

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

PRINTED: 04/24/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/10/2014
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NAME OF PROVIDER OR SUPPLIER MAYFAIR MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 3300 TATES CREEK ROAD LEXINGTON, KY 40502
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F 000	INITIAL COMMENTS A Recertification Survey was initiated on 04/08/14 and concluded on 04/10/14 with deficiencies cited at the highest Scope and Severity of a "D".	F 000	F-280 1. Resident #3's Comprehensive Care Plan was reviewed. An anti-depressant plan of care was included in the Comprehensive Care Plan; however, a Psychotropic Care Plan was omitted. On April 10, 2014 a Psychotropic plan of care related to the use of an anti-depressant was also added to Resident #3's Comprehensive Care Plan.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure the Comprehensive Plan of Care was revised for one (1) of eleven (11) sampled residents (Resident #3).	F 280	2. All residents' medications will be reviewed for the use of psychotropic medication by the Director of Nursing/Assistant Director of Nursing/ Unit Manager and the Minimum Data Set Coordinators. The Comprehensive Car Plan for any resident identified receiving psychotropic will be reviewed and updated accordingly. The Minimum Data Set Coordinator (MDS) will ensure residents' psychotropic care plans are accurately reflected for each resident identified by May 23, 2014. 3. MDS staff was in-serviced to include Psychotropic care plan for anti-depressants use and not limit care plan to just an anti-depressant care plan. The Interdisciplinary Team (IDT) will review each care plan with resident admission, incident or change of condition in clinical meeting which is lead by the Director of Nursing/Assistant of Nursing. Identified non-compliance of the care plan process will be reported to the Administrator weekly and forwarded to the At Risk meetings for review and follow-up. 4. The Director of Nursing/Assistant Director of Nursing/ Minimum Data Set Coordinator or Medical Records will audit monthly all residents care plans to ensure development of care plans reflect the usage of psychotropic medications using the Psychotropic Monthly Audit Log(PMAL). The PMAL will be completed monthly for three months and then quarterly for two. The PMAL results will be forwarded to the Director of Nursing for follow up and review. Care Plan results will be reported to the MONTHly Assurance Committee to include the Administrator and the Facility Medical Director for review and follow up for further recommendations.	5/30/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kelcee Martin</i>	TITLE <i>Administrator</i>	(X6) DATE <i>5/23/14</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.

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F 280	<p>Continued From page 1</p> <p>A Physician's Order was received on 03/24/14 to discontinue Resident #3's Effexor (antidepressant medication) and to start Cymbalta (antidepressant medication) 20 milligrams (mg's) at night however, there was no documented evidence the Comprehensive Care Plan was revised related to the antidepressant medication.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Care Plans-Comprehensive", revised October 2010, revealed the Care Planning Interdisciplinary Team was responsible for review and updating care plans when there was a significant change in the resident's condition, when the desired outcome was not met, when the resident had been re-admitted to the facility from the hospital stay, and at least quarterly. Further review revealed assessment of residents was ongoing and Care Plans were revised as information about the resident's condition changed.</p> <p>Review of Resident #3's medical record revealed diagnoses which included Non Alzheimer's Dementia and Depression. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 03/24/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of a fourteen (14) out of fifteen (15) indicating the resident was cognitively intact. Further review revealed the facility assessed the resident as receiving an antidepressant medication seven (7) days out of the past seven (7) days.</p> <p>Review of the Physician's Orders dated 03/01/14 through 03/31/14, revealed an order for Effexor 37.5 mg's with an order date of 02/02/14.</p>	F 280		
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F 280	<p>Continued From page 2</p> <p>Continued review of the Physician's Orders revealed an order dated 03/26/14 at 12:00 PM revealed to discontinue the Effexor, and start Cymbalta 20 mg's daily at night related to Depression and pain relief component. Review of the Physician's Orders dated 04/01/14 through 04/30/14 revealed the order for Cymbalta 20 mg's daily at bedtime was ongoing.</p> <p>Review of the Comprehensive Care Plan dated 10/12/13, revealed a problem stating Resident #3 was at risk for and/or experiencing Depression with a goal stating the resident would participate with care and activities of choice. Review of the Care Plan revealed intervention included: after all other behavior management techniques have been explored, administer medications as ordered and monitor behaviors per tracking tool. However, further review revealed no documented evidence of reference to or an approach related to psychotropic drug use of the Cymbalta to include monitoring for the risks, complications, side effects and effectiveness of the medication.</p> <p>Interview, on 04/09/14 at 2:40 PM, with MDS Coordinator #2 revealed she and MDS Coordinator #1 completed all MDS's for the facility and also developed and revised Care Plans. MDS Coordinator #2 revealed the MDS Coordinators attended the daily Clinical Meetings Monday through Friday and received copies of all new Physician's Orders in the meetings and updated the Care Plans according to the orders. MDS Coordinator #2 stated she had completed Resident #3's last Annual MDS Assessment 10/11/13, and had also completed the Quarterly MDS Assessment dated 03/24/14. She stated the Quarterly MDS Assessment dated 03/24/14, indicated the resident was on an antidepressant</p>	F 280		
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F 280 Continued From page 3
medication and the Care Plan should have been revised at that time related to the resident receiving Effexor. Further interview revealed when the new order for Cymbalta was received on 03/26/14, the care plan should have been reviewed and revised related to the medication. She stated it must have been "missed". Continued interview revealed if a resident was receiving a psychotropic medication, there should be information in the care plan related to the reason for the medication, the need for monitoring for side effects of the medication, the need for monitoring for the effectiveness of the medication, and the need to assess for possible dose reduction. MDS Coordinator #2 further stated the Corporate Consultant did quarterly reviews of a percentage of residents' Care Plans to ensure the care plans were accurate and complete.

