

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

PRINTED: 05/11/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/27/2011
NAME OF PROVIDER OR SUPPLIER  NORTH HARDIN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160	
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F 000	<p>INITIAL COMMENTS</p> <p>An abbreviated survey to investigate KY#16117 and KY #16196 was conducted on 04/19/11 through 04/21/11 and a partially extended survey was conducted on 04/25/11-04/27/11. Immediate Jeopardy related to KY#16117 was identified on 04/21/11 in the areas of 42 CFR 483.20 (F282) S/S: K, 42 CFR 483.25 (F323) S/S: K, and 42 CFR 483.75 (F490) S/S: K. Substandard quality of care was identified in 42 CFR 483.25 (F323). The facility was notified of the Immediate Jeopardy and Substandard Quality of Care on 04/21/11.</p> <p>The facility failed to ensure residents' individual care plans were implemented to prevent falls with injury. The facility assessed Resident #1 needing assistance of two persons for all transfers and toileting needs. The comprehensive care plan was developed with instructions for the staff to transfer and toilet Resident #1 with the assistance of two persons. On March 7, 2011, CNA #1 (certified nursing assistant) transferred Resident #1 from the wheelchair to the toilet by herself. The resident lost his/her balance, fell against the toilet and onto the bathroom floor. A large hematoma (size of a baseball) developed to the resident's lumbar. The hematoma (localized collection of blood from broken blood vessels) had to be surgically removed leaving a large open area on the resident's back that required treatment twice a day.</p> <p>The facility failed to identify the cause of the fall and did not provide additional staff training or interventions to ensure all residents were transferred according to which method (one person, two person, or mechanical lift) the facility</p>	F 000	<p>Facility Administrator states that the plan of correction contained here-in constitutes the facilities allegation of compliance with all deficiencies cited, that no separate notification of compliance is required by virtue of this allegation of compliance, and that this allegation of compliance may presume the facility's compliance until substantiated by a revisit or other means.</p>	

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

TITLE

(X6) DATE

*Karen M. Meredith*

*Administrator*

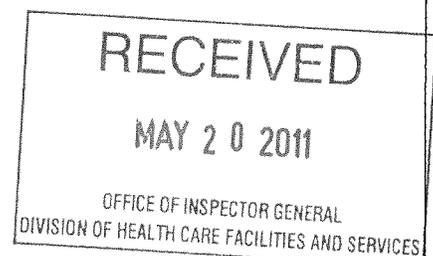
5-20-11

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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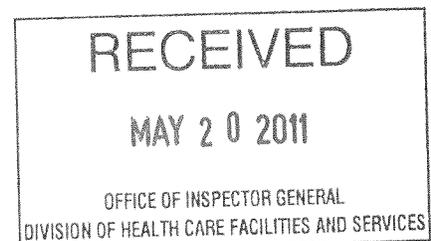
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F 000	<p>Continued From page 1</p> <p>had assessed each resident required. Review of the care tracker (computer documentation) revealed multiple nurse aides continued to transfer Resident #1 with assist of one person after the injurious fall on 03/07/11.</p> <p>In addition, Resident #9 sustained an injurious fall on 04/20/11 when the resident attempted to self transfer from the bed. The resident sustained a nasal and cervical fracture, laceration to the nose, hematoma to the right forehead, and facial bruising. The resident had sustained seven falls since January 2011 either from self transferring from the bed or attempting to toilet. The facility failed to identify this trend and did not implement appropriate interventions to prevent the resident from sustaining additional falls.</p> <p>A partially extended survey was conducted on 04/25/11 - 04/27/11 which determined Immediate Jeopardy existed from 03/07/11 - 04/26/11. The facility provided an acceptable credible Allegation of Compliance (AOC) for the removal of IJ on 04/27/11. The state agency verified Immediately Jeopardy was removed prior to exit on 04/27/11, with remaining non-compliance at 42 CFR 483.20 Assessments (F282), 42 CFR 483.25 25 Quality of Care (F323) Accidents, and 42 CFR 483.75 (F490) Administration, at scope and severity to a "E".</p> <p>In addition, deficient practice was identified in 42 CFR 483.13 (F221) Physical Restraints at S/S = "E" during the partially extended survey.</p> <p>KY# 16196 was determined to be unsubstantiated; however, regulatory violations were cited as a result of the investigation.</p>	F 000			



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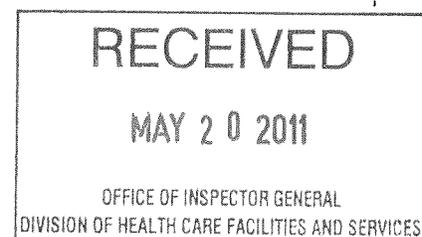
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F 221 SS=E	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, and facility policy it was determined the facility failed to ensure all resident were free from physical restraints for four (4) of nine (9) residents with restraints, out of a total of fifteen (15) sampled residents. (#12, #8, #9, and #6). The facility failed to ensure the physical restraint was appropriate and periodically restraint reduction was attempted. Resident #9 had a seat belt restraint applied after several falls from the bed. Resident #12 had a seat belt restraint applied after a fall. The resident was resisted to the application of the physical restraint.</p> <p>In addition, Resident #6 and #8 had no documented evidence a reduction was attempted.</p> <p>The findings include: Review of the facility policy/procedure regarding Physical Restraints effective 01/01/09 revealed it is the intent of this facility that each resident attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the</p>	F 221	<p>F 221</p> <p>Residents # 12, 8, 9 and 6 were reviewed by the Restraint Committee on 4-27-11 and 4-28-11. Each was reviewed to determine appropriateness of the device, continued need, possible alternatives, any reduction efforts that were appropriate, and an individual release plan. Care plans were updated at that time to reflect any changes.</p> <p>All other resident with restraints were reviewed by the Restraint Committee on 4-27-11 and 4-28-11 to determine appropriateness of the device, continued need, possible alternatives, any reduction efforts that were appropriate and an individual release plan. All care plans were updated as needed to reflect any changes.</p> <p>On 4-27-11 and 4-28-11 the West Wing Unit Coordinator and three LPN's in-serviced nursing staff regarding the need to release any/all physical restraints no less than every two hours, this was done to ensure that all restraints were released until the individual plans could be established, and all care plans updated.</p>	5-21-11



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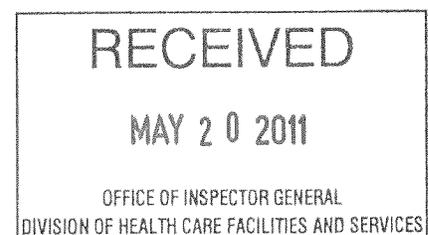
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F 221	<p>Continued From page 3</p> <p>use of restraints.....It is the practice of this facility to evaluate the use of all devices. If a device is determined to be a restraint, the facility will ensure that the least restrictive device is used for the least amount of time. The facility will periodically re-evaluate the use of a restraint to determine if reduction in use is appropriate.</p> <p>1. Resident #12 was admitted on 04/07/11 with Alzheimer's Disease and the facility assessed the resident to be at risk for falls. Review of Resident #12's clinical record on 04/26/11 revealed Resident #12 was found on the floor on 04/04/11 with the wheelchair turned over. No injuries occurred. Interventions for the fall was a chair alarm to be placed on the wheelchair. On 04/24/11 the resident sustained another fall while attempting self-transfer. The resident stood up from the wheelchair and fell. No injuries was noted. The facility applied an alarming seat belt restraint.</p> <p>Review of the restraint assessment form completed on 04/25/11 revealed the medical reason for the restraint was "Alzheimer's Disease and risk for falls".</p> <p>Observation of Resident #12 during the breakfast meal on 04/27/11 at approximately 8:00am, revealed the resident pulling at the seat belt restraint and said, "How do I get this thing off?".</p> <p>Interview with the Unit Coordinator on the West Hall on 04/26/11 at 1:30pm revealed the family had requested the seat belt on the wheelchair after the second fall to prevent further falls. The Unit Coordinator stated a restraint assessment</p>	F 221	<p>Corporate consultants provided education to the Restraint Committee: the Administrator, the Activity Director, MDS Coordinator, and Unit Managers on 4-27-11. This included review of the Policy, all forms including the revision of the assessment and review forms to include a release plan, the definition of a restraint, purpose, definition of medical symptom, appropriateness, reduction plans, release plans and periodic review process. The facility restraint policy was reviewed by the corporate consultants and revisions were incorporated in the assessment and review forms to include a release plan for each resident. Nursing staff were then re-educated on the use of restraints including the release plans by the administrative nurses and designated staff and this education was completed on 5-20-11.</p> <p>Audits will be conducted to ensure that individual release plans are being followed. These audits will be conducted by licensed nursing personnel and assigned staff daily for 2 weeks, then one time per week for 4 weeks to ensure that release plans are being followed. The results of these audits will be reviewed daily by the nursing</p>		



