

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

PRINTED: 07/30/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185388	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/16/2014
NAME OF PROVIDER OR SUPPLIER  MASONIC HOME OF LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 240 MASONIC HOME DRIVE MASONIC HOME, KY 40041		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  An Abbreviated Survey investigating complaint #KY21940 was initiated on 07/15/14 and concluded on 07/16/14. The Division of Health Care substantiated the allegation with deficiencies cited at the highest scope and severity of a "G".	F 000	The preparation and execution of this plan of correction does not constitute an admission 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 it is required by federal and state law.		
F 281 SS=G	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 interviews, closed record review, and review of the facility's care plan policy, it was determined the facility failed to ensure an interim care plan was developed that was sufficient in meeting the resident's identified needs (risk for falls) for one (1) of seven (7) sampled residents (Resident #1).  The facility admitted Resident #1 on 05/29/14 with a diagnosis of Cerebrovascular Accident (CVA) with left sided weakness. Upon admission, the facility assessed the resident to be at risk for falls and the physician ordered a bed/chair alarm at all times. Review of the patient transfer form, from the acute hospital revealed the resident was forgetful, did not use the call light for communication, needed falls' protocol with alarms, and required the assist of two (2) for transfers. However, the interim care plan did not include these risk factors, or the physician ordered alarm device.	F 281	1. Resident #1 was identified as having been affected by the issue identified on the S.O.D. Resident #1 was discharged to the hospital 6/13/14. The facility has implemented corrective actions to address the identified issue in items 3, 4, and 5 below. 2. 100% Audit of all initial care plans was completed on 7/31/14 by Nurse Leadership, including DON, ADON, and Household Nurse Leaders to ensure all were individualized with interventions included on the care plan. The facility has implemented corrective actions to address the issue identified in items 3, 4, and 5 below. 3. The facility has initiated the following corrective measures to assure the identified practice does not reoccur : • C NA #1 had education regarding supervision of residents when toileting on 6/13/2014 and was repeated on 7/28/14-8/1/14 regarding falls program • The Care Plan policy was reviewed by DON and Administrator on 7/18/14. No revisions were necessary. • The Care Plan Update Tool was revised and approved by QA committee on 7/18/14 (see attachment #1). • Nurse Leaders were re-educated on 7/21/2014 by DON on initial care planning with emphasis on individualization and the transfer of information from care plan to caregiver assignment sheet (see attachment 7).		

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

TITLE

(X6) DATE

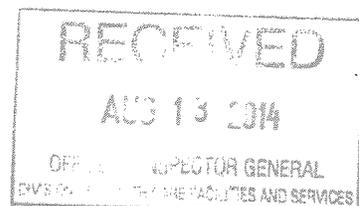
*[Signature]* Administrator 8/13/14

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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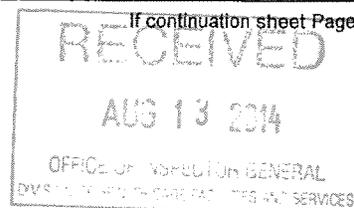
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F 281	<p>Continued From page 1</p> <p>On 06/13/14, Resident #1 was placed on the commode and left unattended by a Certified Nurse Aide (CNA). Resident #1 fell from the commode and sustained a hip fracture to the left femoral neck. The resident required surgical intervention to repair the fracture.</p> <p>The findings include:</p> <p>Review of the facility's care plan policy, revised April 2014, revealed the policy included initial admission care plans. The policy stated the facility would implement care planning procedures in accordance with acceptable standards of practice. The initial admission care plan would be initiated upon admission and revised until the comprehensive care plans were completed. The Admission Nurse would complete the initial care plan based on the admission assessment information. The Nurse Leaders would review orders, clinical issues, and update the care plan as indicated with new or discontinued treatments and changes of conditions. Care plan interventions were incorporated into the CNA assignment sheets as indicated to ensure implementation of interventions.</p> <p>Review of the closed clinical record for Resident #1 revealed the facility admitted the resident on 05/29/14 with diagnoses of CVA with left sided weakness, Dementia, Dysphagia, and late effect Dis-Cognition Deficit. During the admission process, the facility conducted a fall assessment of Resident #1 that identified a fall risk.</p> <p>Review of the Minimum Data Set (MDS) assessment, with Assessment Reference Date (ARD) of 06/05/14, revealed the facility assessed</p>	F 281	<ul style="list-style-type: none"> <li>• Licensed nurses were re- educated by DON with specific emphasis on the importance of individualization through a review of admission records, risk assessments and interventions to address risk factors. Re-education was completed 7/30, 7/31, 8/5/14 (see attachment # 8).</li> <li>• Nursing orientation materials were revised by the DON and Staff Development to include education on care planning and individualization on 8/5/14 (see attachment #11).</li> <li>• All initial care plans will be audited for individualization by the nurse leaders under supervision of the DON beginning 7/21/14 (see attachment #2).</li> </ul> <p>4. The facility has implemented the following interventions to monitor the corrective action to ensure that performance is sustained as follows:</p> <ul style="list-style-type: none"> <li>• The Nurse Leaders and DON will continue to audit initial care plans for individualization on all new admissions for six months. Corrections and additions will be added to initial care plan as necessary during audit.</li> <li>• An indicator was added to the facility's QA Committee "Initial Care plans are individualized based on resident's assessed needs". The reports will be presented to the Quality Assurance Committee for monitoring of effectiveness and recommendation, monthly beginning at the August 2014 Quality Assurance Committee meeting. The initial Care Plan auditing schedule and QA reporting will be maintained for at least six months. Frequency will be revised by review of QA committee.</li> </ul> <p>5. The Quality Assurance Committee will review required audits and supportive documentation to ensure effectiveness of the compliance plan and make revisions as necessary on an ongoing basis completed by</p>	8/6/2014



