

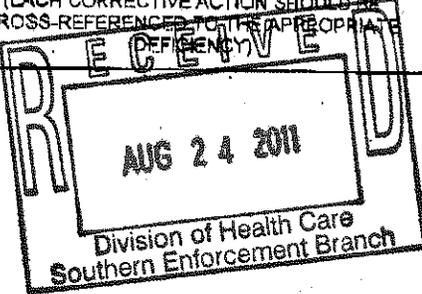
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/04/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/21/2011
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NAME OF PROVIDER OR SUPPLIER EDGEWOOD ESTATES	STREET ADDRESS, CITY, STATE, ZIP CODE 195 BERRYMAN ROAD FRENCHBURG, KY 40322
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<p>F 000</p> <p>F 281 SS=D</p>	<p>INITIAL COMMENTS</p> <p>A standard health survey was conducted on 07/19-21/11. Deficient practice was identified with the highest scope and severity at "G" level, with no opportunity to correct.</p> <p>An abbreviated standard survey (KY16697) was also conducted at this time. The allegation was substantiated with related deficiencies.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to meet accepted professional standards of quality for one of eighteen sampled residents. The facility failed to verify Resident #18's gastrostomy tube placement prior to administering medications via the gastrostomy tube.</p> <p>The findings include:</p> <p>Resident #18 was admitted to the facility on 05/13/04, with diagnoses of Traumatic Brain Injury, Dysphagia, and Gastrostomy Tube Placement. A quarterly review assessment completed on 06/28/11, revealed the resident required extensive assistance for all activities of daily living.</p> <p>An observation of medication pass conducted on 07/20/11, at 11:30 AM, revealed Licensed</p>	<p>F 000</p> <p>F 281</p>	<div style="text-align: center;">  </div> <p>F 281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The facility has ensured the following corrective actions:</p> <ul style="list-style-type: none"> On 7/20/11 Licensed Practical Nurse (LPN) #1 received 1:1 counseling and additional in-service training by the Director of Nursing regarding the verification of g-tube placement when administering enteral tube medications. (Attachment #1). <p>The facility has taken the following action to prevent this practice from affecting other residents:</p> <ul style="list-style-type: none"> A Protocol for G-Tube Administration of Medications was developed on 7/21/11. All Nursing Staff (RN & LPN) were in-serviced on the protocol on that date, or prior to beginning their assigned shift of work. (Attachment #2) On 7/20/11, an immediate verbal in-service review was conducted by the Director of Nursing with nursing staff on duty, and followed up with the remainder of the nursing staff prior to beginning their assigned shift regarding the requirement for verification of g-tube placement when administering enteral tube medications. (Attachment #3) <p>The facility has initiated the following systemic changes to prevent this practice from recurring:</p> <ul style="list-style-type: none"> Review of the G-Tube Administration of Medications has been added to the orientation checklist for new staff nurses. (Attachment #4) 	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Anne Hills</i>	TITLE <i>Administrative</i>	(X8) DATE <i>8/24/11</i>
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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.

Received Time Aug. 24. 2011 5:07PM No. 1678

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F 281	Continued From page 1 Practical Nurse (LPN) #1 administered medication to Resident #18 via the gastrostomy tube route. LPN #1 flushed the resident's gastrostomy tube with water and then administered the medication; however, the LPN was not observed to check the gastrostomy tube placement prior to administering the medication. An interview conducted on 07/20/11, at 11:45 AM, with LPN #1 confirmed she did not verify Resident #18's gastrostomy tube placement prior to administration of the medications. The LPN further revealed gastrostomy tube placement should have been verified prior to administering medication. An interview conducted on 07/20/11, at 4:00 PM, with the Director of Nursing (DON) revealed a resident's gastrostomy tube should have been checked to verify proper placement prior to the administration of any medication. The DON further revealed the facility had no policy regarding the administration of gastrostomy tube medications.	F 281	The facility will sustain performance through the following monitoring practice: • As part of the monthly QI review checks, the Director of Nursing and/or Designee will complete a 25% random sampling of the of facility residents who receive enteral medications and shall visually monitor the administration of a resident's g-tube medication. The sampling shall cross all shifts, residents who receive enteral medication, and all nurses on a rotational basis. Additional in-service training /education, if required, shall be accomplished at the time of each 1:1 observation. (Attachment #5) • The Director of Nursing shall summarize the number of times a g-tube verification of placement error occurred on the departmental Monthly CQI report. (Attachment #6) • The Director of Nursing and / or Designee (ADON, Pharmacist, etc.) shall continue to make monthly observations of Nurse/CMA staff during medication pass to monitor for correctness of all medications and their administration, as part of the ongoing quality improvement process.	