Interview, on 04/09/14 at 3:30 PM, with the Director of Nursing (DON) revealed the Care Plans were reviewed in the care plan meetings which occurred on admission, quarterly, yearly and with a significant change by all the disciplines including the Assistant Director of Nursing (ADON), Activities, Dietary, and Social Services. She further stated the care plans were also updated Monday through Friday in the morning meeting from the Physician's Orders. She stated there should have been a psychotropic drug care plan related to the Cymbalta for Resident #3.

F 280

F 282 : 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN
SS=D

F 282

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of

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F 282	<p>Continued From page 4 care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure services where provided by the facility in accordance with the Interim Care Plan (ICP) for one (1) of eleven (11) sampled residents (Resident #12). Resident #12's ICP revealed the resident was a fall risk and was not to be left unsupervised in the bathroom. However, the ICP was not followed on 04/09/14, as Resident #12 sustained a fall resulting in a skin tear to the resident's left arm on 04/09/14.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing on 04/10/14 at 5:05 PM, revealed the facility did not have a policy on following care plans.</p> <p>Review of Resident #12's medical record revealed the facility admitted the resident on 04/07/14, with diagnoses which included Rehabilitation for Status Post Fixation of a Tibial/Fibular Fracture. Review of the Admission Nursing Assessment, Fall Risk Evaluation section dated 04/07/14, revealed Resident #12 was assessed as a fall risk related to health conditions and medications. Continued record review revealed Resident #12 had sustained (1) or more falls in the ninety (90) days prior to admission with the most recent fall occurring on 04/01/14. Record review revealed Resident #12 was assessed as being non-weight bearing, two (2) person assist for stand to pivot transfers and a one (1) person assist for toileting, using a</p>	F 282	<p>F-282</p> <ol style="list-style-type: none"> 1. Resident #12's Interim Care Plan was reviewed. The commode extender was immediately changed and secured to an elevated toilet seat with legs and arm supports. SRNA #1 was coached and counseled on April 9, 2014 by the Director of Nursing regarding following Resident #12 SRNA care plan regarding toileting. SNRA #2 is no longer employed with facility. 2. All residents were immediately assessed for use of commode extender seat. All seats were inspected on April 9, 2014 by Maintenance department and were secure. Upon further review of care plan "unsupervised" verbiage, it was not intended that all residents would have clinical staff within reach of resident while toileting and that alert residents could be granted privacy with toileting in bathroom with call bell in reach and nursing staff in close proximity of the bathroom. Therefore, the verbiage "unsupervised" was revised to "observe". All Comprehensive Care Plans and State Registered Nursing Assistant (SRNA) care plans will be reviewed and update accordingly to include "observe resident while toileting" allowing privacy to residents during bathroom toileting. 3. Staff Development Coordinator (SDC) will educate the Nurses and SRNA's by May 23, 2014 to utilize and follow the SRNA care plan for all resident care; to include guidance of resident care regarding observation of residents while toileting to ensure residents remain as free of injury and hazards as possible. The SDC/ Assistant Director/Unit Manager will monitor staff regarding following the plan of care to avoid accidental injury to residents. All newly hired Nurses and SRNA's will be in-serviced during orientation on following the resident care plan. <p style="text-align: right;">5/30/14</p>	
