Neglect Policy by the Staff Development Coordinator / designee and the Quality Management Specialist by 02/23/12. A post test was used to validate understanding of the education provided. Education for any inactive staff will be completed prior to returning to active status by the DON / designee prior to their first shift. This was verified as completed through in-service sign in sheets and interviews within this statement of deficiency on 02/23/12.</p> <p>All facility licensed nurses were educated in the process related to falls, fall prevention, supervision, conducting an investigation, interventions, implementing and updating care plans and nurse aide data sheets by the Quality Management Nurse, Director of Nurses, Assistant Director of Nurses, and the Staff Development Coordinator / designee by 02/23/12. A post test and or return verbal understanding was used to validate understanding of the education provided. Education for any inactive staff will be completed prior to returning to active status by the DON / designee prior to their first shift. This was verified as completed through in-service sign in sheets and interviews within this statement of deficiency on 02/23/12. The Administrator was provided re-education by the Regional Vice President of Operations on 02/17/12 to re-educate on administration of the</p>

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F 490	<p>Continued From page 57</p> <p>Findings include:</p> <p>A review of the Facility Administrator's job description, undated, revealed the Job Summary as overseeing patient/resident care, managing overall operation, employee management, fiscal management, and ensured compliance with State and Federal regulations. Job responsibilities included development of a facility organizational structure and participation in the development, interpretation and implementation of policies and procedures, ensured the facility was free of any unsafe conditions, reviewed, monitored and followed-up on incident reports, adverse incidents, and developed plans of action to correct and responded to identified quality and risk issues.</p> <p>A review of the facility's policy and procedure, "Falls," dated 04/28/11, revealed upon admission, the facility would identify residents at risk for falls by utilization of the "Falls Risk Analysis" form. Based on the falls analysis, preventive/safety measures were implemented as appropriate, for residents identified at risk for falls. In the event of a fall, a post fall analysis was to be conducted to aid in identifying contributing factors.</p> <p>A review of the facility's "Alleged Abuse Reporting/Investigation," revised 06/17/11, revealed the facility defined "Neglect" as a failure or omission on the part of the care giver to provide the care, supervision, and services necessary to maintain the physical and mental health of the disabled adult or elderly person, including but not limited to providing food, clothing, medicine, shelter, supervision and medical services that a prudent person would</p>	F 490	<p>F490 (continued)</p> <p>facility in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well being of each resident. This includes establishing and overseeing policies and practices to avoid instances of abuse or neglect. As the administrator and leader of the facilities QA&amp;A committee, the administrator leads the group and supports them in implementing process to identify areas of quality that may be deficient and to develop action plans to achieve desired quality. The Administrator verbalized understanding of the training provided.</p> <p><u>Monitoring Measures to Maintain On-going Compliance:</u></p> <p>A specially called Quality Assurance (QAA) Assessment meeting including the Administrator, Director of Nurses, Assistant Director of Nurses, Clinical Nurse Supervisor, MDS Coordinator, Unit Nurses, Rehab Director, Activities, Business Office, Admission Office, Dietary manager, Medical Records, and Social Services was conducted on 02/17/12 that validated the completion of the fall risk analysis, updates to the comprehensive plans of care and nurse aide data sheets for all residents currently residing in the facility and was validated as completed within this statement of deficiency on 02/23/12.</p> <p>The Regional Vice President of Operations from our resource team will provide oversight to the administrator monthly times 3 months then quarterly times 6 months.</p> <p>The Director of Nurses / designee will review the Fall Risk Analysis for completion with corresponding updates to the comprehensive plan of care and nurse aide data sheets, upon admission, readmission, quarterly, annual,</p>