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, incident reports, and fall investigation review, it was determined the facility failed to provide care in	F 282	COMPLETION DATE: 7/29/11 F 282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The facility has ensured the following corrective actions: • On 7/11/11, Resident #1 had an alarming seatbelt placed on the wheelchair per physician orders. (Attachment #7)	

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F 282	<p>Continued From page 2</p> <p>accordance with the resident's written care plan for one of eighteen sampled residents. Resident #1 was assessed and care planned to require an alarming seat belt restraint to the wheelchair at all times. However, on 07/11/11, the resident was placed in a wheelchair without an alarming seat belt, stood up unassisted, and sustained a fall resulting in a left elbow fracture.</p> <p>The findings include:</p> <p>The facility admitted Resident #1 on 04/10/11, with diagnoses of Status Post Cerebral Vascular Accident, Osteoporosis, Dementia, Hypertension, Chronic Pedat Edema, and Pain.</p> <p>An Incident Report completed on 06/10/11, revealed Resident #1 was found lying on the floor and unable to explain what happened. A review of the Fall Risk Evaluation dated 06/10/11, revealed the facility assessed Resident #1 at high risk for falls with a score of 20. According to the evaluation, a score of 10 or above represented a high risk for falls. A review of the Physical Restraints Care Area Assessment (CAA) dated 06/14/11, revealed Resident #1 required an alarming seat belt restraint while up in the wheelchair due to attempts to get up without assistance.</p> <p>A review of the resident's comprehensive care plan revealed Resident #1 had a care need identified related to potential for falls which was updated on 06/14/11, to include an alarming seat belt. Review of the Certified Nursing Assistant (CNA) care plan (no date) revealed an alarming seat belt restraint was to be utilized when the resident was up in the wheelchair.</p>	F 282	<p>The facility has taken the following action to prevent this practice from affecting other residents:</p> <ul style="list-style-type: none"> On 7/11/11, all Residents' safety devices were inspected for accuracy and proper usage by the Medical Records / Central Supply Clerk, and verified by the Assistant Director of Nursing and Restorative Nurse Coordinator with each Resident's Physician's Orders and Individual Plan of Care. <p>The facility has initiated the following systemic changes to prevent this practice from recurring:</p> <ul style="list-style-type: none"> A comprehensive list of all Safety Devices used by facility Residents was developed on 7/12/11 by the ADON and Restorative Nurse Coordinator (Interventions/Alarms Flow Sheet: Attachment #8a - North and #8b South). All facility nursing staff (RNs, LPNs, CMAs, SRNAs) were informed via an in-service training to initiate the following practice: <ol style="list-style-type: none"> At each shift change, the SRNA going off-shift and the one coming on-shift will complete a walking round of Resident rooms to verify placement of all safety devices as listed on the Interventions/Alarms sheet for their assigned unit. The completion of this review will be evidenced by each SNRA's signature on the Interventions/Alarm sheet. The completed sheet, with signatures, is then to be given to the on-coming Shift Charge Nurse. The Shift Charge Nurse will complete a separate walking round to verify each device after the change of shift round has been completed. This visual check shall be evidenced by the Charge Nurse's individual signature on the Interventions / Alarm sheet. The Charge Nurse shall place the completed sheet in the ADON mailbox for review. The ADON shall review for appropriate signatures and forward to the DON, who shall review and then forward the signature sheets to the Administrator for review and filing. 	
