

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185332	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/15/2014
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NAME OF PROVIDER OR SUPPLIER GRAND HAVEN NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 105 RODGERS PARK CYNTHIANA, KY 41031
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(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)	(X6) COMPLETION DATE
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F 000 INITIAL COMMENTS

A Recertification Survey was initiated on 05/13/14 and concluded on 05/15/14. Deficiencies were cited with the highest Scope and Severity of a "G".

F 278 483.20(g) - (j) ASSESSMENT
SS=D ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

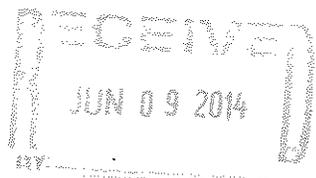
Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced

F 000 Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 6-9-14
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the 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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FORM APPROVED
OMB NO. 0938-0391

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F 278	<p>Continued From page 1</p> <p>by: Based on interview, record review, and review of facility's policy, it was determined the facility failed to ensure the Minimum Data Set (MDS) Assessment accurately reflected the resident's status for two (2) of thirteen (13) sampled residents (Residents #6 and #8).</p> <p>Resident #6's MDS was not coded accurately related to weight. Although the last recorded weight for Resident #6 was a weight obtained by the hospital of 208.7 pounds on 07/20/13, the Quarterly Minimum Data Set (MDS) Assessment dated 03/04/14, revealed the facility assessed the resident's weight as 254 pounds.</p> <p>Resident #8's MDS dated 06/01/14 section J1800 revealed the MDS was coded as no falls, and section J11900 was not coded as the resident sustaining a Major Injury from a fall; however, documentation and interview revealed the resident sustained a fall on 03/06/14 at 6:00 AM, sustaining a Right Closed Fracture of the Patella.</p> <p>The findings include:</p> <p>Review of facility's "RAI Completion", Policy undated revealed the facility was to follow federal and state guidelines for completion of the Resident Assessment Instrument (RAI) according to the MDS 3.0 Manual. Per the policy, the Registered Nurse was responsible for ensuring the completion of the Resident Assessment Process. The policy stated, the Minimum Data Set (MDS) Coordinator assumed responsibility for completion of the RAI by assigning facility staff to complete appropriate sections of the MDS and Care Area Assessments (CAAS).</p>	F 278	<p>F 278 D 483.20(G)-(J) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>Action for Residents Affected by Deficient Practice</p> <p>Resident #6 and #8 were re-assessed by the DON on 5/19/14.</p> <p>A comprehensive assessment was completed for resident #6 with an ARD of 5/19/14. Section K of the MDS has been updated to reflect the resident's physician's orders. A modification of prior assessment was completed for resident #8 with an ARD of 5/1/14. Section J has been modified to reflect the resident's condition.</p>	

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F 278 Continued From page 2

1. Review of Resident #6's medical record revealed the facility admitted the resident on 02/25/13 with diagnoses which included Diverticulitis, Hypertension, Emphysema, Type II Diabetes, Depression, Dementia, Neurogenic Pain and Chronic Obstructive Pulmonary Disease (COPD). Review of the Quarterly Minimum Data Set (MDS) Assessment dated 03/04/14, revealed the facility assessed the resident's weight as 254 pounds.

Review of the Weight Worksheet, revealed on 06/12/13, the facility weighed the resident using lift scales and recorded a weight of 198.2 pounds.

Review of Resident #6's Physician's orders dated 06/14/13, revealed orders to discontinue the resident's weight assessment per family request due to Chronic Back Pain.

Review of an Admission History from the hospital dated 07/20/13 revealed the resident was weighed by the hospital by use of the bed scales and the recorded weight was 208.7 pounds

Review of the Dietary Nutrition Assessments for 07/30/13 and 08/26/13 revealed an "actual" weight of 198.2 pounds. Interview by phone with the Registered Dietitian, on 05/15/14 at 12:15 PM, revealed Resident #6's weights for the Nutrition Assessments completed on 07/30/13 and 08/26/13 were received from the facility's "weight book". She stated the weight recorded on the Nutrition Assessments came from the last recorded weight on 06/12/13 of 198.2 pounds.

Interview with the MDS Coordinator, on 05/15/14 at 5:00 PM, revealed she used the weights from the the Dietary Section of the resident's chart and the weight book at the nurses station for coding

F 278

Identification of Other Residents Affected by Deficient Practice

On 6/2/14 through 6/13/14, the Interdisciplinary Team (IDT) completed a facility wide audit of each resident's most current MDS to validate coding accuracy. Any discrepancies were corrected immediately.

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F 278 Continued From page 3

weights on MDS's. She further stated, the weight for the MDS dated 03/04/14 of 254 pounds may have been automatically received from the point, click, care system (MDS Tracking System). Observation of the MDS Tracking System with the MDS Coordinator revealed the last weight in the system was 202.1 pounds obtained on 06/11/13.

Further interview with the MDS Coordinator, revealed a possible data entry error occurred on the MDS. The MDS Coordinator stated the MDS Assessments were used to create plans of care for the residents and incorrectly coded weights on the MDS, as indicated in this situation, would suggest that the resident was "obese". She further stated an incorrect code for the weight could lead to the resident being placed on an incorrect diet.

2. Review of Resident #8's medical record revealed the facility re-admitted the resident on 10/10/13 with diagnoses which included Schizophrenia, Dementia, History of Fracture Neck of Femur, and Cardiovascular Accident (CVA). Review of the Annual MDS Assessment dated 05/01/14, section J1800 revealed the facility assessed the resident as having no falls since admission/entry or re-entry or prior assessment. Further review of the MDS, section J1900 revealed the facility did not code the resident as having a major injury since admission/entry or re-entry or prior assessment.

Review of the the Nurse's Notes, dated 03/06/14 at 8:45 AM as a late entry for 03/06/14 at 6:00 AM, revealed the State Registered Nursing Assistant (SRNA) reported assisting Resident #8 to turn in the bed, and the resident continued to roll and rolled out of bed. Further review of the

F 278

Systemic Changes for Non-Recurrence

The facility's Director of Nursing will review each MDS for accuracy before the MDS is locked and transmitted to CMS. A second review will be completed by the IDT during the scheduled care conference.

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F 278	<p>Continued From page 4</p> <p>Nurse's Notes/Condition Change Form, dated 03/06/14 at 10:00 AM, revealed the resident complained of right leg pain after rolling out of bed in the AM (morning). Review of the Nurse's Notes/Condition Change Form, dated 03/07/14 at 10:05 AM, revealed Resident #8 complained of right leg pain and a call was placed to the APRN and new orders were received to send Resident #8 to the hospital emergency room. Review of the Hospital Emergency Room Note dated 03/07/14, revealed the resident had a Fracture of the Patella, right closed.</p> <p>Interview, on 05/14/14 at 5:15 PM, with the MDS Coordinator revealed she was responsible for completing the MDS's and obtained information needed to completed the MDS's by observation of the resident, by interviewing staff about the resident's care needs and functional abilities, and by reviewing the chart. She stated she should have coded for a fall and fracture on the Annual MDS dated 05/01/14 for Resident #8.</p> <p>Interview, on 05/15/14 at 3:45 PM and 8:00 PM with the Director of Nursing (DON) revealed the MDS Coordinator completed the MDS's which were compared with the Care Plans and Physician's Orders during the Care Plan meetings. She further stated, no one reviewed for accuracy of actual coding of the MDS's; however, stated the Annual MDS dated 05/01/14 should have been coded as the resident having a fall and a major injury since the resident rolled out of bed and sustained a Right Patella Fracture.</p>	F 278	<p>Monitoring for Sustainment</p> <p>The facility's Quality Assurance Nurse completes weekly audits following the routine MDS schedule. Audits will review the MDS's that were completed the previous week. These audits will occur weekly for 1 month. Audits will resume for 10% of the resident census monthly, as part of the facility's Quality Assurance (QA) program. Audit results are submitted for review to the QA committee members monthly for follow-up and recommendations until compliance has been achieved.</p> <p>Completion Date 6/18/14</p>	6/18/14
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment</p>	F 279		

