

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

PRINTED: 11/20/2013
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 11/06/2013
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
F 000	<p>INITIAL COMMENTS</p> <p>An Abbreviated Survey investigating KY20919 was conducted on 10/31/13 through 11/06/13 to determine the facility's compliance with Federal requirements. KY20919 was substantiated with deficiencies cited with the highest scope and severity of a "G."</p> <p>The facility failed to provide care according to the care plan and provide the resident assistance with bed mobility, per the facility's assessment of the resident's needs. The facility assessed and care planned Resident #1 as requiring two (2) person assist for bed mobility. However; the Minimum Data Set (MDS) Kardex Report (Certified Nursing Assistant Care Plan) stated the resident required one (1) person assist with bed mobility. On 10/09/13 at 3:15 AM, Certified Nurse Aide (CNA) #1 was providing care to Resident #1 without assistance from another staff member, when she turned the resident to his/her side, the resident slid off the bed onto the floor landing on his/her left knee and bilateral shins. The resident complained of pain to his/her left knee. Licensed Practical Nurse (LPN) #1 assessed the resident and identified the resident had a skin tear to the right forearm and increased pain with turning and positioning.</p> <p>At 4:02 AM, the LPN identified there was a knot on the resident's left knee with increased swelling. However, further review revealed the facility failed to consult the resident's physician related to the fall with injury until 9:16 AM, approximately six (6) hours after the fall. Resident #1 was sent to the hospital for an x-ray on 10/09/13 and was diagnosed to have a fractured left femur. Resident #1 returned to the</p>	F 000		

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

Sandra J Dick

TITLE

Administrator

(X6) DATE

11/26/2013

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 000	Continued From page 1	F 000		
F 157 SS=G	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>	F 157	<p>F 157 483.10(b)(11) NOTIFY OF CHANGES</p> <ol style="list-style-type: none"> 1. The corrective action accomplished for resident affected by the deficient practice. <ol style="list-style-type: none"> a. Resident #1's physician notified, orders received and followed on 10-9-2013. 2. Identification of other residents having the potential to be affected by the same deficient practice. <ol style="list-style-type: none"> a. All residents who reside in the facility have the potential to be affected by this deficient practice. 3. Measures and systemic changes to ensure that the deficient practice will not recur: <ol style="list-style-type: none"> a. Licensed staff in-serviced regarding adherence to physician notification when there is an accident involving the resident, which results in injury and has the potential for requiring physician intervention and a need to alter treatment. b. Facility policy and procedure regarding physician notification reviewed, updated, and in-serviced. 4. Facility monitoring its performance to ensure that solutions are sustained: <ol style="list-style-type: none"> a. Unit Coordinators will monitor adherence to policy by audits. b. Weekly audits will be given to Nursing Director. c. Results of findings and corrections will be submitted to Quality Assurance Committee on a quarterly basis. d. Quality Assurance action plans will be developed if indicated. <p>F 157 Completion Date:</p>	12/20/2013

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F 157	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy and procedure it was determined the facility failed to consult with one (1) of five (5) sampled residents' (Resident #1) physician when there was an accident that resulted in injury and had the potential for requiring physician intervention and a need to alter treatment.</p> <p>On 10/09/13 at 3:15 AM, Certified Nurse Aide (CNA) #1 provided care to Resident #1. When she rolled the resident over to his/her side, the resident fell from the bed onto his/her left knee and shins. The resident complained of pain to the left knee; staff identified a knot on the resident's left knee with increased swelling. The on-call physician was faxed at 3:15 AM, but the nurse did not call the physician's office to consult with the physician until 9:16 AM. The physician's office called the facility back at 10:51 AM with orders to send the resident to the emergency room for x-rays. The physician was not consulted for approximately six (6) hours after the fall with injury. Resident #1 was sent to the emergency room and it was determined the resident had a fractured left femur. The resident returned to the facility and continued to complain of pain to the right leg. Resident #1 was sent back to the hospital and it was determined the resident had a fractured right tibia.</p> <p>The findings include:</p> <p>Record review revealed the facility admitted Resident #1 on 03/26/08 with diagnoses which included Atrial Fibrillation, Pain, Psychotic Mood</p>	F 157			