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F 282	<p>Continued From page 3</p> <p>Review of the nurse's note dated 07/11/11, at 10:50 AM, revealed Resident #1 was sitting in a wheelchair by the nurses' station on the South Hall. The resident stood up and fell to the floor. The resident was assessed with complaints of left elbow pain and was transferred to the hospital for evaluation. The resident was diagnosed with a fractured left elbow.</p> <p>A review of the Incident Report and Fall Review Assessment dated 07/11/11, revealed Resident #1 was in the wheelchair when the resident attempted to stand/transfer unassisted and fell to the floor. The report identified an alarming seat belt restraint was not implemented or in place as required on the resident's plan of care when the resident fell.</p> <p>Resident #1 was observed on 07/20/11, at 10:15 AM, sitting in the wheelchair in front of the South Hall nurses' station. A chair and seat belt alarm were in place. A sling was observed on the resident's left upper arm.</p> <p>An interview with CNA #1 on 07/21/11, at 11:15 AM, revealed she was assigned to provide Resident #1's care on the day the fall occurred (07/11/11). CNA #1 stated resident restraints would be included on the CNA care plan. The CNA reported she did not always look at the care plans at the start of her shift and would sometimes get verbal report from the CNA on the prior shift. CNA #1 reported she received in-service training about once a month on restraints and stated she was trained to apply alarming seat belt restraints per the resident's care plan. CNA #1 stated on the day Resident #1</p>	F 282	<ul style="list-style-type: none"> A training Protocol was developed on 7/12/11 for <i>Monitoring of Alarms and Safety Devices</i>. (Attachment #9). In-service training provided by the Director of Nursing on 7/12/11 (verbally on 7/11/11) to licensed and certified nursing staff on the <i>Monitoring of Alarms and Safety Devices Protocol</i>. (Attachment #10) <p>The facility will sustain performance through the following monitoring practice:</p> <ul style="list-style-type: none"> The Director of Nursing shall update all Resident Care Plans daily for any change in safety device orders per physician directive. The Director of Nursing shall ensure the Restorative Nurse Coordinator is informed of any change via mailbox notification on the <i>Safety Device Change Form</i>. (Attachment #11). The Restorative Nurse Coordinator shall ensure each device is installed and updates are made to the comprehensive Interventions / Alarm sheet. In the weekly Fall Committee Meeting, each Resident's safety device(s) shall be reviewed by the interdisciplinary team for: 1) medical symptom that warrants device; 2) other devices that may be least restrictive; and 3) documentation of reason device should/should not be continued. An updated list will be placed at each nurse station by the Restorative Nurse Coordinator, or assigned designee, of the committee changes. This new list is to be used by all direct care staff as the daily checklist for the upcoming week. The Restorative Nurse Coordinator shall continue to monitor the use of Resident safety devices as part of the departmental Continuous Quality Improvement process. The Director of Nursing and / or Designee shall continue to monitor resident care plans through the multidisciplinary care planning process a minimum of: on admission/readmission; quarterly; for significant change, & PRN. 	

