

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

PRINTED: 09/25/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2015
NAME OF PROVIDER OR SUPPLIER SPRING CREEK HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>An Abbreviated Survey investigating Complaint #KY23752 was conducted on 09/09/15 through 09/11/15. Complaint #KY23752 was substantiated with deficiencies cited at the highest Scope and Severity of a "G".</p> <p>On 08/11/15, the facility admitted Resident #1 for rehabilitation following a long stay in the hospital for an Acute Septic Left Knee. On 08/17/15 at 8:00 PM, Certified Nurse Aide (CNA) #1 failed to follow the care plan, which required two (2) staff to assist with transfers when she transferred Resident #1 from the chair to the bed without the assistance of another staff and without the use of a gait belt, as required per facility policy. Resident #1's left leg was caught underneath the bed and twisted during the transfer. CNA #1 failed to report the incident to her supervisor so the resident could be assessed for injury. On the morning of 08/18/15, Resident #1 complained of pain with redness and swelling of the left knee and was sent to the hospital Emergency Room (ER). Resident #1 had sustained a fracture of the left tibia which required the resident to be non-weight bearing for two (2) weeks and delayed the resident's rehabilitation and discharge back to the community.</p>	F 000		
F 282 SS=G	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 282	<p>F282.483.20 (K)(3)(11) Services by qualified persons / per care plan.</p> <p>1. The corrective action accomplished for the resident found to be affected by the deficient practice:</p> <p>a. Resident #1's care plan was reviewed by the Nursing Director and Unit Coordinator 2.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sandra J Dick</i>	TITLE <i>Administrator</i>	(X8) DATE <i>10-28-15</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 282	<p>Continued From page 1</p> <p>by: Based on observation, interview, record review, facility policy and procedure review; and, review of the Hospital Emergency Room Record and Hospital Discharge Record, it was determined the facility failed to provide services in accordance with each resident's written plan of care for one (1) of five (5) sampled residents (Resident #1).</p> <p>On 08/11/15, the facility assessed and care planned Resident #1 to require the assistance of two (2) staff for transfers; however, on 08/17/15, CNA #1 transferred the resident without the assistance of another staff; the resident's left leg caught underneath the bed and twisted. Resident #1 sustained a fractured tibia and was non-weight bearing for two (2) weeks which caused the resident's rehabilitation and discharge back into the community to be delayed.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Resident Care Plan", dated 08/2014, revealed the Interdisciplinary Team will develop a comprehensive resident care plan from information on the Minimum Data Set (MDS) Assessment, the resident's medical record and observations made while interviewing the resident. Staff should check the plan of care daily for updates. Staff not following the plan of care will receive appropriate counseling up to and/or including suspension and/or termination.</p> <p>Record review revealed the facility admitted Resident #1 on 08/11/15, after a forty-nine (49) day stay in the hospital with diagnoses which included Acute Septic Left Knee, Staph Aureus to Left knee, Severe Malnutrition, Severe</p>	F 282	<p>b. Nursing Director & Unit Coordinator 2 provided face to face education for following the resident #1's plan of care and the facility policy for the plan of care to be followed at all times. CNA #1 received a written warning and suspension for not following Resident #1's care plan.</p> <p>2. Identification of other residents having the potential to be affected by the same deficient practice.</p> <p>a. It was determined that all residents residing in the facility on the days of survey could have been affected by the same deficient practice if care plans were not followed.</p> <p>b. Assistant Director and Nursing Director walked from station to station on 9-10-15 and 9-11-15 observing care being given ensuring the care plans were being followed for all residents residing in the facility on the days of the survey. There were not any new problems identified.</p> <p>3. The measures and systemic changes to ensure that the deficient practice will not recur. The RN Clinical Educator has provided from 9-11-15 to 10-9-15 face to face in-service education to RN'S, LPN's, CNA's, and NA's regarding</p>		