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F 157	<p>Continued From page 3</p> <p>Disorder, Epilepsy, Depression, Dementia, Congestive Heart Failure, Hypertension, Glaucoma, Parkinson's, Overactive Bladder, Osteoarthritis, and Pacemaker.</p> <p>Review of a Nursing Note, dated 10/09/13 at 8:29 AM, revealed Licensed Practical Nurse (LPN) #1 documented she was called to Resident #1's room by CNA #1 at 3:15 AM. The CNA stated she was providing care to Resident #1 and when she turned the resident on his/her side the resident slid off of the bed onto his/her left knee and bilateral shins. When LPN #1 entered the room, the resident was sitting on the floor on his/her bottom with his/her knees bent and had complaints of pain in the left knee. The LPN assessed the resident for injury and identified bruising to the bilateral shins and a skin tear to the right wrist. The resident complained of pain to the left knee and exhibited more pain with turning and repositioning. Further review of the clinical record revealed the resident was given more pain medication. At 4:03 AM, the Nurse placed an ice pack on Resident #1's left knee related to a knot on the resident's knee and increased swelling. There was no documented evidence the on call or primary care physician was consulted about the fall with injuries and the resident's increased complaints of pain.</p> <p>Review of the Post Fall Assessment, dated 10/09/13 at 4:22 AM, revealed the physician was notified at 3:15 AM, but it does not reveal the means used to notify the physician. Review of a facsimile (fax) sent to the on-call physician's office related to Resident #1's fall revealed a date of 10/09/13, with no time noted. Interview with LPN #1, on 11/01/13 at 8:37 AM, revealed she did not call the on call physician at the time of the</p>	F 157			

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F 157	<p>Continued From page 4</p> <p>incident (3:15 AM) but sent a fax because it was so early in the morning. Further review of the Nursing Notes revealed the primary physician's office was called on 10/09/13 at 9:16 AM, approximately six (6) hours after the fall, and the physician's staff was made aware of Resident #1's fall, injuries and that the LPN had identified the resident had crackles in the lower bases of his/her lungs. Review of a Nurse's Note, dated 10/09/13 at 10:51 AM, revealed the facility received orders to send the resident to the emergency room to obtain an x-ray of the resident's left knee to rule out a fracture and his/her chest to rule out pneumonia.</p> <p>Review of the Emergency Room Record, dated 10/09/13 at 11:50 AM, revealed Resident #1 was transferred to the hospital and an x-ray, dated 10/09/13 at 1:16, revealed there was no fracture to the right leg; however, review of an x-ray, dated 10/09/13 at 2:48 PM, revealed a fracture of the left femur. Resident #1 stayed in the hospital for nine (9) days and was discharged back to the nursing facility on 10/18/13 at 1:05 PM.</p> <p>Review of Nursing Notes and pain assessments, dated 10/18/13 -10/23/13 revealed Resident #1 was having pain to the right leg. The resident was given Lortab for the pain but the pain continued.</p> <p>Review of a Nurse's Note, dated 10/23/13 at 3:36 AM, revealed Resident #1 had a large amount of dark, coffee ground emesis and complaints of pain in the right leg. A physician's order was obtained to send Resident #1 to the emergency room for evaluation and treatment. Review of the Radiology report, dated 10/23/13 at 7:19 AM, revealed an acute, impacted fracture of the right</p>	F 157			

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F 157	Continued From page 5 tibia, which was not revealed on the prior radiographic examination of the right knee from 10/09/13. Interview with Resident #1's primary care physician, on 11/06/13 at 9:00 AM, revealed he never received a phone call and even though a fax was sent to the on-call physician regarding the incident, a phone call should have been made as well, as this was the protocol per the hospital and nursing home policy. The Physician stated he felt the right tibia fracture was not seen on the first x-ray done on 10/09/13 and the Radiologist and Orthopedic doctor both read the x-ray film and missed the break.	F 157			
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and procedure it was determined the facility failed to ensure the services provided or arranged by the facility were provided by qualified persons in accordance with each resident's written plan of care for one (1) of five (5) sampled residents (Resident #1). Review of Resident #1's Comprehensive Care Plan revealed a plan of care for two (2) person assistance with bed mobility. However, the Minimum Data Set (MDS) Kardex Report (CNA Care Plan) stated the resident required one (1)	F 282	F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 1. The corrective action accomplished for the resident found to be affected by the deficient practice. a. The kardex was updated to match the comprehensive care plan. 2. Identification of other residents having the potential to be affected by the same deficient practice: a. All residents who reside in the facility have the potential to be affected by the same deficient practice. 3. Measures and systemic changes to ensure that the deficient practice will not recur: a. Nursing staff have been in-serviced regarding policy and procedure and adherence for reviewing and following plan of care. 4. Facility monitoring of its performance to ensure that solutions are sustained. a. Unit Coordinators will monitor staff's adherence to the care plan policy and procedure. b. Unit Coordinators will audit the care plan and kardex to ensure they match.		