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F 282	<p>Continued From page 4</p> <p>fall she (CNA #1) failed to check the CNA care plan prior to caring for Resident #1 and failed to check the alarming seat belt restraint after transferring Resident #1 to the wheelchair.</p> <p>An interview with CNA #2 on 07/21/11, at 1:40 PM, revealed she assisted CNA #1 to transfer Resident #1 into the wheelchair on the day of the fall/incident. The CNA stated she had taken care of Resident #1 earlier in the month and remembered the resident had a seat belt restraint at that time. CNA #2 said she did not notice if Resident #1's alarming seat belt was in place as she was only assisting CNA #1 with a transfer. CNA #2 stated she would have expected CNA #1 to manage any application of restraints. CNA #2 reported all CNAs are trained to review the CNA care plans at the beginning of each shift to determine the resident care needs.</p> <p>An interview with Certified Medication Assistant (CMA) #1 on 07/21/11, at 9:50 AM, revealed seat belt restraints and alarms were documented on the resident's Medication Administration Record/Treatment Administration Record (MAR/TAR) and the CNA care plans. The CMA stated it was the CMA's responsibility to ensure the CNAs were applying alarms/restraints as required and to document this on the MAR/TAR twice per day, at 9:00 AM and 8:00 PM. According to the CMA, on the day of the resident's fall with injury, she only verified the chair alarm to be in place, and did not check for the alarming seat belt. However, record review of Resident #1's MAR revealed staff had signed the MAR on 07/11/11, indicating the seat belt was in place at 7:00 AM, prior to the resident's fall.</p>	F 282	<p>The Director of Nursing and / or Designee shall expand the monthly chart audit to include a 20% (14 charts) random sampling of resident care plans to monitor for correct implementation.</p> <p>COMPLETION DATE: 7/22/11</p>	

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F 282	<p>Continued From page 4</p> <p>fell she (CNA #1) failed to check the CNA care plan prior to caring for Resident #1 and failed to check the alarming seat belt restraint after transferring Resident #1 to the wheelchair.</p> <p>An interview with CNA #2 on 07/21/11, at 1:40 PM, revealed she assisted CNA #1 to transfer Resident #1 into the wheelchair on the day of the fall/incident. The CNA stated she had taken care of Resident #1 earlier in the month and remembered the resident had a seat belt restraint at that time. CNA #2 said she did not notice if Resident #1's alarming seat belt was in place as she was only assisting CNA #1 with a transfer. CNA #2 stated she would have expected CNA #1 to manage any application of restraints. CNA #2 reported all CNAs are trained to review the CNA care plans at the beginning of each shift to determine the resident care needs.</p> <p>An interview with Certified Medication Assistant (CMA) #1 on 07/21/11, at 9:50 AM, revealed seat belt restraints and alarms were documented on the resident's Medication Administration Record/Treatment Administration Record (MAR/TAR) and the CNA care plans. The CMA stated it was the CMA's responsibility to ensure the CNAs were applying alarms/restraints as required and to document this on the MAR/TAR twice per day, at 9:00 AM and 9:00 PM. According to the CMA, on the day of the resident's fall with injury, she only verified the chair alarm to be in place, and did not check for the alarming seat belt. However, record review of Resident #1's MAR revealed staff had signed the MAR on 07/11/11, indicating the seat belt was in place at 7:00 AM, prior to the resident's fall.</p>	F 282		

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F 282	Continued From page 5 An interview with the Director of Nursing (DON) on 07/21/11, at 2:10 PM, revealed nurses were trained in orientation to monitor the use of restraints. The nurse was responsible to check behind the CMAs to see if they were documenting on the MAR/TAR that residents' restraints were in place. The DON stated nurses were also trained to go behind CMAs and do visual checks to ensure restraints were in place. An interview conducted with LPN #2 on 07/21/11, at 6:40 PM, revealed on the day of the incident she observed Resident #1 stand up and also heard the chair alarm sounding. The LPN stated before she could get to the resident he/she fell. Further interview revealed seat belt restraints were monitored through the sign-off on the TAR/MAR. The LPNs were responsible to check after the CMAs to ensure restraint and alarm check-offs were being performed. Furthermore, the LPN stated visual checks were performed to ensure residents' alarms and seat belt restraints were in place. LPN #2 reported she was familiar with Resident #1 and aware Resident #1 had an order for a seat belt restraint. The LPN stated she "had not gotten around to checking CMAs' MARS/TARS" and had not ensured the seat belt was applied prior to the fall on 07/11/11. An interview with the Administrator 07/21/11, at 7:00 PM, revealed the facility had no policy related to Care Plans or Care Plan implementation.	F 282		