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F 279 Continued From page 5
to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and review of facility's policy, it was determined the facility failed to ensure a Comprehensive Plan of Care was developed for each resident that includes measurable objectives and timetables to meet the residents medical and nursing needs that are identified in the comprehensive assessment for one (1) of thirteen (13) sampled residents (Resident #5).

The facility failed to develop Resident #5's Comprehensive Care Plan related to vision, although vision triggered as a problem on the Care Area Assessment Worksheet and Care Area Assessment Summary (CAAS) dated 04/09/14.

F 279 **F 279 D 483.20(D), 483.20(K)(1) DEVELOP COMPREHENSIVE CARE PLANS**

Action for Residents Affected by Deficient Practice
Resident #5 was re-evaluated and a modification of prior MDS assessment was completed with an ARD of 4/3/14. Section B has been updated to reflect Resident #5's condition. The MDS coordinator and the interdisciplinary team have been re-educated on resident specific assessment completion per the RAI guidelines.

Identification of Other Residents Affected by Deficient Practice
On 5/19/14 through 6/13/14, a thorough review was completed by the Director of Nursing. The review included a comparison of the resident's most recent comprehensive MDS assessment including CAAs, the current diagnosis, the nursing care plan, and the daily care plan record. Additional reviews and updates were made as needed to reflect the resident's current status.

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F 279 Continued From page 6
The findings include:

Review of the facility's policy titled, "Individual and Interdisciplinary Plan of Care", undated, revealed the care plan would be comprehensive and reasonable and would be reflective of the needs of the patient. Further review revealed it was the intent of the facility to achieve and maintain each resident's highest practicable physical, psychosocial and functional status. According to the policy, the Care Plan process was the primary instrument used to meet the objectives for each resident.

Review of Resident #5's medical record revealed diagnoses which included Parkinson's Disease, and Cataracts. Review of the Annual Minimum Data Set (MDS) Assessment dated 04/03/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status of a three (3) out of fifteen (15) indicating severe cognitive impairment. Additional review revealed the facility assessed the resident as having adequate vision.

Review of the Care Area Assessment Summary (CAAS) dated 04/09/14 revealed vision triggered and vision would be addressed in the Care Plan. Review of the Care Area Assessment Worksheet, dated 04/09/14, revealed the resident had diseases and conditions of the eye and visual function would be addressed in the care plan as an overall objective to avoid complications, maintain current level of functioning and minimize risks.

Review of an Eye Consult, dated 01/23/14 revealed there were changes in vascular appearance of the retinas and the resident was to

F 279 **Systemic Changes for Non-Recurrence**
The IDT Care Plan Conference agenda and format has been modified to include a review of the MDS assessment, CAAs, the comprehensive care plan, and the daily care plan record. The Director of Nursing met with the interdisciplinary care plan team on 5/29/14 to provide education and information on the updated agenda and format. The management nurse consultant met with the interdisciplinary care plan team on 6/5/14 to further discuss the updated agenda and format of care plan meetings. During care plan meetings, the resident's daily care plan record, nursing care plan, and most recent MDS assessment, and CAAs are compared for accuracy. All comprehensive assessment triggers are reviewed to ensure that they were proceeded to care plan if indicated. Any discrepancies noted are corrected by the MDS coordinator.

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F 279 Continued From page 7
follow up in six (6) to nine (9) months for a Dilated Fundus Exam.

Review of the Comprehensive Plan of Care, revised 04/01/14, revealed there was no Care Plan to address vision although the resident had a diagnosis of Cataracts.

Interview, on 05/14/14 at 5:15 PM and 05/15/14 at 7:00 PM, with the MDS Coordinator, revealed she developed and revised care plans and the interdisciplinary team reviewed them in the care plan meetings. After chart review, she stated vision triggered on the CAAS, and she should have care planned vision related to the resident's eye disease. Further interview revealed when she developed care plans, she care planned what triggered from the comprehensive assessment. She stated it must have been missed.

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP
SS=G

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed

F 279 **Monitoring for Sustainment**
The facility's DON, ADON, and/or Quality Assurance Nurse will complete weekly reviews following the routine Care Conference schedule. Reviews are completed utilizing a checklist and attending Care Conference meetings. These reviews will occur weekly for 1 month. Reviews will resume monthly as part of the facility's Quality Assurance (QA) program. The results of these reviews are submitted for review to the QA committee members monthly.

F 280 **Completion Date**
6/18/14

6/18/14

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F 280 Continued From page 8 and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on Interview, record review and review of the facility's policy, it was determined the facility failed to ensure the Comprehensive Care Plan was revised for two (2) of fourteen (14) sampled residents (Resident #8 and #6).

Resident #8 was assessed by the facility on 01/29/14, to require the assistance of two (2) staff for bed mobility. However, review of the Comprehensive Care Plan revealed no documented evidence it was revised to include this information until 03/06/14, when Resident #8 experienced a fall from his/her bed while being assisted by only one (1) staff person. Resident #8 sustained a Right Patella (Kneecap) Fracture as a result of the fall. Also, at the time of the survey, staff caring for Resident #8 were not aware the resident was to have two (2) staff assist with bed mobility.

Additionally, Resident #6's Comprehensive Care Plan was not revised in regards to discontinuing weights as per a family request and written Physician's Order on 08/28/13.

The findings include:
Review of the facility's policy titled, "Individual and Interdisciplinary Plan of Care", undated, revealed it was the policy of the facility to maintain an up to date care plan for each resident. The Care Plan

F 280

F 280 G 483.20(D)(3), 483.10(K)(2) RIGHT TO PARTICIPATE IN PLANNING CARE-REVISE CARE PLAN

Action for Residents Affected by Deficient Practice
Resident #8 was re-assessed by the DON on 5/19/14; the care plan was reviewed and updated. A modification of the annual assessment with an ARD of 5/1/14 was completed with for resident #8. On 5/22/14, resident #8 had a follow-up appointment with her orthopedic physician; her care plan was updated upon her return to reflect the physician's orders and current status. Resident #6's care plan was reviewed and updated for no weights per MD order on 5/16/14. The MDS coordinator and the Interdisciplinary team have been re-educated on resident specific assessment completion per the RAI guidelines.