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F 282	<p>Continued From page 5 bedpan, after evaluation by Physical Therapy (PT) and Occupational Therapy (OT).</p> <p>Review of the ICP dated 04/07/13, revealed Resident #12 was a fall risk and interventions included not to leave him/her unsupervised in the bathroom.</p> <p>Review of the Nursing Assistant Care Record dated April 2014, revealed Resident #12 was a non-weight bearing, stand to pivot transfer with two (2) person assist. Continued review revealed Resident #12 was not to be unsupervised in the bathroom.</p> <p>Review of the OT evaluation dated 04/08/14 at 4:00 PM, revealed Resident #12 would safely perform toileting tasks using an elevated commode seat or a "3 in 1" commode (bedside commode that could also be used over the toilet bowl) with moderate assist and fifty percent (50%) verbal cues for safety while turning and for use of compensatory strategies with reduced risk for falls.</p> <p>Interview with the Rehabilitation Services Manager on 04/10/14 at 3:20 PM, revealed her expectation of a resident not being left unsupervised while toileting, would be to crack the bathroom door, make sure the call light was at in reach and instruct the resident to call for assistance.</p> <p>Review of the facility's investigation dated 04/09/14 at 5:00 PM, revealed Resident #12 was on the toilet and when staff attempted to help him/her, the elevated toilet seat slid off the commode and Resident #12 fell.</p>	F 282	<p>4. The SDC/Assistant Director/Unit Manager will use the Care Plan Audit Tool (CPAT) to monitor and audit all resident care plans to ensure care plans are being followed. The CPAT will cover the following areas: mobility, ADL, elimination, diet, safety and senses The CPAT will be completed on all residents by 5/30/14. Twenty CPAT's will be completed monthly for three months and then quarterly for two. The Administrator/Director of Nursing/ Assistant of Nursing or Unit Manager will review each incident at the daily clinical meeting to determine cause root. The resident care plan will be updated as needed. Any findings of non-compliance of following the SRNA care plan which resulted in injury will be reported to the Administrator and Director of Nursing. The staff member responsible for non-compliance will be coached and disciplined accordingly. Results of the CPAT will be reported to the monthly Quality Assurance Committee to include the Administrator and the facility Medical Director for review and follow-up for further recommendations.</p>	5/30/14
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F 282 Continued From page 6

Interview with Resident #12 on 04/10/14 at 11:30 AM, revealed State Registered Nursing Assistant (SRNA) #1 and SRNA #2 took him/her to the bathroom (BR) the evening of 04/09/14 before supper and they waited outside the door with it slightly cracked to give him/her privacy. Resident #12 indicated there was no one in the bathroom with him/her. Continued interview revealed the resident leaned forward to cleanse, the elevated commode seat "wobbled" and he/she fell towards the left side causing a skin tear on his/her left arm from the tiles.

Review of SRNA #1's written statement dated 04/09/14, untimed, revealed she and SRNA #2 had assisted Resident #12 to the toilet and she had stepped away from the bathroom to speak with the resident's roommate but, had Resident #12 still in her sight. Further review revealed she heard the resident fall, turned around and SRNA #2 was beside Resident #12 and she went to get the nurse.