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F 282	<p>Continued From page 2</p> <p>Osteoarthritis, Coronary Artery Disease, Cardiomyopathy, Atrial Fibrillation, and Implantable Cardiac Defibrillator. Review of the Initial Minimum Data Set (MDS) Assessment, dated 08/18/15, revealed the facility assessed Resident #1's cognition as cognitively intact with a Brief Interview of Mental Status (BIMS) score of fifteen (15) which indicated the resident was interviewable.</p> <p>Further review of the Initial MDS Assessment, dated 08/18/15 and review of the Comprehensive Care Plan and MDS Kardex Report, dated 08/11/15, revealed Resident #1 was assessed and care planned to require the extensive assistance of two (2) staff for transfers.</p> <p>Interview with CNA #1, on 09/10/15 at 8:18 AM, revealed she responded to Resident #1's call light on the evening of 08/17/15 and the resident requested to be assisted to bed. CNA #1 stated she asked the resident's spouse how the resident was assisted and the spouse stated, "By two (2) people and she (spouse) would help with the transfer". CNA #1 revealed she did not want the resident's spouse to feel she was ignoring what he/she had told her, so she proceeded to attempt to transfer the resident. However, when she attempted to transfer the resident the resident's spouse did not assist her and she struggled to place the resident on the bed so the resident would not fall. CNA #1 said the spouse told her the resident's left leg was caught under the bed and twisted; the resident never complained of pain. The CNA stated she did not use a gait belt during the transfer and she did not report the incident to the nurse because she was not aware the resident had sustained any injury. CNA #1 stated there were three (3) sources to determine</p>	F 282	<p>following the facility's care plan policy and to always follow residents plan of care.</p> <p>4. The facility plans to monitor its performance to ensure that solutions are sustained by:</p> <p>a. The Unit Coordinators 1, 2, 3, 4 RN Weekend Supervisor & Afternoon RN Supervisor will perform 10 weekly visual audits each on all shifts weekdays and weekends to ensure adherence to care plans.</p> <p>b. If there are care plans identified not being followed by the Unit Coordinators or RN Supervisors immediate correction will be made with the employee.</p> <p>c. Results will be given to Nursing Director weekly in writing if there were care plans identified not being followed.</p> <p>d. Unit coordinator 1, 2, 3, 4 will report results of finding and corrective actions quarterly at Quality Assurance Meetings. QA members include: Nursing Director, Assistant Nursing Director, Unit Coordinators 1, 2, 3, 4, Administrator, Medical Director, Infection Control, Rehabilitation, Dietician, Social Workers, Activities Coordinator, Staffing Coordinator, PI/Risk Coordinator, Food Services Supervisor, Clinical Educator, Pharmacy Director,</p>		

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F 282	<p>Continued From page 3</p> <p>how a resident was to be cared for, which included the care plan, the kiosk and the nurse on duty. The CNA stated she did not use any of these forms of communication before attempting to transfer the resident alone.</p> <p>Review of a Nursing Progress Note, dated 08/18/15 at 11:00 AM, revealed Resident #1 complained of increased left knee pain. Resident #1 stated, "When being put to bed last night, my knee extended backward and has hurt some since." The resident's left knee was noted to be warm, red and swollen. The Physician was notified and orders were received to send the resident to the hospital ER for evaluation and treatment, if indicated.</p> <p>Review of the Hospital Emergency Room Record and Hospital Discharge Record, dated 08/18/15, revealed on 08/18/15 the resident complained of increased knee pain since sustaining a twisting injury and a hyperextension of the knee when his/her leg was caught under the bed on the evening of 08/17/15. The ER Physician documented that the resident's radiological study (Computerized Tomography (CT) Scan) revealed a displaced fracture of the proximal left tibia medial aspect with osteochondral fracture of the tibia plateau and loose bodies and a joint effusion. Resident #1 was discharged back to the facility on 08/18/15 with a knee immobilizer and orders to continue the brace with non-weight bearing to the left lower extremity for two (2) weeks.</p> <p>Interview with LPN/Charge Nurse #4, on 09/10/15 at 1:13 PM, Physical Therapy Assistant (PTA), on 09/10/15 at 11:10 AM, and, the Unit Coordinator on Station Two (2) and Three (3), on 09/09/15 at</p>	F 282	<p>Maintenance, Facility Assistant, Environmental Services Supervisor, MDS Coordinator, and Medical Records.</p> <p>e. Action plans will be developed if indicated and recommended by QA Committee and the Nursing Director will be responsible for any further monitoring.-assignments.</p> <p>f. Employees will receive administrative counseling up to termination for not adhering to facility policy for providing services in accordance with each residents written plan of care.</p> <p>g. The audits as a result of this plan of correction will be followed until our next annual relicensure survey by the Unit Coordinators 1, 2, 3, 4, Weekend RN Supervisor and Afternoon Supervisor and Nursing Director.</p> <p>h. Facility declares compliance with F282 on October 10, 2015.</p>	10/10/15	