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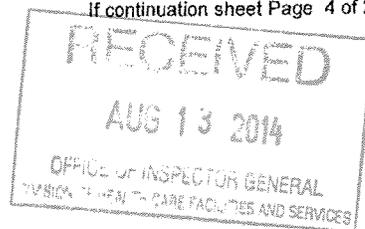
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F 281	<p>Continued From page 2</p> <p>the resident to be totally dependent on staff for bed mobility, transfers, dressing, and toilet use with support of two (2) person physical assist. The balance test revealed the resident was not steady and needed staff assistance for stabilization for moving from a seated to standing position, and surface to surface transfer. Range of Motion (ROM) was impaired on the left side. A Brief Interview for Mental Status (BIMS) was performed with a score of eight (8) out of fifteen (15) obtained with the resident not being able to recall with cues, three (3) of three (3) words minutes after having them repeated. Review of the Care Area Assessment (CAA) summary revealed falls triggered and the facility documented a new care plan was started.</p> <p>Review of the Falls Care Plan, initiated on 05/29/14, revealed the resident was at risk for falls with a goal that the resident would not sustain a fall with injury by utilizing fall precautions through the next review on 08/29/14. Care plan approaches were to use the fall risk screen to identify risk factors, observe medications for side effects and report to physician, call light within reach, provide adaptive devices (walker, wheelchair), and remind the resident to lock the brakes on the bed/chair, Etc, before transferring. Referrals to Speech, Physical, and Occupational Therapy were included. The care plan was a standardized, check all that applies paper form. Further review revealed there were no specific approaches from the fall risk screen, nor did the care plan include the bed/chair alarm ordered by the physician upon admission. In addition, the initial care plan had not been revised to include therapy evaluations. The interventions for the call light to be within reach and remind the resident to lock</p>	F 281		



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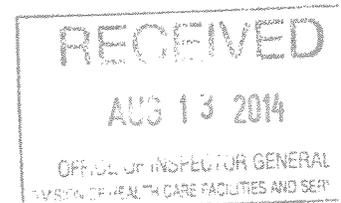
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F 281	<p>Continued From page 3</p> <p>the wheelchair brakes were not specific to this resident. Upon admission, the facility was knowledgeable that the resident did not utilize the call light system in the hospital and could not transfer without assistance of two (2) persons.</p> <p>Continued record review revealed an Interdisciplinary Care Plan meeting was held on 06/09/14 with Nursing, Dietary, Therapy, Social Worker, MDS Coordinator and Resident #1's spouse in attendance. The purpose of the meeting was to discuss the plan of care, goals, and concerns for Resident #1. However, there was no evidence the Falls Care Plan had been revised to reflect the resident's current functional status.</p> <p>Review of Speech Therapy Notes revealed an evaluation and treatment was initiated on 05/30/14. The Speech Therapist assessed the resident's cognition as moderate impairment and he/she was at risk for injury due to lack of orientation and judgment/reasoning. The Therapist documented the resident had difficulty with memory.</p> <p>Interview with the Speech Therapist, on 07/16/14 at 9:42 AM, revealed the resident had difficulty following directions and remembering. She stated she had to provide frequent cues and reminders.</p> <p>Review of the Occupational Therapy (OT) Notes revealed an evaluation and treatment was initiated on 05/30/14. The Therapist assessed the resident to require maximum assistance of two (2) persons to achieve balance on the commode and, to complete toileting tasks.</p> <p>Review of the Physical Therapist Notes, dated</p>	F 281			



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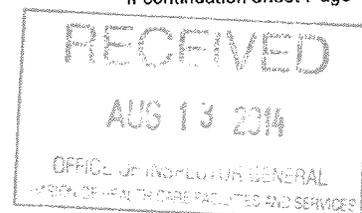
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F 281	<p>Continued From page 4</p> <p>06/12/14, revealed an evaluation and treatment was initiated on 05/30/14. On 06/12/14, a postural assessment scale for stroke patients was conducted. The test revealed the resident could stand with the strong support of two (2) people and could sit for more than ten (10) seconds without support. The test noted the resident could not sit for five (5) minutes without support. The Note stated if the resident was discharged at that time, the resident would be at increased risk of falling and functional decline.</p> <p>Interview with the Physical Therapist, on 07/16/14 at 9:57 AM, revealed she had been working with the resident on bed mobility, transfers and ambulation. She stated the resident's sitting balance was poor and he/she could not maintain for five (5) minutes without support. The resident's standing was very poor and he/she could not stand without support.</p> <p>Review of the closed clinical record revealed, on 06/13/14 at 10:35 AM, an entry by LPN #1, stated Resident #1 was found on the bathroom floor by the resident's daughter. The resident was found laying on his/her left side and complained of left hip pain.</p> <p>Further record review revealed a portable x-ray was ordered for the left hip that revealed a fractured femoral head. The resident was transferred to an acute hospital and required surgery to repair the left hip fracture.</p> <p>Interview with Certified Nurse Aide (CNA) #1, on 07/16/14 at 9:05 AM, revealed she was familiar with the resident's care needs. She stated on the day of the fall, she had taken Resident #1 into the bathroom to give the resident a sponge bath. She</p>	F 281			