Interview with SRNA #1 on 04/09/14 at 6:15 PM, revealed SRNAs used the Nursing Assistant Care Record to know residents' care needs but, she had not looked at it since coming on shift at 3:00 PM. Continued interview revealed she and SRNA #2 had assisted Resident #12 to the bathroom, pulled the roommate's curtain and she stood in the doorway with her back turned to give Resident #12 privacy. Further interview revealed she heard a noise, turned around and Resident #12 was lying on the floor. An additional interview with SRNA #1 on 04/10/14 at 3:33 PM, revealed the elevated toilet seat did not wobble when she and SRNA #2 assisted Resident #12 to sit on it. She stated SRNA #2 stood outside the bathroom door and she had stepped to the foot of the

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F 282	<p>Continued From page 7</p> <p>roommate's bed and looked around the curtain to see what he/she wanted.</p> <p>Interview with SRNA #2 on 04/10/14 at 1:45 PM, revealed he had helped SRNA #1 to assist Resident #12 to the bathroom and closed the bathroom door a little for privacy. Continued interview revealed he did not see Resident #12 fall, his back had been turned but that he/she was not out of his sight. He further stated he was unaware of SRNA#1's location in the room at the time.</p> <p>Interview, on 04/10/13 at 3:30 PM, with the OT who evaluated Resident #12, revealed either the elevated commode seat or a "3 in 1" commode toilet assistive device would have been appropriate for Resident #12, as one was not any safer than the other. The OT stated the main concern was for him/her not to bend. She stated she had worked with Resident #12 on toileting, using the same elevated toilet seat without any concerns, during her evaluation on 04/08/14. The OT indicated Resident #12 had not had any concerns using the elevated toilet seat. She further stated that her expectation if a resident was not to be left unsupervised while toileting, was for staff to be within arm's reach during transfers and toileting, until the resident had reached his/her goal.</p> <p>Interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 04/10/14 at 5:05 PM, revealed SRNA #1 had alerted the ADON of Resident #12's fall and the ADON had assisted in the assessment and with dressing the skin tear on his/her left arm. Continued interview with the ADON revealed Resident #12 did not complain of any pain or</p>	F 282		
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F 282	Continued From page 8 injury, he/she just wanted off the floor. The DON revealed recommendations about assistive devices, such as, elevated toilet seats and resident safety to use those devices were made by PT after an evaluation. The DON indicated her expectation of "do not leave unsupervised while toileting", would be for staff to be attentive to resident to assist if needed and staff would not have to stand right beside the resident. The DON stated if a resident was cognitively intact, she would expect staff to also maintain dignity and privacy by cracking the bathroom door. The DON stated she would expect staff to remain within eyesight and ear shot and to not leave the resident if he/she was a fall risk. The DON and ADON both verified Resident #12 was cognitively intact.	F 282		5/30/14
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.	F 322	<p>F322</p> <ol style="list-style-type: none"> On April 9, 2014 Registered Nurse #4 was educated on proper administration of medications and fluids through Gastrostomy tube (G-tube) for Unsampled Resident A to include checking G-tube placement prior to each administration of any solution. Unsampled Resident A did not develop any complications from the omission of G-tube placement check. Director of Nursing did verify placement of Unsampled Resident A G-tube on April 9, 2014. Two residents reside in facility with G-tubes. Nursing staff caring for those residents were immediately educated on proper administration of solutions through G-tubes to include checking placement. No adverse findings were identified. The SDC will educate and observe administration of medication competency for G-tubes for all Nursing staff by May 23, 2014. The SDC will educate and perform Competency checks regarding G-tube medication administration during medication competency for newly hired nurses during orientation and annually. The Director of Nursing/Assistant of Nursing/Unit Manager/SDC will audit 100% of nurses for competency regarding administration of solutions through G-tube. Any discrepancy will be reported immediately to the Director of Nursing/Administrator for immediate action to include education and return demonstration until the nurse is deemed proficient. Report of audit will be reviewed in the facility monthly Quality Assurance Meeting for any further recommendations. 	