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F 282	<p>Continued From page 4</p> <p>7:37 AM, revealed Resident #1 was in bed on 08/18/15 complaining of increased pain to the left knee rating his/her pain at an eight (8) on a ten (10) point pain scale. Resident #1's knee was noted to be swollen, red and hot to touch with decreased range of motion. Further interview with LPN/Charge Nurse #4 revealed the resident stated his/her knee had been hurting more since the evening before when one (1) staff member transferred him/her back to bed and caught his/her leg under the bed and twisted it. LPN/Charge Nurse #4 contacted the physician and the resident was sent to the ER. Resident #1 returned from the ER the same day with orders for a leg brace and to be non-weight bearing for two (2) weeks. The resident required an increased amount of assistance after the injury and continued to take pain medications which he/she would call for as needed. They stated the staff should have followed the care plan, which required the extensive assistance of two (2) staff for transfers.</p> <p>Observation of Resident #1, on 09/10/15 at 10:55 AM, revealed he/she was in a therapy session with the PTA. The resident was noted to have a knee hinged immobilizer to the left knee and he/she required extensive assistance with transfers and the assist of a walker. In addition, staff used a gait belt with transfers to a wheelchair which was approximately five (5) steps.</p> <p>Interview with the Certified Occupational Therapy Assistant (COTA), on 09/10/15 at 11:20 AM, revealed Resident #1 sustained a decline in his/her therapy routine related to the resident having restriction of not being able to bear weight on the left leg for two (2) weeks. He stated he</p>	F 282			

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F 282	<p>Continued From page 5</p> <p>expected the nursing staff to follow the Physical and Occupational Therapy evaluation and to use the care plan and kardex as their guide for transfers. He stated this resident required moderate to maximum assistance for transfers.</p> <p>Interview with Resident #1's Primary Care Physician, on 09/11/15 at 10:32 AM, revealed the resident had just spent forty-nine (49) days in the hospital related to a septic left knee infection from a steroid injection he/she received. He stated that while in the hospital, the resident became very weak and malnourished causing him/her to require rehabilitation at this nursing facility. He stated the fracture of the left knee has caused a major setback for this resident and has delayed his/her rehabilitation potential which has caused his/her discharge back into the community to be on hold at this time. He further stated the fracture should not have happened if the proper techniques had been used that were safe for this resident.</p> <p>Interviews on 09/10/15 with CNA #2 at 1:45 PM, CNA #3 at 1:58 PM, CNA #4 at 2:10 PM, and CNA #5 at 2:25 PM revealed all staff should follow the care plan. CNA #3 and CNA #4 stated they have cared for Resident #1 many times and have always transferred the resident with two (2) staff assistance. The CNAs further stated when a staff did not provide the assessed amount of persons needed for a transfer, they would be concerned the resident could fall or sustain an injury.</p> <p>Interview with the Director of Nursing (DON), on 09/09/15 at 7:15 AM, revealed on 8/17/15, CNA #1 transferred Resident #1 by herself without the assistance of another staff member per the</p>	F 282			

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F 282	Continued From page 6 resident's care plan. The DON stated CNA #1 said she asked the spouse how many (persons) it took to transfer the resident and the spouse told her two (2) persons but that she would help her. Further interview with the DON revealed CNA #1 admitted she did not follow the care plan. The DON stated she expected staff to follow the care plan related to the amount of staff needed for care.	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 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 observation, interview, record review, hospital emergency room record review, and the facility's policy and procedure review, it was determined the facility failed to ensure adequate supervision and an assistive device to prevent accidents was provided for one (1) of five (5) sampled residents (Resident #1). The facility admitted Resident #1 for rehabilitation due to weakness after being in the hospital for forty-nine (49) days for an Acute Septic Left Knee. On 08/17/15 at 8 00 PM, Certified Nurse Aide (CNA) #1 failed to transfer Resident #1 from the chair to the bed with a gait belt and the assistance of another staff, as required by the	F 323	F323 483.25 (h) Free of Accident Hazards / Supervision Devices. 1. The corrective action accomplished for resident affected by the deficient practice: a. On 8/18/15 at approximately 10:30 a.m. physical therapy assistant reported that resident #1 had increased pain during physical therapy treatment. Upon assessment per Unit Coordinator 2 noted the left knee had increased swelling and redness. Dr. Blalock was notified and resident sent to ER at approximately 11:00 a.m. Resident returned from ER at 5:15 p.m. with a knee immobilizer and new diagnosis of left medial tibial plateau fracture. New orders were received for left knee immobilizer and no weight bearing to left leg. 2. Identification of other residents having the potential to be affected by the same deficient practice.		