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F 282	<p>Continued From page 6</p> <p>person assist with bed mobility. Certified Nurse Aide (CNA) #1 provided care for Resident #1 alone. When she turned the resident over in the bed, the resident slid from the bed to the floor landing on his/her left knee and bilateral shins. The resident sustained a fractured left femur and a fractured right tibia.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled, "Resident Care Plan", last revised 09/2013, revealed staff should check the plan of care daily for updates.</p> <p>Review of the facility's policy and procedure titled, "Nursing Assistant Kardex", last revised 07/2013, revealed the Nurse Aide Care Plan should be initiated on admission then updated as needed with change in condition and for hospital stay information. It should include but not be limited to: Mobility, Transfer, Special Equipment, Reposition, Falls, and Safety Device Documentation. Change in condition (improvement or decline) should be reported to the licensed staff for update of the care plan, as needed. "It's the responsibility of each employee to follow the resident's plan of care, (i.e. if a resident requires two assist for transfers then staff is not to transfer resident with one assist)."</p> <p>Record review revealed the facility admitted Resident #1 on 03/26/08 with diagnoses which included Atrial Fibrillation, Pain, Psychotic Mood Disorder, Epilepsy, Depression, Dementia, Congestive Heart Failure, Hypertension, Glaucoma, Parkinson's, Overactive Bladder, Osteoarthritis, and Pacemaker. Review of the Quarterly Minimum Data Set (MDS) assessment,</p>	F 282	<p>c. Unit Coordinators will submit copies of monitors</p> <p>d. Any variances will be corrected at the time they are found.</p> <p>e. Data will be submitted to the Quality Assurance Committee on a quarterly basis.</p> <p>f. Quality Assurance action plan will be developed and implemented if indicated.</p> <p>g. Employee will receive administrative counseling up to termination for not adhering to facility policy.</p> <p>F 282 Completion Date:</p>	12/20/2013	

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F 282	<p>Continued From page 7</p> <p>dated 08/16/13, revealed the facility assessed Resident #1 as being cognitively intact and the resident required the extensive assist of two (2) staff for bed mobility and transfer. In addition, the resident was non-ambulatory.</p> <p>Review of the Comprehensive Care Plan for "ADL Self-Care Performance", last revised 08/20/13, revealed the resident required two (2) staff assist and one-half (1/2) side rails to aide in turning and repositioning. However, review of the MDS Kardex Report (CNA Care Plan), not dated, revealed the resident required the assistance of one (1) staff to turn and reposition in bed every two (2) hours and as necessary.</p> <p>Review of a Nursing Note, dated 10/09/13 at 8:29 AM, revealed Licensed Practical Nurse (LPN) #1 documented she was called to Resident #1's room by CNA #1 on 10/09/13 at 3:15 AM. The CNA stated she was providing care to Resident #1 and when she turned the resident to his/her side the resident slid off of the bed onto his/her left knee and bilateral shins. When LPN #1 entered the room, the resident was sitting on the floor on his/her bottom with his/her knees bent. The resident complained of pain in the left knee. The LPN assessed the resident for injury and identified bruising to the bilateral shins and a skin tear to the right wrist. The resident was transferred back to bed with a mechanical lift. The resident complained of pain to the left knee and exhibited more pain with turning and repositioning; the resident was given pain medication. At 4:03 AM, LPN#1 placed an ice pack on Resident #1's left knee related to a knot on his/her knee and increased swelling. At 10:51 AM, nursing received a telephone order to send the resident to the emergency room for x-rays of</p>	F 282			