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F 490	<p>Continued From page 58</p> <p>consider essential for the well being of the disabled adult or elderly person. Neglect can also mean the failure of care givers to make a reasonable effort to protect a disabled adult or elderly person from abuse, neglect or exploitation by others. Neglect can be either repeated conduct or a single incident of carelessness which produced or could be reasonably expected to result in serious physical or psychological injury or a substantial risk of death.</p> <p>A review of the Falls Risk Analysis for Resident #1, dated 04/26/11, revealed, upon admission to the facility, the facility assessed the resident as at risk for falls related to having three or more falls in the past three months prior to admission to the facility, having balance problems, decreased muscular coordination, being on four medications (Antihypertensive, Diuretic, Hypoglycemic, and a Narcotic) with side effects to include dizziness and unsteadiness. Predisposing factors for Resident #1 included Stoke, Fractures, Diabetes, and Anemia.</p> <p>A review of the Post Fall Analysis, dated 05/14/11 at 4:00 AM, revealed Resident #1 was in his/her room, sitting on the side of the bed with a mat and a PC alarm in place. It was documented the PC alarm sounded at the time of the fall. Further documentation revealed, under "Environmental factors that may be related to the fall," was "Resident was sitting on the side of the bed, lost balance and fell forward." The resident was assessed as high risk for falls related to left sided paralysis, balance problems, decreased muscular coordination, and had received a narcotic two hours prior to the fall with side effects to include dizziness and unsteadiness. There was no</p>	F 490	<p>F490 (continued)</p> <p>significant change, and following a fall event through the daily AQA process using an investigation checklist and revised daily AQA form to document this review with validation that interventions are implemented. On weekends the charge nurse will be responsible to validate the Fall Risk Analysis for completion with corresponding updates to the comprehensive plan of care and nurse aide data sheets following any fall event or new admission to validate that the interventions are implemented.</p> <p>Any issues identified with the above process will have re-education provided to the individual staff member by the Staff Development Coordinator / designee. Additional re-education on the facility's Abuse / Neglect policy, process related to falls, fall prevention, supervision will be completed for all facility staff. Additional re-education on conducting an investigation, interventions, implementing and updating care plans and nurse aide data sheets will be completed for all nursing staff. These educational sessions will be conducted monthly times three months then quarterly for one year by the Staff Development Coordinator / designee. A post test will be utilized to validate understanding of training received. The audit results will be reported to the monthly QAA meeting by the Director of Nurses / designee for the next six months to ensure interventions are effective to achieve and maintain compliance. If any findings indicate a concern the frequency of monitoring may be increased to validate ongoing compliance.</p>

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NAME OF PROVIDER OR SUPPLIER  PRINCETON HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1333 WEST MAIN ST. PRINCETON, KY 42445		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 490	Continued From page 59  evidence the facility determined the resident was left alone sitting on the side of the bed prior to the fall; however, interview with State Registered Nurse (SRNA) #1, on 02/13/12 at 10:30 AM, revealed on the morning of 05/14/11, at approximately 4:00 AM, Resident #1 requested to sit up on the side of the bed. She stated she assisted the resident up on the side of the bed, then left the room to go answer other call lights. She stated a personal clip (PC) alarm was attached to the right side of the resident's gown as she left the room. She stated she was in a room down the hall when she heard a loud noise, like a chair moving, and ran back down the hall to Resident #1's room to find the resident on the floor mat. Resident #1 was bleeding from his/her knees and from an area on his/her head. She stated the resident's alarm did not sound. She stated she was aware Resident #1 was paralyzed on the left side, and required extensive assistance with all care. She stated Resident #1 only wanted to sit up 5-10 minutes at a time, then asked to lay back down. She stated she should not have left the resident alone sitting on the side of the bed, but it was a busy night and she "had to do what she had to do." An interview with SRNA #1, on 02/27/12 at 9:27 AM, revealed she made the nurse aware about Resident #1's request for medication for leg pain on the night of the fall. The nurse gave Resident #1 pain medication about an hour prior to the fall.  Interview with SRNA #2 on 02/15/12 at 12:10 PM, SRNA #3 on 02/15/12 at 11:55 AM, SRNA #4 on 02/13/12 at 10:43 AM, SRNA #5 on 02/15/12 at 12:45 PM, SRNA #6 on 02/15/12 at 10:55 AM, and SRNA #7 on 02/14/12 at 10:00 AM, revealed Resident #1 had periods of weakness and was	F 490			