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F 323	<p>Continued From page 7</p> <p>care plan. Resident #1's left leg got caught underneath the bed and twisted during the transfer. CNA #1 failed to report the incident to her supervisor so the resident could be assessed for injury. On the morning of 08/18/15, Resident #1 complained of pain and his/her knee was noted to be red, swollen and hot to touch. Resident #1 had sustained a fracture of the left tibia which required the resident to be non-weight bearing for two (2) weeks and delayed the resident's rehabilitation so the resident could be discharged back to the community.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Resident Care Plan", dated 08/2014, revealed the interdisciplinary team will develop a comprehensive resident care plan from information on the Minimum Data Set (MDS) Assessment, the resident's medical record and observations made while interviewing the resident. Staff should check the plan of care daily for updates. Staff not following the plan of care will receive appropriate counseling up to and/or including suspension and/or termination.</p> <p>Review of the facility's policy titled, "Nursing Assistant Worksheets", dated 08/19/15, revealed all services are furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.</p> <p>Review of the facility's policy titled, "Gait Belt", dated 07/2013, revealed nursing staff will use gait belts for residents needing one (1) or more staff assistance in transfer and ambulation, unless contraindicated.</p>	F 323	<p>a. All residents who reside in facility had potential to be affected by this deficient practice as the environment did not remain free of accident hazards. The facility failed to provide adequate supervision and assistance devices to prevent an accident.</p> <p>b. The Assistant Director and Nursing Director walked from station to station on 9-10-15 and 9-11-15 observing care being given ensuring adequate supervision and use of assistive devices to prevent accidents. There were not any new problems identified.</p> <p>3. Measures and systemic changes to ensure that the deficient practice will not recur.</p> <p>a. The RN Clinical Educator has provided face to face inservice education from 9-11-15 to 10-9-15 to RN's, LPN's, CNA's, and NA's. The inservices covered policies and procedures for ensuring adequate supervision for residents and the use of assistive devices to prevent accidents if care planned.</p> <p>4. Facility monitoring of its performance to ensure that solutions are sustained.</p> <p>a. Each Unit Coordinator 1, 2, 3, 4,</p>		

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F 323	<p>Continued From page 8</p> <p>Review of the facility's "Certified Nursing Assistant (CNA) Organizational Expectations", dated 07/14/15, revealed the CNA shall promote a culture of safety for residents and employees through proper identification, reporting, documentation and prevention.</p> <p>Review of the facility's policy titled, "Incident /Reportable Events Reporting", dated 03/2015, revealed the person discovering an incident or having the primary responsibility for an incident occurring should initiate a report of the incident. Reporting should be completed for incident/events that any actual or potential physical injury resulting from an accident on the premises.</p> <p>Record review revealed the facility admitted Resident #1 on 08/11/15 after a forty-nine (49) day stay in the hospital with diagnoses which included Acute Septic Left Knee, Staph Aureus to Left knee, Severe Malnutrition, Severe Osteoarthritis, Coronary Artery Disease, Cardiomyopathy, Atrial Fibrillation, and Implantable Cardiac Defibrillator. Review of the Initial Minimum Data Set (MDS) Assessment, dated 08/18/15, revealed the facility assessed Resident #1's cognition as intact with a Brief Interview of Mental Status (BIMS) score of fifteen (15) which indicated the resident was interviewable. In addition, the facility assessed Resident #1 required extensive assistance of two (2) staff for transfers.</p> <p>Review of the Comprehensive Care Plan, dated 08/11/15, revealed Resident #1 had an Activities of Daily Living (ADL) self-care performance deficit related to activities intolerance and an intervention for the assistance of two (2) persons</p>	F 323	<p>Afternoon RN Supervisor and RN Weekend Supervisor will monitor staff's adherence to identify adequate supervision and/or an assistive device not in place. Each Unit Coordinator 1, 2, 3, 4, RN Weekend Supervisor and RN Afternoon Supervisor will perform 10 visual audits each week to ensure compliance.</p> <p>b. Unit Coordinators will submit copies of monitors to Nursing Director weekly.</p> <p>c. When variances are identified & adequate supervision and/or an assistive device not in place then the licensed nurse who finds the variance will make the correction and counsel employee. This information will be given to Nursing Director for further education for the employee.</p> <p>d. Unit Coordinators 1, 2, 3, 4 will report data to the Quality Assurance Committee on a quarterly basis.</p> <p>e. Quality Assurance action plan will be developed and implemented if indicated by the QA Committee: Nursing Director, Assistant Nursing Director, Unit Coordinators 1, 2, 3, 4, Administrator, Medical Director, Infection Control, Rehabilitation, Dietician, Social Workers, Activities Coordinator, Staffing Coordinator, PI/Risk Coordinator,</p>		