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	F 323	F 323 FREE OF ACCIDENT HAZARDS/SUPERVISION / DEVICES	

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F 323	<p>Continued From page 6</p> <p>as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, policy review, and review of the facility's fall investigation, it was determined the facility failed to ensure one of eighteen sampled residents (Resident #1) received adequate supervision and assistance to prevent accidents. Resident #1 was assessed as a high risk for falls and to require an alarming seat belt restraint while up in the wheelchair due to attempting to get up unassisted. The facility failed to ensure resident safety by monitoring implementation of interventions determined necessary to prevent accidents/injuries to Resident #1. On 07/11/11, Resident #1 was placed in a wheelchair that did not contain an alarming seatbelt. The resident stood from a sitting position in the wheelchair and fell. The resident sustained a fracture of the left elbow.</p> <p>The findings include:</p> <p>A review of the facility's Fall/Risk Committee Policy Statement (revised 06/01/11) revealed staff was required to assess all residents for fall risk upon admission, quarterly, and as needed. Residents identified as having a high fall risk would have individualized interventions documented on their care plan.</p> <p>The facility admitted Resident #1 on 04/10/10,</p>	F 323	<p>The facility has ensured the following corrective actions:</p> <ul style="list-style-type: none"> On 7/11/11, the Director of Nursing completed individual employee warning /counseling sessions for all nursing staff assigned to Resident #1's care, regarding (1) the daily review of Resident Care Plans for updates / changes prior to current shift; and (2) monitoring of safety device placement and usage. (Reviewed by Survey Team at time of inspection). <p>The facility has taken the following action to prevent this practice from affecting other residents:</p> <ul style="list-style-type: none"> On 7/12/11, the Director of Nursing completed in-service training to all nursing employees regarding the daily review of Resident Care Plans and monitoring of all safety device placement and usage. (Attachment #7) <p>The facility has initiated the following systemic changes to prevent this practice from recurring:</p> <ul style="list-style-type: none"> A comprehensive list of all Safety Devices used by facility Residents was developed on 7/12/11 by the ADON and Restorative Nurse Coordinator (Interventions/Alarms Flow Sheet: Attachment #8a - North and #8b South). All facility nursing staff (RNs, LPNs, CMAs, SRNAs) were informed via an in-service training to initiate the following practice: <ol style="list-style-type: none"> At each shift change, the SRNA going off-shift and the one coming on-shift will complete a walking round of Resident rooms to verify placement of all safety devices as listed on the Interventions/Alarms sheet for their assigned unit. The completion of this review will be evidenced by each SNRA's signature on the Interventions/Alarm sheet. The completed sheet, with signatures, is then to be given to the on-coming Shift Charge Nurse. 	
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F 323	<p>Continued From page 7</p> <p>with diagnoses of Status Post Cerebral Vascular Accident, Osteoporosis, Pain, Dementia, Insomnia, Depression, Hypertension, Weight Loss, and Anorexia. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 03/13/11, revealed the facility assessed the resident to be totally dependent and to require the assistance of two staff persons for transfers.</p> <p>An Incident Report completed on 06/10/11, revealed Resident #1 was found lying on the floor and unable to explain what happened. The Falls Risk Evaluation dated 06/10/11, revealed the facility assessed Resident #1 to have a summary score of 20. According to the evaluation, a score of 10 or above represented a high risk for falls.</p> <p>A review of nurse's notes dated 06/10/11, at 8:30 AM, revealed Resident #1 sustained a fall, reason unknown. Further review of the nurse's notes revealed the Falls Committee met on 06/14/11, and determined due to Resident #1's cognitive loss/Dementia and attempts to get up without assistance, an alarming seat belt restraint would be implemented while up in a wheelchair.</p> <p>Record review revealed on 06/14/11, Resident #1 was care planned to need a bed/chair alarm at all times, and an alarming seat belt while up in a wheelchair, to be checked every 30 minutes and released every 2 hours. This intervention was added to the resident's Certified Nursing Assistant (CNA) care plan and the resident's Medication Administration Record (MAR) to be checked each shift.</p> <p>A review of the Incident Report and Fall Review Assessment dated 07/11/11, at 10:55 AM,</p>	F 323	<p>2) The Shift Charge Nurse will complete a separate walking round to verify each device after the change of shift round has been completed. This visual check shall be evidenced by the Charge Nurse's individual signature on the Interventions / Alarm sheet. The Charge Nurse shall place the completed sheet in the ADON mailbox for review.