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F 490	<p>Continued From page 60</p> <p>only able to maintain balance while sitting on the side of the bed for a maximum of ten minutes with assistance because the resident swayed and was "wobbly." Each of the SRNA interviews revealed it was not safe to leave Resident #1 alone sitting on the side of the bed.</p> <p>An interview with the MDS Coordinator, on 02/14/12 at 1:35 PM, and on 02/15/12 at 4:40 PM, revealed she was ultimately responsible for the accuracy of the individual care plans. She stated she did not address the issue of dizziness or unsteadiness on the falls care plan, She revealed side effects from narcotic use were addressed on the care plan for pain, and included monitoring for signs and symptoms of dizziness, unsteadiness, blurred vision and oversedation. She offered no explanation as to why no interventions were noted on either the initial care plan or the comprehensive care plan.</p> <p>An interview with the attending Physician, on 02/13/12 at 9:10 AM, whose signature appeared on the certified copy of Resident #1's death certificate, revealed the Intracranial Hemorrhage listed as the underlying cause of death on Resident #1's death certificate was the result of the fall the resident sustained while at the nursing facility and was the cause of Resident #1's death.</p> <p>An interview with the Administrator and the Director of Nursing (DON), on 02/14/12 at 3:00 PM, revealed Resident #1 was on the Falling Star Program which meant the resident was a high risk for falls and it should have been "common knowledge" that the resident should not be left sitting on the side of the bed. On 02/15/12 at 9:52 AM, the Administrator stated no further</p>	F 490	

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F 490	Continued From page 61  Investigation was conducted related to the resident's fall from the bed because the resident stated he/she lost his/her balance and fell; therefore, that was thought to be the cause of the fall.  2. A record review revealed the facility admitted Resident #3 on 04/27/11 with diagnoses to include Osteoarthritis, Anticoagulation use, Hypertension, Anxiety, Depressive Disorder and Anemia. The Comprehensive Care Plan, "At Risk for Falls," dated 05/17/11, included an intervention for non-skid socks to be on at bedtime as the resident allowed. A review of a Fall Risk Analysis, dated 01/03/12, revealed Resident #3 was high risk for falls.  A review of the quarterly MDS, dated 01/18/12, revealed the facility assessed Resident #3 as cognitively intact, required extensive assistance of two staff for bed mobility, transfers, ambulation, toileting, and extensive assistance of one staff for person hygiene and bathing.  An interview with Resident #3, on 02/14/12 at 12:00 PM, revealed he/she experienced a fall "last night while I was using the toilet." Resident #3 stated while an SRNA assisted him/her to pull up his/her pants, his/her feet slipped out from under him/her, and caused him/her to fall back onto the toilet. Resident #3 was not able to recall the staff who assisted him/her. The resident stated he/she required the staff's assistance to the toilet, on and off the toilet, and to pull his/her pants up and down due to hand weakness. Resident #3 stated the non-skid socks he/she wore when the fall occurred, on 02/14/12, were worn out and did not prevent his/her feet from	F 490		

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F 490	<p>Continued From page 62</p> <p>sliding. The resident stated the staff was aware of the need for new socks.</p> <p>The facility presented an Incident/Accident report, on 02/16/12 at 9:45 AM, which included three staff statements which did not address the incident as was reported by the resident. LPN #1 was the charge nurse and her statement revealed no fall was reported to her on the night of 02/13/12. SRNA #8's statement revealed she took Resident #3 to the toilet and the resident always "plops down hard" on the toilet and this was usual behavior for the resident, so she did not feel it was necessary to report it to the nurse. She stated the resident refused assistance to sit on the toilet and did not complain of pain. SRNA #9 denied any knowledge of the incident. The facility did not present evidence of an investigation establishing the root cause of the fall.</p> <p>3. A record review revealed the facility admitted Resident #4 to the facility on 12/08/09 with diagnoses to include Rheumatoid Arthritis, Osteoarthritis, Degenerative Joint Disease, Diabetes Type II, Malaise and Fatigue. The Comprehensive Care Plan for Falls, dated 11/17/11, revealed Resident #4 was at risk for falls related to an unsteady gait and impaired mobility.</p> <p>A review of the Fall Risk Analysis, dated 01/18/12, revealed the resident was assessed to be at high risk for falls. A review of the quarterly MDS, dated 01/24/12, revealed the facility assessed Resident #4 as requiring extensive assistance of one staff for ambulation, dressing, hygiene and bathing.</p>	F 490		