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F 280	<p>Continued From page 9</p> <p>was to be comprehensive and reflect the needs of the residents. According to the Policy, it was the intent of the facility to achieve and maintain each resident's highest practicable physical, psychosocial, and functional status.</p> <p>1. Review of Resident #8's medical record revealed diagnoses which included History of a Fracture of the Femur Neck, Depression, Schizophrenia, Dementia, Cerebrovascular Accident and Neurogenic Bladder.</p> <p>Review of Resident #8's Quarterly Minimum Data Set (MDS) Assessment, dated 01/29/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of thirteen (13) which indicated the resident was not cognitively impaired. Further review of the MDS revealed the facility assessed Resident #8 to require extensive two (2) staff assist for bed mobility and as being frequently incontinent of bowel and bladder.</p> <p>Review of the Comprehensive Care Plan dated 05/22/13, revealed Resident #8 an Activities of Daily Living (ADL's) care plan related to the resident's diagnoses of Stroke, Dementia, and Impaired Balance. Continued review of the ADL care plan revealed an intervention dated 05/22/13 which was revised 10/20/13 that stated Resident #8 required limited assist of one (1) staff to turn and reposition in bed. Further review of the ADL care plan revealed an intervention which was undated, that stated Resident #8 was to have the extensive assist of two (2) to turn and reposition in bed. In addition, review of the Comprehensive Care Plan revealed a risk for falls care plan revised 05/15/13, revealed a goal which stated Resident #8 would not sustain serious injury.</p>	F 280	<p>Identification of Other Residents Affected by Deficient Practice</p> <p>On 5/19/14 through 6/13/14, a thorough review of the RAI process was completed by the Director of Nursing. The review included a comparison of the resident's most recent MDS assessment, CAAs, the current diagnosis, physician's orders, the nursing care plan, and the daily care plan record. Additional reviews and updates were made</p>	

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F 280	<p>Continued From page 10</p> <p>Further review of the risk for falls care plan revealed an intervention dated 03/06/14, the date of the resident's fall, which stated Resident #8 was to have two (2) staff members assistance for bed mobility.</p> <p>Review of the Resident #8's "Nurse Aide Daily Care Plan Record" dated March 2014, which was utilized by State Registered Nursing Assistants (SRNAs) to inform them of residents' care needs, revealed bed mobility was marked as extensive assist of one (1) staff, highlighted as changed on 03/06/14, and marked as assist of two (2) staff.</p> <p>Review of the Nurse's Notes revealed a "late entry, dated 03/06/14 at 8:45 AM, written by the DON. Continued review of the "late entry" Note revealed it was documented in regards to an incident which occurred on 03/06/14 at 6:00 AM, where a SRNA reported she was assisting Resident #8 to turn in the bed when the resident rolled out of bed and fell to the floor. Further review of the "late entry" Note revealed Resident #8 reported he/she rolled close to the edge of the bed and rolled out of the bed.</p> <p>Review of the Nurse's Notes/Condition Change Form, dated 03/06/14 at 10:00 AM, revealed the resident complained of right leg pain after rolling out of bed that morning. The Physician ordered an x-ray; x-ray results were received; and, sent to the Physician with no new orders received.</p> <p>Review of the Nurse's Note, dated 03/06/14 at 7:10 PM, revealed the Advanced Practice Registered Nurse, (APRN) called with new orders regarding the x-ray results and staff was to obtain a orthopedics consult for Resident #8. Continued review of the Nurse's Notes/Condition Change Forms, revealed on 03/07/14 at 10:05 AM,</p>	F 280	<p>as needed to reflect the resident's current status.</p> <p>Systemic Changes for Non-Recurrence</p> <p>The Director of Nursing met with the interdisciplinary care plan team on 5/29/14 to report on the agenda for care plan meetings forward. The management nurse consultant met with the interdisciplinary care plan team on 6/5/14 to further discuss the updated agenda and format of care plan meetings. During care plan meetings, the resident's daily care plan record, comprehensive care plan, physician's orders, and most recent MDS assessment are compared by the IDT for accuracy and consistency. Any discrepancies noted are corrected by the MDS coordinator and IDT.</p>	
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F 280 Continued From page 11
Resident #8 complained of right leg pain and a call was placed to the APRN with an order received to transfer Resident #8 to the hospital Emergency Room (ER).

Review of the Hospital ER Note dated 03/07/14, revealed Resident #8 was diagnosed with a Fracture of the right Patella.

Interview, on 05/14/14 at 12:10 PM, with Resident #8 revealed a SRNA was providing perineal care and he/she was trying to help with rolling over so the SRNA cleanse him/her. Resident #8 stated he/she was being assisted by only the one (1) SRNA at the time, and rolled too close to the edge of the bed, and ended up rolling out onto the floor.

Phone interview, on 05/14/14 at 4:40 PM, with State Registered Nursing Assistant (SRNA) #4, revealed she was often assigned to Resident #8. SRNA #4 explained SRNA's referred to the "nurse aide care plan" (Daily Care Plan Record) at the nurse's station to know what care residents' needed. She stated when she was in a resident's room she had nothing to refer to related to the resident's care. She stated sometimes it was hard to remember all the interventions listed on the Daily Care Plan Record, and reported she was unsure what the care plan said regarding bed mobility for Resident #8. She stated on 03/06/14, she was providing incontinence care for Resident #8 when the resident rolled over too far in the bed and fell to the floor. Continued interview revealed she was never questioned about the incident or educated by the DON or by administrative staff related to the incident. She reported she was still turning and repositioning Resident #8 by herself at that time and the

F 280
Monitoring for Sustainment
The facilities DON, ADON, and/or Quality Assurance Nurse will complete weekly reviews of each care plan following the routine Care Conference schedule. Reviews are completed utilizing a checklist and attending the Care Conference meetings. These reviews will occur weekly for 1 month. Reviews will resume monthly as part of the facility's Quality Assurance (QA) program. The results of these reviews are submitted for review to the QA committee members monthly.

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F 280	<p>Continued From page 12</p> <p>resident still tried to help and often rolled over too far. SRNA #4 stated other staff were also turning and positioning the resident in the bed without assistance of two (2) staff.</p> <p>Phone interview on 05/14/14 at 5:05 PM, with Registered Nurse (RN) #2 who was assigned to Resident #8 at the time of the fall on 03/06/14, revealed SRNA #4 reported the resident had rolled out of bed and had landed on the floor, but had not hit his/her head. She stated she was never questioned about the incident or educated by the DON or administration. She indicated she thought Resident #8 was a one (1) person assist with bed mobility at the time of the fall. Continued interview revealed she thought Resident #8 was still a one (1) person assist for bed mobility and did not think that had changed after the fall on 03/06/14. RN #2 further stated staff referred to the Nurse Aide Care Plan or the Comprehensive Care Plan for a reference for care.</p> <p>Interview, on 05/14/14 at 5:15 PM and 5:45 PM, with the MDS Coordinator, revealed she obtained information needed to completed the MDS's by interviewing staff about the residents care needs and functional abilities. She stated she also had the SRNAs' complete the seven (7) days of Activities of Daily Living (ADL) Tracker which specified what type of assistance residents required, and how many staff was required to assist the residents with bed mobility, eating, transfers and toileting. The MDS Coordinator stated she also observed staff during care to see how much assistance the residents required. Further interview revealed the MDS Coordinator generated the Comprehensive Care Plans and the Daily Care Plan Record from the MDS Assessments. Continued interview with the MDS</p>	F 280	<p>Completion Date 6/18/14</p>	6/18/14
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F 280: Continued From page 13

Coordinator revealed the DON, Social Services (SS) and the Activities Coordinator worked together as a team to develop and revise care plans in the care plan meetings. After reviewing the MDS dated 01/29/14, and the Comprehensive Care Plan and Daily Care Plan Record, the MDS Coordinator stated the Comprehensive Care Plan and Daily Care Plan Record was not revised until after Resident #8's fall on 03/06/14 to include the required two (2) staff assist for bed mobility. However, she stated the intervention for the two (2) staff assist with bed mobility should have been added to the Care Plans after she completed the 01/29/14 MDS.

