

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

PRINTED: 07/13/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
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NAME OF PROVIDER OR SUPPLIER MADONNA MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017
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F 000	INITIAL COMMENTS	F 000		
F 282 SS=G	<p>An Abbreviated Survey investigating KY#00018572 was initiated on 06/22/12 and concluded on 06/28/12. KY#00018572 was substantiated with unrelated deficiencies cited. The highest scope and severity was a "G".</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy it was determined the facility failed to ensure services were provided in accordance with each resident's written Plan of Care for one (1) of three (3) sampled residents (Resident #2).</p> <p>Resident #2's Interim Care Plan, undated, stated the resident would have no falls or injuries and the interventions included a Sara lift. However, on 06/21/12, the resident was transferred with a one (1) person pivot transfer causing the resident to twist his/her ankle resulting in a right ankle sprain. (Refer to F323)</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Using the Care Plan", undated, revealed the Care Plan shall be used in developing the resident's daily care routines and will be available to staff personnel</p>	F 282	<p>The completion and submission of this plan of correction does not constitute an admission that the facility agrees with the cited 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 has submitted an Informal Dispute Resolution for the following citations F282 and F323.</p> <p>The facility alleges compliance as of July 2, 2012.</p>	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Executive Director	(X6) DATE 7-19-12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 282	<p>Continued From page 1 who have responsibility for providing care or services to the resident.</p> <p>Review of Resident #2's clinical record revealed the facility admitted the resident on 05/12/12 with diagnoses which included Cerebral Vascular Accident with Hemiplegia. Review of the Physician's Orders dated 05/14/12 revealed Physical Therapy had recommended the Sara lift to be used as needed for transfers and safety. Review of the Interim Plan of Care, undated, revealed a problem of falls with approaches included the use of the Sara lift. Review of the Admission Minimum Data Set (MDS) Assessment, dated 05/25/12, revealed the facility assessed the resident with a Brief Interview Mental Status (BIMS) of fifteen (15) which indicated no cognitive loss.</p> <p>Interview, on 06/28/12 at 4:30 PM, with Licensed Practical Nurse (LPN) #4 revealed the staff used a gait belt and two (2) person assistance to transfer Resident #2 on admission, and after Physical Therapy assessed the resident on 05/14/12, a Sara lift was recommended and ordered per the Physician's Orders dated 05/14/12.</p> <p>Interview with Resident #2, on 06/28/12 at 11:45 AM, revealed a Certified Nursing Assistant (CNA) had lifted him/her from the wheelchair to the recliner and his/her foot got caught under the chair and he/she heard his/her foot "pop". Resident #2 stated he/she informed the CNA before the transfer, that it would take two (2) staff; however, the CNA continued with the transfer. Resident #2 stated he/she notified the nurse of pain in the foot and an x-ray was ordered.</p>	F 282	<p>F282 Services provided or arranged by the facility must be performed by qualified persons in accordance with each resident's written plan of care.</p> <p>On May 22, 2012 through the facility Quality Assurance process it was determined that 1 employee CNA # 9 failed to follow 1 residents care plan for resident #2. Employee #9 was re-educated and received a formal coaching for failing to follow resident #2 care plan. That coaching occurred on 5/22/2012(see attachment 1) Employee #2 did attend orientation as well as the February 10, 2012 in-service where staff was again educated on the policy that staff must follow resident care cards and to look at them prior to giving care. (See attachment 2) On May 22 and on June 8th 2012 staff was also reminded to look at and follow resident care cards prior to giving care. (See attachment 3)</p> <p>The QA committee was informed on May 22 of the May 21st incident and requested that the ADON do random audits for two weeks observing care to residents was being completed per resident care cards and to follow up with the QA committee. (See attachment 4 Care plan and Care Card Audit tool) The QA committee was satisfied with results of the audits and discontinued them.</p>		