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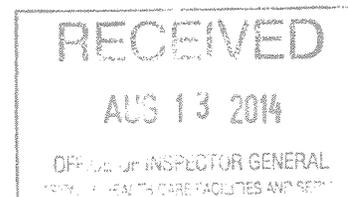
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F 281	<p>Continued From page 5</p> <p>transferred the resident from the wheelchair to the commode (by herself) because that was normally where she bathed the resident. CNA #1 stated she had removed the resident's clothing, completed the sponge bath, and started to dress the resident (pants and underwear were pulled up to the resident's knees) when she received a message on her electronic device (device to alert staff when residents ring for assistance) that the emergency call light was activated from a resident's bathroom, directly across the hall. She stated the electronic device had been going off for some time and she was concerned about the resident across the hall. She stated she felt Resident #1 was safe to leave alone. CNA #1 instructed the resident to remain on the commode and told him/her that she would be right back.</p> <p>CNA #1 left Resident #1 alone in the bathroom. In addition, she failed to tell the daughter (who was in the resident's room) she was leaving the resident alone. CNA #1 stated she went across the hall and found the other resident brushing his/her teeth. She deactivated the light and returned to Resident #1's room. However, before she could reach the resident's room, she saw the resident's daughter running toward the bathroom and heard her say the resident was falling. When the aide entered Resident #1's bathroom, the resident was laying on the floor, on his/her left side. She notified the nurse and she came to assess the resident. CNA #1 stated she would know the resident's safety and care needs, because that information should be on the CNA's assignment sheet. However, CNA #1 stated she did not recall anything on the resident's sheet and she was unaware of the resident's fall risk, functional mobility status, and safety precautions. She stated she would not have left the resident</p>	F 281			



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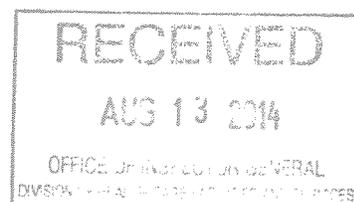
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F 281	<p>Continued From page 6</p> <p>alone if she had known about the resident's fall risk. When asked if the resident had an alarm attached, she said she knew nothing about an alarm and to her knowledge the resident had not utilized an alarm in the bed or chair.</p> <p>Request to review the assignment sheet for 06/13/14 was unsuccessful. The facility had deleted the resident from the current computer program and they did not keep a hard copy with that information.</p> <p>Interview with the daughter, on 07/16/14 at 12:15 PM, revealed she was in the resident's room (not the bathroom) when the fall occurred. She stated a nurse aide had transferred the resident into a wheelchair and taken him/her to the bathroom for a bath. She stated she was on the phone when she heard a yell and a crash sound in the bathroom. She jumped up and saw the resident laying on the bathroom floor. The wheelchair was unlocked and pushed to the middle of the bathroom floor. She noticed the left toilet rail had not been placed down as usual. She indicated she did not know when the aide had left the resident alone and stated the resident should never be left alone. She stated she did not recall any alarms being used in the bed or the chair.</p> <p>Interview with the Assistant Director of Nursing (ADON), in the presence of the new Director of Nursing, on 07/15/14 at 8:40 AM, revealed the root cause analysis of the fall was CNA #1 left the resident alone and did not inform the daughter she was leaving. He stated it was not a common practice to leave a resident on the commode alone. He continued, stating that Resident #1 was not stable enough to be left alone. He stated instructions or communication provided to CNA</p>	F 281	
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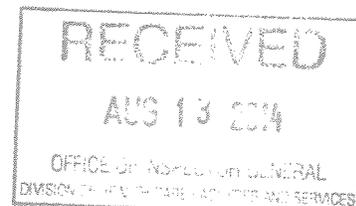
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F 281	<p>Continued From page 7</p> <p>#1 in regards to Resident #1's care needs and safety interventions would have been on the CNA's assignment sheet. However, the ADON could not provide a copy of the assignment sheet for the day of the fall (06/13/14) and did not know what the resident's needs were at that time.</p> <p>Another interview with the ADON, on 07/16/14 at 11:40 AM, revealed communication between Therapy and Nursing occurred during the weekly utilization meetings. He stated residents under skilled care were discussed regarding the residents' care needs, goals, and functional mobility. He stated he would then update the CNA's assignment sheet with that information. He could not recall if Resident #1's assignment sheet included therapy's evaluation of the resident's functional mobility (including balance). He stated he would have considered what the resident was doing in therapy and compared that with nursing's goals. The ADON revealed he was unaware Resident #1 utilized a bed/chair alarm. He confirmed he had not revised the care plan until after the resident's fall.</p> <p>Interview with the Director of Nursing, on 07/16/14 at 12:49 AM, revealed she had asked several nurse aides about the alarm for the bed/chair and there was some confusion about if the resident ever utilized the alarm. She revealed she was not working at the facility when Resident #1 fell and had just recently reviewed the fall investigation. She stated the alarm use was not included in the root cause analysis.</p> <p>Interview, on 06/16/14 at 1:15 PM, with Registered Nurse (RN #1) who completed the admission paperwork for Resident #1, revealed the resident's admission was late in the day and</p>	F 281			