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F 282	<p>Continued From page 8 .</p> <p>the left knee to rule out a fracture and an x-ray of the chest to rule out pneumonia.</p> <p>Interview with CNA #1, on 11/01/13 at 8:07 AM, revealed the MDS CNA Kardex revealed the resident required one (1) staff assistance for bed mobility and was changed after the fall to two (2) staff assistance. She admitted to caring for the resident by herself most of the time because the resident was able to assist with turning and positioning. CNA #1 stated in hind sight she felt she should have called for assistance prior to assisting the resident. Additionally, she stated she did not question the change in the care plan from two (2) staff assist to one (1) person assist.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 , on 11/01/13 at 8:37 AM; and, on 11/05/13 at 2:00 PM, revealed on 10/09/13 she was called to the resident's room by CNA #1 who was providing care to Resident #1 after the resident had vomited on the bed and on himself/herself. CNA #1 reported to LPN #1 that when she turned the resident over on his/her side to change the bed linen, the resident's legs slid off the bed. When she reached for the call light to call for assistance, the resident continued to slide off the bed to the floor landing on his/her bilateral knees. Additionally, she revealed that when she entered the room the CNA had the resident and the bed stripped and she did not see any vomitus on the bed or the resident. The resident was lying on the floor nude. LPN #1 revealed the resident did not complain of pain until he/she was placed back in the bed per lift and was being repositioned for assessment. The resident was complaining of pain in the left knee; there was a knot noted on the resident's left knee. The resident sustained a skin tear to his/her right upper wrist resulting from</p>	F 282			

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F 282	<p>Continued From page 9</p> <p>the fall. LPN #1 stated she placed an ice pack on the resident's left knee due to increased pain and swelling. An order was received to send the resident to the emergency room for an x-ray of the left knee on 10/09/13 at 10:51 AM.</p> <p>Review of the Emergency Room Record, dated 10/09/13 at 11:50 AM, revealed Resident #1 was brought to the hospital and x-rays were conducted on the left and right leg. Review of the x-ray reports, dated 10/09/13 revealed there was no fracture to the right leg however, the resident had a fractured left femur. Resident #1 stayed in the hospital for nine (9) days and was discharged back to the nursing facility on 10/18/13 at 1:05 PM. Review of the Nursing Notes and pain assessments, dated 10/18/13 -10/23/13 revealed Resident #1 was having pain to the right leg.</p> <p>Review of a Nurse's Note, dated 10/23/13 at 3:36 AM, revealed Resident #1 had a large amount of dark, coffee ground emesis and complaints of pain in the right leg. A physician's order was obtained to send Resident #1 to the emergency room for evaluation and treatment. Review of the Radiology report, dated 10/23/13 at 7:19 AM, revealed an acute, impacted fracture of the right proximal metaphysis of the tibia, which was not revealed on the prior radiographic examination of the right knee from 10/09/13.</p> <p>Interview with Resident #1's primary care physician, on 11/06/13 at 9:00 AM, revealed he felt the right tibia fracture was not seen on the first x-ray done on 10/09/13 and the Radiologist and Orthopedic doctor both read the x-ray film and missed the break</p> <p>During further interview, LPN #1 stated she felt</p>	F 282			

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F 282	<p>Continued From page 10</p> <p>there was no reason for the CNA to attempt to provide care for the resident alone when the care plan stated the resident required two (2) staff assistance. She stated even if staffing was an issue, the CNA should find someone to assist with care especially if the resident required two (2) staff assist. Additionally, the facility failed to conduct an investigation to identify the root cause of the fall. LPN #1 stated she knew what happened and did not feel the need to do an investigation.</p> <p>Interview with CNA #3 on 11/05/13 at 1:45 PM, revealed she had taken care of Resident #1 and the CNA Care Plan indicated the resident required one (1) staff assist for bed mobility. She stated she would usually care for the resident without assistance because the resident could assist with bed mobility.</p> <p>Interview, with CNA #4, on 11/05/13 at 3:00 PM, revealed Resident #1's CNA Care Plan called for two (2) staff assist for bed mobility and transfers. She stated if she needed to, she would provide care to a resident by herself even if the care plan indicated the resident required two (2) staff assistance if there was no staff available because they were on break or busy assisting other residents.</p> <p>Interview with Registered Nurse (RN) #1, on 11/04/13 at 12:40 PM revealed Resident #1 did not want to get out of bed and had been steadily deteriorating in his/her health status. He stated the fall had a major impact on his/her mental status as well as resulting in increased pain and medication. Additionally, he stated the CNA Care Plan indicated the resident required two (2) staff assist for bed mobility and he did not feel</p>	F 282			