</p> <p>3) The ADON shall review for appropriate signatures and forward to the DON, who shall review and then forward the signature sheets to the Administrator for review and filing.</p> <ul style="list-style-type: none"> A training Protocol was developed on 7/12/11 for <i>Monitoring of Alarms and Safety Devices</i>. (Attachment #9). In-service training provided by the Director of Nursing on 7/12/11 (verbally on 7/11/11) to licensed and certified nursing staff on the <i>Monitoring of Alarms and Safety Devices Protocol</i>. (Attachment #10) <p>The facility will sustain performance through the following monitoring practice:</p> <ul style="list-style-type: none"> The Director of Nursing shall update all Resident Care Plans daily for any change in safety device orders per physician directive. The Director of Nursing shall ensure the Restorative Nurse Coordinator is informed of any change via mailbox notification on the <i>Safety Device Change Form</i>. (Attachment #11) The Restorative Nurse Coordinator shall ensure each device is installed and updates are made to the comprehensive Interventions / Alarm sheet. In the weekly Fall Committee Meeting, each Resident's safety device(s) shall be reviewed by the interdisciplinary team for: 1) medical symptom that warrants device; 2) other devices that may be least restrictive; and 3) documentation of reason device should/should not be continued. An updated list will be placed at each nurse station by the Restorative Nurse Coordinator, or assigned designee, of the committee changes. This new list is to be used by all direct care staff as the daily checklist for the upcoming week. 	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/21/2011
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NAME OF PROVIDER OR SUPPLIER EDGEWOOD ESTATES	STREET ADDRESS, CITY, STATE, ZIP CODE 195 BERRYMAN ROAD FRENCHBURG, KY 40322
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F 323	<p>Continued From page 8</p> <p>revealed Resident #1 was in the wheelchair when the resident attempted to stand/transfer without assistance and fell to the floor. The report noted the alarming seat belt was not in place/use at the time of the fall.</p> <p>Review of nurse's notes dated 07/11/11, at 10:50 AM, revealed Resident #1 was sitting in a wheelchair at the nurse's desk on the South Hall. Resident #1 stood up and then fell forward onto the floor. The bed/chair alarm was sounding and Licensed Practical Nurse (LPN) #2 witnessed the fall. Resident #1 complained of left elbow pain and was transferred to the hospital. The resident was diagnosed with a fractured left elbow.</p> <p>Resident #1 was observed on 07/20/11, at 10:15 AM, sitting in a wheelchair in front of the South Hall nurses' station. A chair and seat belt alarm were in place. A sling was observed on the resident's left upper arm.</p> <p>An interview with Certified Medication Assistant (CMA) #1 on 07/21/11, at 9:50 AM, revealed staff was responsible to ensure seat belt restraints were in place. The CMA stated seat belt restraints and alarms were documented on the resident's Medication Administration Record/Treatment Administration Record (MAR/TAR) and the CNA care plans. The CMA stated it was the CMA's responsibility to check for the presence of the resident restraints/alarms and to document this on the MAR/TAR twice per day, at 9:00 AM and 9:00 PM. Further interview with CMA #1 revealed the CMA had verified the resident's chair alarm on 07/11/11, but had not checked the resident's seat belt. Review of Resident #1's MAR revealed staff had signed the</p>	F 323	<ul style="list-style-type: none"> The Restorative Nurse Coordinator shall continue to monitor the use of Resident safety devices as part of the departmental Continuous Quality Improvement process. To ensure the environment is free of potential hazards that could lead to or cause an accident, the Safety Committee, chaired by the Environmental Services Director, shall continue to complete the safety checklist during monthly rounds to monitor all areas of the environment. A summary of the rounds shall continue to be presented to and acted upon as needed, by the safety committee during the monthly meetings <p>COMPLETION DATE: 7/22/11</p>	