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F 490	<p>Continued From page 63</p> <p>A review of the Nurses' Note, dated 01/29/12 at 3:30 AM, revealed documentation of two quarter-sized purple discolorations to the left cheek from lying on the left side with his/her hand under his/her head. A review of the physician's progress notes, dated 01/29/12, revealed documentation by the Advance Practice Registered Nurse (APRN), who noted two quarter-sized dark bluish bruises on the resident's left cheek and forehead, and the resident stating he/she bumped that area trying to get out of the bed.</p> <p>A review of an Incident/Accident report, dated 01/29/12, identified two quarter-sized bruises on the left cheek and stated the cause was related to the resident lying on the left side with his/her hand under his/her head. For action to be taken, it was noted that the bruising would be monitored for ten days and then reassessed. Further review of the Incident /Accident report revealed to pad the bedside table, monitor bruising and start on anti-inflammatory medication in the morning. An interview with the Assistant Director of Nursing (ADON), on 02/16/12 at 3:55 PM, revealed she did not know why an investigation was not completed. She stated the next day Resident #4 mentioned that he/she fell and hit the table, so she added an intervention to pad the bedside table as a precautionary measure. The occurrence of a fall from bed was not mentioned in the report. The facility was not able to provide evidence of an investigation as to the root cause of the injury.</p> <p>An observation of Resident #4, on 02/13/12 at 7:10 AM, revealed the resident was sitting in a wheelchair in his/her room. The resident was</p>	F 490		

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F 490	<p>Continued From page 64</p> <p>noted with a large pink and purple bruise on the left cheek. When questioned about what happened to his/her cheek, the resident stated he/she fell off the bed and hit his/her face on the table.</p> <p>An interview with the Administrator, on 02/22/12 at 9:30 AM, revealed when there was an accident or incident, the licensed nurse was notified and that person was to initiate an investigation by utilization of the Incident/Accident Form. The nurse also filled out an investigative analysis which indicated the what, when, how, and why the incident occurred. When a determination was made, the physician and the family were notified. If it was an emergent situation, care was provided before this took place and the Administrator and the DON were notified. Every incident was addressed in the AQA meeting held on Monday through Friday. If the incident occurred on the weekend, the Staff Development/Week-end Supervisor reviewed it. Intervention are discussed in the AQA meeting. The licensed nurse is to be contacted with any questions. The resident's record is to be reviewed. The care plan and the the Nurse Aide Data Sheet are updated. A care plan progress note is to be documented on the care plan section of the resident's record. If the resident was sent to the hospital they were reassessed upon return from the hospital. While the facility Administrator detailed this as their process the facility was unable to provide evidence that their process was thorough in identifying causal factors, abuse, neglect in order to address concerns and prevent further recurrence.</p> <p>An acceptable Allegation of Compliance was</p>	F 490		
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F 490	Continued From page 65 received on 02/22/12 and detailed the following:  The Administrator was re-educated by the Regional Vice President of operations from our resource team, on 02/17/12. The requirement of the administrator to administer the facility in a manner that enabled it to use its' resources effectively and efficiently to attain or maintain the highest practical, physical, mental and psychosocial well-being of each resident. This included the need to oversee the investigative process for incidents and accidents and utilize the facility resources to validate the interventions were developed, care planned, communicated and implemented. It also included establishing and overseeing policies and procedures to avoid instance of abuse or neglect. As leader of the facility's Quality Assessment and Assurance Committee, the Administrator leads the group and supports them in implementing processes to identify areas of quality that may be deficient and to develop action plans to achieve desired quality and monitor the effectiveness of the plans.  The ADON will be responsible to monitor oncoming shifts to assure that all staff scheduled to work have been trained in the planned education for their position. The ADON will train or assign a qualified designee to provide training to anyone oncoming who lacks the required training. Any employee not available for their training due to leave or valid reason, will be sent a certified letter instructing them that they may not work until they have successfully completed all training.  A post test that covers training provided will be administered a week after training was initiated.	F 490			

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F 490	Continued From page 66  The test will be tailored for each department to validate retention and understanding. Additional testing will be conducted monthly for three months and quarterly for one year. Education of the process will be included in the orientation of new employees in the respective departments  Verification of removal of Immediate Jeopardy was completed as follows:  Training of the Administrator, on 02/18/12, was verified by a review of the sign-in sheet on 02/23/12.  A review of the completed post test and a scheduled up-coming post test validated the process was in place on 02/23/12.  The facility presented a copy of the letter of notification mailed to staff on leave or otherwise absent instructing them that they may not work until they have successfully completed all training.  Based on the above interviews and record reviews, it was determined the Immediate Jeopardy was removed, effective 02/19/12, as alleged in the AoC with the scope and severity lowered to a "D" based on the need of the facility to continue to evaluate the implementation of changes and quality assurance activities.	F 490		
F 520 SS=J	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the	F 520	F520 <u>483.75(o)(1) QAA Committee-Members / Meet Quarterly/ Care plans</u> It is the practice of Princeton Health and Rehab Center to maintain a quality assessment and assurance committee (QAA) consisting of the director of nursing services, a physician, and at least 3 other facility staff that meets at least quarterly to identify which issues with respect to	04/06/12