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

PRINTED: 11/20/2013
FORM APPROVED
OMB NO. 0938-0391

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F 282	Continued From page 11 there was any reason for the CNA to care for the resident alone. Interview with the Assistant Director of Nursing (ADON), on 11/05/13 at 4:15 PM, revealed she did not know why the Comprehensive Care Plan stated Resident #1 required two (2) assist with bed mobility and the CNA care plan stated one (1) staff for bed mobility. The ADON revealed she would have expected the CNA to question a change to the CNA care plan when bed mobility changed from two (2) staff assist to one (1) staff assist. She stated the CNAs were taught a resident's status may change daily and they were to check the CNA Care Plan prior to beginning care on each shift. Additionally, she stated if a CNA was aware a resident required two (2) staff assist and provided care alone whether an injury resulted or not, they would be reprimanded for not following the care plan. She stated it was her responsibility to supervise all staff, from the Unit Managers down the line. Interview with the Director of Nursing (DON), on 11/04/13 at 10:00 AM, revealed the CNA Care Plan indicated one (1) staff assist and the coding may have been changed in the computer system as a glitch. She further stated she chose not to council the CNA because she felt the CNA was doing what she thought she was supposed to do by getting the resident out of the vomit.	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	F 323	F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 1. The corrective action accomplished for resident affected by the deficient practice: a. Resident #1's Kardex was updated to match the comprehensive care plan. 2. Identification of other residents having the		

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

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F 323	<p>Continued From page 12 prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and procedure it was determined the facility failed to ensure one (1) of five (5) sampled residents (Resident #1) received adequate supervision to prevent accidents. Resident #1 was assessed and care planned for two (2) staff assistance with bed mobility; however, the Minimum Data Set (MDS) Kardex Report (CNA Care Plan) stated the resident required one (1) person assist with bed mobility. On 10/09/13, Certified Nurse Aide (CNA) #1 provided care for Resident #1 without the assistance of another staff. When she turned the resident to his/her side the resident slid from the bed onto the floor landing on his/her left knee and bilateral shins. Resident #1 sustained a fractured left femur and right tibia.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Risk Team", last revised 02/2011, revealed "The Risk Team" promotes resident safety and reduces risk to residents through an environment that encourages recognition and acknowledgment of risks to resident safety; initiation of interventions to reduce these risks; internal reporting of what has been found and the actions taken; focus on process and systems; Non-punitive management of errors and occurrences. The maintenance and improvement of resident safety, is a coordinated and collaborative effort, the approach to optimal</p>	F 323	<p>potential to be affected by the same deficient practice.</p> <p>a. All residents who reside in facility have potential to be affected by this deficient practice.</p> <p>3. Measures and systemic changes to ensure that the deficient practice will not recur: a. Nursing staff have been in-serviced regarding policy and procedure and adherence for reviewing and following plan of correction.</p> <p>4. Facility monitoring of its performance to ensure that solutions are sustained. a. Unit Coordinators will monitor staff's adherence to the care plan policy and procedure. b. Unit Coordinators will audit the care plan and kardex to ensure they match. c. Unit Coordinators will submit copies of monitors to Nursing Director weekly. d. Any variances will be corrected at the time they are found. e. Data will be submitted to the Quality Assurance Committee on a quarterly basis. f. Quality Assurance action plan will be developed and implemented if indicated. g. Employee will receive administrative counseling up to termination for not adhering to facility policy.</p> <p>F 323 Completion Date:</p>	12/20/2013