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F 323	<p>Continued From page 9</p> <p>MAR on 07/11/11, indicating the seat belt was in place at 7:00 AM, prior to the resident's fall.</p> <p>An interview conducted with CNA #1 on 07/21/11, at 11:15 AM, revealed she was assigned to provide Resident #1's care on 07/11/11. CNA #1 stated if a resident utilized a restraint it would be indicated on the CNA Care plan. The CNA stated she did not always look at care plans at the beginning of the shift and would sometimes get verbal report from the CNA on the prior shift. CNA #1 stated she transferred Resident #1 to the wheelchair from a personal recliner with the assistance of another CNA. CNA #1 stated she did not check to ensure the seat belt restraint was on the resident. The CNA stated she had not taken care of Resident #1 in July until two days prior to Resident #1's fall. Review of records revealed CNA #1 signed Resident #1's Restraint Flow Sheet indicating she had checked the restraint every 30 minutes and released the restraint every 2 hours. Further interview with CNA #1 revealed, "I didn't pay attention to the checklist I was signing; thought it was the chair alarm." The CNA said she could see Resident #1 had a chair alarm. The CNA stated she had been trained to sign the restraint checklist after observing the restraint on the resident. Furthermore the CNA reported she should have checked the CNA care plan to see if restraints were ordered.</p> <p>An interview conducted with CNA #2 on 07/21/11, at 1:40 PM, revealed she was familiar with Resident #1 but was not responsible for Resident #1's care on the day of the fall. The CNA reported she helped CNA #1 transfer Resident #1 to the wheelchair from the commode and did not</p>	F 323		
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F 323	<p>Continued From page 10</p> <p>notice if the seat belt restraint was in place. The CNA stated she had taken care of Resident #1 earlier in the month and remembered the resident had a seat belt restraint at that time. The CNA said she expected CNA #1 would manage Resident #1's restraint since she was assigned to provide Resident #1's care. Further interview revealed it was the CNA's responsibility to review the CNA care plan at the beginning of each shift to determine each resident's care needs. The CNAs were also responsible to check restraints every 30 minutes, release every 2 hours, and document in CNA restraint checklist check that the release was performed.</p> <p>An interview conducted with LPN #2 on 07/21/11, at 6:40 PM, revealed she was at the South Hall nurses' desk at the time of the incident. LPN #2 stated she observed Resident #1 stand up and also heard the chair alarm sounding. The LPN stated before she could get to the resident he/she fell. Further interview revealed seat belt restraints were monitored through the sign-off on the TAR/MAR. The LPNs were responsible to check after the CMAs to ensure restraint and alarm check-offs were being performed. Furthermore, the LPN stated visual checks were performed to ensure residents' alarms and seat belt restraints were in place. LPN #2 reported she was familiar with Resident #1 and aware Resident #1 had an order for a seat belt restraint. The LPN stated she "had not gotten around to checking CMAs' MARS/TARS" prior to Resident #1's fall on 07/11/11.</p> <p>An interview with the Director of Nursing (DON) on 07/21/11, at 2:10 PM, revealed nurses were trained in orientation to monitor the use of seat</p>	F 323		
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F 323	Continued From page 11 belt restraints by following behind the CMAs to see if they were documenting on the MAR/TAR that residents' restraints were in place. Nurses were also trained to go behind CMAs and do visual checks to ensure restraints were in place.	F 323		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to provide foods/liquids that were palatable and at the proper temperature during the noon meal on 07/19/11. The findings include: A review of the Meal Timeframe policy (revised on 01/19/10) revealed meals were to be served that were palatable and in accordance with accepted professional practice. The policy did not include specific timeframes for resident meal trays to be distributed. Observation of the noon meal service on 07/19/11, revealed the food cart was delivered from the kitchen to the South Hall at 11:30 AM. The last tray was removed from the cart at 12:07 PM (37 minutes after the cart was delivered to the floor). A food temperature and palatability test	F 364	F 364 NUTRITIVE VALUE / APPEAR, PALATABLE/PREFER TEMP The facility has ensured the following corrective actions: <ul style="list-style-type: none"> On 8/11/11, a revision was made to the Meal Timeframe Policy and Schedule, with the addition of specific timeframes for the delivery of Resident meal trays from the food carts. (Attachment #12) Dietary and Nursing personnel were in-serviced on the timeframe revision on this date. (Attachments #13 & 14) The facility has taken the following action to prevent this practice from affecting other residents: <ul style="list-style-type: none"> The facility's revised Meal Timeframe Policy includes specific time limits for meal tray delivery to ensure all meals are served in accordance with professional standards of practice. On 7/20/11, the Registered Dietitian conducted an immediate in-service with dietary staff regarding meal temperatures and seasoning of foods. (Attachment #15) The facility has initiated the following systemic changes to prevent this practice from recurring: <ul style="list-style-type: none"> The Meal Timeframe Policy and attached meal delivery schedule were revised to indicate specified time limits for the delivery of meal trays from the food carts. 	

