

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

PRINTED: 12/28/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185279	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/12/2012
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NAME OF PROVIDER OR SUPPLIER MILLS HEALTH & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 800 BECK LANE MAYFIELD, KY 42066
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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 000	INITIAL COMMENTS An abbreviated survey (KY #19484) was conducted 12/10/12 through 12/12/12. KY #19484 was substantiated with deficiencies cited a scope and severity of "G". The facility failed to ensure care plan interventions were implemented to provide the required supervision when assisting a resident with bed mobility and incontinent care. Resident #1 was assessed to require a two person assist with bed mobility and incontinent care. On 12/05/12, one staff person assisted the resident to turn in the bed while providing incontinent care. The resident rolled off the bed onto the floor and sustained an impacted fracture to the left femur.	F 000		
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 policy review it was determined the facility failed to ensure care was provided in accordance with the resident's plan of care for one of three sampled residents (Resident #1). Resident #1 was assessed and care planned for the assistance of two staff for bed mobility and incontinent care. On 12/05/12 at 6:50 AM, Certified Nursing Assistant (CNA) #1 was providing incontinent care to Resident #1 without assistance and	F 282	Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is submitted solely because it is required by the provision of federal and state law. <u>483.20(k)(3)(II) Services by Qualified Persons/Per Care Plan.</u> It is the routine practice of Mills Health and Rehab Center to provide or arrange services in accordance with each resident's written plan of care. <u>Corrective Measures for Resident Identified in the deficiency:</u> Resident #1 is provided incontinent care and bed mobility utilizing 2 staff members in accordance with the resident's plan of care. CNA #1 was re-educated on 12/5/12 and verbalized understanding of following the Nurse Aide Data Sheet. Upon resident #1's return to facility on 12/11/12, she was assessed by licensed nurse. Unannounced observations of care delivery to validate services are being provided in accordance with the plan of care were initiated on 12/11/12 daily for 4 weeks for Resident #1. The observations will be conducted by the Licensed Nurses DON, ADON or Staff Development Nurse and Unit Managers.	12/21/12



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Maria Reyes</i>	TITLE Administrator	(X6) DATE 2-1-2013
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 282	<p>Continued From page 1</p> <p>Instructed Resident #1 to turn to the opposite side of the bed. The resident turned and was unable to grab the grab bar attached to the bed. Resident #1 rolled off the bed, onto the floor, and landed on his/her left side. The resident was transferred to the hospital for further evaluation and was diagnosed with a fractured left femur. (Refer to F323)</p> <p>The findings include:</p> <p>A review of the facility's policy entitled "Comprehensive Care Plans" dated 01/01/07 and revised 06/14/11 revealed residents would have a plan of care for assessed needs. Care plan approaches would be communicated to staff for use in providing direction in care. The plan of care would clearly state and identify the resident's problem, have measurable goals to be achieved, which include timetables to meet resident's needs, and the interventions to be followed by staff in providing the resident care. Each approach would identify the discipline responsible for the care delivery.</p> <p>Resident #1 was readmitted to the facility on 10/19/12 with diagnoses to include Above the Knee Amputation, Congestive Heart Failure and Senile Dementia. A review of the significant change Minimum Data Set (MDS) assessment, dated 10/12/12, revealed the facility assessed the resident as severely impaired in his/her cognition and required extensive assistance of two staff with bed mobility, transfers and toilet use.</p> <p>A review of the comprehensive care plan, dated 10/15/12, revealed Resident #1 required the assistance of two staff for incontinent care and</p>	F 282	<p>F-282 (cont)</p> <p><u>How other residents who may be affected by this practice were identified:</u> All residents Nurse Aide Data Sheets were reviewed by the MDS Coordinator, MDS Staff, Staff Development Nurse and ADON to identify residents who require staff assistance with ADL's on 12/3/12 and 12/6/12. Unannounced observations of care being delivered for these residents are being conducted by the DON, ADON, or Staff Development, Unit Managers and Licensed Nurses, to validate services are being provided in accordance with the plan of care as specified on the Nurse Aide Data Sheet.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> Re-education was initiated on 12/5/12 by Director of Nursing, Assistant Director of Nursing, Staff Development Nurse and Unit Managers to educate all Nursing Staff on following the Nurse Aide Data Sheet for staff requirements as established by the interdisciplinary care plan team for care delivery for residents. The inservicing will continue to be provided to all oncoming nursing staff prior to working their assigned shift until all staff are re-educated. The inservicing will be provided by the DON, ADON, Staff Development Nurse and Unit Managers. The Director of Nursing will be responsible to arrange or provide the additional education for any Nursing Staff member who has not completed the inservicing prior to the last session on 12/17/12 before their next shift worked. In addition to the above inservicing a Post Test was given to the Nursing Staff to verify understanding of the information provided during the education sessions. This test was given by the DON, Staff Development Nurse, ADON, and Unit Managers.</p>	