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F 221	<p>Continued From page 4</p> <p>was completed, and found to be an appropriate intervention. He added that a restraint care plan would be developed, and revealed there were no specific times to release the restraint but it should be released during toileting and meal times. However, observation of the breakfast meal on 04/27/11 revealed the resident's seat belt restraint was not released during the meal.</p> <p>2. Resident #6 was admitted on 09/08/10 for rehabilitation and was assessed as a high risk for falls due to an unsteady gait. Review of the care plan revealed the seat belt restraint was ordered on 11/16/10 and the resident could release the seat belt; however, the resident could not remove the belt upon request. Attempts to interview the resident on 04/26/11 at 1:00pm revealed the resident did not understand and could not remove the belt. Review of the clinical record revealed no documented evidence an attempt to reduce the physical restraint had been attempted since initial placement of the seat belt (11/16/10) or re-evaluated for a lesser restrictive device.</p> <p>Observations during the breakfast meal in the East Wing Dining Room on 04/27/11 at 8:15am revealed Resident's #12, #6, #14, and #15 had wheelchair seat belts applied during the entire breakfast. Resident #12 was observed to be pulling at the seat belt restraint and said, "How do I get this thing off?"</p> <p>Interview with CNA#11, #13, and #15 on 04/26/11 at 2:30pm revealed restraints are to be removed with toileting, dining, and just get up to walk. They stated it use to be on the care plans to release every two hours, but it is not on there anymore.</p>	F 221	<p>supervisor to allow for re-education as needed. These audits will also be reviewed by the facility QA Committee. The Restraint Committee will continue to meet monthly to review all restraints, assessments and plans. A corporate consultant will attend these meetings monthly for six months to ensure the committee understands and is following the policy correctly.</p> <p>The Director of Nursing or her designee will present a list of all residents that are identified as having physical restraints, the type of device, the date of the most recent reduction attempts and the individual release plan to the facility QA Committee monthly for 6 months for review.</p>		



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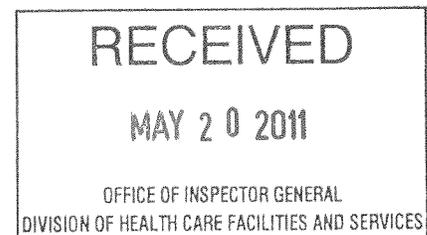
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F 221	<p>Continued From page 5</p> <p>Interview with the Unit Coordinator on the West Hall on 04/26/11 at 1:45pm revealed the facility has a restraint program where all restraints are reviewed by the interdisciplinary team for appropriateness. The team would determine if a reduction was needed, or if the restraint could be eliminated. The physical restraints are released during toileting, activities, meals, or on the turning schedule.</p> <p>Interview with the Regional Vice President on 04/26/11 at 2:00pm revealed restraint reviews are completed. She stated the restraint policy did not address release of restraints but restraint release is incorporated into the interdisciplinary reviews, and should incorporate toileting plans, such as every three hours; this would also include during meals, activities, which would mean the restraints should be released at those times. However, observation during the breakfast meal on 04/27/11 revealed the physical restraints were not released for the above residents.</p> <p>3. Observation of Resident #9 on 04/25/11 at 10:45am revealed the resident sitting up in a wheelchair in the resident's room. A hard collar neck brace was applied. Bilateral bruising and orbital edema was under the resident's eyes. Profound bruising and edema was noted on the bridge of the nose. A large hematoma was observed on the resident's right forehead. The resident had eyes closed and did not response to conversation. An alarming seat belt restraint was applied around the resident's waist.</p> <p>Interview with the daughter-in-law at the time of the above observation revealed the seat belt had been placed on the resident after a fall on</p>	F 221		

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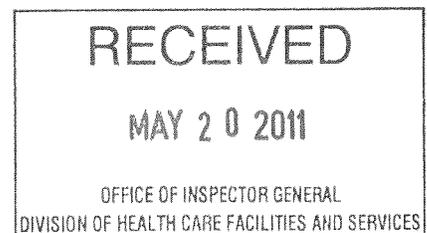
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F 221	<p>Continued From page 6 04/20/11.</p> <p>Review of Resident #9's clinical record revealed an admission date of November 2010 with a history of falling. Review of the admission MDS completed on 11/23/10 revealed the facility assessed the resident to require extensive assistance from one-person with bed mobility, transfers, and ambulation, and two-person assist with toilet use. The facility assessed the resident to have a balance deficit and unsteady gait. The most recent MDS assessment completed on 04/20/11 revealed the facility assessed the resident to require the same amount of assistance (one-person) with bed mobility, transfers, and ambulation. Toilet use was now completed with assist of one-person. Review of the CAA (Care area assessment) dated 04/14/11 revealed Resident #9 had four falls since the last review. The report stated the resident has a diagnosis of Alzheimer's Disease which could impact her decision making ability. Review of the care plan dated 04/21/11 revealed a seat belt was to be applied to the wheelchair. No reduction plan was noted. Review of the April CNA care plan revealed a seat belt alarm to wheelchair but no instructions to when the restraint was to be released.</p> <p>On 04/20/11 at 9:30pm, documentation in the nurses' notes revealed the resident was found lying on the floor. A large hematoma was noted to the resident's right forehead and laceration across the bridge of the nose. An abrasion was noted to the right shoulder and bilateral knees. A skin tear was noted to the right forearm. The resident stated, "I was trying to go to the BR (bathroom) when I fell." The resident was sent to</p>	F 221			



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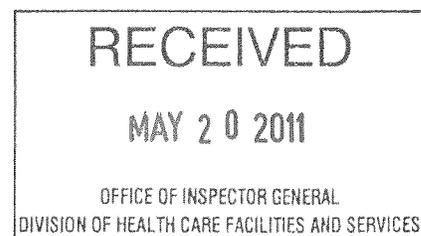
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F 221	<p>Continued From page 7</p> <p>the hospital for evaluation with the findings of a nasal fracture and C-2 (cervical) fracture to the neck. A hard collar neck brace was applied. Refer to F323</p> <p>Review of the incident report for the fall on 04/20/11 revealed the resident was attempting to self-transfer from the bed. Review of a telephone physician order dated 04/21/11 revealed an alarming seat belt restraint was ordered to be worn when the resident was up in a wheelchair. Review of the physical restraint assessment completed on 04/21/11 revealed a seat belt restraint was recommended related to unsteady gait and history of falls and the interventions tried prior to the restraint was a "pad alarm". However, the sensor pad alarm was ordered for the bed on 04/12/11 not the wheelchair and there was no documented evidence the resident ever had a fall from the wheelchair. In addition, the restraint assessment stated the resident was non-ambulatory; however, interview with staff and review of the MDS assessment, revealed the resident could walk.</p> <p>On 04/21/11 after the injurious fall, a low bed and an alarming seat belt restraint to the wheelchair was ordered.</p> <p>Interview with the West Unit Coordinator on 04/25/11 at approximately 2:30pm revealed the seat belt was ordered after the 04/20/11 fall because he was afraid the resident would attempt to get up from the wheelchair and fall. He confirmed most of the falls occurred when the resident attempted self-transfers from the bed or in the bathroom.</p>	F 221			



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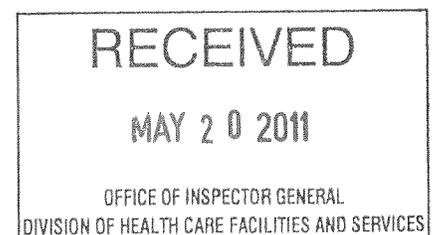
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F 221	<p>Continued From page 8</p> <p>Observation on 04/27/11 at 10:45am revealed Resident #9 sitting in a recliner in the resident's room. There was no sensor alarm attached to the chair or resident. Interview with CNA#18 present during the above observation revealed the resident does not attempt to get up from the recliner or wheelchair.</p> <p>4. Observation on 04/25/11 at 10:15am revealed Resident #8 sitting in a wheelchair (in the resident's room) with a seat belt restraint applied around the resident's waist. The resident could not release the seat belt upon request and did not know why the seat belt was there.</p> <p>Review of Resident #8's clinical record revealed a seat belt restraint was applied on 12/30/10. The restraint assessment completed on 12/30/10 revealed the seat belt restraint was to be applied when the resident was up in a wheelchair because of "unsteady gait". The Review of the care plan revealed no reduction plan. On 01/26/11 and 02/23/11 the facility conducted a review of the physical restraint with recommendation to continue the use of the seat belt restraint with no reduction attempted.</p> <p>Interview with LPN#3 (who completed the restraint reviews) on 04/27/11 at 1:00pm revealed she could not find any documented evidence an attempt to reduce or remove the seat belt restraint had been conducted.</p> <p>Review of the list of facility restraints (updated on 04/25/11) revealed 25 residents utilized seat belt restraints in the facility.</p> <p>Interview with the Vice President of Operations on</p>	F 221		