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F 282	Continued From page 2 Review of the Assignment Sheet, dated 05/21/12, revealed LPN #4 and CNA #9 were assigned to Resident #2 on the evening shift. Interview, on 06/28/12 at 6:30 PM, with CNA #9, revealed she was familiar with Resident #2 and was frequently assigned to him/her. She stated she transferred Resident #2 by herself on 05/21/12 with a gait belt; the resident's legs buckled; and, the resident's foot twisted and caught under the recliner chair. She further stated the resident complained of pain in the foot and she notified the nurse, which was LPN #4 to the best of her memory. Further interview revealed she always transferred Resident #2 by herself because the resident could stand up very good on one (1) leg to transfer. CNA #9 stated the CNAs were to refer to the Care Card which was kept inside the resident's closet door for reference for any care including transfers. Per interview, at that time the Care Card did not specify which transfer technique to use for this resident or how many staff were to assist with the transfer. Interview, on 06/28/12 at 4:30 PM, with LPN #4 revealed she and CNA #9 were assigned to Resident #2 on 05/21/12 and Care Cards were in place inside the closet doors for the CNAs to use for a reference related to resident care. She indicated she did rounds and spot checked to ensure the CNAs were using the correct transfer technique as per the Care Plan and Care Cards. Further interview revealed she did not remember CNA #9 notifying her of the resident complaining of pain in the foot or having any concerns related to Resident #2 on 05/21/12. She further stated, a	F 282	As part of our clinical morning meeting a review of care cards was put into place effective 11/2011 Care Cards are reviewed five days a week at the morning clinical meeting that is attended by the DON, ADON, MDS Coordinator, Social Worker, Therapist, Household Nurse and Household Team Leader. Care cards are reviewed and updated according to the care plan the team leader makes staff aware of a change and reminds team to look at the care cards. (See attachment 5) Nurses on the households do make rounds thought their shift and spot check staff to monitor that CNAs are using the correct techniques as per the Care plan and Care Card and meeting the residents' needs. Care card audits are also performed twice a week by the Household Team Leader example (attachment 6) these audits are turned into the care plan nurse to match care cards to care plans. This audit system was initiated 11/2011. The QA committee reviews accidents each time they meet, identifies the need for audits and programmatic changes as necessary. (See attachment 7) Resident #2 remains in the facility and continues to make progress in therapy and care card is followed.	

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F 282	<p>Continued From page 3</p> <p>day or two after the incident, Resident #2 told her a CNA had transferred him/her by herself and LPN #4 was also questioned by Administration about this same time. She stated, on 05/21/12, either a Sara lift or a two (2) person pivot transfer was allowed and staff was using both techniques.</p> <p>Review of the Physical Therapy (PT) Notes, dated 05/22/12 at 11:46 PM, revealed Resident #2 reported that his/her right ankle twisted during a transfer the previous evening. The note indicated the resident's ankle was swollen and bruised and the resident reported pain with weight bearing. Further review revealed Therapy was holding weight bearing until results of x-ray were obtained.</p> <p>Review of the Comprehensive Progress Notes, dated 05/22/12 at 2:48 PM, revealed Resident #2 had two (2) plus edema to the right ankle and complained of pain when standing. Further review revealed a new order was noted for an x-ray and family was aware.</p> <p>Further review of the Physician's Orders, dated 05/22/12, revealed orders for an x-ray to the right ankle due to swelling, and to apply ice to the right ankle as needed, for ten (10) minutes duration, for pain and swelling.</p> <p>Further review of the PT Notes, dated 05/23/12 at 5:05 PM, revealed x-rays of the right ankle were negative; however, there was swelling, bruising, and pain to the right ankle indicating a probable sprain.</p> <p>Interview on 06/28/12 at 2:00 PM with MDS/LPN #3, revealed she investigated all falls and</p>	F 282	<p>The policy for care cards were reviewed by the DON and Medical Director and revisions were not made.</p> <p>Staff was again educated on June 29, 2012 to look at card cards prior to care and to follow them. (See attachment 8)</p> <p>Care Cards are reviewed five days a week at the morning clinical meeting that is attended by the DON, ADON, MDS Coordinator, Social Worker, Therapist, Household Nurse and Household Team Leader. Care cards are reviewed and updated according to the care plan the team leader makes staff aware of a change and reminds team to look at the care cards. (See attachment 4) Nurses on the households do make rounds and spot check staff to monitor that CNAs are using the correct techniques as per the Care plan and Care Card and meeting the residents' needs.</p> <p>To prevent other residents from being effected Care card audits continue to be performed twice a week by the Household Team Leader example (attachment 7) these audits are turned into the care plan nurse to match care cards to care plans.</p> <p>The QA committee reviews accidents each time they meet, identifies the need for audits and programmatic changes as necessary. (See attachment 6)</p> <p>Resident #2 remains in the facility and continues to make progress in therapy and care card is followed.</p>	