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F 282	<p>Continued From page 2</p> <p>turning and repositioning. A review of the Nurse Aide Data Sheet dated 10/15/12 revealed the resident required the assistance of two staff for turning every two hours and for toileting.</p> <p>A review of the nurse's notes, dated 12/05/12 at 7:30 AM, revealed documentation of the nurse tech changing the resident's brief in bed and the resident rolled from the bed to the floor. The resident sustained a skin tear to the right forearm, and complained of pain in his/her head, neck and left arm. The resident was sent to the hospital emergency room, the family was notified and a fax was sent to the physician.</p> <p>An interview with CNA #1, on 12/11/12 at 11:34 AM, revealed she provided care to Resident #1 previously. She did not review Resident #1's care plan prior to providing care to the resident and did not know how much assistance the resident required. Additionally, she did not have another staff member to aide her in completing the incontinent care or turning the resident. She revealed the resident turned to the opposite side of her and rolled off the bed.</p> <p>An interview with Registered Nurse (RN) #1, on 12/11/12 at 10:42 AM, revealed she was at the desk the morning of 12/05/12, when CNA #1 came up the hall to get the attention of the nurses. She entered Resident #1's room and observed CNA #1 beside the resident who was lying on the floor. She asked the CNA #1 what happened and she explained the resident rolled off the bed while turning to the opposite side. RN #1 revealed she was aware the resident required extensive assistance of two staff for turning and incontinent care which was provided in the bed.</p>	F 282	<p>F-282 (cont)</p> <p>A score of 100% was required in order to pass the test. All Staff members who were present to current have passed the test with a score of 100%.</p> <p>The DON will be responsible to provide or arrange for the post test to any staff member who has been on leave or vacation.</p> <p>The facility will continue to include education for new hires on following the Nurse Aide Data Sheets in accordance with the residents plan of care during the orientation process. In addition, a post test was added to the orientation process to verify understanding of the education given.</p> <p><u>Monitoring Measures to Maintain On-going Compliance:</u> Unit managers, Licensed staff, ADON, or Staff development Nurse will randomly select 2 residents (10%) per shift, for each wing daily for two weeks who require assistance with ADL's without prior notification, staff providing care for these residents will be observed performing care to validate compliance with following the Nurse Aide Data Sheet in accordance with the residents plan of care. The observations will continue to be conducted three times a week for eight weeks, then two times per week for eight weeks, then weekly times four weeks, then monthly x 6 months. In addition the unannounced observations of care delivery will continue to be conducted ongoing on a quarterly basis for a selected sample of Certified Nursing Assistants. This will be conducted by the Staff Development Nurse, ADON, DON or Unit Managers. Findings of the observations will be reported to the Director of Nursing and to the facility's Quality Assurance Committee. The Committee will review findings of the observations if concerns are identified retraining/discipline will result. The committee may make further recommendations of increasing the frequency and/or duration of the unannounced observations being conducted.</p>	
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F 282	<p>Continued From page 3</p> <p>She revealed the CNA did not provide care according to the resident's plan of care. She could not explain why the CNA wasn't following the plan of care but it resulted in the resident having a fractured hip.</p> <p>An interview with the Director of Nursing (DON), on 12/12/12 at 12:14 PM, revealed she came in the morning of 12/5/12 and was informed of the resident falling. She reviewed the resident's care plan and saw the resident required the assistance of two staff for repositioning and incontinent care. She talked to CNA #1 and asked her if she knew the resident required the assistance of two staff for incontinent care. The DON reported CNA #1 informed her she did not know the resident required the assistance of two staff for incontinent care. Per interview, the staff did not follow the care plan and it resulted in the resident falling from his/her bed.</p>	F 282		
F 323 SS-G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's investigation it was determined the facility failed to ensure one of three sampled</p>	F 323	<p>F-323</p> <p><u>483.25(h) Free of Accident Hazards/Supervision/Devices</u></p> <p>It is the practice of Mills Health and Rehab to maintain the facility in a manner that the resident environment remains as free of hazards as is possible; and each resident receives adequate supervision and assistance to prevent accidents.</p>	12/25/12