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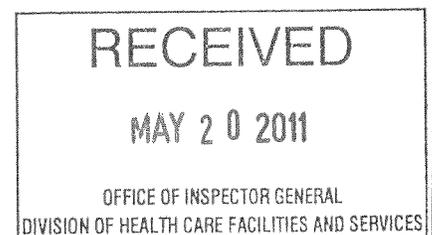
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F 221	Continued From page 9 04/26/11 approximately 2:00pm revealed the nurse had placed a seat belt restraint on Resident #9's wheelchair even though the resident had falling attempting to self-transfer from the bed. She stated the staff was afraid the resident would attempt self-transfers from the wheelchair and didn't want the resident to sustain another fall. She acknowledged there was a high number of seat belt restraints in the facility and additional education was needed for the staff.	F 221	F 282 Resident #1 was reassessed as to his transfer status. Resident #1's care plan an nurse aide care plan has been reviewed and updated as appropriate.	5-21-11
F 282 SS=K	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 record review and interview it was determined the facility failed to provide care and services in accordance with the care plan for one (#1) of fifteen (15) sampled residents. The facility failed to ensure staff was knowledgeable and implemented the resident's plan of care. The facility assessed and care planned Resident #1 needing assistance of two persons for all transfers and toileting needs. However, on March 7, 2011, CNA #1 (certified nursing assistant) transferred Resident #1 from the wheelchair to the toilet by herself. The resident lost his/her balance, fell against the toilet and onto the bathroom floor. A large hematoma (size of a baseball) developed to the resident's lower back and had to be surgically removed leaving a large open area on the resident's back that requires	F 282	After removal of the Immediate Jeopardy the corporate consultants reviewed all resident care plans and nurse aide care plans to ensure that all transfer status and safety devices were identified appropriately. The Unit Managers and Director of Nursing were advised of the results of the review. This was completed on 5-6-11. Education was provided to the Unit Managers and Director of Nursing at that time by the corporate consultants on the process of updating and reviewing care plans. The Director of Nursing and Unit Managers completed a second review of all care plans and nurse aide care plans by 5-20-11 to ensure that the policy of updating and reviewing care plans was followed.  Staff education was conducted again beginning on 5-1-11 and continuing thru 5-20-11 regarding following of care plans, updating care plans and documentation of care provided.	



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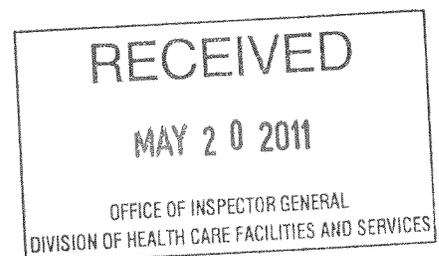
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/27/2011
NAME OF PROVIDER OR SUPPLIER  NORTH HARDIN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160	
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F 282	<p>Continued From page 10</p> <p>treatment twice a day. The facility failed to identify the care plan was not followed and did not provide additional staff training or interventions to ensure all residents were transferred according to which method (one person, two person, or mechanical lift) the facility had assessed each resident to need for a safe transfer.</p> <p>This failure to identify the causal factor of the fall allowed the inappropriate transfers to continue to occur after the 03/07/11 fall with injury.</p> <p>A partially extended survey was conducted on 04/25/11 - 04/27/11 which determined Immediate Jeopardy existed from 03/07/11 - 04/26/11. The facility provided an acceptable credible Allegation of Compliance (AOC) for the removal of IJ on 04/27/11. The state agency verified Immediately Jeopardy was removed prior to exit on 04/27/11, with remaining non-compliance at 42 CFR 483.20 Assessments (F282), 42 CFR 483.25 25 Quality of Care (F323) Accidents, and 42 CFR 483.75 (F490) Administration, at scope and severity to a "E".</p> <p>The findings include:</p> <p>Review of the Fall Management policy effective date January 1, 2010, revealed when a resident sustain a fall, a review of the current plan of care and necessary revision of interventions are to be completed.</p> <p>Review of the comprehensive care plan (dated 08/05/10 and revised on 01/11/11 and 04/11/11) revealed the resident was at risk for falls related to a history of falling and CVA (stroke). Review of the approaches revealed an alarming seat belt</p>	F 282	<p>This education was conducted by Unit Managers, Fall Manager and the Director of Nursing.</p> <p>The facility has continued to observe staff to ensure that the care plan is being followed. Results of these audits are reviewed by administrative staff when completed. Staff education/ counseling if appropriate is being done when issues are noted. The transfer audits will continue three (3) times per week for two (2) weeks then weekly for one (1) month. Audits will be reviewed by the Administrative staff and results will be reviewed by the QA Committee for appropriate action.</p>	



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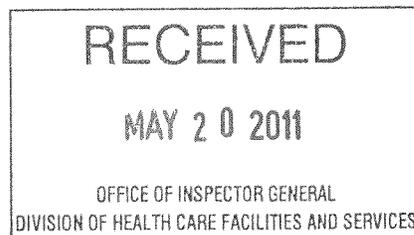
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F 282	<p>Continued From page 11</p> <p>restraint was implemented on 08/07/10, bed/chair alarm, low bed, and "transfer with assist of 2 and gait belt". Review of January, February, and March 2011 nursing assistant care plans revealed instructions to have two persons to transfer the resident and use the gait belt with all transfers.</p> <p>Review of the transfer status assessment completed on 07/28/10, 01/07/11 and 04/06/11 revealed the facility had assessed Resident #1 to require two staff for transfers.</p> <p>Interview with LPN#3(the nurse who had completed the assessments) on 04/20/11 at 10:30am revealed Resident #1 required two-person assist with all transfers to be safe. The nurse stated the resident was impulsive and doesn't retain safety instructions.</p> <p>Interview with CNA#1 on 04/19/11 at 8:00pm revealed on 03/07/11 (early morning) she had transferred Resident #1 by herself from the bed to the wheelchair, wheeled the resident into the bathroom, and was attempting to transfer the resident to the toilet. She stated the resident slipped in urine and fell onto the floor, hitting the toilet during the fall. The CNA revealed she was unaware the resident was care planned to have two person assisted transfers. She stated she had transferred Resident #1 by herself many times prior to the fall on 03/07/11.</p> <p>Continued interview with CNA #1 revealed she had worked at the facility since November 2011 and observed other staff transferring Resident #1 with one-person assist. She stated she thought this was the method used to transfer the resident; however, she did not review the care plan to</p>	F 282			



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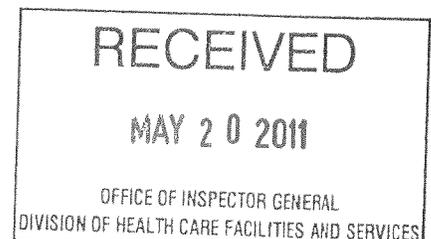
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F 282	<p>Continued From page 12</p> <p>ensure that was the correct method. She confirmed the nurse who assessed the resident after the fall, nor any other facility staff, questioned her regarding the one-person assist and following the care plan. The CNA stated she had been documenting one-person assisted transfers in the care tracker for awhile and nobody had told her it was wrong. She stated having another person available may have prevented the fall.</p> <p>Review of Resident #1's clinical record (nurse's notes, dated 03/07/11 at 4:50am) revealed the nurse was called to Resident #1's room by CNA #1 and found Resident #1 lying on the floor beside the commode. A large hematoma with an abrasion was observed on the resident's lower back. The facility nurse assessed the resident, applied ice to the injured area, administered pain medication, and made notification to the family.</p> <p>Interview with LPN#1 on 04/19/11 at 8:30pm revealed CNA#1 had reported Resident #1 had falling on 03/07/11. She found the resident lying on the bathroom floor beside the toilet. Upon assessment, a large hematoma was noted to the resident's lumbar area. The nurse stated CNA#1 told her that she was transferring the resident from the wheelchair onto the toilet when the resident slipped in urine and fell. The nurse confirmed she completed the incident report regarding the fall on 03/07/11; however, she stated she had not reviewed Resident #1's care plan to ensure the correct transfer method was used and indicated she was unaware the resident required a two-person assist with all transfers and toileting needs.</p>	F 282			