Interview, on 05/14/14 at 4:10 PM and 7:00 PM and 05/15/14 At 3:45 PM, with the Director of Nursing (DON), revealed the MDS Coordinator completed the Comprehensive Care Plans which were reviewed for accuracy in the care plan meetings by her and the other Interdisciplinary staff, which consisted of SS, the MDS Coordinator and sometimes therapy staff. She stated the care plan information was then put on the Nurse Aide Care Plan/Daily Care Plan Record by the MDS Coordinator. Per interview, the DON revealed the last MDS completed, prior to the fall on 03/06/14, was a Quarterly MDS completed on 01/29/14, which stated Resident #8 required two (2) staff to assist with bed mobility. However, the DON stated both the Comprehensive Care Plan and the SRNA's Daily Care Plan Record were not updated until after Resident #8's fall on 03/06/14, for two (2) staff to assist him/her with bed mobility. According to the DON, the Comprehensive Plan of Care and the Daily Care Plan Record should have been updated at that time to reflect Resident #8 required two (2) staff assist with bed mobility as the Care Plan was

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F 280	<p>Continued From page 14</p> <p>generated from the MDS Assessment. The DON revealed the interdisciplinary team met the morning after any fall to discuss causes for the falls and need for any new interventions. She stated for Resident #8's 03/06/14 fall she felt the root cause was the resident being assisted by only one (1) staff instead of two (2) for bed mobility. The DON revealed she had not re-educated the staff involved at the time of Resident #8's fall, and stated staff were not always informed of changes in the care plan. The DON explained SRNA's were to review the Daily Care Plan Record which was kept at the nurse's station, daily at the beginning of their shift to know what care residents required. She further stated the only communication to staff for any changes made in reference to care of residents, was by them reviewing the Daily Care Plan Record or Comprehensive Care Plan.</p> <p>Interview, on 05/14/14 at 6:35 PM, with the Quality Assurance (QA) Nurse revealed revisions made to the Comprehensive Care Plans or the Daily Care Plan Record (nurse aide care plan) were not communicated verbally to staff. The QA Nurse stated however, the SRNA's were expected to read the Daily Care Plan Record at the beginning of each shift and should recognize any changes then to residents' care.</p> <p>2. Review of Resident #6's medical record revealed diagnoses which included Emphysema, Dementia, Neurogenic Pain, Chronic Obstructive Pulmonary Disease (COPD), Type II Diabetes and Depression.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment dated 03/04/14, revealed the facility assessed Resident #6 as having a BIMS</p>	F 280		
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F 280 Continued From page 15

score of nine (9) indicating moderate cognitive impairment. Additional review revealed the facility assessed Resident #6's weight as two hundred and fifty-four (254) pounds.

Review of the May 2014 Physician's Orders, revealed an order, with an original order date of 08/26/13, to discontinue Resident #6's weight assessments as requested by Resident #6's family due to the resident's Chronic Back Pain.

Review of the Comprehensive Plan of Care dated 06/06/13, revealed a care plan related to nutritional status in regards to the family bringing in full meals at least three (3) times a week for Resident #6. Continued review of the care plan revealed a goal for the resident not to develop complications related to Obesity. Further review revealed no documented evidence the Comprehensive Care Plan was revised to discontinue Resident #6's weights as per the Physician's Order.

Interview, on 05/14/14 at 5:15 PM and 05/15/14 at 5:00 PM, with the MDS Coordinator revealed Resident #6's Comprehensive Care Plan was not revised to discontinue the resident's weight measurements. She stated if the facility weighed Resident #6 because the request was not care planned, it could have contributed to increasing the resident's back pain or caused emotional distress for him/her. The MDS Coordinator stated she was responsible for ensuring the care plans were revised; however, it was also a team approach and the care plans were reviewed by the DON, Social Services and the Activities staff during care plan meetings. She stated revisions of care plans was supposed to be automatic when the Physician's Order was written because

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F 280	Continued From page 16 there was a three (3) part form and one (1) of those was the care plan update. The MDS Coordinator reported when she completed residents' MDS Assessments she was supposed to go through the care plan updates forms and transcribe the pertinent information to the Comprehensive Care Plan. Further interview revealed Resident #6's Comprehensive Care Plan should have been revised to include the intervention to discontinue the weights as the original order was dated 08/26/13, and the last MDS was completed 03/04/14.	F 280	6/18/14
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to ensure services provided by the facility meet professional standards of quality for one (1) of thirteen (13) sampled residents (Resident #3). The facility failed to follow the Physician's orders for Bunny Boots to both heels while in bed for Resident #3; however, observation of Resident #3 revealed the resident was not wearing bunny boots in the bed. The findings include: Review of the facility "Physician's Orders" Policy, undated, revealed all Physician's Orders must be	F 281	<u>F 281 D 483.20(K)(3)(I) SERVICES MEET PROFESSIONAL STANDARDS</u> <u>Action for Residents Affected by Deficient Practice</u> A skin assessment was completed on 5/21/14 for resident #3 with no new areas identified. The physician's order sheet dated May 2014 for resident #3 includes the order: "May have bunny boots to both heels while in bed for pressure relief". Upon investigation of the surveyor's

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F 281	<p>Continued From page 17 followed.</p> <p>Review of Resident #3's medical record revealed diagnoses which included Non Alzheimer's Dementia, and Cerebral Vascular Accident (CVA), Osteoarthritis, Chronic Obstructive Pulmonary Disease (COPD), and Diabetes Mellitus. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 03/11/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a ten (10) out of fifteen (15) indicating moderate cognitive impairment. Further review revealed the facility assessed the resident as being at risk for pressure ulcers.</p> <p>Review of the Comprehensive Plan of Care, revised 03/01/14, revealed the resident had the potential for pressure ulcer development related to a history of ulcers, and immobility. The interventions included follow facility policies/protocols for the prevention and treatment of skin breakdown.</p> <p>Review of the Physician's Orders dated May 2014, revealed an order for Bunny Boots to both heels while in bed for pressure relief.</p> <p>Observation of Resident #3 on 05/14/14 at 9:32 AM, revealed the resident was in bed on her/his back, and there were no Bunny Boots on the resident's feet.</p> <p>Interview at the time of the observation with State Registered Nurse Aide (SRNA) #11, revealed she was assigned to the resident. She stated she was unsure if the resident was to have Bunny Boots and she/he did not have them on when she arrived for her shift early that morning. She</p>	F 281	<p>findings, it was determined that the bunny boots for resident #3 were being laundered at the time identified and cited in the Statement of Deficiencies. On 6/5/14, the physician was consulted regarding clarification of this order. The physician advised facility to follow nursing intervention best practices for pressure reduction as needed; the physician's orders were updated to reflect this.</p> <p>Identification of Other Residents Affected by Deficient Practice</p> <p>On 6/2/14 through 6/14/14, the interdisciplinary team completed a thorough review of physician's orders, the comprehensive care plan and the daily care plan record in comparison to the residents' status. Any discrepancies noted were corrected immediately.</p>		

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F 281 Continued From page 18
stated, she would ask the nurse if the resident still needed them. She further stated there were no Bunny Boots in the room. SRNA #11 stated she used the nurse aide care plan as a reference for care. Review of the Daily Care Plan Record (nurse aide care plan) dated may 2014, revealed the resident may have Bunny Boots on while in bed.