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F 323	<p>Continued From page 9</p> <p>with a knee brace and non-weight bearing to the left leg. Review of the "MDS Kardex Report", dated 08/11/15, revealed ADLs for transfer required extensive assistance of two (2) persons.</p> <p>Interview with CNA#1, on 09/10/15 at 8:18 AM, revealed she responded to Resident #1's call light on the evening of 08/17/15 and the resident requested to be assisted to bed. She stated she asked the resident's spouse how the resident was assisted and the spouse stated "two (2) people and he/she would help with the transfer". During further interview, CNA #1 stated she did not want the spouse to feel she was ignoring what he/she had said, so she proceeded to attempt to transfer the resident. She stated she attempted to transfer the resident, but the resident's spouse offered no assistance and she struggled to place the resident on the bed so the resident would not fall. CNA #1 said the spouse said the resident's left leg was caught under the bed and the resident's leg was twisted. She stated she did not know the resident's leg had become trapped under the bed, as the resident never complained of pain. CNA #1 stated she did not use a gait belt during the transfer and she did not report the incident to the nurse because she was not aware the resident had sustained any injury. She further stated, she should have followed the facility's policy and used the gait belt. She also stated there were three (3) sources to determine how a resident is to be cared for which included the care plan, the Kiosk and the nurse on duty. CNA #1 stated she was told by LPN #4 that Resident #1 required the assistance of two (2) staff for transfers.</p> <p>Review of CNA #1's "Lift Belt Agreement", revealed CNA #1 signed and acknowledged that</p>	F 323	<p>Food Services Supervisor, Clinical Educator, Pharmacy Director, Maintenance, Facility Assistant, Environmental Services Supervisor, MDS Coordinator, and Medical Records.</p> <p>f. Employee will receive administrative counseling up to termination for not adhering to facility policy and F323 to ensure that the residents environment remains as free of accident hazards as is possible by the Unit Coordinators 1, 2, 3, 4 or Nursing Director.</p> <p>g. The audits as a result of this plan of correction will be followed until our next relicensure survey by the Unit Coordinators 1, 2, 3, 4 and Nursing Director.</p> <p>5. The facility declares compliance with F323 deficiency effective October 10, 2015</p>	10-10-15	