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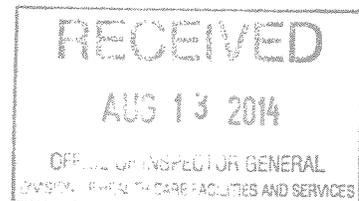
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F 281	Continued From page 8 she recalled the paperwork from the acute hospital ordered fall protocols. She stated that would mean bed/chair alarms and the facility utilized the pressure sensor type. She did put that order on the admission medication/treatment orders and verified with the resident's physician. She validated she initiated the Initial Care Plan for falls.  Interview with the two (2) MDS Coordinators, on 07/16/14 at 4:31 PM, revealed neither developed or revised the fall's care plan for Resident #1. They both stated the falls care plan was not specific to this resident's functional status. Normally, they would complete the fall assessment then develop interventions addressing the identified risks. MDS Coordinator #1 stated since the resident was status post a new CVA, she would have written on the care plan form other interventions that were pertinent to this resident. She stated she would have spoken with Therapy and developed specific interventions to ensure the resident's safety. She indicated the bed/chair alarm and level of assistance required should have been on the interim care plan.	F 281		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	1. Resident #1 was identified as having been affected by the issue identified on the S.O.D. Resident #1 was discharged to the hospital 6/13/14. CNA #1 had education regarding supervision of residents when toileting on 6/13/2014 by ADON and was repeated on 7/28/14-8/1/14 regarding falls program by DON. The facility has implemented corrective actions to address the identified issue in items 3, 4, and 5 below.	



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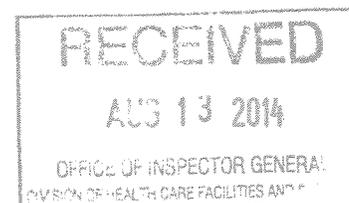
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F 323	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews, closed record review, and review of the facility's Fall Policy, it was determined the facility failed to ensure one (1) of seven (7) sampled residents (Resident #1) received adequate supervision and assistive devices to prevent accidents while receiving daily care assistance. The facility admitted Resident #1 on 05/29/14 with diagnosis of Cerebrovascular Accident (CVA) with left sided weakness. Upon admission the facility assessed the resident to be at risk for falls. The physician ordered a bed/chair alarm at all times. On 06/13/14, Resident #1 was placed on the commode without the alarm and was left unattended by a Certified Nurse Aide (CNA). Resident #1 fell from the commode and sustained a hip fracture to the left femoral neck. The resident required surgical intervention to repair the fracture.</p> <p>The findings include:</p> <p>Review of the facility's Fall Policy, revised April 2014, revealed a fall risk assessment would be conducted upon admission, re-admission, quarterly, with significant changes, and post fall incidents. The objectives of the fall assessment would be to identify residents at high risk for falls and identify resident-specific fall prevention interventions for at risk residents. Co-morbidities for falls identified in the policy included stroke (CVA).</p> <p>Review of the closed clinical record for Resident #1 revealed the facility admitted the resident on 05/29/14, with diagnoses of CVA with left sided weakness, Dementia, Dysphagia, and late effect</p>	F 323	<p>2. The facility has implemented corrective actions to address the issue identified in items 3, 4, and 5 below.</p> <ul style="list-style-type: none"> <li>• A 100% sample of residents was assessed utilizing the new falls risk assessment by DON, ADONs, Nurse Leaders and completed on 7/31/2014.</li> <li>• A 100% sample of all residents to ensure ordered alarms were in place and on CNA assignment sheets was completed by DON, ADON, Household Nurse Leaders on 7/31/2014.</li> </ul> <p>3. The facility has initiated the following corrective measures to assure the identified deficient practice does not reoccur:</p> <ul style="list-style-type: none"> <li>• Falls Program Policy was reviewed and revised and approved by QA Committee on 7/18/14(see attachment #3).</li> <li>• Fall Risk Assessment Policy was developed and approved by QA Committee on 7/18/14 (see attachment #4)</li> <li>• A new Fall Risk Assessment tool was selected and approved by QA Committee on 7/18/14(see attachment #5)</li> <li>• A new initial care plan was designed by the DON to correlate with the new fall risk assessment on 7/21/2014(see attachment #6)</li> <li>• Education on the new fall risk assessment and new initial care plan was held with nursing leadership on 7/24/2014 and with all nurses on 7/30/2014, 7/31/2014, and 8/5/14 by DON( see attachment #7&amp;8)</li> <li>• Education on the new fall program by packet and test was given to the nursing assistants by DON and completed by 8/5/14. To ensure staff, who are busy with residents who cannot be left alone, the nursing assistant education included emphasis on not leaving residents alone when high risk of falls. To back-up for assistance for call call-lights all licensed nursing staff and nursing assistants receive, via electronic notification,</li> </ul>		