Interview with Registered Nurse (RN) #3, who was assigned to the resident, on 05/14/14 at 10:00 AM, revealed the resident was to have Bunny Boots while in the bed for protection. She stated she did rounds in the mornings and checked for devices and she stated the resident had on Bunny Boots earlier that morning and they may have been sent to laundry. However, further interview revealed she was unaware of anyone sending the Boots to laundry that morning and if some one had sent them to the laundry they should have ensured the resident had another pair to wear. She checked the Treatment Administration Record (TAR) and stated the intervention for Bunny Boots was on the TAR, and when she did treatments she also looked for devices.

Interview with the Director of Nursing (DON), on 05/15/14 at 8:00 PM, revealed her expectation was for Physicians' Orders to be followed. She stated the intervention for the Bunny Boots was on the TAR and the Daily Care Plan Record and staff should ensure the order was followed.

F 282 SS=D 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

F 281 **Systemic Changes for Non-Recurrence**
Re-education was provided to the nursing staff regarding following resident care plans and physician's orders. Education was provided by the Staff Development Coordinator (SDC) beginning 5/16/2014 through 5/19/2014. Daily care rounds are conducted by the nurse management team including the DON, SDC, QA Nurse, ADON, and MDS Coordinator to ensure nursing interventions and physician's orders are being followed.

Monitoring for Sustainment
In addition to systemic changes, a comprehensive review is completed weekly by members of the nurse management team including the DON, ADON, and/or Quality Assurance Nurse the review will follow the routine Care Conference schedule. Reviews are completed by comparing the residents' care plan, the daily care record, and the physician's orders with the status of the resident to ensure all interventions are being followed. Results of the reviews are submitted to the QA Committee monthly for recommendations if indicated.

6/18/14

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F 282 Continued From page 19
 accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
 Based on interview, and record review, it was determined the facility failed to ensure services were provided in accordance with each resident's written plan of care for one (1) of fourteen (14) sampled residents (Resident #8).

On 03/06/14, Resident #8 was being assisted by one (1) staff member with bed mobility during incontinence care and fell off the bed sustaining a Right Patella (Kneecap) Fracture. Resident #8's Comprehensive Care Plan in regards to falls was updated on 03/06/14 with interventions for two (2) staff to assist with bed mobility. However, interviews with staff revealed they were continuing to assist Resident #8 with bed mobility with only one (1) staff member. Even though the resident rolled over too far at times which created the potential for him/her to fall off the bed again. Staff interviews revealed they were also unaware the care plan had been updated, after Resident #8 sustained the fall with a fracture on 03/06/14, for the resident's need of two (2) staff to assist with bed mobility

The findings include:
 Review of Resident #8's medical record revealed diagnoses which included Dementia, Schizophrenia, History of a Fracture to the Neck of the Femur, Depression, and a closed Fracture to the Right Patella.

Review of Resident #8's Quarterly Minimum Data

F 282

F 282 D 483.20 (L)(3)(II) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

Action for Residents Affected by Deficient Practice
 Resident #8 was re-evaluated by the IDT. The care plans were reviewed and updated to reflect the resident's condition. Resident #8 is now being seen by physical therapy.

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NAME OF PROVIDER OR SUPPLIER GRAND HAVEN NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 105 RODGERS PARK CYNTHIANA, KY 41031
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(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 282	<p>Continued From page 20</p> <p>Set (MDS) Assessment, dated 01/29/14, and Annual MDS Assessment, dated 05/01/14, revealed the facility assessed the resident as having moderate cognitive impairment. Continued review of the two (2) MDS Assessments revealed the facility assessed Resident #8 as requiring extensive assistance of two (2) persons for bed mobility and as being frequently incontinent of bladder and bowel.</p> <p>Review of the Comprehensive Care Plan revised on 10/29/13, revealed Resident #8 required assistance with Activities of Daily Living (ADL's) related to diagnoses of Stroke, Dementia and Impaired Balance. Continued review of the ADL care plan revealed the goal stated Resident #8 would maintain the current level of function related to bed mobility. The interventions revised 10/29/13, revealed Resident #8 required limited assist of one (1) to turn and reposillon in bed. Further review of the ADL care plan revealed an undated intervention which stated Resident #8 was to have extensive assist of two (2) to turn and reposition in bed. Continued review of the Comprehensive Care Plan revealed Resident #8 also had a risk for falls care plan, revised 05/15/13, related to Resident #8 being unaware of his/her safety needs. Review of the risk for falls care plan revealed a goal which stated the resident would not sustain serious injury. Further review of the care plan revealed on 03/06/14 a new intervention was added after the Resident #8 experienced the fall on that date. The new intervention Resident #8 was to have two (2) staff members for bed mobility.</p> <p>Review of the Comprehensive Care Plan with a date of 05/22/14, revealed Resident #8's ADL care plan interventions included the resident</p>	F 282	<p>Identification of Other Residents Affected by Deficient Practice</p> <p>On 5/19/14 through 6/14/2014, reviews were completed by the Director of Nursing, ADON, QA Nurse, and MDS Coordinator. The reviews included a comparison of the residents' care plan, the daily care plan record, and the residents' current interventions and status. Any discrepancies noted were re-evaluated and corrected immediately.</p>	
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F 282	Continued From page 21 requiring extensive assist of two (2) staff to turn and reposition in bed. Review of the "Nurse Aide Daily Care Plan Record" for May 2014, revealed Resident #8's bed mobility was marked for the resident to require assist of two (2) staff. Review of the facility's Fall Risk Evaluation for Resident #8, dated 04/30/14, revealed it stated a total score of ten (10) or above represented a high risk for falls. Continued review of the Evaluation revealed Resident #8's total score was eighteen (18) indicating he/she was a high risk for falls. Review of the Nurse's Notes dated 03/06/14 at 8:45 AM, noted as a late entry for 03/06/14 at 6:00 AM, which had been completed by the Director of Nursing (DON), revealed a State Registered Nursing Assistant (SRNA) reported assisting Resident #8 to turn in the bed, and the resident had rolled out of bed. Continued review of the late entry Note revealed Resident #8 stated he/she had rolled close to the bed edge and rolled out of the bed. Review of the Nurse's Notes/Condition Change Form, dated 03/06/14 at 10:00 AM, revealed the resident complained of right leg pain after rolling out of bed in the "AM" (morning) and the Physician had ordered an x-ray. Review of the Nurse's Notes/Condition Change Form, dated 03/07/14 10:05 AM, revealed Resident #8 complained of right leg pain, a call was placed to the Advanced Registered Nurse Practitioner (ARNP), and new orders were received to send Resident #8 to the Emergency Room (ER). Review of the ER Note dated 03/07/14, revealed	F 282	Systemic Changes for Non-Recurrence Re-education was provided to the nursing staff regarding following resident care plans and physician's orders. Education was provided by the Staff Development Coordinator (SDC) on 5/16/2014 through 5/19/2014. Daily care rounds are conducted by the nurse management team including the DON, SDC, QA Nurse, ADON, and MDS Coordinator to ensure nursing interventions and physician's orders are being followed.		