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F 323	<p>Continued From page 10</p> <p>she had received proper training on the use of a gait belt and had received a copy of the facility's policy on the use of gait belts and agreed to follow this policy which was to use the gait belt for residents needing one (1) or more staff assistance in transfers and ambulation.</p> <p>Review of the Nursing Progress Note, dated 08/18/15 at 11:00 AM, revealed Resident #1 complained of increased left knee pain; he/she stated, "When being put to bed last night, my knee extended backward and has hurt some since." The resident's left knee was noted to be warm, red and swollen. The Physician was notified and orders were received to send the resident to the Hospital ER for evaluation and treatment, if indicated.</p> <p>Interview with the Physical Therapy Assistant (PTA), on 09/10/15 at 11:10 AM, revealed on the morning of 08/17/15, Resident #1 was in bed complaining of increased pain to the left knee rating his/her pain at an eight (8) on a ten (10) point pain scale. The PTA stated when she examined the resident's knee she observed the knee was swollen, red and hot to touch with decreased range of motion. The PTA revealed the resident stated his/her knee had been hurting more since the evening before when one (1) staff member transferred him/her back to bed and caught his/her knee under the bed and twisted it. The PTA stated she called the Physical Therapist (PT) to come and evaluate the knee and was assisted by the nurse. Further interview revealed the PTA stated the Physician was notified and orders were received to transfer the resident to the Emergency Room (ER) for further evaluation.</p> <p>Interview with the Licensed Practical Nurse</p>	F 323			

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F 323	<p>Continued From page 11</p> <p>(LPN)/Charge Nurse #4, on 09/09/15 at 12:15 PM, revealed Resident #1 had placed his/her call light on and asked to be assisted to bed on the evening of 08/17/15. LPN #4 stated she informed the resident he/she required the assistance of two (2) staff to assist him/her to bed and she would get two (2) CNAs to assist him/her as soon as they were free. LPN #4 said she informed CNA #1, the resident was requesting to be assisted to bed and he/she needed the assistance of two (2) staff members. Further interview with LPN/Charge Nurse #4, on 09/10/15 at 1:13 PM, revealed she expected staff to follow the care plan when it stated assist of two (2) staff. LPN #4 stated she was called by PT to come in and evaluate the resident's leg on 08/18/15. She contacted the Physician and received orders to send the resident to the ER for evaluation. LPN #4 stated the resident returned from the ER the same day with orders for a leg brace and non-weight bearing for two (2) weeks. LPN #4 stated she expected her staff to know a resident's care plan, follow the care plan or ask a nurse if unclear. LPN #4 stated the resident required an increased amount of assistance after the injury and continued to take pain medications which he/she would call for as needed. LPN #4 stated she considered this event to be an unusual event and it should have been reported to the Charge Nurse as soon as it occurred so the nurse could have completed an assessment of the resident to determine if he/she had been injured.</p> <p>Interview with the Unit Coordinator on Station Two (2) and Three (3), on 09/09/15 at 7:37 AM, revealed Resident #1 was admitted with a septic left knee due to steroid injection prior to admission. She stated CNA #1 was pivoting the resident to bed without the use of a gait belt and</p>	F 323			

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F 323	<p>Continued From page 12</p> <p>the resident's leg went up under the bed and his/her knee twisted backward on 08/17/15. The Unit Coordinator stated that prior to this incident, the resident was able to weight bear on that leg. She stated the Comprehensive Care Plan identified the resident required two (2) person assistance with transfers and she expected CNA #1 to have asked another staff to assist her with the transfer of Resident #1. She stated the resident did not immediately complain of pain; however, the next day the PTA noted the resident's knee was swollen, redden and hot to touch. She stated the Physician was notified and the resident was sent to the ER for evaluation and the resident was identified as having a fracture of the left tibia. She stated the policy of the facility was all residents that required assistance with ambulation or transfers must be assisted by the staff using a gait belt. Additionally, she stated any incident or event affecting a resident must be reported to the Charge Nurse immediately.</p> <p>Review of the Hospital Emergency Room Record, dated 08/18/15, revealed on 08/18/15 the resident complained of increased knee pain since getting his/her leg caught under the bed on the evening of 08/17/15. The Physician documented the resident reported he/she sustained a twisting injury when his/her leg became caught under the bed and his/her leg twisted and hyper-extended the knee on 08/17/15 at 8.00 PM. Further review revealed the resident complained of pain with weight bearing. The ER Physician further documented a radiological study (CT Scan) was performed which showed a displaced fracture of the proximal left tibia medial aspect with osteochondral fracture of the tibia plateau and loose bodies and a joint effusion. Review of the</p>	F 323			