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F 322	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure a resident who received medications through a Gastrostomy Tube (g-tube) received appropriate treatment and services to prevent Aspiration Pneumonia for one (1) unsampled resident (Unsampled Resident A). Observation during a medication pass revealed the nurse failed to check for g-tube placement prior to the administration of medication via the g-tube for Unsampled Resident A. The findings include: Review of the facility's policy titled, "Medication Administration-Nasogastric Tubes, Gastrostomy and Jejunostomy Tubes", effective December 2010, revealed the procedural steps included: to explain the procedure to residents; assist residents to a Semi-Fowler (elevating the head of the bed to 30 degrees which decreases the risk of the patient aspirating the tube feeding) position unless contraindicated; checking patency of the tube and for placement of the tube prior to administering any solution. Review of Unsampled Resident A's medical record revealed diagnoses which included Congenital Hydrocephalus, Dysphagia, and Gastrostomy Tube. Review of the Quarterly Minimum Data Set Assessment dated 03/11/14,	F 322		
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NAME OF PROVIDER OR SUPPLIER MAYFAIR MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 3300 TATES CREEK ROAD LEXINGTON, KY 40502
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F 322	<p>Continued From page 10</p> <p>revealed the facility assessed the resident as having both short and long term memory loss. Further review revealed the facility assessed the resident as having a feeding tube.</p> <p>Observation of a medication pass for Unsampled Resident A on 04/9/14 at 5:20 PM, revealed Registered Nurse (RN) #4 administered thirty (30) milliliters (mls) of water through a syringe into the residents g-tube, then administered Phenytoin (anti-seizure medication) Suspension ten (10) mls then again administered thirty (30) mls of water through the g-tube. Continued observation revealed the nurse did not check for placement of the g-tube prior to the administration of the water and medication. Additionally, observation revealed RN #4 did not check for residual tube feeding by aspirating the resident's stomach contents with a syringe prior to the administration of the water or medication.</p> <p>Interview, on 04/09/14 at 5:25 PM, with RN #4 revealed she had checked for residual earlier in the shift however, had not yet checked for placement during the shift, even though she had started her shift and medication administration earlier in the morning. She stated she did not feel comfortable checking for g-tube placement because she would have to put air into the resident's stomach with a syringe and she did not want to blow the resident's stomach up with air. She confirmed the resident received continuous tube feedings for twenty (20) hours per day.</p> <p>Interview, on 04/10/14 at 11:58 AM, with the Director of Nursing (DON) revealed nurses should check for placement of a g-tube by pushing air through a syringe and auscultating with a stethoscope prior to administration of</p>	F 322		
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F 322 Continued From page 11
medication through a g-tube. The DON stated nurses should also check residual prior to administration of medications by aspirating stomach contents with a syringe. She stated it was her expectation for nurses to follow the policy related to administration of medications through a g-tube.

F 322

5/30/14

F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES
SS=D

F-323

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

1. Resident #12's Interim Care Plan was reviewed. SRNA #1 was coached and counseled on April 9, 2014 by the Director of Nursing regarding following Resident #12 SRNA care plan regarding toileting. SNRA #2 is no longer employed with facility. The commode extender was immediately changed and secured to an elevated toilet seat with legs and arm supports.
2. All Comprehensive Care Plans and State Registered Nursing Assistant (SRNA) care plans will be reviewed and update to ensure each resident received adequate supervision and assistive devices to prevent falls. All residents were immediately assessed for use of commode extender seat. All seats were inspected on April 9, 2014 by Maintenance department and were secure.
3. Staff Development Coordinator (SDC) will educate Nurses and SRNA's staff by May 23, 2014 to utilize and follow the SRNA care plan for guidance of resident care regarding observation of residents while toileting to ensure adequate supervision and use of assistive devices to ensure the residents remain as free of injury and hazards as possible. All newly hired nurses and SRNA's will be educated during orientation. The SDC, Assistant Director/Unit Manager will use the CPAT to audit 100 % of the residents by 5/30/14. The CPAT will be used monthly for three months and quarterly for two to ensure that staff is following the plan of care to avoid accidental injury to residents.
4. The Administrator/Director of Nursing/ Assistant Director of Nursing or Unit Manager will review each incident to determine cause of injury related to fall. Incidents will be reviewed in the daily clinical meeting. Any findings of non-compliance of following the SRNA care plan which resulted in injury will be reported to the Administrator and Director of Nursing. The staff member responsible for non-compliance will be coached and disciplined accordingly. Results of non-compliance will be reported to the Monthly Quality Assurance Committee to include the Administrator and the facility Medical Director for review and follow-up for further recommendations.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure each resident received adequate supervision and assistive devices to prevent falls for one (1) of twelve (12) sampled residents (Resident #12).