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F 282 Continued From page 22
Resident #8 had a Fracture of the right Patella.

Interview, on 05/14/14 at 12:10 PM, with Resident #8 revealed he/she was had rolled out of bed when a SRNA was completing his/her perineal care. Resident #8 stated there was only the one (1) SRNA assisting him/her at the time he/she rolled out of bed onto the floor.

Phone interview, on 05/14/14 at 4:40 PM, with SRNA #4 revealed she was familiar with Resident #8 and frequently assigned to his/her care. She explained on 03/08/14, she was providing incontinence care for Resident #8 when the resident rolled over too far and fell off the bed onto the floor. She stated she got the nurse after the fall and she assessed Resident #8. SRNA #4 stated she was never questioned or educated by the DON or by administrative staff related to the fall. SRNA #4 stated she continued turning and repositioning Resident #8 by herself, even though the resident still tried to help when being turned and often rolled over too far. Continued interview with SRNA #4 revealed other staff also continued turning and positioning Resident #8 in the bed without assistance. However, review of Resident #8's Daily Care Plan Record revealed it was revised 03/08/14 for the resident to have assistance of two (2) staff for bed mobility. Further interview with SRNA #4 revealed SRNA's were to refer to the "nurse aide care plan" (Daily Care Plan Record) at the nurse's station when caring for residents. Per interview, SRNA #4 stated it was hard to remember all the interventions on the "nurse aide care plan". She stated she was unsure what Resident #8's care plan now said regarding bed mobility assistance.

Phone interview, on 05/14/14 at 5:05 PM, with

F 282

Monitoring for Sustainment

A comprehensive review is completed weekly by members of the nurse management team including the DON, ADON, and/or Quality Assurance Nurse the review will follow the routine Care Conference schedule. Reviews are completed by comparing the residents' care plan, the daily care record, and the physician's orders with the status of the resident to ensure all interventions are being followed. Results of the reviews are submitted to the QA Committee monthly for recommendations if indicated.

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F 282	<p>Continued From page 23</p> <p>Registered Nurse (RN) #2 who was assigned to Resident #8 at the time of the fall on 03/06/14, revealed SRNA #4 reported the resident's fall to her and she had assessed him/her. She stated the DON or administration had not provided any education or questioned her about the fall. RN #2 stated she thought Resident #8 was still to have assistance of only one (1) staff for bed mobility and did not think that had changed after the fall. However, review of the Comprehensive Care Plan and Daily Care Plan Record revealed they had been revised on 03/06/14 for Resident #8 to have assist of two (2) staff for bed mobility. Continued interview with RN #2 revealed staff were to use the "Nurse Aide Care Plan" or the Comprehensive Care Plan for reference to determine residents care needs.</p> <p>Interview, on 05/14/14 at 4:10 PM and 7:00 PM and 05/15/14 at 3:45 PM, with the DON revealed Resident #8 was being assisted with one (1) staff, instead of two (2) for bed mobility on 03/06/14, and she felt this was the root cause of the fall. She stated both the Comprehensive Care Plan and the Daily Care Plan Record for Resident #8 was updated on 03/06/14 for two (2) staff to assist with bed mobility. Continued Interview with the DON revealed she had not performed interviews or re-education with the staff involved at the time of the resident's fall. Per interview, the DON stated changes in residents' care plans were not necessarily verbalized to staff, and SRNAs were to review the Daily Care Plan Record every day at the beginning of their shift for changes in residents' care. She stated all communication to staff for any changes made in reference to care of a resident, was by review of the Daily Care Plan Record or Comprehensive Care Plan.</p>	F 282		
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F 282	Continued From page 24 Interview, on 05/14/14 at 6:35 PM, with the Quality Assurance Nurse confirmed changes made to the Comprehensive Care Plans or the Daily Care Plan Record were not communicated verbally to staff; however, the SRNA's were expected to read the Daily Care Plan Record at the beginning of each shift and should recognize any changes then.	F 282	Completion Date 6/18/14.	6/18/14
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F 318 SS=D	<p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy, it was determined the facility failed to ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for one (1) of thirteen (13) sampled residents (Resident #3).</p> <p>Resident #3 was discharged from Physical Therapy (PT) with a referral to the Restorative Nursing Program (RNP); however, record review and interviews with staff revealed the facility failed to place the resident in the RNP as per PT recommendations.</p>	F 318	<p>F 318 D 483.25(E)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Action for Residents Affected by Deficient Practice Resident #3 was screened by PT on 5/15/2014 and OT on 5/23/2014. No decline in functional status was noted since the last review. A physician's order was received for resident #3 to be placed on restorative nursing, proper documentation was completed to reflect the new order including care plans and flow sheets.</p>	
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F 318	Continued From page 25 The findings include: Review of the facility's policy titled, "Restorative Nursing Referrals Rehabilitation Policy", undated, revealed all restorative nursing referral recommendations from a licensed rehabilitation therapist would be given to the Restorative Nurse Manager. The Policy further stated the Rehab Manager and the Restorative Nurse Manager would take the restorative referral to the Interdisciplinary Plan of Care (IPOC) meeting to discuss the individual resident's plan of care. The Restorative Nurse Manager would obtain a Physician's Order for the individual's restorative program and after obtaining the order, would write the Restorative Plan of Care for the resident. According to the Policy, a copy of the Restorative Plan of Care would be placed in the Restorative Nursing Assistants book and a copy would be placed in the resident's medical record. Review of Resident #3's medical record revealed diagnoses which included Non Alzheimer's Dementia, and Cerebral Vascular Accident (CVA), Osteoarthritis, Chronic Obstructive Pulmonary Disease (COPD), and Diabetes Mellitus. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 03/11/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a ten (10) indicating moderate cognitive impairment. Further review revealed the facility assessed the resident as requiring total assistance of two (2) persons for transfers, and as ambulation not occurring. Review of Physician's Orders dated 03/13/14 revealed orders for Physical Therapy three (3) times a week for thirty (30) days of therapeutic	F 318	Identification of Other Residents Affected by Deficient Practice The Nurse Management team, DON, ADON, QA Nurse, and MDS Coordinator reviewed therapy discharge notes on 6/10/14 that were completed in the last 3 months to determine a need for restorative nursing interventions.	

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F 318 Continued From page 26
exercise, therapeutic activities, safety education, and resident/care giver training for treatment of muscle weakness due to Osteoarthritis, COPD, and Diabetes Mellitus.

Review of the Physical Therapy Updated Plan of Progress dated 04/14/14, which was in the medical record, revealed the resident received PT from 03/11/14 through 04/11/14. The discharge recommendations revealed the resident was to be placed on the RNP to allow continued strengthening and endurance training. Further review revealed the resident's progress was impeded by passive participation.

Review of the Restorative Book at the nurses station revealed there was no Restorative Plan of Care for Resident #3.