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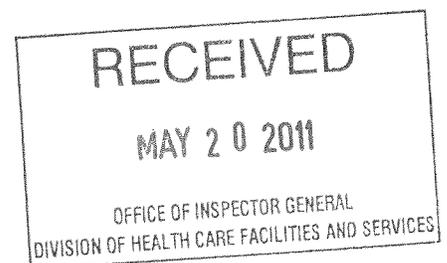
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F 282	<p>Continued From page 13</p> <p>Interview with LPN#1 on 04/19/11 at 8:30pm revealed CNA#1 came running to her and informed her Resident #1 had falling. The resident was found lying on the bathroom floor beside the toilet. Upon assessment, a large hematoma was noted to the resident's lumbar area. The nurse stated CNA#1 told her that she was transferring the resident from the wheelchair onto the toilet when the resident slipped in urine and fell. The CNA was unable to prevent the fall. After assessing the resident, the nurse completed an incident report. She revealed she never reviewed Resident #1's care plan to ensure the correct transfer method was used and indicated she was unaware the resident was to be a two-person assist with all transfers and toileting needs.</p> <p>Interview with West Wing Unit Coordinator on 04/20/11 at 11:45am and 04/21/11 at 8:45am revealed he reviewed the fall incident report for 03/07/11 involving Resident #1 and included that information on the fall tracking log. He acknowledged the comprehensive care plan nor the nurse aide care plan was reviewed to ensure the care plan had been implemented. He stated information on the fall tracking log was obtained from the incident report only. He confirmed he was unaware the resident had been transferred with an assist of one instead of two as indicated on the care plan.</p> <p>Interview with the Director of Nursing (DON) on 04/19/11 at 3:15pm revealed she had reviewed the incident report and was told the resident fell because the resident had slipped in urine on the bathroom floor. She stated Resident #1 sustained injury to the resident's lumbar (large hematoma)</p>	F 282		



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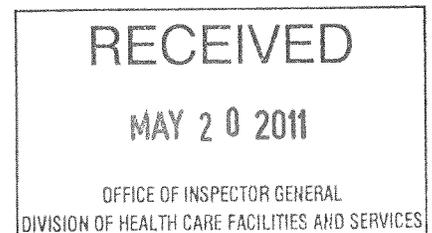
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F 282	<p>Continued From page 14</p> <p>that required surgical intervention. the DON stated she was unaware the resident had been transferred by the wrong method because she only focused on the resident slipping in the urine and did not consider the care plan had not been followed. She acknowledged she did not know the resident was being transferred with only one assist instead of two as indicated by the care plan.</p> <p>Interview with the Administrator on 04/21/11 at 9:00am revealed she had reviewed the incident report regarding Resident #1's fall of 03/07/11. She stated she did not identify the resident had been transferred using the wrong method (assist of one person rather than two) as indicated on the comprehensive care plan. She stated she relied on other administrative staff to identify root causes of the fall and bring forward to the fall committee. She stated it was apparent the care plan had not been followed.</p> <p>An acceptable AOC was received on 04/27/11 and the Immediate Jeopardy was found to be corrected prior to exit on 04/27/11.</p> <p>The following measures were validated as completed prior to the survey exit on 04/27/11:</p> <p>* Facility reviewed all incident reports (back to January 2011) regarding falls on 04/22/11 to ensure the investigation was completed appropriately, causal factors were determined, interventions identified and implemented, and the interventions were appropriated and communicated to staff. This included care plan revision.</p>	F 282		



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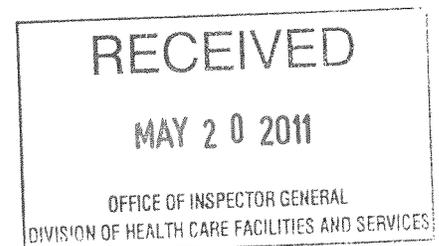
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F 282	<p>Continued From page 15</p> <ul style="list-style-type: none"> <li>* Facility reassessed all residents for accurate transfer status on 04/22/11. The facility identified two other falls related to wrong transfer status. The falls resulted in no injuries. Care plans and nurse aide care plans were revised to reflect any changes in transfer status. Completed on 04/22/11.</li> <li>* Caretracker reports were reviewed against sampled residents care plan, transfer status assessment, CNA care plan, and MDS assessment and was validated correct on 04/27/11.</li> <li>* Observation of transfers during the partial extended survey (april 25-27, 2011) validated the correct transfer method was used according to each resident's assessment and care plan.</li> <li>* The facility notified the Medical Director of the IJ on 04/21/11 and a special Quality Assurance meeting was held on 04/22/11 with the Medical Director in attendance. Validation through interview with the Medical Director on 04/25/11 and review of the QA sign in sheet dated 04/22/11.</li> <li>* The facility reeducated all nursing staff (04/22/11-04/24/11) on the use of the care plan, revision of care plan, and following the care plan. In addition, education on proper transfer methods (one-person, two-person, mechanical lift) was provided to all nursing staff. The training was validated through sign in sheets against the facility staff roster. In addition, interviews with 12 different CNAs on both west and east wing, 2 RNs, and 4 LPNs validated the staff was knowledgeable of what was presented in the</li> </ul>	F 282		



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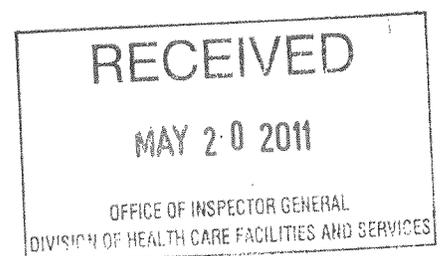
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F 282	Continued From page 16 training and how to apply that information.  * Facility observed a minimum of 10 CNAs for proper transferring method April 22-24, 2011. Review of the transfer audits revealed 10 CNAs were observed performing different transfer methods (one-person, two-person, and mechanical lift) on April 22, 23, and 24th. Validation was also conducted through observation by the surveyors.  * The Vice President of Operations educated the Administrative staff and fall committee on 04/25/11 on investigation of falls, review of incident reports, and appropriate interventions. Validation with the unit managers on 04/26/11 verified the training.  * The facility developed a communication tool for a change in resident's transfer status. In addition, a master list of all residents requiring two-person assist or mechanical lift was created. Validation through review of these tools was conducted on 04/25/11.  Immediate Jeopardy was verified removed prior to exit on 04/27/11 with remaining non-compliance at 42 CFR 483.20 Assessments, scope and severity at a "E" while the facility's Quality Assurance monitors the effectiveness of transfer observation audits, caretracker reports, and accuracy of transfer status assessments.	F 282			
F 323 SS=K	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	F 323			



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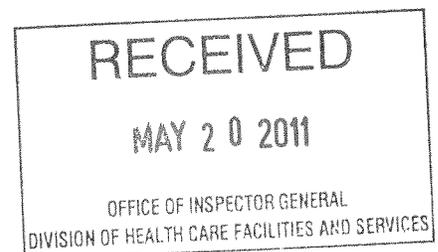
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F 323	Continued From page 17 adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, facility policy and falls tracking log review, it was determined the facility failed to ensure the fall management policy was implemented effectively. The facility failed to thoroughly investigate to determine causal factors, which prevented the facility from implementing effective interventions to prevent the recurrence of falls. The facility assessed Resident #1 as requiring assist of two staff with all transfers; however, on 03/07/11, the facility failed to transfer Resident #1 using two staff. Resident #1 fell during the transfer sustaining a large hematoma (localized collection of blood from broken blood vessels) to the lumbar (lower back) requiring surgical intervention.  Resident #9 sustained an injurious fall on 04/20/11 during a self transfer from the bed. Record review revealed the resident had sustained eight (8) falls since January 2011 without the facility identifying a trend and implementing appropriate interventions to prevent additional falls.  The facility failed to have an effective system to thoroughly investigate accidents, determine causal factors, and implement effective action plans in response. The failure and the facility's non-compliance has caused or is likely to cause Resident #1 and other residents identified at risk	F 323	F 323 Resident #1 has been reassessed related to his transfer status. Resident #1's care plan and nurse aide care plan have been updated as needed. Resident #1's transfer status was reviewed again on 5-18-11.  Resident #9 has been reviewed, and all falls related to resident #9 have been reviewed for causal factors. Resident #9's care plan and nurse aide care plan have been updated as needed.  All incident reports from January 2011 forward have been reviewed and all incidents reports from 4-26-11 until present have been reviewed to ensure causal factors have been identified. These were completed by the Director of Nursing, the Unit Coordinators, the Administrator and the Falls Committee.  All falls are reviewed daily in the morning meeting. Causal factors are identified and any immediate actions are reviewed to ensure appropriateness. Any changes necessary are made. Staff have been educated by the Director of Nursing and Unit Managers on the completion of the incident	5-21-11