Resident #12's was care planned not to be left unsupervised in the bathroom. However, on 04/09/14 Resident #12 experienced a fall after being left unsupervised in the bathroom. The fall resulted in a skin tear to Resident #12's left arm.

The findings include:

Review of the facility's Fall Policy dated April 2012, revealed it was the intent of the facility to

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F 323	<p>Continued From page 12</p> <p>provide assistance and supervision in an effort to minimize the risk of falls and fall related injuries.</p> <p>Review of Resident #12's medical record revealed the facility admitted the resident on 04/07/14, with diagnoses which included Rehabilitation for Status Post Fixation of a Tibial/Fibular Fracture. Review of the Admission Nursing Assessment dated 04/07/14 under the Fall Risk Evaluation section revealed Resident #12 was assessed to be a fall risk. Record review revealed Resident #12 had experienced falls with a recent fall on 04/01/14. Continued record review revealed Resident #12 was assessed to be non-weight bearing and a two (2) person assist for stand to pivot transfers. Further record review revealed Resident #12 was a one (1) person assist for toileting, using a bedpan, until evaluation by Physical Therapy (PT) and Occupational Therapy (OT).</p> <p>Review of Resident #12's Interim Care Plan dated 04/07/13, revealed Resident #12 was a fall risk and staff were not to leave the resident unsupervised in the bathroom.</p> <p>Review of the Nursing Assistant Care Record dated April 2014, revealed it included the interventions for Resident #12 in regards to being non-weight bearing, a stand to pivot transfer with two (2) person assist and was not to be left unsupervised in the bathroom.</p> <p>Review of the OT's evaluation dated 04/08/14 at 4:00 PM, revealed Resident #12 would safely perform toileting tasks using an elevated commode seat or a "3 in 1" commode (bedside commode which could be used over an existing toilet bowl) with moderate assist. Further review</p>	F 323		
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F 323	<p>Continued From page 13</p> <p>revealed the resident required fifty percent (50%) verbal cues for safety while turning and for use of compensatory strategies with reduced risk for falls.</p> <p>Interview with the Rehabilitation Services Manager on 04/10/14 at 3:20 PM, revealed she expected for residents to not be left unsupervised while toileting was for staff to leave the bathroom door cracked, ensure the call light was in reach and instruct the resident to call for assistance.</p> <p>Review of the facility's investigation dated 04/09/14 at 5:00 PM, revealed staff were attempting to help Resident #12 up after he/she had used the toilet and, the elevated toilet seat slid off the commode. Further review revealed Resident #12 experienced a fall as a result of this.</p> <p>Review of State Registered Nursing Assistant (SRNA) #1's written statement dated 04/09/14, untimed, revealed she and SRNA #2 had taken Resident #12 to the bathroom and assisted him/her to sit on the toilet. Continued review of the statement revealed SRNA #1 noted she stepped away from the bathroom to talk to Resident #12's roommate, however still had the resident in her sight. Further review of the statement revealed SRNA #1 documented she heard Resident #12 fall and turned around where she saw SRNA #2 beside the resident. In addition, SRNA #1 noted she went to get a nurse.</p> <p>Interview with Resident #12 on 04/10/14 at 11:30 AM, revealed SRNA #1 and SRNA #2 had taken her to the bathroom before supper on 04/09/14 and left her in the bathroom to give him/her privacy, with the door open a crack. She</p>	F 323		
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F 323 Continued From page 14

indicated the SRNAs did not stay in the bathroom with her, but were outside the door. Resident #12 stated as he/she leaned forward to cleanse, the elevated toilet seat "wobbled" and he/she fell towards his/her left side. Resident #12 reported he/she had a skin tear on his/her left arm from the tiles after the fall.