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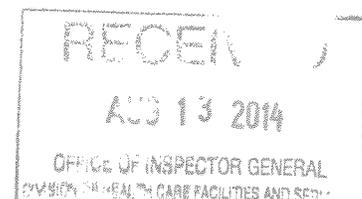
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F 323	Continued From page 10 Dis-Cognition Deficit. Review of the patient transfer form from the acute hospital, dated 05/29/14, revealed the resident was forgetful, did not use a call light for communication, needed fall protocols with alarms, and required assist of two (2) for transfers. Review of the admission orders revealed the physician at the nursing facility had ordered the use of a bed/chair alarm at all times. Review of the History and Physical revealed the resident had fallen at home with the CVA. During the admission process, the facility conducted a fall assessment for Resident #1 that revealed a score of fourteen (14) with fifteen (15) or greater representing high risk. However, further review revealed the facility did not assess the resident's gait/balance status, and instead documented the resident was unable to participate in the test.  Review of the admission assessment, with an Assessment Reference Date (ARD) of 06/05/14, revealed the facility assessed the resident as totally dependent on staff for bed mobility, transfers, dressing, and toilet use with the support of a two (2) person physical assist. The balance test revealed the resident was not steady and needed staff assistance for stabilization for moving from seated to standing position, and surface to surface transfers. Range of motion (ROM) was impaired on the left side. A Brief Interview for Mental Status (BIMS) was performed with a score of eight (8) out of fifteen (15) obtained with the resident not being able to recall with cues, three (3) of three (3) words minutes after having them repeated. Review of the Care Area Assessment (CAA) summary revealed falls triggered and the facility documented a new care plan was started. Review of the CAA worksheet for falls revealed the facility identified the resident as being at risk for falls	F 323	and are expected to answer all call-lights when primary nursing assistant are unavailable (see attachment #9) • New falls documentation after 7/31/2014 will be reviewed for accuracy using "Clinical Documentation of Falls audit tool" by DON, ADONs, and Nurse Leaders (see attachment#10) • Licensed nursing orientation will include the new Fall Risk Assessment and individualizing initial care plan (see attachment #11) • All falls will continue to be audited utilizing the Falls Audit Tool by nurse leaders under supervision of the DON (see attachment#12). 4. The facility has implemented the following interventions to monitor the corrective action to ensure that performance is sustained: • An indicator was added to the facility's QA Committee "Falls Audit Tool". The reports will be presented to the Quality Assurance Committee for monitoring of effectiveness and recommendation, monthly beginning at the August 2014 Quality Assurance Committee meeting. The Falls Tool auditing schedule and QA reporting will be maintained for six months and then reevaluated. 5. The Quality Assurance Committee will review required audits and supportive documentation to ensure effectiveness of the compliance plan and make revisions as necessary on an ongoing basis completed by	8/6/2014



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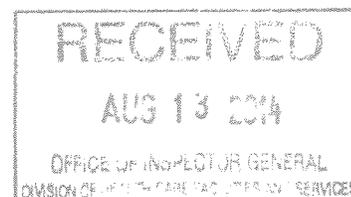
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F 323	<p>Continued From page 11 related to a history of falls, CVA with left hemiplegia, and a cognition impairment.</p> <p>Review of the Falls' Care Plan, initiated on 05/29/14, revealed the resident was at risk for falls with a goal that the resident would not sustain a fall with injury by utilizing fall precautions through the next review on 08/29/14. Care plan approaches were to use the fall risk screen to identify risk factors, observe medications for side effects and report to the physician, call light within reach, provide adaptive devices (walker, wheelchair), and remind the resident to lock brakes on the bed, chair, etc., before transferring. Referrals to Speech, Physical, and Occupational therapy were included. The care plan was a standardized, check all that applies paper form. Further review revealed there were no specific approaches from the fall risk screen, nor did the care plan include the bed/chair alarm that was ordered by the physician upon admission. (Refer to F-281)</p> <p>Review of the Speech Therapy Notes revealed an evaluation and treatment was initiated on 05/30/14. The Speech Therapist assessed the resident to have cognition with moderate impairment and was at risk for injury due to lack of orientation and judgment/reasoning. The goal for the resident to have functional problem solving and safety awareness for daily living tasks was not met. The Therapist documented the resident had difficulty with memory.</p> <p>Interview with the Speech Therapist, on 07/16/14 at 9:42 AM, revealed she was working with Resident #1 on safe swallowing techniques and orientation. She indicated the resident had difficulty following directions and remembering.</p>	F 323			