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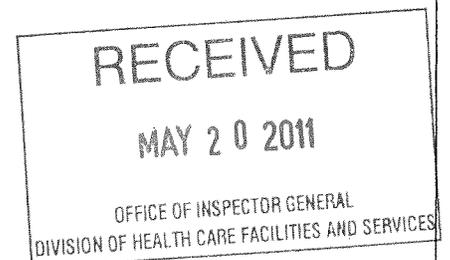
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F 323	<p>Continued From page 18</p> <p>for falls, serious injury, harm, impairment, or death to a resident.</p> <p>A partially extended survey was conducted on 04/25/11 - 04/27/11 which determined Immediate Jeopardy existed from 03/07/11 - 04/26/11. The facility provided an acceptable credible Allegation of Compliance (AOC) for the removal of IJ on 04/27/11. The state agency verified Immediately Jeopardy was removed prior to exit on 04/27/11, with remaining non-compliance at 42 CFR 483.20 Assessments (F282), 42 CFR 483.25 25 Quality of Care (F323) Accidents, and 42 CFR 483.75 (F490) Administration, at scope and severity to a "E".</p> <p>The findings include:</p> <p>Review of the Fall Management policy, effective date: January 1, 2010 revealed procedures to identify risk factors and manage residents who experienced a fall, i.e. complete a fall risk screen upon admission and complete an incident report whenever a resident sustained a fall. Under the management of a fall, the facility policy stated a Post Fall Investigation Tool would be completed, review of current plan of care with necessary revised interventions, and falls would be tracked to analyze trends.</p> <p>1. Interview with West Wing Unit Coordinator on 04/20/11 at 11:45am and 04/21/11 at 8:45am revealed he reviews all incident reports regarding falls. He transfers the information from the incident reports and Post Fall Investigation reports into a Fall tracking log. That information is forwarded to the Fall Committee meeting that is</p>	F 323	<p>report and the post fall investigations—completed on 5-20-11. All incident reports are reviewed daily and any report not completed appropriately is returned to the staff for completion. This began 5-19-11. All falls are referred to the weekly falls committee for review. Care plans and nurse aide care plans are updated as needed. The falls committee was educated by a corporate consultant on 4-26-11 regarding reviewing the incident report, the post fall investigation, the identification of causal factors, the implementation of appropriate interventions and alternatives to the use of restraints.</p> <p>After removal of the Immediate Jeopardy the corporate consultants reviewed all resident care plans and nursing aide care plans to ensure that all transfer status and safety devices were identified appropriately. The Unit Managers and Director of Nursing were advised of the results of the review. This was completed on 5-6-11. Education was provided to the Unit Managers and Director of Nursing at that time by the corporate consultants on the process of updating and reviewing care plans. The Director of Nursing and Unit Managers completed</p>	



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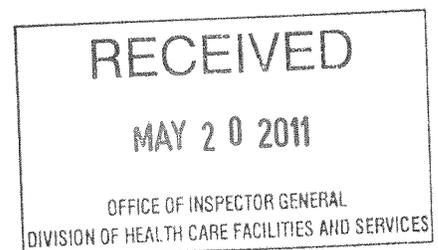
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/27/2011
NAME OF PROVIDER OR SUPPLIER  NORTH HARDIN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160	
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F 323	<p>Continued From page 19</p> <p>held weekly on Wednesdays. Continued interview with the West Wing Unit Coordinator revealed he had reviewed the fall incident report regarding Resident #1's fall on 03/07/11 and included that information on the fall tracking log that was forwarded to the fall committee. He indicated each resident's fall is suppose to be reviewed for causal factors and look at interventions implemented to prevent additional falls. He acknowledged the comprehensive care plan nor the nurse aide care plan was reviewed to ensure the care plan had been implemented. He stated information on the fall tracking log was obtained from the incident report only. In addition, the Unit Coordinator revealed the care tracker reports were not reviewed to ensure residents were being transferred by the correct method.</p> <p>Review of Resident #1's clinical record revealed the facility admitted Resident #1 on 07/26/10 with diagnoses of CVA (stroke) with hemiplega, facial weakness, and history of falls. The facility identified the resident to be at risk for falls upon admission due to sustaining two falls during hospitalization (June 23 &amp; 29, 2010) that was documented in the hospital's discharge summary. Review of the admission MDS (minimum data set) assessment completed on 08/06/10 revealed the facility assessed the resident to have a cognition deficit and unable to verbalize understanding of cues. The facility assessed the resident as having a balance deficit and required extensive assist of two-persons for bed mobility, transfers, and toilet use, and having sustained falls.</p> <p>Review of the comprehensive care plan (dated 08/05/10 and revised on 01/11/11 and 04/11/11)</p>	F 323	<p>a second review of all care plans and nurse aide care plans by 5-20-11 to ensure that the policy of updating and reviewing care plans was followed.</p> <p>The facility has continued to observe staff to ensure that the care plan is being followed. Results of these audits are reviewed by administrative staff when completed. Staff education/ counseling if appropriate is being done when issues are noted. The transfer audits will continue three (3) times per week for two (2) weeks then weekly for one (1) month. Audits will be reviewed by the Administrative staff and results will be reviewed by the QA Committee for appropriate action.</p> <p>The falls committee will continue to meet weekly and the corporate consultant will attend no less than monthly for six (6) months to ensure that the process of reviewing falls for causal factors continues. All reports will be reviewed by the QA Committee for appropriate follow up.</p>	



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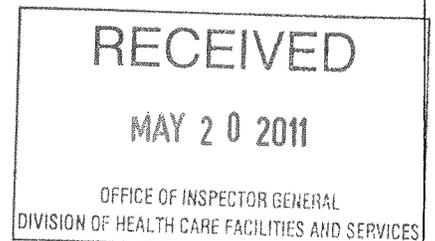
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F 323	<p>Continued From page 20</p> <p>revealed the facility identified the resident was at risk for falls related to a history of falling and CVA (stroke). Review of the approaches revealed an alarming seat belt restraint was implemented on 08/07/10, bed/chair alarm, low bed, and "transfer with assist of 2 and gait belt". Review of January, February, March, and April 2011 nursing assistant care plans revealed instructions to have two persons to transfer the resident and use the gait belt with all transfers. Refer to F282.</p> <p>Interview with CNA#1, on 04/19/11 at 8:00pm, revealed on 03/07/11 (4:50am) she had transferred Resident #1 from the bed to the wheelchair, wheeled the resident into the bathroom, and was attempting to transfer the resident to the toilet. She stated she assisted the resident to a standing position when the resident started urinating on the floor. She indicated the resident slipped in the urine and fell onto the floor, hitting the toilet during the fall. CNA#1 stated she attempted to catch the resident but she could not prevent the resident from falling and the resident's back hit the toilet. She stated the resident was hurt so she left the resident lying in the floor to get the nurse. The CNA revealed she was unaware the resident was care planned to have two person assisted transfers and had not reviewed the CNA care plan prior to providing care. She stated she had transferred Resident #1 by herself many times prior to the fall on 03/07/11.</p> <p>Review of the nurse's notes, dated 03/07/11 at 4:50am, revealed Resident #1 sustained a fall with injury. The nurse documented CNA #1 reported Resident #1 had falling during a transfer from the wheelchair to the toilet. The nurse found the resident lying on the floor beside the toilet. A</p>	F 323		