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F 282	<p>Continued From page 4</p> <p>or/injuries immediately after they occurred. She stated she, the Director of Nursing (DON), Assistant Director of Nursing (ADON), Social Services Director, CNA team leaders, a nurse for each hall, and the Administrator attended a team meeting each morning in which each resident was discussed related to new Physician's orders and new incidents. She further stated the Care Cards were updated after each meeting. She was informed during a meeting on 05/22/12 by a nurse that the resident's ankle was swelled and hurting and the nurse felt it happened during a transfer. Further interview revealed she talked to Resident #2 who told her CNA #9 transferred him/her by herself causing injury to the ankle. Continued interview revealed an x-ray was ordered which was negative and a meeting was held with Physical Therapy related to transfer technique for this resident.</p> <p>Interview on 06/28/12 at 5:00 PM with the DON, revealed the Interim Care Plan was the care plan in use at the time of the transfer on 05/21/12 because the Comprehensive Plan of Care had not yet been developed. She stated the Interim Care Plan intervention revealed staff was to use the Sara lift; however, the care plan and interventions were not dated and it was difficult to know when this intervention was started. Per interview, she was unable to specify which intervention was in place related to the transfer on 05/21/12. Continued interview revealed the Care Card was revised by nurses as they transcribed Physician's Orders and there were several interventions related to transfer technique for this resident on the current Care Card. She stated, the current Care Card did specify two (2) persons were to assist with transfers, and on</p>	F 282	<p>The facility maintains that if indeed this event was the result of a deficient practice that the citation should be one of past non-compliance. With a compliance date of May 22. As the facility had completed in plan of correction and the care card was followed for resident #2 on June 28th 2012 when OIG came to facility to investigate a complaint which the surveyor found to be unsubstantiated.</p>		

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F 282	Continued From page 5 05/21/12, CNA #9 transferred the resident by herself. Continued interview, revealed according to the most recent Physician's Orders, prior to the 05/21/12 transfer, the Sara lift was to be used as needed because the order was written as recommended. She stated this meant staff would not necessarily have to use the Sara lift and could use two (2) person assist to stand and pivot the resident. However, the resident's Interim Care Plan specified the use of a Sara lift only.	F 282	F323 The facility must ensure that the resident environment remains as free of accidents hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents.	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy it was determined the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for one (1) of three (3) sampled residents (Resident #2). The facility failed to ensure Resident #2 was transferred per the resident's care plan which resulted in an injury to the resident's right ankle. Review of the resident's Interim Care Plan revealed a Sara lift was to be used for transfers. On 05/21/12 staff transferred Resident #2 with	F 323	On May 22, 2012 through the facility Quality Assurance process it was determined that 1 employee CNA # 9 failed to follow 1 residents care plan for resident #2. Employee #9 was re-educated and received a formal coaching for failing to follow resident #2 care plan. That coaching occurred on 5/22/2012(see attachment 1) Employee #2 did attend orientation as well as the February 10, 2012 in-service where staff was again educated on the policy that staff must follow resident care cards and to look at them prior to giving care. (See attachment 2) On May 22 and on June 8 th 2012 staff was also reminded to look at and follow resident care cards prior to giving care. (See attachment 3) The QA committee was informed on May 22 of the May 21 st incident and requested that the ADON do random audits for two weeks observing care to residents was being completed per resident care cards and to follow up with the QA committee. (See attachment 4 Care plan and Care Card Audit tool) The QA committee was satisfied with results of the audits and discontinued them.	

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F 323	<p>Continued From page 6</p> <p>only a one (1) person assistance causing the resident to twist his/her ankle causing swelling and discoloration to the right ankle, and bruising to the top of the foot and fifth toe. The incident resulted in the resident having a right ankle sprain with pain which limited the resident's participation in Physical Therapy, from 05/22/12 through 05/28/12.</p> <p>The findings include:</p> <p>Review of the facility "Falls Clinical Protocol", revised 10/08, revealed staff and physician would monitor and document the individual's response to interventions intended to reduce falling.</p> <p>Review of Resident #2's medical record revealed the facility admitted the resident on 05/12/12 with diagnoses which included Cerebral Vascular Accident with Hemiplegia. Review of Resident #2's Fall Risk Assessment, dated 05/12/12, revealed the resident was assessed to be at risk for falls related to requiring assistance with elimination, ambulated with problems and with devices, was not steady and was only able to stabilize with human assistance, was over 85 years old, health conditions, and medications. The resident's fall risk score was a fourteen (14) with a score over nine (9) indicating risk for falls.</p> <p>Interview, on 06/28/12 at 4:30 PM, with Licensed Practical Nurse (LPN) #4 revealed the staff used a gait belt and two (2) person assistance to transfer Resident #2 on admission; however, after Physical Therapy assessed the resident on 05/14/12, a Sara lift was recommended and ordered per the Physician's Orders dated 05/14/12.</p>	F 323	<p>As part of our clinical morning meeting a review of care cards was put into place effective 11/2011</p> <p>Care Cards are reviewed five days a week at the morning clinical meeting that is attended by the DON, ADON, MDS Coordinator, Social Worker, Therapist, Household Nurse and Household Team Leader. Care cards are reviewed and updated according to the care plan the team leader makes staff aware of a change and reminds team to look at the care cards. (See attachment 5) Nurses on the households do make rounds thought their shift and spot check staff to monitor that CNAs are using the correct techniques as per the Care plan and Care Card and meeting the residents' needs.</p> <p>Care card audits are also performed twice a week by the Household Team Leader example (attachment 6) these audits are turned into the care plan nurse to match care cards to care plans. This audit system was initiated 11/2011.</p> <p>The QA committee reviews accidents each time they meet, identifies the need for audits and programmatic changes as necessary. (See attachment 7)</p> <p>Resident #2 remains in the facility and continues to make progress in therapy and care card is followed.</p>		