Interview, on 05/15/14 at 12:00 PM with State Registered Nurse Aide (SRNA) #1/Restorative Aide, revealed once the resident was discontinued from PT, she would receive the RNP referral from PT. She stated she had given the referral to the Restorative Nurse for Resident #3 and the Restorative Nurse had stated she was not going to place the resident on the RNP because the resident had declined the RNP in the past. She stated she needed a Physician's Order before she could start RNP.

Interview and record review on 05/15/14 at 12:30 PM and 1:15 PM with the Restorative Nurse revealed the resident was discharged from PT to the RNP on 04/11/14; however, she was unaware of the referral. She further stated after the last fall the resident had refused the RNP and she did not know if the resident would have participated. Continued interview revealed she usually

F 318
Systemic Changes for Non-Recurrence
Therapy discharge notes are being reviewed by the DON or designee to ensure that recommendations are being followed.
On 5/30/14 a therapy representative attends the routine restorative meetings to discuss any residents that may benefit from a restorative nursing program as well as reviewing residents that are currently receiving restorative. The therapy manager and restorative nursing assistant were educated by the Director of Nursing on 6/10/14 on the importance of ensuring restorative recommendations are implemented.

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F 318 | Continued From page 27

discussed the referral with the Restorative Aide; however, she could not remember if she had discussed this situation and did not see any documentation in the medical record as to why the resident was not to receive the RNP.

Interview with the Physical Therapist on 05/15/14 at 12:45 PM revealed she left the RNP Form/Referral on the Restorative Nurse Aides desk. She further stated she did not attend the morning meetings; however, was told each morning in the morning meeting the residents who were to be discharged from PT with RNP referrals were discussed with nursing by the Rehab Manager. She further stated this was also discussed in the weekly medicare meetings. Continued interview revealed therapy did not write for the Physician's Order for the RNP, and that was the responsibility of nursing. The PT stated the Restorative Plan of Care for Resident #3 was in the PT file.

Review of the Restorative Program: Range of Motion Form (Restorative Plan of Care) which was in the PT file, dated April 2014, and signed by the Physical Therapist on 04/12/14, revealed Resident #3 had the diagnoses of Muscle Weakness. The problem stated the resident's current range of motion indicated decreased lower extremity strength and the baseline revealed the resident was able to stand for one (1) minute or perform the ped cycle approximately three (3) continuous minutes. The goal stated the resident would maintain or improve current range of motion as evidenced by continued ability to stand greater to or equal to one (1) minute and perform lower extremity exercise through restorative care at least fifteen (15) minutes daily, six (6) to seven (7) days a week with restorative

F 318 |

Monitoring for Sustainment

Therapy discharges are reviewed during the weekly utilization meetings to ensure any recommendations for restorative are implemented.

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F 318	<p>Continued From page 28</p> <p>staff. The interventions included active range of motion to bilateral lower extremities with assistance of the Restorative Aide.</p> <p>Interview with the Director of Nursing on 05/15/14 at 1:15 PM, revealed if PT recommended RNP, they were to write the Physician's Order for RNP. She stated the Rehab Manager was to get the Referral Forms together for the Restorative Nurse; however, she was unaware of the Rehab Manager bringing the referral information to the morning meetings.</p> <p>Interview on 05/15/14 at 1:25 PM with the Rehab Manager, revealed she attended the morning meetings and the Discharge Notice stating when the resident was to be discontinued from therapy, as well as the copy of the Restorative referral information was passed out to the Billing Manager and the Restorative Nurse every day in the morning meeting. She further stated she also verbalized who would be discontinuing PT and starting the RNP during the meeting. Continued interview revealed the Restorative Aide received her own copies of the Restorative referral information and the Restorative Aide communicated the need for RNP to the Restorative Nurse. Further interview revealed she had always attended the morning meetings and verbalized which residents were going to be discontinued from PT and being referred to the RNP.</p> <p>Review of the Therapy Screen dated 05/15/14 completed by the PT, revealed the resident had no decline in transfer status or mobility. Interview with the PT on 05/15/14 at 3:45 PM, revealed she had observed the resident to transfer and no decline in transfer ability was noted. She further</p>	F 318		
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F 318 Continued From page 29
stated she would not have expected a decline yet, as the resident was just discharged from PT on 04/11/14.

F 318; Completion Date 6/18/14

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

F 323

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

This REQUIREMENT is not met as evidenced by:
Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure each resident received adequate supervision and assistance to prevent accidents for one (1) of fourteen (14) sampled residents (Resident #8).

Resident #8 was assessed by the facility to require the assistance of two (2) staff for bed mobility per the Minimum Data Set (MDS) Assessment dated 01/29/14; however, the Comprehensive Care Plan revised 10/29/13 revealed the resident required limited assist of one (1) staff to turn and reposition in the bed. The Daily Care Plan Record, a reference State Registered Nursing Assistants (SRNAs) used to indicate residents' care needs, dated March 2014, revealed Resident #8 required extensive assistance of one (1) staff member for bed mobility. On 03/06/14, Resident #8 was being assisted by one (1) staff member with bed

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185332	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/15/2014
NAME OF PROVIDER OR SUPPLIER GRAND HAVEN NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 105 RODGERS PARK CYNTHIANA, KY 41031		
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F 323	<p>Continued From page 30</p> <p>mobility during incontinence care, even though he/she had been assessed to require two (2) staff for this. Resident #8 fell off the bed and sustained a Right Patella (Kneecap) Fracture.</p> <p>In addition, there was no documented evidence of a Nurse's Note written in the medical record by the nurse who assessed the resident at the time of the fall which occurred on 03/06/14 at 6:00 AM, to include an assessment and notifications to the Physician and the Responsible Party. Also, there was no documented evidence staff who was assigned to Resident #8's care at the time of the fall were questioned to try and determine the root cause of the fall.</p> <p>Additionally, the facility failed to ensure the residents' environment remained as free of accident hazards as possible as evidenced by a hanging ceiling vent cover over the toilet in a resident bathroom which staff indicated could cause harm to the resident if it fell.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Falls Management Program", revised 10/16/12, revealed it was the policy of the facility to safeguard residents while promoting the highest possible level of independence and quality of life. The Policy stated this would be accomplished through: assessment of all residents to establish their risk for falls; care planning; and implementing appropriate interventions to minimize falls and injuries related to falls; and, tracking and trending patterns.</p> <p>Review of Resident #8's medical record revealed diagnoses which included Schizophrenia,</p>	F 323	<p><u>F 323 G 483.25 (H) FREE OF ACCIDENT HAZARDS/SUPERVISION DEVICES</u></p> <p>Action for Residents Affected by Deficient Practice</p> <p>Resident #8 was re-evaluated. The fall risk assessment was reviewed and revised on 5/14/14 to reflect the appropriate score. A modification of Resident #8's annual MDS assessment was completed with an ARD of 5/1/14; the care plan and daily care record were updated. The SRNA #4 received re-education on promoting and maintaining a safe environment while providing resident care on 6/10/14. The vent in room 211 was repaired on 5/13/14 by the maintenance director.</p>	

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Dementia, History of a Fracture to the Neck of the Femur, Depression and Neurogenic Bladder.