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F 323	<p>Continued From page 4</p> <p>residents (Resident #1) received adequate supervision to prevent accidents. On 12/06/12 at 6:50 AM, Certified Nursing Assistant (CNA) #1 was providing incontinent care to Resident #1 without assistance and instructed Resident #1 to turn to the opposite side of the bed. The resident turned and was unable to grab the grab bar attached to the bed. Resident #1 rolled off the bed, onto the floor, and landed on his/her left side. Resident #1 was assessed and care planned for the assistance of two staff for bed mobility and incontinent care. CNA #1 failed to have the required number of staff present while providing care to Resident #1, resulting in the resident falling from his/her bed. (Refer to F282) The resident was transferred to the hospital for further evaluation and was diagnosed with a fractured left femur.</p> <p>The findings include:</p> <p>Review of the facility's investigation of Resident #1's fall revealed the facility determined the cause of Resident #1's fall was CNA #1 provided care to the resident by herself and did not review the resident's care plan prior to assisting the resident.</p> <p>Resident #1 was readmitted to the facility on 10/19/12 with diagnoses to include Above the Knee Amputation, Congestive Heart Failure and Senile Dementia. A review of the significant change Minimum Data Set (MDS) assessment, dated 10/12/12, revealed the facility assessed the resident as severely impaired in his/her cognition and required extensive assistance of two staff with bed mobility, transfers and toilet use.</p> <p>A review of the comprehensive care plan, dated</p>	F 323	<p>F-323 (cont)</p> <p><u>Corrective Measures for Resident Identified in the deficiency:</u></p> <p>Resident #1 is provided incontinent care and bed mobility utilizing 2 staff members in accordance with the resident's plan of care. CNA #1 was re-educated on 12/5/12 and verbalized understanding of following the Nurse Aide Data Sheet. CNA#1 was re-educated on incident/accidents on 12/13/12. Upon resident # 1's return to facility on 12/11/12, she was assessed by licensed nurse. Unannounced observations of care delivery to verify that planned interventions and safety devices are provided as planned, and to verify that the environment is free of hazards, were initiated on 12/11/12 daily for 4 weeks for Resident #1. The observations will be conducted by the Licensed Nurses, DON, ADON, Staff Development Nurse and Unit Managers.</p> <p><u>How other residents who may have been affected by this practice were identified:</u></p> <p>All residents Nurse Aide Data Sheets were reviewed by the MDS Coordinator, MDS Staff, Staff Development Nurse and ADON to identify residents who require staff assistance with ADL'S on 12/5/12 and 12/6/12, to provide supervision and verify that care is being provided in accordance with the plan of care as specified on the Nurse Aide Data Sheet. Additionally the resident environment is observed to verify that planned devices are in use and that the environment is free of avoidable hazards. The unannounced observations of care are</p>	
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F 323	<p>Continued From page 5</p> <p>10/15/12, revealed Resident #1 required the assistance of two staff for Incontinent care and turning and repositioning. A review of the Nurse Aide Data Sheet dated 10/16/12 revealed the resident required the assistance of two staff for turning every two hours and for toileting.</p> <p>A review of the nurse's notes, dated 12/05/12 at 7:30 AM, revealed the nurse tech changed the resident's brief in bed and the resident rolled from the bed to the floor. The resident sustained a skin tear to the right forearm, and complained of pain in his/her head, neck and left arm. The resident was sent to the hospital emergency room, the family was notified and a fax was sent to the physician.</p> <p>A review of the Diagnostic Imaging Report dated 12/05/12 revealed there was an impacted fracture in the proximal left femur, in the subcapital region.</p> <p>An interview with CNA #1, on 12/11/12 at 11:34 AM, revealed she was the aide in the room with Resident #1 on 12/05/12. She entered the room around 8:50 AM to get the resident up for breakfast when the resident reported having a bowel movement. CNA #1 walked to the left side of the bed, unfastened the resident's brief on the right side, and instructed the resident to roll toward her (to the left side). She tucked the brief underneath the resident and directed him/her to roll to the right side and to reach for the bar. As Resident #1 reached for the bar he/she missed the bar and went over the side of the bed. CNA #1 tried to stop the resident but she was unable to stop him/her. She ran to the other side of the bed and knelt down beside him/her to check to</p>	F 323	<p>F-323 (cont)</p> <p>being conducted for these residents by the DON, ADON, Staff Development, Unit Managers and Licensed Nurses</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>Re-education on the incident/accident policy was initiated for all Nursing Staff on 12/13/12 by the Staff Development Nurse and ADON. The training provided included emphasis on consistent implementation of care planned interventions and the requirement to maintain the environment as free of hazards as is possible. Education will continue until all staff have been re-educated on the policy. This will be conducted by the DON, ADON, Staff Development Nurse and Unit Managers. The DON will be responsible to arrange or provide training for any staff who were on leave or vacation during the sessions. Re-education was initiated on 12/5/12 by Director of Nursing, Assistant Director of Nursing, Staff Development Nurse and Unit Managers to educate all Nursing Staff on following the Nurse Aide Data Sheet for staff requirements as established by the interdisciplinary care plan team for care delivery for residents. The inservicing will continue to be provided to all oncoming nursing staff prior to working their assigned shift until all staff are re-educated. The inservicing will be provided by the DON, ADON, Staff Development Nurse or Unit Managers. The Director of Nursing will be responsible to arrange or provide the additional education for any Nursing Staff member who</p>	