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F 323	<p>Continued From page 7</p> <p>Review of the Physician's Orders, dated 05/14/12, revealed Physical Therapy had recommended the Sara lift to be used as needed for transfers and safety. Review of the Interim Plan of Care, with no date, revealed a problem of falls with approaches which included the use of a Sara lift.</p> <p>Interview on 06/28/12 at 11:45 AM with Resident #2, whom the facility had assessed with no cognitive loss on 05/24/12, revealed a Certified Nursing Assistant (CNA) had lifted him/her from the wheelchair to the recliner, although she told the CNA prior to the transfer, he/she could not be lifted by one (1) person. The resident stated his/her foot got caught under the chair and he/she heard his/her foot "pop". Resident #2 stated he/she informed the nurse of pain in the foot and an x-ray was ordered.</p> <p>Phone interview, on 06/28/12 at 6:30 PM, with CNA #8 revealed she was familiar with Resident #2 and often was assigned to him/her. She stated she transferred the resident by herself on 06/21/12 with a gait belt. She further stated the resident's legs buckled and the resident's foot got twisted and caught under the recliner chair causing the resident to have pain in the foot. She stated she notified the nurse which was LPN #4 to the best of her memory. Continued interview revealed she always transferred Resident #2 by herself because the resident could stand up very good on one (1) leg to transfer. She stated the CNAs were to refer to the Care Card which was kept inside the resident's closet door for reference for any care including transfers; however at that time the Care Card did not</p>	F 323	<p>The policy for care cards were reviewed by the DON and Medical Director and revisions were not made.</p> <p>Staff was again educated on June 29, 2012 to look at card cards prior to care and to follow them. (See attachment 8)</p> <p>Care Cards are reviewed five days a week at the morning clinical meeting that is attended by the DON, ADON, MDS Coordinator, Social Worker, Therapist, Household Nurse and Household Team Leader. Care cards are reviewed and</p> <p>updated according to the care plan the team leader makes staff aware of a change and reminds team to look at the care cards. (See attachment 4) Nurses on the households do make rounds and spot check staff to monitor that CNAs are using the correct techniques as per the Care plan and Care Card and meeting the residents' needs.</p> <p>To prevent other residents from being effected Care card audits continue to be performed twice a week by the Household Team Leader example (attachment 7) these audits are turned into the care plan nurse to match care cards to care plans.</p> <p>The QA committee reviews accidents each time they meet, identifies the need for audits and programmatic changes as necessary. (See attachment 6)</p>	