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F 520	<p>Continued From page 67</p> <p>facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy and procedure, it was determined the facility's Quality Assurance Program failed to identify quality issues related to fall investigations, causal factor identification, and failed to develop and implement appropriate plans of action to correct identified quality deficiencies for three residents (#1, #3 and #4), in the selected sample of four residents.</p> <p>On 05/14/11, at approximately 2:00 AM, a PRN (as needed) dose of Lortab (pain medication) was administered to Resident #1. At 4:00 AM, the staff assisted Resident #1 upon the side of the bed to a sitting position and then left him/her alone in the</p>	F 520	<p>F520 (continued)</p> <p>QAA activities are necessary, and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p><u>Corrective Measures for Resident Identified in the deficiency:</u></p> <p><u>Resident #1</u> was discharged from the facility on 5/14/11 to the hospital and expired on 05/19/11, so no additional measures were possible for this resident.</p> <p><u>Resident #3</u> fall risk analysis was updated on 02/16/12, was screened by Physical Therapy on 02/18/12 and placed on caseload with the following recommendations: will transfer to bedside commode only at this time with assist of 1 with rolling walker. Resident's plan of care and nurse aide data sheet were updated to reflect these changes by the Unit Charge Nurse. This was completed on 02/18/12. Resident was seen by an orthopedic surgeon on 02/28/12 with only recommendation to keep a knee immobilizer or brace to 90 knee while out of bed. All non skid socks identified by the resident as worn out were validated to ensure non skid grips were intact.</p> <p><u>Resident #4</u> fall risk analysis was updated on 02/16/12, has had the care plan reviewed and revised by the Director of Nurses to reflect the bruising problem related to long term steroid use related to Rheumatoid Arthritis and refusal of padding to table to decrease risk of bruising.</p> <p><u>How Other Residents Were Identified Who May Have Been Impacted by the Practice:</u></p> <p>A Fall Risk Analysis was completed on each resident currently residing in the facility by the MDS Coordinator, Unit Charge Nurses or licensed Nurse designee and was verified as completed within this statement of deficiency on 02/23/12. The comprehensive plan of care and nurse aide data sheet were reviewed and updated as needed with all current interventions on each</p>	

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F 520	Continued From page 68 room, which resulted in Resident #1 falling from the bed, sustaining an intracranial hemorrhage (bleeding within the skull). Resident #1 subsequently expired on 05/19/11. Intracranial Hemorrhage was listed as the underlying cause of death on a certified copy of Resident #1's death certificate. The facility's investigation failed to identify that the staff did not provide the necessary supervision to prevent accidents and the comprehensive care plan was not complete with risk risk factors. Resident #3 sustained a fall, on 02/14/12, when his/her feet slipped from under him/her as staff pulled his/her underwear up, after being on the toilet. A review of the facility's Incident/Accident Report, dated 02/16/12, revealed the investigation did not include evidence of the cause of Resident #3's feet slipping from under him/her. Resident #4 sustained a fall from the bed resulting in a bruise to the left cheek. The facility's Incident/Accident Report, dated 01/29/12, submitted as an investigation, failed to address the issue of the fall from bed. The facility could provide no evidence that the Quality Assurance Program identified these quality issues and took action to prevent recurrence.  This failure caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/16/12 and determined to exist on 05/14/11. An acceptable Allegation of Compliance (AoC) was received on 02/22/12. Immediate Jeopardy was removed, effective 02/19/12, as alleged in the AoC with the scope and severity lowered to a "D" as the facility had not completed the QA initiative related to staff monitoring, analysis of monitoring audit results and the development and	F 520	F520 (continued) resident currently residing in the facility by the Unit charge nurses or Licensed Nurse designee and was verified as completed within this statement of deficiency on 02/23/12.  <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u>  The facility members of the Quality Assurance Committee including the Administrator, Director of Nurses, Assistant Director of Nurses, Clinical Nurse Supervisor, MDS Coordinator, Unit Nurses, Rehab Director, Activities, Business Office, Admission Office, Dietary manager, Medical Records, and Social Services, conducted a QAA meeting on 02/17/12 and 02/20/12. During the 02/17/12 meeting all attendees were provided education by the Quality Management Specialist affirming the committee is to facilitate a process that involved areas of the facility operation to systematically monitor the performance of the various areas of concern or quality deficiencies with facility systems, and develop action plans to correct areas identified. They were also educated that it was the responsibility of the committee to oversee implementation of the plans, monitor the effectiveness of the plans, and make adjustments to the plan if the desired outcomes were not achieved. On 02/20/12 the Medical Director was trained on this above process by the Quality Management Specialist with return verbal understanding of the training provided. The above education process was verified as completed within this statement of deficiencies on 02/23/12. The QAA meetings held on 02/17/12, 02/20/12, and 03/14/12 reviewed the implementation of the plans developed for correction, monitored the effectiveness of the plans, and evaluated for the need for changes to the plan.		