Review of Resident #8's Quarterly Minimum Data Set (MDS) Assessment, dated 01/29/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15), indicating he/she was cognitively intact. Continued review revealed the facility assessed Resident #8 as requiring extensive assistance of two (2) persons for bed mobility and as being frequently incontinent of bladder and bowel. Review of the seven (7) day Activities of Daily Living (ADL's) Tracking form dated 01/23/14 through 01/29/14, for the MDS dated 01/29/14, revealed Resident #8 required two (2) staff to assist with bed mobility.

Review of the Comprehensive Care Plan dated 05/22/13, revealed Resident #8 required assistance with Activities of Daily Living (ADL's) related to diagnoses of Stroke, Dementia and Impaired Balance. Continued review of the ADL care plan revealed the goal stated Resident #8 would maintain the current level of function related to bed mobility, transfers, toilet use, and personal hygiene. The interventions dated 05/22/13 and revised 10/20/13, revealed Resident #8 required limited assist of one (1) to turn and reposition in bed. Further review of the ADL care plan revealed an undated intervention which stated Resident #8 was to have extensive assist of two (2) to turn and reposition in bed. Continued review of the Comprehensive Care Plan revealed a risk for falls care plan, revised 05/15/13, related to Resident #8 being unaware of his/her safety needs. Review of the risk for falls care plan revealed a goal which stated the resident would not sustain serious injury. Further

F 323

Identification of Other Residents Affected by Deficient Practice
On 6/10/14 falls risk assessments were reviewed by licensed nurse members of the IDT to ensure scores are accurate and reflected appropriately in the residents' individual care plans. Care plans and daily care records were updated for any concerns identified. The DON and Nurse Consultant reviewed the past 3 months of facility internal event documentation to ensure the medical records reflect the residents' status beginning 6/9/14 through 6/14/14.

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F 323	<p>Continued From page 32</p> <p>review of the risk for falls care plan revealed a new intervention added on 03/06/14, after the resident's fall that day, which stated Resident #8 was to have two (2) staff members for bed mobility.</p> <p>Review of the "Daily Care Plan Record" for March 2014, revealed bed mobility was marked as extensive assist of one (1) staff, and highlighted as changed on 03/06/14 to indicate Resident #8 required assist of two (2) staff.</p> <p>Interview, on 05/14/14 at 4:10 PM and 7:00 PM and 05/15/14 At 3:45 PM, with the DON revealed the Comprehensive Care Plan and the Daily Care Plan Record should have also reflected Resident #8's assessed need for two (2) to assist with bed mobility, as the Care Plan was generated from the MDS. However, she stated both the Comprehensive Care Plan and the Daily Care Plan Record were not updated until 03/06/14 after Resident #8's fall to include the intervention for two (2) staff to assist with bed mobility.</p> <p>Review of the facility's Fall Risk Evaluation form, dated 01/28/14 which was the last Fall Risk Evaluation completed before Resident #8's fall on 03/06/14, revealed when all the scores on the form were added the total score equaled sixteen (16) which indicated the resident was a high risk for falls. The Evaluation form stated a total score of ten (10) or above represented a high risk for falls. However, further review of the Fall Risk Evaluation revealed the total score documented on the form for Resident #8 was noted to be six (6), instead of sixteen (16) which would not indicate the resident was a high risk for falls. Continued review of the Fall Risk Evaluation revealed the parameters evaluated included</p>	F 323	<p>On 5/21/14, the Administrator and Maintenance Director completed thorough rounds throughout the facility to ensure that each vent in resident rooms was appropriately affixed to the ceiling. Any identification was corrected by the maintenance director through 6/2/14. The Administrator completed follow-up rounds on 6/3/14 to ensure that all vents are adequately maintained.</p>	

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F 323	<p>Continued From page 33</p> <p>Resident #8's status or condition related to disorientation, chair bound, not able to perform gait/balance, current medications and three (3) or more predisposing diseases.</p> <p>Interview, on 05/14/14 at 5:15 PM and 5:45 PM, with the MDS Coordinator revealed she completed Fall Risk Evaluatons on all residents on admission, quarterly, yearly and with a significant change. She stated she had inadvertently written a six (6) instead of a sixteen (16) on the Fall Risk Evaluation completed on 01/28/14 for Resident #8 and she clarified the resident was at high risk for falls.</p> <p>Review of the Nurse's Notes revealed no documented evidence a Nurse's Note was written at the time of Resident #8's fall on 03/06/14 at 6:00 AM. However, review of the Nurse's Notes dated 03/06/14 at 8:45 AM, noted as a late entry for 03/06/14 at 6:00 AM, which had been completed by the Director of Nursing (DON) revealed a SRNA reported assisting Resident #8 to turn in the bed, and the resident continued to roll, and rolled out of bed. Continued review revealed vital signs were documented as: blood pressure as 123/63, pulse as 78, respirations as 18, and temperature as 98.2. Continued review of the late entry Note revealed Resident #8 stated he/she had rolled close to the bed edge and rolled out of the bed. The late entry Note stated the Physician was notified with no new orders at that time, and the resident's family was also notified.</p> <p>Review of the Nurse's Notes/Condition Change Form, dated 03/06/14 at 10:00 AM, revealed Resident #8 complained of right leg pain after rolling out of bed in the "AM" (morning). Per the</p>	F 323	<p>Systemic Changes for Non-Recurrence</p> <p>Falls risk assessments are reviewed during the care plan conference meetings, care plan and daily care records are updated as needed to reflect assessment results. The facility's Director of Nursing will review each MDS for accuracy before the MDS is locked and transmitted to CMS. A second review is completed by the IDT during the scheduled care conference. During care plan meetings, falls risk assessments are reviewed for accuracy. Any discrepancies noted are corrected by the MDS coordinator.</p>	

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Note, an x-ray was ordered by the Physician and Radiology and the family was notified. Review of the Nurse's Notes, dated 03/06/14 at 5:00 PM, revealed x-ray reports were received and sent to the Physician with no new orders received.

Review of the Nurse's Notes, dated 03/06/14 at 7:10 PM, revealed the Advanced Practice Registered Nurse (APRN) called with new orders regarding the results of the x-rays and staff was to obtain a orthopedics consult. Review of the Nurse's Notes dated 03/07/14 9:00 AM, revealed Resident #8 was encouraged to stay in bed and not put weight on the right knee, and the resident denied complaints of pain or discomfort.

Review of the Nurse's Notes/Condition Change Form, dated 03/07/14 10:05 AM, revealed Resident #8 complained of right leg pain, a call was placed to the APRN, and new orders received to send Resident #8 to the hospital Emergency Room (ER). Review of the Nurse's Notes, dated 03/07/14 at 10:20 AM, revealed Emergency Medical Services (EMS) was notified for transport and the resident was transported on 03/07/14 at 10:35 AM.

Review of the Hospital ER Note dated 03/07/14, revealed Resident #8 had a Fracture of the right Patella. Continued review of the Hospital ER Note revealed Resident #8 was to be non-weight bearing and was to keep an ace wrap on the right leg for support.

Interview, on 05/14/14 at 12:10 PM, with Resident #8 revealed he/she was trying to assist an SRNA with completing his/her perineal care in bed and had rolled over so the SRNA could finish washing him/her. Resident #8 stated he/she was being

F 323

On 6/2/14 through 6/9/14, facility staff was in-serviced on the facilities policy and procedure in completing maintenance requests. Ceiling vent covers were added to environmental rounds checklist on 5/21/14. These rounds are completed by the maintenance technician weekly. Any identified