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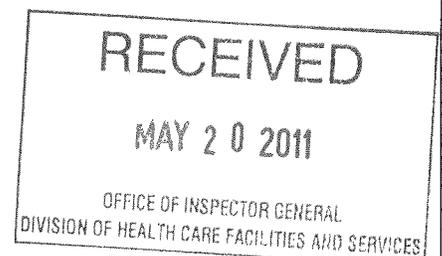
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F 323	Continued From page 21 large hematoma with an abrasion was observed on the resident's midback.  Interview with LPN#1 on 04/19/11 at 8:30pm revealed CNA#1 came running to inform her Resident #1 had falling on 03/07/11. She found the resident lying on the bathroom floor beside the toilet. Upon assessment, a large hematoma was noted to the resident's lumbar area. The nurse stated CNA#1 told her that she was transferring the resident from the wheelchair onto the toilet when the resident slipped in urine and fell. The CNA told the nurse she was unable to prevent the resident from falling. After assessing the resident, the nurse completed an incident report. She stated she never reviewed Resident #1's care plan to ensure the correct transfer method was used and indicated she was unaware the resident required a two-person assist with all transfers and toileting needs.  At 6:30am, the nurse documented the hematoma had increased in size and felt "harder". The resident's physician was notified and a portable x-ray was obtained that revealed no fractures. On 03/11/11, the resident's primary physician assessed the hematoma and referred the resident to a surgical specialist. On 03/22/11, the resident had the hematoma surgically removed. The nurse documented the necrotic top skin layer and a baseball size clot was removed. Treatment orders were received to clean and dress the surgical wound twice a day.  Review of the Post Fall Investigation Tool for Resident #1's fall on 03/07/11 revealed written documentation the resident was getting "off" the toilet and there was a wet floor. Under the	F 323			



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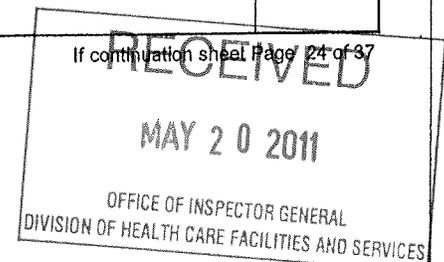
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F 323	<p>Continued From page 22</p> <p>evaluate findings section LPN#1 documented the Resident #1 was attempting self-transfer and slipped in urine. However, interview with LPN#1 and CNA#1 revealed this was not how the resident fell. Actions taken by the facility after Resident #1's fall were to apply ice to the injury and counsel the CNA on making sure the floor was dry. This report was reviewed by the West Wing Unit Coordinator, DON, and Administrator; however, there was no evidence that their review identified staff had not followed the plan of care. In addition, there was no evidence their review identified the incident report's inconsistencies related to the actual event, i.e. resident attempting to transfer self versus one staff assisting with transfer at the time of the fall.</p> <p>Interview with the Director of Nursing (DON) on 04/19/11 at 3:15pm revealed she had reviewed the incident report and was told the resident fell because the resident had slipped in urine on the bathroom floor. The DON stated she was unaware the resident had been transferred by the wrong method because she only focused on the resident slipping on the urine and did not consider the care plan had not been followed.</p> <p>Observation of staff toileting the resident on 04/20/10 at 9:40am revealed the resident was transferred by two CNAs (CNA#2 and CNA#3). Resident #1 was observed to require continuous verbal cues and hands-on touch to hold onto the grab bar beside the toilet and one CNA had to physically guide the resident's body in the direction of the toilet so the resident could sit on the commode. Observation revealed the resident attempted to get up without assistance and one CNA stood in front of the resident while the other</p>	F 323		



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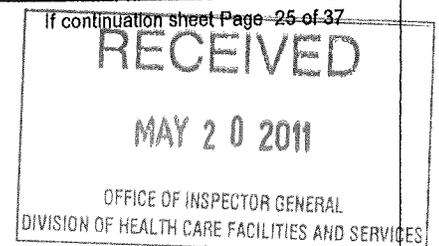
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F 323	<p>Continued From page 23</p> <p>CNA physically held the resident steady during the transfer from the toilet back into the wheelchair. The resident was observed to sway back and forward.</p> <p>Interview with CNA #2 and CNA#3 at the time of the observation revealed they were told by the nurse to be sure to do a two-person assisted transfer today. Both CNAs stated they had transferred Resident #1 by themselves prior to this observation. CNA#2 stated the resident was not steady during transfers and required verbal cues to perform any task.</p> <p>Review of the care tracker reports with dates of March 1-6, 2011 revealed nine (9) different CNAs had documented they had transferred Resident #1 with assist of only one person prior to the injuries fall on 03/07/11. In addition, continued review of the care tracker reports (03/07/11 through 04/19/11, beginning of the survey) the facility staff continued to transfer Resident #1 with only one person assist.</p> <p>Review of the transfer status assessment form completed on 07/28/10, 01/07/11, and 04/06/11 revealed the facility had assessed Resident #1 to required two staff for transfers.</p> <p>Interview with LPN#3 (nurse who completed the assessments) on 04/20/11 at 10:30am revealed the resident required two-person assist with all transfers to be safe. The nurse stated the resident is impulsive and doesn't retain safety instructions. She revealed whenever she had transferred the resident, she had always requested assistance from another staff.</p>	F 323		



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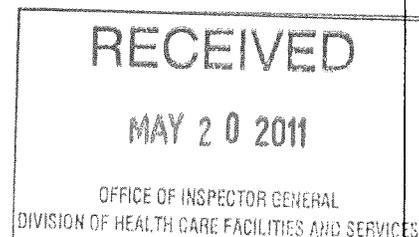
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F 323	<p>Continued From page 24</p> <p>Interview with the Administrator on 04/21/11 at 9:00am revealed she had reviewed the incident report regarding Resident #1's fall on 03/07/11. She stated she had not identified the resident had been transferred using the wrong method (assist of one person rather than two) as indicated on the comprehensive care plan. She stated she relied on other administrative staff to identify root causes of the fall and bring forward that information to the fall committee. She stated it was apparent the care plan had not been followed.</p> <p>2. Review of Resident #9's clinical record revealed an admission date of November 2010 with a history of falling. The resident sustained a hip fracture after a fall while the resident was residing at another facility on 12/27/09. Review of the admission MDS completed on 11/23/10 revealed the facility assessed the resident to require extensive assistance from one-person with bed mobility, transfers, and ambulation, and two-person assist with toilet use. The facility assessed the resident as having a balance deficit and unsteady gait.</p> <p>Review of the clinical record and the fall tracking log revealed Resident #9 had the following falls:</p> <ol style="list-style-type: none"> <li>01/05/11 at 7:20am (In the bathroom, self-transferring, lost balance, no injuries) facility action: staff to ensure resident had proper footwear for resident.</li> <li>01/29/11 at 12:45pm (resident slipped trying to get out of bed, no injuries) facility action: staff educated to have proper footwear.</li> <li>02/13/11 at 7:00pm (in bathroom, slipped on the floor during self-assisted transfer, no injuries) facility action: non-skid strips added in bathroom.</li> </ol>	F 323			



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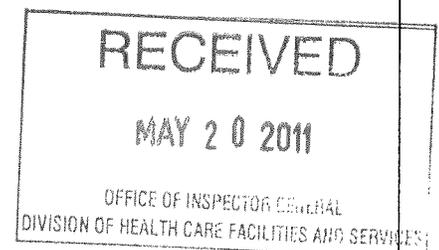
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F 323	Continued From page 25 4. 03/07/11 at 5:00pm (missed the toilet and fell onto floor, unwitnessed, no injuries) facility action: "Isolated incident, independent with toileting: 5. 03/15/11 at 1:30pm (bathroom, slipped getting off the toilet unassisted, no injuries) facility action: "toilet riser." 6. 03/31/11 at 8:10am resident was leaving the bathroom, lost balance and fell. This was witnessed by CNA present at that time. Facility action: therapy ordered. 7. On 04/12/11 at 4:50pm (the resident fell during a self- transfer from the bed, no injuries), facility action: a bed alarm was placed to bed. Review of the fall tracking log revealed the 04/20/11 injurious fall was not listed. A physician order dated 04/21/11 revealed a low bed and an alarming seat belt restraint to the wheelchair was ordered on 04/21/11.  The most recent MDS assessment completed on 04/20/11 revealed the facility assessed the resident to require the same amount of assistance (one-person) with bed mobility, transfers, and ambulation. Toilet use was now completed with assist of one-person. Review of the CAA (Care area assessment) dated 04/14/11 revealed Resident #9 had four falls since the last review and appears to be unaware of safety needs. The resident has an unsteady gait during ambulation with a rolling walker. The report stated the resident has a diagnosis of Alzheimer's Disease which could impact her/his decision making ability. The facility assessed the resident to have a cognition deficit. Review of the care plan dated 04/14/11 revealed the resident was to be a one-person assist with all transfers. On 04/21/11, the facility revised the care plan to a two-person assist.	F 323		