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F 323	<p>Continued From page 6</p> <p>make sure the resident was okay, then left the room and yelled for the nurse. CNA #1 went back into the room and Licensed Practical Nurse (LPN) #1 and Registered Nurse (RN) #1 came into the room along with two other aides. The nurses checked Resident #1 and he/she had a skin tear to his/her right arm. The nurses cleaned the skin tear and completed incontinent care on the resident. The resident was transferred back to the bed with the assistance of staff. Per interview, CNA #1 revealed she did not know how many staff was needed to provide the resident's incontinent care and she did not look at Resident #1's care plan before she started his/her care.</p> <p>An interview with RN #1, on 12/11/14 at 10:42 AM, revealed she was at the desk on 12/06/12 when CNA #1 yelled for a nurse. She reported when she entered Resident #1's room, she saw the resident on the floor on his/her left side with CNA #1 knelt down beside him/her. RN #1 assessed the resident and Resident #1 complained of his/her head and left arm hurting. They provided incontinent care to the resident and LPN #1 took care of the skin tear on the resident's arm. One of the aides pulled out a draw sheet and they placed the resident on it and transferred him/her back to the bed. She explained to the resident, she was going to send him/her out to be evaluated at the hospital and that she would contact his/her family as well the physician. When the emergency medical services arrived to transport Resident #1 to the hospital, Resident #1 verbalized complaints of head, arm, and spine hurting. RN #1 stated that Resident #1 required extensive assistance of two staff with his/her activities of daily living (ADL's) such as transfers, bed mobility and incontinent</p>	F 323	<p>F-323 (cont)</p> <p>has not completed the inservicing prior to the last session on 12/17/12 before their next shift worked.</p> <p>In addition to the above inservicing a Post Test was given to the Nursing Staff to verify understanding of the information provided during the education sessions. This test was given by the DON, Staff Development Nurse, ADON and Unit Managers. A score of 100% was required in order to pass the test. All Staff members who were present to current have passed the test with a score of 100%. The DON will be responsible to provide or arrange for the post test to any staff member who has been on leave or vacation. The facility will continue to include education for new hires on following the Nurse Aide Data Sheets in accordance with the residents plan of care during the orientation process. In addition, a post test was added to the orientation process to verify understanding of the education given. Unit Managers, and licensed nurses will provide supervision to avoid accidents that are preventable and observe for environmental hazards during routine rounds throughout their shifts.</p> <p><u>Monitoring Measures to Maintain On-going Compliance:</u></p> <p>Unit managers, Licensed staff, ADON or Staff development Nurse will randomly select 2 residents (10%) per shift, for each wing daily for two weeks who require assistance with ADL's. Without prior notification, staff providing care for these residents will be observed performing care to validate compliance with following the Nurse Aide Data Sheet in accordance with the</p>	
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F 323	Continued From page 7 care. An interview with LPN #1, on 12/11/12 at 2:14 PM, revealed it was about 6:50 AM on 12/05/12 when CNA #1 came out of Resident #1's room and she heard her say "I need a nurse". Both she and RN #1 responded. When she walked into the room, she observed CNA #1 kneeling down by Resident #1 on the floor. The resident was lying on his/her left side and there was blood on the floor. Resident #1 said he/she was hurling and "I'm on the floor, I need help, get me up". RN #1 assessed the resident and the resident had a skin tear to the right forearm. LPN #1 cleaned the skin tear, applied a pad, and wrapped the arm in Kerlix. Staff put a lift pad under Resident #1 and transferred the resident back to the bed. An interview with the Director of Nursing (DON), on 12/12/12 at 12:14 PM, revealed it was about 7:30 AM when someone told her about the fall and she immediately went to the resident's room. When she arrived, the ambulance staff was in the room with Resident #1. The resident was complaining of pain in the head, arm and spine and was transported to the hospital for further evaluation. She reviewed Resident #1's care plan which revealed the resident was assist of two for changing his/her brief. The DON talked to CNA #1 and asked her if she knew the resident was assist of two and CNA #1 said "no". The DON stated staff was expected to follow the resident's care plan when providing care.	F 323	F-323 (cont) residents plan of care including the use of assistive devices. The observations will continue to be conducted three times a week for eight weeks, then two times per week for eight weeks, then weekly times four weeks, then monthly x 6 months. At the same time the resident's environment will be observed for hazards. Findings of the observations will be reported to the Director of Nursing and to the facility's Quality Assurance Committee. The Committee will review findings of the observations. If concerns are identified retraining/discipline will result. The committee may make further recommendations of increasing the frequency and/or duration of the unannounced observations being conducted.		