

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

PRINTED: 04/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185210	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/11/2013
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NAME OF PROVIDER OR SUPPLIER THE JAMES B. HAGGIN MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 464 LINDEN AVENUE HARRODSBURG, KY 40330
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(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS An Abbreviated Survey to investigate KY00020005 was initiated on 04/08/13 and concluded on 04/11/13. KY00020005 was substantiated with a deficiency cited with a scope and severity of a "D".	F 000		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure one (1) of three (3) sampled residents received adequate supervision and assistance to prevent accidents. The facility failed to ensure staff followed proper procedures when Resident #1 was being transferred by a mechanical lift, on 04/02/13. Facility staff failed to follow proper procedures when the legs of the lift were too close together, staff were not at the resident's side during the transfer and the resident fell to the floor from the sling. The findings include: Review of the clinical record revealed Resident #1 was admitted to the facility, on 05/11/12, with	F 323	Please see attached.	5/13/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Dwight Steel</i>	TITLE LNA/CEO	(X6) DATE 5/13/13
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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 her 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 323	<p>Continued From page 1</p> <p>diagnoses which Included Dementia, Hypertension and Status Post Cerebrovascular Accident (stroke). Review of the Quarterly Minimum Data Set (MDS) assessment, dated 03/06/13, revealed the facility assessed Resident #1 to be totally dependent for care and to require two person assist for all transfers.</p> <p>Review of the Comprehensive Care Plan revealed it was revised on 12/04/12 to include instructions for Resident #1 to be transferred by mechanical lift with the assist of two (2) persons. The care plan was reviewed by the facility on 03/04/13 and 04/02/13 and the transfer instructions were to continue until the next review date of 06/06/13.</p> <p>Review of Physician's Orders, dated 12/04/12, revealed Resident #1 was to be transferred by a mechanical lift with the assistance of two (2) staff members.</p> <p>Review of the facility Incident Form, dated 04/02/13, revealed two aides were transferring Resident #1 by utilizing a mechanical lift when the resident fell backward out of the lift and struck his/her head on the floor.</p> <p>Interview with Registered Nurse (RN) #1, on 04/09/13 at 3:00 PM, revealed she was at the nurse's station on 04/02/13 when she heard a commotion in Resident #1's room and State Registered Nursing Assistants (SRNA) #1 and SRNA #2 cried out for help. Further interview revealed as she entered the room, Resident #1 was on the floor. She stated after assessing the resident and assisting to get him/her back in the bed, she interviewed SRNAs #1 and #2 about the</p>	F 323		

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F 323	<p>Continued From page 2</p> <p>incident. RN #1 stated SRNA #2 did not have room to maneuver the lift after Resident #1 was lifted from the bed, and SRNA #1 found herself blocked from access to the resident by the chair. RN #1 stated "it was a positioning problem". She further stated she observed the base legs were not in the wide open position, which would have provided more stability.</p> <p>Interview with SRNA #2, on 04/10/13 at 8:30 AM, revealed she was steering the lift at the time of the incident, and SRNA #1 was assisting. She stated after the resident was lifted off the bed into the air, she backed the lift away from the bed to turn and position Resident #1 over the chair. She further stated she did not have room to maneuver the lift into the proper position. She had to close the gap between the base legs of the lift to make room for turning the lift in order to complete the transfer. Continued interview revealed her helper, SRNA #1, was on the far side of the chair and was unable to reach the resident for hands on stabilization during the transfer. On further interview, SRNA #2 stated proper transfer procedure included maintaining the base legs in the wide open position for increased stability. In addition, she stated SRNA #1 should have been in place at the resident's side for closer supervision during the procedure. SRNA #2 reported the resident "flipped out" of the lift and landed on the floor.</p> <p>Interview with SRNA #1, on 04/10/13 at 9:25 AM, revealed she assisted SRNA #2 with the transfer procedure for Resident #1. She stated SRNA #2 was to steer the lift while SRNA #1 was to assist in positioning the resident over the chair. She further stated SRNA #2 positioned the lift over the</p>	F 323		