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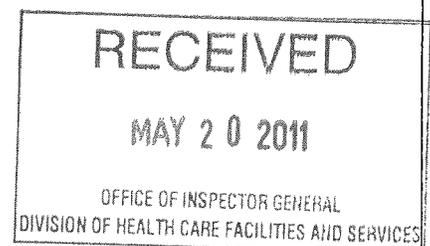
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F 323	Continued From page 26  On 04/20/11 at 9:30pm, documentation in the nurses' notes revealed the resident was found lying on the floor. A large hematoma was noted to the resident's right forehead and laceration across the bridge of the nose. An abrasion was noted to the right shoulder and bilateral knees. A skin tear was noted to the right forearm. The resident stated, "I was trying to go to the BR (bathroom) when I fell." The resident was sent to the hospital for evaluation with the findings of a nasal fracture and C-2 (cervical) fracture to the neck. A hard collar neck brace was applied.  Observation of Resident #9 on 04/25/11 at 10:45am revealed the resident was sitting up in a wheelchair in the resident's room. A hard collar neck brace was applied. Bilateral bruising and orbital edema was noted under the resident's eyes. Profound bruising and edema was noted on the bridge of the nose. A large hematoma was observed on the resident's right forehead. The resident had eyes closed and did not response to conversation.  Interview with the West Unit Coordinator on 04/25/11 at approximately 2:30pm revealed interventions were implemented after each fall and acknowledged staff education regarding proper footwear was the only intervention after consistent falls. He confirmed most falls occurred when the resident was attempting self-transfers. He indicated he had not identified a trend with the resident falling in the bathroom. He confirmed most of the falls occurred when the resident attempted self-transfers and was in the bathroom. He stated he had considered the 03/07/11 fall to	F 323		



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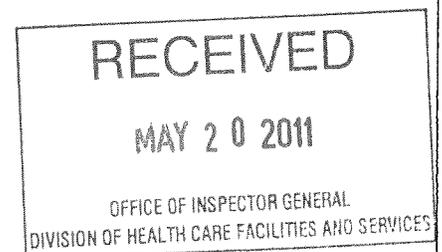
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F 323	<p>Continued From page 27</p> <p>be an isolated event; however, the resident was in the bathroom alone at the time of the fall. He stated the resident had been placed on a toileting schedule but the resident continued to self-transfer to the bathroom. He had not placed the 04/20/11 fall on the fall log because he was awaiting the next fall committee meeting.</p> <p>Interview with the Vice President of Operations on 04/25/11 at 9:05am revealed she had identified a problem with the fall committee's knowledge of evaluating incident reports and fall log information after review of the facility's systems. She stated analysis of falls were not occurring.</p> <p>An acceptable AOC was received on 04/27/11 and the Immediate Jeopardy was found to be corrected prior to exit on 04/27/11.</p> <p>The following measures were validated as completed prior to the survey exit on 04/27/11:</p> <ul style="list-style-type: none"> <li>* Facility reviewed all incident reports (back to January 2011) regarding falls on 04/22/11 to ensure the investigation was completed appropriately, causal factors were determined, interventions identified and implemented, and the interventions were appropriated and communicated to staff. This included care plan revision.</li> <li>* Facility reassessed all residents for accurate transfer status on 04/22/11. The facility identified two other falls related to wrong transfer status. The falls resulted in no injuries. Care plans and nurse aide care plans were revised to reflect any changes in transfer status. Completed on</li> </ul>	F 323			



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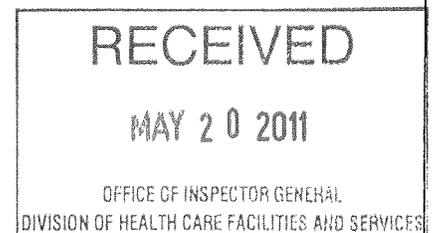
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F 323	Continued From page 28 04/22/11.  * Caretracker reports were reviewed against sampled residents care plan, transfer status assessment, CNA care plan, and MDS assessment and was validated correct on 04/27/11.  * Observation of transfers during the partial extended survey (april 25-27, 2011) validated the correct transfer method was used according to each resident's assessment and care plan.  * The facility notified the Medical Director of the IJ on 04/21/11 and a special Quality Assurance meeting was held on 04/22/11 with the Medical Director in attendance. Validation through interview with the Medical Director on 04/25/11 and review of the QA sign in sheet dated 04/22/11.  * The facility reeducated all nursing staff (04/22/11-04/24/11) on the use of the care plan, revision of care plan, and following the care plan. In addition, education on proper transfer methods (one-person, two-person, mechanical lift) was provided to all nursing staff. The training was validated through sign in sheets against the facility staff roster. In addition, interviews with 12 different CNAs on both west and east wing, 2 RNs, and 4 LPNs validated the staff was knowledgeable of what was presented in the training and how to apply that information.  * Facility observed a minimum of 10 CNAs for proper transferring method April 22-24, 2011. Review of the transfer audits revealed 10 CNAs were observed performing different transfer	F 323			



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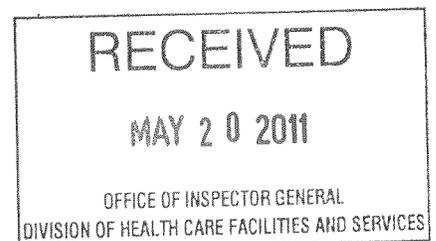
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NAME OF PROVIDER OR SUPPLIER  <b>NORTH HARDIN HEALTH &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>599 ROGERSVILLE RD. RADCLIFF, KY 40160</b>		
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F 323	Continued From page 29 methods (one-person, two-person, and mechanical lift) on April 22, 23, and 24th. Validation was also conducted through observation by the surveyors.  * The Vice President of Operations educated the Administrative staff and fall committee on 04/25/11 on investigation of falls, review of incident reports, and appropriate interventions. Validation with the unit managers on 04/26/11 verified the training.  * The facility developed a communication tool for a change in resident's transfer status. In addition, a master list of all residents requiring two-person assist or mechanical lift was created. Validation through review of these tools was conducted on 04/25/11.  Immediate Jeopardy was verified removed prior to exit on 04/27/11 with remaining non-compliance at 42 CFR 483.25 Quality of Care, scope and severity at a "E" while the facility's Quality Assurance monitors the effectiveness of transfer observation audits, caretracker reports, and accuracy of transfer status assessments.	F 323			
F 490 SS=K	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.  This REQUIREMENT is not met as evidenced	F 490			



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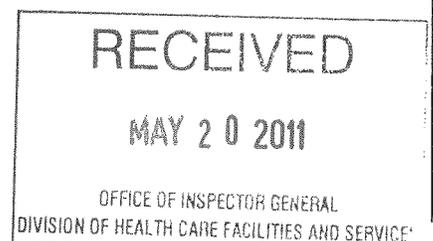
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F 490	Continued From page 30 by: Based on interview, record and policy review, it was determined the facility failed to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental psychosocial well-being for residents regarding adequate supervision to prevent accidents for two residents (#1 and 9) of fifteen (15) sampled residents. The facility administration failed to ensure the policies and procedures were implemented regarding falls. The facility administration failed to identify that their system to thoroughly investigate accidents, determine causal factors, and implement appropriate action plans in response was not being implemented effectively.  On 03/07/11, facility staff inappropriately transferred Resident #1, during the transfer, the resident fell sustaining a hematoma to the back which required surgical intervention. The facility's investigation failed to identify the causal factor therefore preventing the facility from implementing interventions to prevent the recurrence.  In addition, Resident #9 sustained an injurious fall on 04/20/11 during a self transfer from the bed. Record review revealed the resident had sustained eight (8) falls since January 2011 without the facility identifying a trend and implementing appropriate interventions to prevent additional falls. Refer to F323.  Based on the above findings, it was determined the facility failure to ensure policies and procedures were implemented to thoroughly investigate accidents, determine causal factors,	F 490	F 490  The facility Administrator, Director of Nursing, Incoming Assistant Director of Nursing (Currently RN Supervisor), Unit Coordinators, MDS Coordinator, Falls Manager and Therapy Coordinator were educated by corporate consultants on the facility policy and procedures regarding falls management and restraint management from 4-26-11 thru 5-12-11. All voiced understanding. The facility Administrator and Director of Nursing are attending the falls meeting and restraint committee meeting at least monthly for six (6) months to evaluate continued effectiveness of these programs. The Administrator and Director of Nursing are to audit all incident reports for completeness and accuracy. The Administrator and Director of Nursing will review all transfer observation audits and all care tracker audits to ensure compliance with this plan and to ensure ongoing identification of any problems. The QA Committee will meet monthly for six (6) months to ensure sustained compliance. The facility corporate consultant will also attend falls committee and restraint	5-21-11