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F 364	<p>Continued From page 12</p> <p>was conducted of the pureed food items from the last tray with the Dietary Manager (DM). The food temperatures revealed the chicken and dumplings was 101.2 degrees Fahrenheit, the mashed potatoes was 95.5 degrees Fahrenheit, the broccoli was 94 degrees Fahrenheit, the orange gelatin fruit dessert was 66 degrees Fahrenheit, and the thickened milk was 61.9 degrees Fahrenheit. The palatability test revealed the chicken and dumplings, mashed potatoes, and broccoli tasted cold. The gelatin dessert tasted cool and the thickened milk tasted warm. Furthermore, the mashed potatoes and broccoli tasted bland with little seasoning.</p> <p>Resident #7 received a tray prior to the last tray being removed from the lunch food cart. Resident #7 stated his/her food tasted cold.</p> <p>Observations of the evening meal service on 07/19/11, revealed the food cart was delivered to the South Hall from the kitchen at 4:50 PM, and the last tray was removed at 5:15 PM. Temperatures obtained revealed the pureed fish was 108.8 degrees Fahrenheit, the potato soup was 126 degrees Fahrenheit, and the thickened milk was 63 degrees Fahrenheit. The palatability test of the foods revealed the fish tasted lukewarm and bland, and the potato soup tasted warm and bland.</p> <p>A group interview was conducted on 07/20/11, at 2:30 PM, with eight alert/oriented residents. Residents stated foods were sometimes "not as hot as they should be" when served and needed more seasoning.</p> <p>An interview conducted with the DM on 07/19/11,</p>	F 364	<ul style="list-style-type: none"> The Dietary staff shall contact the Charge Nurse on duty, or designee, on each unit prior to sending the meal cart from the kitchen area. The Dietary personnel shall record the cart exit time from the kitchen once the cart has been set in the hallway outside the kitchen area. (<i>Mealtime Delivery Record</i> - Attachment #16). The certified nurse aides staff shall pass the trays within the allocated timeframe of 15 minutes per the schedule. The Charge Nurse on duty shall oversee and record the time the last tray leaves the meal cart, and return the record of times to the Dietary Director, or, on weekends, place it in her mailbox for review. <p>The facility will sustain performance through the following monitoring practices:</p> <ul style="list-style-type: none"> All Mealtime Delivery Record sheets shall be reviewed weekly, and acted upon if needed, by the Director of Nursing and Dietary Manager. A summary of Mealtime Delivery Records shall be reviewed at the Dietary Review & Quality Assurance Audit held each month between the Registered Dietitian, the Director of Nursing, the Dietary Manager and the Administrator. <p>COMPLETION DATE: 8/12/11</p>	
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F 364	<p>Continued From page 13</p> <p>at 12:20 PM, revealed the food trays should be distributed to the residents within 15-20 minutes after the food cart was delivered to the floor. The DM stated test trays were conducted weekly to evaluate/monitor food temperatures and/or palatability. The DM stated the facility had not identified problems related to cold food temperatures and palatability. The DM also stated the facility did not have a specific policy/procedure related to meal service.</p> <p>An interview conducted with the Registered Dietician (RD) on 07/19/11, at 5:15 PM, revealed the facility had used low-sodium chicken bouillon to season the potato soup and only a small amount of salt.</p>	F 364		
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