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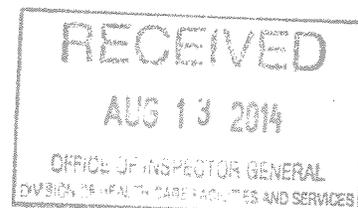
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F 323	<p>Continued From page 12</p> <p>She stated she had to provide frequent cues and reminders.</p> <p>Review of the Occupational Therapy (OT) Notes revealed an evaluation and treatment was initiated on 05/30/14. The Therapist assessed the resident to require a maximum assistance of two (2) persons to achieve balance on the commode and complete toileting tasks. Review of the Discharge Summary, dated 06/20/14, revealed the resident did not meet the goal of being able to achieve balance on the commode utilizing an arm sling and toilet rails with the minimum assistance of one (1) and moderate-maximum assistance for toilet transfers. The resident was identified as being at high risk for falls. The OT was not available for interview during the survey.</p> <p>Review of the Physical Therapist Notes revealed an evaluation and treatment was initiated on 05/30/14. On 06/12/14, the Therapist documented the resident was able to safely complete stand-pivot-sit transfers from bed to wheelchair with maximum assistance. A postural assessment scale for stroke patients was conducted on 06/12/14 with a score of 15/36 obtained. This test revealed the resident could stand with strong support of two (2) people and could sit for more than 10 seconds without support. Further review revealed the Note stated if the resident was discharged at that time, the he/she would be at increased risk of falling and functional decline. Review of the Discharge Summary Note, completed on 06/16/14, revealed the resident did not meet any goals and could not stand without support and required maximum assistance with bed mobility and transfers.</p> <p>Interview with the Physical Therapist, on 07/16/14</p>	F 323			



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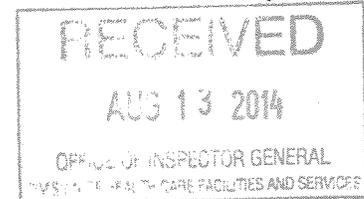
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F 323	<p>Continued From page 13</p> <p>at 9:57 AM, revealed she had been working with the resident on bed mobility, transfers and ambulation. She stated the resident's sitting balance was poor and could not be maintained for five (5) minutes without support. The resident's standing was very poor and he/she could not stand without support.</p> <p>Review of the closed clinical record revealed documentation by a Clinical Coordinator, on 06/13/14 at 9:56 AM, that stated she was called to Resident #1's room regarding the resident's fall. Review of the Note revealed she had spoken with the daughter regarding the fall. During a physical assessment, the resident complaining of mild pain during range of motion to the left hip. She suggested to LPN #1 to notify the Nurse Practitioner (ARNP) and request a left hip x-ray.</p> <p>Continued review of the closed clinical record revealed an entry by LPN #1, on 06/13/14 at 10:35 AM, category of accident/incident, which revealed Resident #1 was found on the bathroom floor by the resident's daughter. The resident was laying on the left side and he/she said they had hit his/her head and left side during the fall. The resident was moved from the floor and placed in a wheelchair then into bed. The resident complained of hip pain. A portable x-ray of the left hip was ordered.</p> <p>Review of the clinical record revealed no documentation regarding the time of the fall, and what actions were taken at that time. (Refer to F-514)</p> <p>Review of a late entry documented, on 06/15/14 at 5:56 PM, by LPN #1, who had documented the fall under the category of accident/incident, report</p>	F 323			



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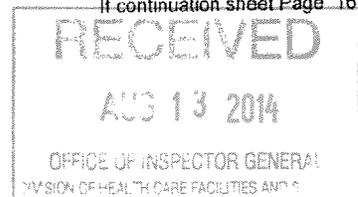
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F 323	<p>Continued From page 14</p> <p>revealed the resident was on the commode and the nurse aide left to answer a call light. The daughter, who was in the resident's room, heard the resident hit the bathroom floor. The daughter requested an x-ray be obtained to rule out injury. The nurse documented she called the ARNP and obtained an order to get a portable x-ray of the left hip. The x-ray was obtained with findings of a left femur neck fracture. Further review revealed the resident's physician was called and orders were received to send the resident to the emergency room. The nurse documented the nurse aide was educated for future references to never leave the resident in the bathroom alone because the resident did not always remember that he/she could not walk or stand alone.</p> <p>Interview with Certified Nurse Aide (CNA) #1, on 07/16/14 at 9:05 AM, revealed she had worked with Resident #1 before and was familiar with the resident's care needs. She stated on the day of the fall, she had taken Resident #1 into the bathroom to give him/her a sponge bath. She transferred the resident from the wheelchair to the commode (by herself) because that was normally where she bathed the resident. She removed the resident's clothing, completed the sponge bath, and had started to dress the resident (pants and underwear was to the resident's knees) when she received a message on her electronic device that the emergency call light was activated from a resident's bathroom, directly across the hall. She stated the electronic device had been going off for some time and she was concerned about the resident across the hall. She stated she felt Resident #1 was safe to leave alone. CNA #1 instructed the resident to remain on the commode and told the resident she would be right back. As she was leaving the bathroom,</p>	F 323			