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implementation of the POC to ensure interventions are effective and will prevent recurrence, in order to achieve and maintain compliance. Substandard Quality of Care was identified at 483.13 Resident Behavior and Facility Practices and 483.25 Quality of Care. (Refer to F224, F279, F280, F282, F323, and F490)

Findings include:

A review of the facility's policy and procedure, Quality Assessment and Assurance Committee, revised 05/26/11, revealed the policy of the facility was to establish and maintain a Quality Assessment and Assurance Committee for the purpose of monitoring compliance with regulatory guidelines and identifying quality of care and quality of life issues within the scope of services provided by the facility. Procedures include the authority to supervise, and make recommendations and take corrective actions on concerns identified which impacted resident service or facility operations. The committee would have formal methods to identify issues in the facility which required review and would respond to identified issues.

An interview with the Administrator, on 02/22/12 at 9:30 AM, revealed when there was an accident or incident, the licensed nurse was notified and that person was to initiate an investigation by utilization of the Incident/Accident Form. The nurse also filled out an investigative analysis which indicated the what, when, how, and why the incident occurred. When a determination was made, the physician and the family were notified. If it was an emergent situation, care was provided

F 520  
F520 (continued)  
Monitoring Measures to Maintain On-going Compliance:

A specially called Quality Assurance (QAA) Assessment meeting including the Administrator, Director of Nurses, Assistant Director of Nurses, Clinical Nurse Supervisor, MDS Coordinator, Unit Nurses, Rehab Director, Activities, Business Office, Admission Office, Dietary manager, Medical Records, and Social Services was conducted on 02/17/12 that validated the completion of the fall risk analysis, updates to the comprehensive plans of care and nurse aide data sheets for all residents currently residing in the facility and was validated as completed within this statement of deficiency on 02/23/12.

The Quality management Nurse or designee will attend the Quality Assessment and Assurance meetings for the next 6 months to provide guidance and or direction if indicated. The Quality Management Specialist will review the minutes to the meetings and any action plans developed to validate ongoing compliance with identification of potential quality issues. The results of the review will be discussed with the Administrator, Director of Nurses and QA&A members. The results will also be reviewed with the Medical Director during her quarterly participation in the QA&A meeting. If any opportunities for improvement are identified during the review, re-education will be provided by the Quality Management Nurse.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185316	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/27/2012
NAME OF PROVIDER OR SUPPLIER  PRINCETON HEALTH & REHAB CENTER, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1333 WEST MAIN ST. PRINCETON, KY 42445	
(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)
F 520	<p>Continued From page 70</p> <p>before this took place and the Administrator and the DON were notified. Every incident was addressed in the AQA meeting held on Monday through Friday. If the incident occurred on the weekend, the Staff Development/Week-end Supervisor reviewed it. Interventions are discussed in the AQA meeting. The licensed nurse is to be contacted with any questions. The resident's record is to be reviewed. The care plan and the the Nurse Aide Data Sheet are updated. A care plan progress note is to be documented on the care plan section of the resident's record. If the resident was sent to the hospital they were reassessed upon return from the hospital.</p> <p>An Interview with the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON) and the Quality Management Nurse, on 02/22/12 at 3:00 PM, revealed all incidents are reviewed Monday through Friday in the Abbreviated Quality Assurance (AQA) meeting and if a trend was identified, they developed an action plan. An action plan was in place on 01/27/11 through 06/09/11, during which time inservices related to fall precautions and alarms were completed. The Licensed Nurses and Charge Nurses were to complete checks to ensure alarms were in place and working. Audits were completed, but were shredded after being verified as completed. Validation of the the process was completed by review of the the individual care plans, progress notes completed by the Minimum Data Set (MDS)Coordinator, Licensed Nurses, or the Unit Manager. During the period of 01/27/11 through 06/09/11, problems were identified regarding Resident #1 and were discussed in the AQA meeting on 05/16/11. The facility's AQA identified the resident was sitting on</p>	F 520	