Interview, on 04/10/13 at 3:30 PM, with the OT, who had evaluated Resident #12, revealed the elevated toilet seat or "3 in 1" commode either one (1) would have been appropriate for Resident #12 to use as one (1) was not any safer than the other. The OT stated the main concern was for the resident not to bend. She stated she had worked with Resident #12 on toileting, using the same elevated toilet seat, without any concerns during her evaluation of the resident on 04/08/14. The OT stated Resident #12 had not had any concerns using the elevated toilet seat. She further stated until Resident #12 reached his/her goal it was her expectation the resident was not to be left unsupervised while toileting. The OT indicated she expected staff to be within arm's reach during transfers and toileting until the goal was reached.

Interview with SRNA #1 on 04/09/14 at 6:15 PM, revealed SRNAs used the Nursing Assistant Care Record to know what care needs a resident had. She stated however, she had not looked at the Care Record since coming on shift at 3:00 PM that day. She stated Resident #12 requested to go to the bathroom and, she and SRNA #2 assisted the resident to the bathroom. SRNA #1 stated she pulled the roommate's curtain and stood in the doorway with her back turned towards the bathroom to give Resident #12 privacy. She stated she then heard a noise,

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F 323 Continued From page 15

turned around and observed Resident #12 was lying on the floor. In an additional interview with SRNA #1 on 04/10/14 at 3:33 PM, she indicated when she and SRNA #2 assisted Resident #12 to sit on the elevated toilet seat it did not wobble. SRNA #1 stated she stood outside the bathroom door. She indicated Resident #12's roommate needed something, so she looked around the privacy curtain to see what he/she needed.

Interview with SRNA #2 on 04/10/14 at 1:45 PM, revealed he and SRNA #1 assisted Resident #12 to the bathroom and onto the toilet and closed the bathroom door a little to give the resident privacy. SRNA #2 stated he did his back had been turned and he did not see Resident #12 fall, but he/she was not out of his sight. The SRNA indicated he was not aware of where SRNA #1 was in the room at the time of the fall.

Interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 04/10/14 at 5:05 PM, revealed after Resident #12 fell SRNA #1 had notified the ADON of the fall and she assisted with assessing the resident and applying a dressing to the skin tear on his/her left arm. The ADON stated Resident #12 wanted up off the floor and had not complained of pain or injury. The DON revealed PT evaluated residents and made recommendations for assistive devices, such as, elevated toilet seats, and resident safety in using those devices after the evaluation. The DON stated for residents with an intervention not to be left unsupervised while toileting, she would expect staff to be attentive and assist the resident if needed. She indicated she would not expect staff to stand right beside the resident. The DON and ADON verified Resident #12 as being cognitively intact. The

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F 323 Continued From page 16
DON indicated for residents who were cognitively intact she would expect her staff to maintain the residents' dignity and privacy by standing outside the bathroom door with it cracked. She stated she would expect the staff to be within eyesight and ear shot of the resident and not to leave a resident who was at risk for falls.

F 323

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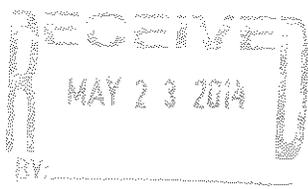
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42CFR 483.70(a) SURVEY UNDER: NFPA 101 (2000 Edition)</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) Story, Type III (200) Unprotected</p> <p>SMOKE COMPARTMENTS: Three (3)</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLERED, SUPERVISED (Dry SYSTEM)</p> <p>EMERGENCY POWER: Type II Diesel</p> <p>A Life Safety Code Survey was initiated and concluded on 04/09/14. The facility was in compliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire) with no deficiencies cited. The facility is licensed for ninety-eight (98) beds and the census was eighty-five (85) on the day of the survey.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Genevieve H. Mauter</i>	TITLE Administrator	(X6) DATE 5/23/14
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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.