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F 323	<p>Continued From page 8 specify which transfer technique to use for this resident.</p> <p>Interview, on 06/28/12 at 4:30 PM, with LPN #4 revealed she and CNA #9 were assigned to Resident #2 on 05/21/12 and Care Cards were in place for the CNAs to use for a reference related to resident care. She stated she did rounds and spot checked to ensure the CNAs were using the correct transfer technique. Continued interview revealed she did not remember CNA #9 notifying her of the resident complaining of pain in the foot or having any concerns related to Resident #2 on 05/21/12. She further stated a day or two after the incident Resident #2 told her a CNA had transferred him/her by herself and LPN #4 was questioned by Administration. She stated at the time of the transfer on 05/21/12, either a Sara lift or a two (2) person pivot transfer was allowed.</p> <p>Interview, on 06/28/12 at 2:00 PM, with MDS/LPN #3 revealed she investigated all falls and/or injuries. She stated she and the Director of Nursing (DON), Assistant Director of Nursing (ADON), Social Services Director, CNA team leaders, a nurse for each hall and the Administrator attended a team meeting each morning in which each resident was discussed for new Physician's orders and new incidents. She further stated she was informed during a meeting, on 05/22/12, in which the nurse stated Resident #2's ankle was swelled and hurting and the nurse felt it happened during a transfer. Continued interview revealed she talked to Resident #2 who told her CNA #9 transferred her by herself and hurt her ankle.</p> <p>Review of the Physical Therapy Notes, dated</p>	F 323	<p>Resident #2 remains in the facility and continues to make progress in therapy and care card is followed.</p> <p>The facility maintains that if indeed this event was the result of a deficient practice that the citation should be one of past non-compliance. With a compliance date of May 22. As the facility had completed in plan of correction and the care card was followed for resident #2 on June 28th 2012 when OIG came to facility to investigate a complaint which the surveyor found to be unsubstantiated.</p>	7-21-12
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/28/2012
NAME OF PROVIDER OR SUPPLIER MADONNA MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 9</p> <p>05/22/12 at 11:45 PM, revealed the patient reported that his/her right ankle twisted during transfer the evening before. The Note stated the ankle was now swollen and bruised and the resident reported pain with weight bearing. Further review of the Note revealed Therapy was holding weight bearing activities until the x-ray results were received.</p> <p>Review of the Progress Notes, dated 05/22/12 at 2:48 PM, revealed Resident #2 had two (2) plus edema to the right ankle and complained of pain when standing. Further review revealed a new order was noted for an x-ray and family was aware. Review of the Physician's Orders, dated 05/22/12, revealed orders for an x-ray to the right ankle related to swelling, and to apply ice to the right ankle as needed for ten (10) minutes duration for pain and swelling.</p> <p>Review of the Physical Therapy Notes, dated 05/23/12 at 5:05 PM, revealed x-rays of the right ankle were negative. The Therapist noted there was swelling, bruising, and pain to the right ankle indicating a probable sprain. The Therapist recommended to limit weight bearing activity on the right foot with no gait today.</p> <p>Further review of the Progress Notes, dated 05/23/12 at 6:43 PM, revealed the x-ray was negative and new orders were received for ice as needed. Review of the Physician's Orders, dated 05/23/12, revealed recommendation for the use of a sliding board or Sara lift for transfers and recommend use of an ace wrap on the right foot as tolerated.</p> <p>Review of the Physical Therapy Notes, dated</p>	F 323			

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NAME OF PROVIDER OR SUPPLIER MADONNA MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017
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F 323	<p>Continued From page 10</p> <p>05/24/12 at 12:00 PM, revealed the patient continued to complain of right ankle pain especially with any weight bearing, and no standing or weight bearing was attempted that day.</p> <p>Review of the Progress Notes, dated 05/24/12 at 3:15 AM, revealed Resident #2 complained of discomfort of the right ankle, slight swelling was noted and the resident requested Tylenol for pain. Further review revealed the CNA notified the writer of discoloration of the fifth toe which was very dark purple in color. Review of the Skin Condition Report, dated 05/24/12 (no time), revealed blue discoloration was present on the left top of foot and a bruise was noted on the top of the fifth toe on the right foot.</p> <p>Review of the Physical Therapy Notes, dated 05/25/12 at 2:55 PM, revealed the patient continued with pain and swelling to the right ankle. Review of the Physical Therapy Notes, dated 05/28/12 at 5:15 PM revealed progress had been limited due to right ankle sprain and pain with weight bearing.</p> <p>Interview was attempted with the Physical Therapist and she was unable to be reached.</p> <p>Interview, on 06/28/12 at 5:00 PM, with the DON, revealed the Interim Care Plan was the care plan in use at the time of the transfer on 05/21/12 and this stated to use the Sara lift; however, the care plan and interventions were not dated and it was difficult to know when this intervention was started. Further review revealed the Care Card was updated as interventions changed and there was several interventions related to transfer</p>	F 323		

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F 323	<p>Continued From page 11</p> <p>technique for this resident. She was unable to specify which intervention was in place related to transfer on 05/21/12. Further interview revealed, according to the most recent Physician's Order, prior to the 05/21/12 transfer, the Sara lift was to be used as needed because the order was written as needed, meaning staff would not necessarily have to use the Sara lift and could use two (2) person assist to stand and pivot the resident. However, the resident's Interim Care Plan specified the use of a Sara lift only. The DON further stated the order for the Sara lift should have been clarified by nursing.</p> <p>Interview with the Attending Physician, on 06/28/12 at 7:40 PM, revealed the order written on 05/14/12 to recommend transfer with a Sara lift was "as needed". He revealed he had seen the resident's ankle after the transfer on 05/21/12 and his impression was that the resident had sustained a sprain to the ankle.</p>	F 323		
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