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F 520	Continued From page 71 the side of the bed unsupervised and fell forward. They initiated mandatory inservicing for all staff on 05/14/11, related to not leaving residents sitting on the side of the bed. They did not have a monitoring tool, as all departments (Housekeeping, Laundry, Dietary) were responsible for monitoring residents observed sitting on the side of the bed. The outcome was no other falls "like that" had occurred. Inservices continued through 06/09/11, which was a period of maintenance. While the facility's AQA process identified staff had left Resident #1 unsupervised and provided training to staff, the AQA system failed to identify that the resident's care plan did not detail all the fall's risk factors, the facility's investigation failed to initially identify that the facility staff left the resident unsupervised, and the facility did not identify that neglect had occurred. These failures prevented the facility from taking necessary action to correct the quality deficiencies. While the facility re-opened the Action Plan in November 2011, after an increase in falls had been identified by the AQA committee, there was no evidence that the facility had identified and took corrective action related to the failures in their investigations to ensure that causal factors were identified and effective interventions were implemented to prevent the recurrence.  An interview with the Administrator and the Director of Nursing (DON), on 02/14/12 at 3:00 PM, revealed Resident #1 was on the Falling Star Program which meant the resident was high risk for falls. It should be "common knowledge" that the resident should not be left alone sitting on the side of the bed; therefore, it was not necessary to document risk factors related to balance. On	F 520			

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F 520	Continued From page 72  02/15/12 at 9:52 AM, the Administrator stated no further investigation was conducted related to the resident's fall from the bed, because the resident stated he/she lost his/her balance and fell; therefore, that was thought to be the cause of the fall.  An acceptable Allegation of Compliance was received on 02/22/12 and detailed the following.  The members of the facility's Quality Assurance and Assessment (QAA) Committee include the Administrator, the DON, the Assistant Director of Nursing (ADON), Clinical Nurse Supervisor, MDS Coordinator, Unit Nurses, Rehab Director, Activities, Business Office, Admission Office, Dietary Manager, Environmental Services Manager, Medical Records, and Social Services. All were provided re-education to affirm that the committee is to facilitate a process that involved areas of the facility operation to systematically monitor the performance of the various areas of concern or quality deficiencies with facility systems, and develop action plans to correct areas identified. They were also educated that it was the responsibility of the committee to oversee the implementation of the plans, monitor the effectiveness of the plans and make adjustments to the plan if desired outcomes were not achieved.  The QAA committee will review the audits and checklist utilized to monitor the completion of the task related to fall risk, care plan revisions and incident investigation through AQA meetings held daily on standard work days and at monthly QAA meetings. This education was provided by the Quality Management Specialist on 02/17/12, and	F 520			

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F 520	<p>Continued From page 73</p> <p>will be repeated for any member not initially trained on their next scheduled work day. The Medical Director will be educated on or before her next visit.</p> <p>Verification of removal of Immediate Jeopardy was completed as follows:</p> <p>The education was initiated on 02/17/12 and verified by review of the sign-in sheet and an interview with LPN #1, on 02/23/12 at 2:10 PM, who was a QAA committee member, validated the content.</p> <p>Discussion with the Medical Director was completed, on 02/20/12, and validated by signature on the sign-in sheet.</p> <p>Based on the above interviews and record reviews, it was determined the Immediate Jeopardy was removed, effective 02/19/12, as alleged in the AoC with the scope and severity lowered to a "D" as the facility had not completed the QA initiative related to staff monitoring, analysis of monitoring audit results and the development and implementation of the POC to ensure interventions are effective and will prevent recurrence, in order to achieve and maintain compliance.</p>	F 520		
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