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F 323	<p>Continued From page 15</p> <p>she saw the resident's daughter in the resident's room, but did not tell her she was leaving the resident. Further interview revealed the family stayed with the resident all the time and would come into the bathroom at times. CNA #1 stated she went across the hall and found the other resident brushing his/her teeth. She deactivated the light and returned to Resident #1's room. However, before she could reach the resident's room, she saw the resident's daughter running toward the bathroom and heard her say the resident was falling. When the aide entered Resident #1's bathroom, the resident was laying on the floor, on his/her left side, to the left of the commode. CNA #1 stated she had failed to put the left toilet rail down. She stated she would normally have placed the toilet rail down so the resident would have something to hold onto for safety. She notified the nurse and she came to assess the resident. Continued interview with CNA #1 revealed she was unaware of the resident's fall risk, functional mobility status, and safety precautions. She stated she would not have left the resident alone if she had known about the resident's fall risk. When asked if the resident had an alarm attached, she said she knew nothing about an alarm and to her knowledge the resident had not utilized an alarm in the bed or chair.</p> <p>Request to review the assignment sheet for 06/13/14 was unsuccessful. The facility had deleted the resident from the current computer program because the resident no longer lived there and they did not keep a hard copy with that information.</p> <p>Interview with the Daughter, on 07/16/14 at 12:15 PM, revealed she was in the resident's room (not</p>	F 323		



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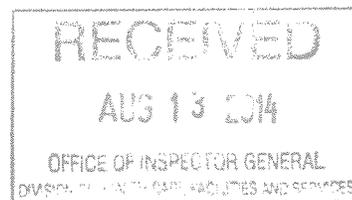
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F 323	<p>Continued From page 16</p> <p>the bathroom) when the fall occurred. She stated a nurse aide had transferred the resident into a wheelchair and took the resident to the bathroom for a bath. She stated the resident recently had a CVA and had left sided weakness and was at the nursing facility to receive therapy with the goal of returning home. She stated the resident would often lean forward and to the left side since the stroke and he/she should not have been left alone. Further interview revealed the family had been staying around the clock and would even go into the bathroom with the resident if that ensured the resident's safety. She said she told staff many times if they needed her assistance, to just let her know. The Daughter stated she was on the phone when she heard a yell and a crash sound in the bathroom. She jumped up and saw the resident laying on the bathroom floor. The wheelchair was unlocked and pushed to the middle of the bathroom floor. She noticed the left toilet rail was up and it had usually been placed down. She indicated she did not know when the aide had left the resident because the resident was never supposed to be left alone. She said she would have stayed with the resident if the aide had told her she needed to leave. Further interview revealed she did not recall any alarms used in the bed or chair. She revealed she had observed staff transferring the resident from the bed to the wheelchair and did not recall an alarm sounding. She said the only thing used was the pendant around the resident's neck that was used as a call light. She stated the resident required surgery to repair the hip fracture and had a decline in the functional mobility since the fall.</p> <p>Interview with the Assistant Director of Nursing (ADON), in the presence of the new Director of Nursing, on 07/16/14 at 8:40 AM, revealed he</p>	F 323		



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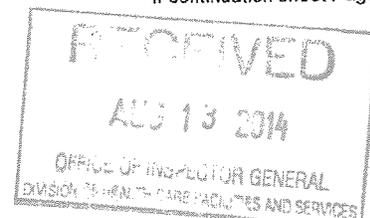
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F 323	<p>Continued From page 17</p> <p>conducted part of the fall investigation and had went to Resident #1's room after the fall. The ADON revealed the root cause analysis of the fall was CNA #1 left the resident alone and did not inform the daughter she was leaving. He stated it was not a common practice to leave a resident on the commode alone and continued to state Resident #1 was not stable enough to be left alone. He indicated the CNA was worried about the resident across the hall and thought Resident #1 would be okay to leave. When asked what instructions or communication had been provided to CNA #1 in regard to Resident #1's care needs, he stated that information would have been on the CNA's assignment sheet. However, the ADON could not provide a copy of the assignment sheet for the day of the fall (06/13/14) and did not know what the resident's needs were at that time. He did not keep a hard copy for the fall investigation. The ADON stated other administrative staff reviewed the fall investigation and confirmed the root cause. He stated CNA #1 was instructed not to leave the resident alone, the care plan and the CNA assignment sheet were all updated after the fall.</p> <p>The facility did not provide access to the fall investigation. The ADON revealed the nurse who assessed the resident and cared for Resident #1 on the day of the fall, 06/13/14, no longer worked at the facility and did not return their calls for further information. The surveyor attempted to contact this nurse three (3) times via telephone with no success. The nurse did not return the requested call.</p> <p>Another interview with the ADON, on 07/16/14 at 11:40 AM, after he provided a late entry note from the computer, dated 06/15/14 at 5:56 PM,</p>	F 323			