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

PRINTED: 11/20/2013
FORM APPROVED
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F 323	<p>Continued From page 13</p> <p>safety establishing the plans, processes and mechanisms that compromise the resident safety activities at the nursing facility.</p> <p>Record review revealed the facility admitted Resident #1 on 03/26/08 with diagnoses which included Atrial Fibrillation, Pain, Psychotic Mood Disorder, Epilepsy, Depression, Dementia, Congestive Heart Failure, Hypertension, Glaucoma, Parkinson's, Overactive Bladder, Osteoarthritis, and Pacemaker. Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment, dated 08/16/13, revealed the facility assessed Resident #1 as being cognitively intact. The resident required the extensive assistance of two (2) staff for bed mobility.</p> <p>Review of the Comprehensive Care Plan for Activities of Daily Living (ADL) Self-Care Performance, last revised 08/20/13, revealed the resident required two (2) staff assist and one-half (1/2) side rails to aide in turning and repositioning. However, review of the MDS Kardex Report (CNA care plan), no date, revealed the resident required assist of one (1) staff to turn and reposition in bed every two (2) hours, and as necessary.</p> <p>Review of the Nursing Note, dated 10/09/13 at 8:29 AM, revealed Licensed Practical Nurse (LPN) #1 was called to Resident #1's room at 3:15 AM. Further review revealed the CNA revealed to LPN#1 that she was providing care to Resident #1 and when she turned the resident to his/her side, the resident slid off the bed onto his/her left knee and bilateral shins. The LPN documented when she entered the room, the resident was sitting on the floor on his/her bottom with his/her knees bent. The resident complained</p>	F 323			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 14</p> <p>of pain to the left knee. When assessed, the LPN identified the resident had a skin tear to the right wrist and bruising to the bilateral shins. The resident was transferred back to bed per mechanical lift; the resident exhibited symptoms of increased pain when turned and repositioned. Resident #1 was administered pain medication.</p> <p>Further review of the Nursing Notes revealed at 4:03 AM, the LPN placed an ice pack on Resident #1's left knee because there was a knot on the resident's knee and increased swelling. The resident's physician's office was notified of the fall with injury at 9:16 AM and, at 10:51 AM nursing received a telephone order to send the resident to the emergency room for x-rays of the left knee to rule out a fracture and an x-ray of the chest to rule out pneumonia.</p> <p>Review of the Emergency Room Record, dated 10/09/13 at 11:50 AM, revealed Resident #1 was transferred to the hospital and x-rays were obtained of the left and right leg. Review of the x-ray reports, dated 10/09/13 revealed there was no fracture to the right leg however, the resident had a fractured left femur. Resident #1 stayed in the hospital for nine (9) days and was discharged back to the nursing facility on 10/18/13 at 1:05 PM. Review of the Nursing Notes and pain assessments, dated 10/18/13 -10/23/14 revealed Resident #1 was having pain to the right leg.</p> <p>Review of a Nurse's Note, dated 10/23/13 at 3:36 AM, revealed Resident #1 had a large amount of dark, coffee ground emesis and complaints of pain in the right leg. A physician's order was obtained to send Resident #1 to the Emergency Room for evaluation and treatment. Review of the Radiology report, dated 10/23/13 at 7:19 AM,</p>	F 323			

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

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OMB NO. 0938-0391

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F 323	<p>Continued From page 15</p> <p>revealed an acute, impacted fracture of the right proximal metaphysis of the tibia, which was not revealed on the prior radiographic examination of the right knee from 10/09/13.</p> <p>Interview with Resident #1's primary care physician, on 11/06/13 at 9:00 AM, revealed he felt the right tibia fracture was not seen on the first x-ray done on 10/09/13 and the Radiologist and Orthopedic doctor both read the x-ray film and missed the break.</p> <p>Interview with CNA #1, on 11/01/13 at 8:07 AM, revealed when she entered the resident's room the resident had vomited and was lying on his/her back. The vomit was on the side of the bed closest to the door. She stated she normally provided care from the other side of the bed. CNA #1 stated she began cleaning the resident and changing the bed linens. When she reached for the call light to call for assistance, the resident's legs slipped off of the bed. CNA #1 stated when she raised her hand off of the resident's legs to pull the call light out of the wall for an emergency call, the resident's upper body was still on the bed and his/her knees were on the floor. She stated she and another CNA, LPN #1, and LPN #2 assisted the resident to the floor. Further interview revealed CNA #1 cared for the resident upon return to the facility after the hospital stay. She stated the resident never returned to his/her self and had increased pain after the fall.</p> <p>Additionally, CNA #1 stated the CNA Care Plan revealed the resident required one (1) staff assistance for bed mobility until after the fall when it was changed to two (2) staff assistance. She stated she cared for the resident by herself most</p>	F 323			