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F 323 Continued From page 3

bed and both SRNAs secured Resident #1 in the sling. SRNA #1 was positioned on the far side of the bed. After the resident was raised off the bed, she was to come around and be in position at the resident's side for hands on safety during the transfer. She indicated the chair was in such a position that SRNA #1 was blocked from access to the resident. Continued interview revealed SRNA #2 was having trouble maneuvering the lift in the small space between the bed and the chair. She stated she saw the resident fall out of the lift and onto the floor, but could not reach her to prevent the fall. On further interview, she stated she was unaware if the base legs on the lift were open or closed, but should have been open for increased stability of the lift. SRNA #1 explained the bed could have been pushed more to the middle of the room which would have provided more space to position the chair, and would have enabled her to be in position at the resident's side for hands on supervision of the procedure.

Interview with the facility Director, on 04/10/13 at 11:05 AM, revealed the facility did not have a written policy related to transferring residents by mechanical lift. She stated she had investigated the incident and determined two causative factors for the incident which included the base legs should have been in the widest position while the resident was suspended and one staff member should have had hands on the resident throughout the procedure. The Director further stated the lift and the sling had been examined by herself and the Biomed Department, and no mechanical defects were found. On further interview, she revealed the two SRNAs involved had recognized and readily acknowledged their

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F 323	Continued From page 4 improper technique. Review of the facility investigation, initiated on 04/02/13 and concluded on 04/08/13, revealed Resident #1 was sent to the Emergency Department for evaluation and was discharged back to the facility within the hour. Further review of the investigation revealed Resident #1 sustained two (2) hematomas. Interview with the Attending Physician, on 04/11/13 at 2:50 PM, revealed Resident #1 had "no head injury" and had no lasting effects resulting from the fall.	F 323		

**PLAN OF CORRECTION
THE JAMES B. HAGGIN MEMORIAL HOSPITAL
EXTENDED CARE FACILITY
SURVEY COMPLETION DATE April 11, 2013**

483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

F 323 S/S=D

Corrective Action For Residents Found To Have Been Affected By The Deficient Practice:

This facility shall 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. The one resident involved had no serious or lasting effects. Although immediately transported to the Emergency Room for evaluation she was returned to our unit with no significant changes. The aides involved received immediate verbal review of proper use of lift and safety.

The Facility Will Identify Other Residents Having the Potential to Be Affected by the Same Deficient Practice:

Fourteen (14) residents had the potential to be affected as they are the residents that require transfer per lift either always or as needed for increased weakness in their care plan, but none were adversely affected.

Measures To Be Put In Place Or Systemic Changes Made To Ensure The Deficient Practices Will Not Recur:

Education on the proper use of lifts and safety measures was provided to the ECF staff via video, and by review and demonstration during competencies with the DON of ECF. This was mandatory for all nursing personnel and was completed on 4/20/13. All new team members receive training on the use of lift with signature verification by team member performing the orientation. This will include our new policy after review/approval process is completed with next monthly QA meeting. This policy, currently and in effect, mandates there is always two staff members present for use of lift. All staff will receive the new policy. The safe and proper operation of mechanical lifts will be kept as a mandatory component of the annual competencies in the future.

How The Facility Plans To Monitor Its Performance To Ensure Solutions Are Sustained:

Random audits of lift use will be completed monthly x 3 months, then quarterly for 12 months. Spot check audits will then be performed on an ongoing basis. We will also review at least annually with "Safety Works" component of our monthly staff meetings. The findings of the monitoring system shall be reported to the ECF Quality Assurance Committee during each quarterly meeting as scheduled. We will ensure following our current monitoring of accident risks and hazards through our environmental rounds; our resident assessment process – including MDS, the medical history, physical and mental exams, and interdisciplinary observations; education and training with focus on reporting; and our quality assurance monitors and programs which include analysis and reporting.

Completion Date: May 22, 2013