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F 323	<p>Continued From page 13</p> <p>Hospital ER Discharge Record dated 08/18/15, revealed a knee immobilizer was placed on the resident and the resident returned to the the facility with orders to continue the brace, with non-weight bearing to the left lower extremity for two (2) weeks.</p> <p>Review of the Orthopedic Physician Progress Notes, dated 08/20/15, revealed the resident was required to seek the evaluation of an Orthopedic Surgeon for monitoring. The Surgeon continued the treatment plan of non-weight bearing for two (2) weeks.</p> <p>Observation of Resident #1, on 09/10/15 at 10:55 AM, revealed he/she was in a therapy session with the PTA. He/she was noted to have a knee hinged Immobilizer to the left knee and required extensive assistance with transfers and the assist of a walker. In addition, staff used a gait belt with the transfer to a wheelchair which was approximately five (5) steps.</p> <p>Interview with the Certified Occupational Therapy Assistant (COTA), on 09/10/15 at 11:20 AM, revealed Resident #1 sustained a decline in his/her therapy routine related to the resident having restriction of not being able to bear weight on the left leg for two (2) weeks. He stated he expected the nursing staff to follow the Physical and Occupational Therapy evaluation and to use the care plan and kardex as their guide for transfers. He stated this resident required moderate to maximum assistance for transfers.</p> <p>Interview with CNA #5, on 09/10/15 at 2:25 PM, revealed she was working on 08/17/15 but was never asked to assist with transferring Resident #1 to bed. She stated staff should check the care</p>	F 323			

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F 323	<p>Continued From page 14</p> <p>plan daily for changes, follow it and if there are questions the Charge Nurse should be notified. She stated gait belts should be used on all residents with transfers and this has always been the facility's policy.</p> <p>Interview with CNA #2, on 09/10/15 at 1:45 PM, revealed all staff should follow the care plan and staff should use a gait belt with anyone that requires assistance with transfers. She stated she would be concerned of an injury or fall if a resident was transferred by one person when they required two (2) persons.</p> <p>Interview with CNA #3, on 09/10/15 at 1:58 PM, revealed a care plan should always be followed and if the family member tried to dictate the care of the resident, the care plan should still be the guide for the resident's care. She stated she had cared for Resident #1 many times and had always transferred him/her with two (2) person assist. CNA #3 stated she had never witnessed anyone transferring him/her alone or without a gait belt.</p> <p>Interview with CNA #4, on 09/10/15 at 2:10 PM, revealed she had cared for Resident #1 and that he/she has always been an assist of two (2) person. She stated the care plan should be followed without exception and a gait belt should be used on every resident with transfers and ambulation.</p> <p>Interview with the Director of Nursing (DON), on 09/09/15 at 7:15 AM, revealed on 08/17/15, CNA #1 transferred Resident #1 by herself without a gait belt per facility policy and without the assistance of another staff member per the resident's care plan. The DON revealed CNA #1</p>	F 323			

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F 323	Continued From page 15 admitted she did not follow the care plan or facility policy and, she expected staff to follow the care plan related to the amount of staff needed for care and to follow the facility's policy and use a gait belt for all transfers. In addition, she stated any incident or unusual event involving a resident should be reported to the Charge Nurse immediately so an investigation could be completed. Interview with Resident #1's Primary Physician, on 09/11/15 at 10:32 AM, revealed Resident #1 had spent forty-nine (49) days in the hospital related to a septic left knee infection from a steroid injection he/she received. The Physician stated while in the hospital, the resident became very weak and malnourished causing him/her to require rehabilitation at this nursing facility. The Physician revealed the fracture of the left knee caused a major setback for this resident and has delayed the resident's rehabilitation potential which has caused his/her discharge back into the community to be on hold at this time. The Physician further stated the fracture would not have happened if the proper techniques had been used that were safe for this resident.	F 323			
F 431 SS=E	483 60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431	F431 483.60 (d)(e) Drug Records, label / store drugs & biologicals. 1. The corrective actions accomplished for medication carts being left unlocked: a. LPN #1 and LPN #2 locked their medication carts when they were made aware by the surveyor that the carts were not locked. The LPN Staffing Supervisor and Assistant Nursing Director checked all other medication carts in the building at 7 a.m. to ensure		