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F 490	<p>Continued From page 31</p> <p>and implement appropriate action plans in response was likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was determined to exist on 03/07/11 at F282 "K", F323 "K", and F490 "K".</p> <p>The facility provided an acceptable credible allegation of removal of Jeopardy on 04/27/11. Immediate Jeopardy was verified to be removed prior to exit on 04/27/11 with remaining non-compliance at 42 CFR 483.20 Assessments (F282), 42 CFR 483.25 25 Quality of Care (F323) Accidents, and 42 CFR 483.75 (F490) Administration, at scope and severity at a "E".</p> <p>The findings include:</p> <p>Review of the Fall Management policy, effective date: January 1, 2010 revealed procedures to identify risk factors and manage residents who experienced a fall. Under the management of a fall, the facility stated a Post Fall Investigation Tool would be completed, review of current plan of care with necessary revised interventions, and falls would be tracked to analyze trends.</p> <p>Interview with West Wing Unit Coordinator on 04/20/11 at 11:45am and 04/21/11 at 8:45am revealed he reviews all incident reports regarding falls. He transfers the information from the incident reports and Post Fall Investigation reports into a Fall tracking log. That information is taken to the Fall Committee meeting that is held weekly on Wednesdays. He indicated each resident's fall is suppose to be reviewed for causal factors and look at interventions implemented to prevent additional falls.</p>	F 490	<p>Committee meeting no less than monthly and the facility QA Committee monthly for six (6) months to report their observations to the Vice President of Operations to ensure continued compliance with the facility programs.</p>	



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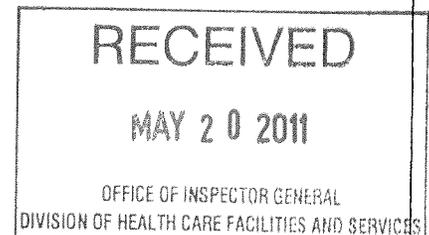
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F 490	<p>Continued From page 32</p> <p>Interview with the Administrator on 04/21/11 at 9:00am revealed she had reviewed the incident report regarding Resident #1's fall on 03/07/11. She stated she had not identified the resident had been transferred using the wrong method (assist of one person rather than two) as indicated on the comprehensive care plan. She stated she relied on other administrative staff to identify root causes of the fall and bring forward that information to the fall committee. She stated it was apparent the care plan had not been followed and it upset her that the facility had not identified this failure. She revealed falls were discussed in each Quality Assurance (QA) meeting with the last QA meeting held on 04/18/11. However, since the problem with care plan implementation was not identified, it was not discussed at that QA meeting. In addition, she acknowledged the root cause analysis of the falls were not consistently identified and nobody was reviewing the care tracker information to ensure the nurse aides were providing care according to each resident's plan of care.</p> <p>Interview with the Vice President of Operations on 04/25/11 9:05am revealed she had identified a problem with the fall committee's knowledge of evaluating incident reports and fall log information on 04/22/11. She stated analysis of falls were not occurring.</p> <p>1. Review of Resident #1's clinical record revealed an admission date of 07/26/10 with diagnoses of CVA (stroke) with hemiplegia, facial weakness, and history of falls. The facility identified the resident to be at risk for falls upon admission due to sustaining two falls during hospitalization (June 23 &amp; 29, 2010) that was</p>	F 490		

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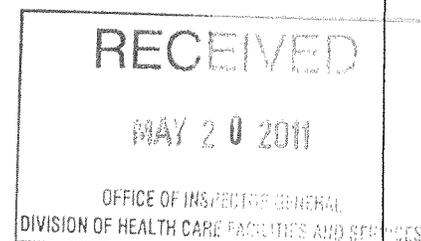
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F 490	<p>Continued From page 33</p> <p>documented in the hospital's discharge summary. The facility assessed and care planned (08/05/10, and revised on 01/11/11) the resident to require extensive assist of two-persons for bed mobility, transfers, and toilet use.</p> <p>On 03/07/11 at 4:50am, Resident #1 sustained a fall with injury. Review of the nurses' notes for 03/07/11 at 4:50am revealed the nurse found the resident lying on the floor beside the toilet. A large hematoma with an abrasion was observed on the resident's back which required surgical intervention on 03/22/11.</p> <p>There was no documented evidence the facility identified the causal factor of the fall was related to the CNA transferring the resident by herself despite Administrator review of the fall incident. Refer to F323.</p> <p>2. Review of Resident #9's clinical record revealed the resident was identified at risk for falls. Resident #9 had falls on: 01/05/11, 01/29/11, 02/13/11, 03/07/11, 03/15/11, 03/31/11, and 04/12/11 where the resident was attempting self transfers due to toileting needs. On 04/20/11 at 9:30pm, documentation in the nurses' notes revealed the resident was found lying on the floor. A large hematoma was noted to the resident's right forehead and laceration across the bridge of the nose. An abrasion was noted to the right shoulder and bilateral knees. A skin tear was noted to the right forearm. The resident stated, "I was trying to go to the BR (bathroom) when I fell." The resident was sent to the hospital for evaluation with the findings of a nasal fracture and C-2 (cervical) fracture to the neck. A hard collar neck brace was applied.</p>	F 490			



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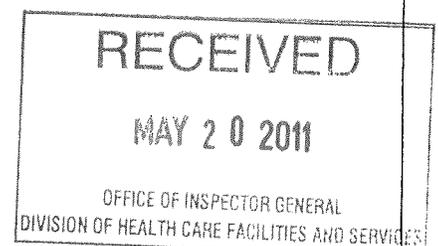
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F 490	Continued From page 34  Interview with the West Wing Unit Coordinator on 04/25/11 at approximately 2:30pm revealed most of the resident's falls occurred when the resident was attempting self-transfers. He indicated he had not identified a trend with the resident falling in the bathroom.  There was no documented evidence that the administration had identified a failure in the investigation of incidents to identify causal factors despite being involved in the falls committee.  An acceptable AOC was received on 04/27/11 and the Immediate Jeopardy was found to be corrected prior to exit on 04/27/11.  The following measures were validated as completed prior to the survey exit on 04/27/11:  * Facility reviewed all incident reports (back to January 2011) regarding falls on 04/22/11 to ensure the investigation was completed appropriately, causal factors were determined, interventions identified and implemented, and the interventions were appropriated and communicated to staff. This included care plan revision.  * Facility reassessed all residents for accurate transfer status on 04/22/11. The facility identified two other falls related to wrong transfer status. The falls resulted in no injuries. Care plans and nurse aide care plans were revised to reflect any changes in transfer status. Completed on 04/22/11.  * Caretracker reports were reviewed against	F 490			



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F 490	<p>Continued From page 35</p> <p>sampled residents care plan, transfer status assessment, CNA care plan, and MDS assessment and was validated correct on 04/27/11.</p> <p>* Observation of transfers during the partial extended survey (April 25-27, 2011) validated the correct transfer method was used according to each resident's assessment and care plan.</p> <p>* The facility notified the Medical Director of the IJ on 04/21/11 and a special Quality Assurance meeting was held on 04/22/11 with the Medical Director in attendance. Validation through interview with the Medical Director on 04/25/11 and review of the QA sign in sheet dated 04/22/11.</p> <p>* The facility reeducated all nursing staff (04/22/11-04/24/11) on the use of the care plan, revision of care plan, and following the care plan. In addition, education on proper transfer methods (one-person, two-person, mechanical lift) was provided to all nursing staff. The training was validated through sign in sheets against the facility staff roster. In addition, interviews with 12 different CNAs on both west and east wing, 2 RNs, and 4 LPNs validated the staff was knowledgeable of what was presented in the training and how to apply that information.</p> <p>* Facility observed a minimum of 10 CNAs for proper transferring method April 22-24, 2011. Review of the transfer audits revealed 10 CNAs were observed performing different transfer methods (one-person, two-person, and mechanical lift) on April 22, 23, and 24th. Validation was also conducted through</p>	F 490			



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F 490	<p>Continued From page 36 observation by the surveyors.</p> <p>* The Vice President of Operations educated the Administrative staff and fall committee on 04/25/11 on investigation of falls, review of incident reports, and appropriate interventions. Validation with the unit managers on 04/26/11 verified the training.</p> <p>* The facility developed a communication tool for a change in resident's transfer status. In addition, a master list of all residents requiring two-person assist or mechanical lift was created. Validation through review of these tools was conducted on 04/25/11.</p> <p>Immediate Jeopardy was verified removed prior to exit on 04/27/11 with remaining non-compliance at 42 CFR 483.75 Administration, scope and severity at a "E" while the facility's Quality Assurance monitors the effectiveness of transfer observation audits, caretracker reports, and accuracy of transfer status assessments.</p>	F 490			