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

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F 323	<p>Continued From page 16</p> <p>of the time because the resident was able to assist with turning and positioning and in hind sight she felt she should have called for assistance prior to assisting the resident.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 , on 11/01/13 at 8:37 AM, revealed that on 10/09/13 she was called to the resident's room by CNA #1, who was providing care to Resident #1 after the resident had vomited on the bed and on himself/herself. CNA #1 reported to LPN #1 that when she turned the resident over on his/her side to change the bed linen, the resident's legs slid off the bed. When she reached for the call light to call for assistance, the resident continued to slide off the bed onto the floor landing on his/her bilateral knees. The LPN stated when she entered the room, the CNA had the resident and the bed stripped and she did not see any vomitus on the bed or the resident. The resident was lying on the floor nude. While the resident was on the floor, LPN #1 revealed she assessed the resident by performing range of motion to all extremities. LPN #2 left the room to get paperwork ready and make phone calls to send the resident to the emergency room for evaluation.</p> <p>Additionally, LPN #1 stated the resident did not complain of pain until he/she was placed back in the bed and was being repositioned so she could perform an assessment. The resident was complaining of pain in the left knee; there was a knot noted on the resident's left knee. The resident sustained a skin tear to his/her right wrist resulting from the fall. LPN #1 stated she placed an ice pack on the resident's left knee due to increased pain and swelling. An order was received to send the resident to the Emergency</p>	F 323			

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

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F 323	<p>Continued From page 17</p> <p>Room for an x-ray of the left knee. She stated there was no reason for the CNA to attempt to provide care for the resident alone when the care plan revealed the resident required two (2) staff assist.</p> <p>Interview with LPN #2, on 11/01/13 at 9:00 AM, revealed when she entered the resident's room the resident was in an odd position. She stated his/her left hip was on the bed side table and his/her feet were underneath him/her. Upon assessment she stated the resident revealed his/her back was hurting. She further revealed the resident was a large person and the bed he/she was on was not large enough to accommodate him/her. She stated after the resident was safely on the floor, she left the room to aide in getting paperwork ready to send the resident to the Emergency Room and to make the necessary phone calls. She agreed that the resident should have been assisted with two (2) staff for safety.</p> <p>Interview with LPN #3, on 11/03/13 at 11:31 AM, revealed she was not familiar with Resident #1 but she did recall the resident's condition changed over the past three (3) or so months prior to his/her death as he/she did not get out of bed and requested increased amounts of pain medication. Additionally, she revealed there was no reason for the accident to have occurred if the care plan had been followed.</p> <p>Interview with Registered Nurse (RN) #1, on 11/04/13 at 12:40 PM, revealed Resident #1 did not want to get out of bed and had been steadily deteriorating in his/her health status. He stated the fall had a major impact on his/her mental status as well as resulting in an increase in pain</p>	F 323			

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

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F 323	<p>Continued From page 18</p> <p>and medication. Additionally, he stated the CNA Care Plan indicated the resident required two (2) staff assist for bed mobility and he did not feel there was any reason for the CNA to care for the resident alone.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 11/05/13 at 4:15 PM, revealed she did not know why the Comprehensive Care Plan stated Resident #1 required two (2) assist with bed mobility and the CNA care plan stated one (1) staff for bed mobility. The ADON stated she would have expected the CNA to question a change to the CNA Care Plan when bed mobility changed from two (2) staff assist to one (1) staff assist. She revealed the CNAs are taught a resident's status may change daily and they are to check the CNA Care Plan prior to beginning care on each shift. Additionally, she revealed if a CNA was aware a resident required two (2) staff assist and provided care alone whether an injury resulted or not, they would be reprimanded for not following the care plan. She stated she was responsible for the supervision of staff.</p> <p>Interview with the Director of Nursing (DON), on 11/04/13 at 10:00 AM, revealed the CNA care plan indicated one (1) staff assist and the coding could have been changed in the computer system as a glitch. She further stated she chose not to council the CNA because she felt the CNA was doing what she thought she was supposed to do by getting the resident out of the vomit.</p>	F 323			