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F 431	<p>Continued From page 16</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy and procedure review, it was determined the facility failed to store all drugs and biologicals in locked compartments and permit only authorized personnel to have access to the keys. Observations revealed three (3) of eight (8) medications carts on two (2) of four (4) units were unlocked and unattended by a licensed staff.</p> <p>Review of the Code Brown List revealed there</p>	F 431	<p>they were all locked. No residents were affected by this deficient practice.</p> <p>2. Identification of other residents having the potential to be affected by the same deficient practice if medication carts were left unlocked or unattended.</p> <p>a. It was determined that all residents residing in the facility on the days of the survey could have been affected by the same deficient practice if the medication carts were left unlocked or unattended..</p> <p>3. Measures and systemic changes to ensure that the deficient practice will not recur:</p> <p>a. RN/s and LPN/s have been in-serviced face to face by RN Clinical Educator regarding medication cart safety and keeping the carts locked or in nurses direct sight as the standard of care from 9-11-15 to 10-9-15.</p> <p>4. The facility plans to monitor its performance to ensure that solutions are sustained by:</p> <p>a. The Assistant Nursing Director will perform 10 weekly audits of medication carts and safety to ensure compliance on all three shifts M-F. The RN Weekend Supervisor will provide 5 audits on weekends of medication carts & safety to ensure compliance.</p>		

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F 431	<p>Continued From page 17</p> <p>were ten (10) residents that were known to have a history of exhibiting the behavior of wandering.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Medication Administration", last revised 07/02/15, revealed the facility will store all drugs in locked compartments and permit only authorized personnel to have access to the keys.</p> <p>During the general facility observation/tour, on 09/09/05 at 4:50 AM, revealed a medication cart observed unlocked on the hallway near the One-hundred (100) Hall nursing station, which was out of site of the nursing staff. There were residents sitting within two (2) feet of the medication cart which remained unlocked for six (6) minutes.</p> <p>During general facility observation, on 09/09/15 at 5:31 AM, revealed two (2) medication carts outside the Four Hundred (400) Hall nursing station. These carts were unlocked and out of site of the nursing staff. There were six (6) residents sitting within five (5) feet of both carts and the carts were unsecured for seven (7) minutes.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 09/09/15 at 4:57 AM, revealed she left the cart unlocked on the One Hundred (100) hall. She stated the cart should have been locked at all times when not in use to prevent resident/staff/visitors from getting medications out of the cart.</p> <p>Interview with LPN #2, on 09/09/15 at 5:32 AM, revealed he was responsible for all of one cart</p>	F 431	<p>b. If carts are left unlocked or not in licensed nurses direct sight upon observation & audits then carts will be locked upon finding.</p> <p>c.. Result of the audits will be submitted to the Nursing Director weekly and written warnings for discipline will be given to licensed nurse who fail to meet F431 requirement.</p> <p>d. The Assistant Nursing Director will report results of finding and corrective actions at the quarterly Quality Assurance Committee meetings.</p> <p>e. Action plans will be developed if indicated by the QA Committee. QA Committee members include: Nursing Director, Assistant Nursing Director, Unit Coordinators 1, 2, 3, 4, Administrator, Medical Director, Infection Control, Rehabilitation, Dietician, Social Workers, Activities Coordinator, Staffing Coordinator, PII/Risk Coordinator, Food Services Supervisor, Clinical Educator, Pharmacy Director, Maintenance, Facility Assistant, Environmental Services Supervisor, MDS Coordinator, and Medical Records.</p>		

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F 431	<p>Continued From page 18 and split the other cart with another LPN. He stated he was responsible for leaving both carts unlocked on the Four Hundred (4) Hall. Further interview revealed the carts being unlocked could be dangerous for residents, who wander, in the facility as they could get into the cart and get the medicine.</p> <p>Interview with the 400 Hall Unit Coordinator, on 09/09/15 at 8:50 AM, revealed she was aware that LPN #2 had left a medicine cart open on the morning of 09/09/15. She stated she expected all medication carts to be locked when not attended to by the nurse and she was concerned with the safety of the residents.</p> <p>Interview with the Director of Nursing (DON), on 09/09/15 at 7:58 AM, revealed all medications carts should be locked if not in sight of the nurse. She stated this was not a new policy and it was a part of standards of nursing practice.</p>	F 431	<p>f. The audits as a result of this plan of correction will be followed until our next annual relicensure survey.</p> <p>g. Facility declares compliance with F431 deficiency effective October 10, 2015.</p>	10-10-15	