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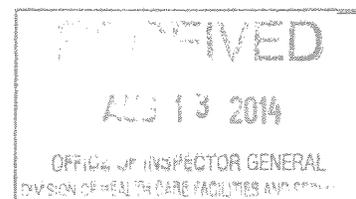
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F 323	<p>Continued From page 18</p> <p>revealed he had requested the nurse to document more information about Resident #1's fall. When he reviewed the incident report he identified the nurse had left out pertinent information and requested the late entry. He also revealed communication between Therapy and Nursing occurred during the weekly utilization meetings. He stated residents under skilled care were discussed regarding the residents' care needs, goals, and functional mobility. He stated he would then update the CNA's assignment sheet with that information. He could not recall if Resident #1's assignment sheet included a therapy evaluation of the resident's functional mobility (including balance). He stated he would have considered what the resident was doing in therapy and compared that with nursing's goals. The ADON revealed he was unaware Resident #1 utilized a bed/chair alarm. He said, it was not included in the facility's fall investigation.</p> <p>Interview with the Director of Nursing, on 07/16/14 at 12:49 AM, revealed she had asked several nurse aides about the alarm for the bed/chair and there was some confusion if the resident ever utilized the alarm. She revealed she was not working at the facility when Resident #1 fell and had just recently reviewed the fall investigation. She stated the alarm use was not included in the root cause analysis.</p> <p>Interview, on 06/16/14 at 1:15 PM, with Registered Nurse (RN #1) who completed the admission paperwork for Resident #1, revealed she recalled the paperwork from the acute hospital had ordered fall protocols. She stated that would mean bed/chair alarm and the facility utilized the pressure sensor type. She put that order on the admission medication/treatment</p>	F 323			



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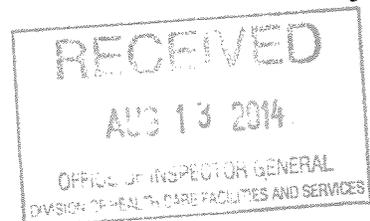
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F 323	Continued From page 19 orders and verified with the resident's physician. She could not recall, but she thought she went to central supply to obtain a sensor alarm, but she did not put it on Resident #1's bed. She stated nurses were supposed to check for those devices, but did not recall if the resident utilized an alarm. She revealed she was not working the day of Resident #1's fall.	F 323		
F 514 SS=D	483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on interviews and record review it was determined the facility failed to ensure the clinical record was accurately documented in regards to a fall, notification of the physician, procedures, and the transfer of a resident to the Emergency Department for one (1) of seven (7) sampled residents (Resident #1). Resident #1 sustained a fall with injury on 06/13/14. However, the facility	F 514	1. Resident #1 was identified as having been affected by the issue identified on the S.O.D. Resident #1 was discharged to the hospital 6/13/14. The facility has implemented corrective actions to address the identified issue in items 3, 4, and 5 below. 2. The facility has implemented corrective actions to address the issue identified in items 3, 4, and 5 below. • An audit of falls clinical documentation was completed by DON, ADON, and Nurse Leaders on 7/31/2014 that resulted in education to all licensed nurses by DON on 7/30/2014, 7/31/2014, and 8/5/2014. (see attachment #7) • The facility will identify other residents who have the potential to be affected by incomplete fall documentation by reviewing all resident's fall documentation occurring after 7/31/14 which was after completion of licensed nurse education (see attachment #10) • Clinical documentation of any new fall event will be reported and reviewed with DON and Nurse Leaders (see attachment #10) • A 100% sample of current residents were assessed utilizing the new falls risk assessment by DON, ADONs, Nurse Leaders completed on 7/31/2014 to ensure other resident's medical records regarding falls were complete, accurate, accessible and organized.	



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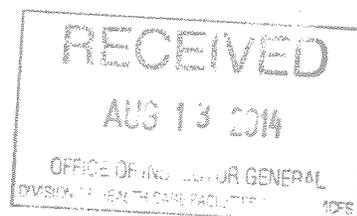
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F 514	<p>Continued From page 20</p> <p>failed to ensure the clinical record included the time of the fall; if pain medications were administered; time the portable x-ray services obtained the film; report of the findings; and when the resident was sent to the hospital.</p> <p>The findings include:</p> <p>The facility did not provide a policy for accurate documentation in the clinical record.</p> <p>Review of the closed clinical record for Resident #1 revealed the facility admitted the resident on 05/29/14 with diagnoses of Cerebrovascular Accident (CVA) with left sided weakness, Dementia, Dysphagia, and late effect Dis-Cognition Deficit.</p> <p>Review of the closed clinical record revealed an entry by Licensed Practical Nurse (LPN) #1, on 06/13/14 at 10:35 AM, which she identified as an accident/incident, revealed Resident #1 was found on the bathroom floor by the resident's daughter. The resident was laying on the left side. The resident said he/she had hit his/her head and left side during the fall. The resident was removed from the floor and placed in a wheelchair then into bed. Resident #1 complained of hip pain. An x-ray was ordered for the left hip. The nurse documented neurological checks would be conducted.</p> <p>Interview with Resident #1's daughter, on 07/16/14 at 12:15 PM, revealed the resident fell in the bathroom at approximately 9:00 AM when he/she was left alone by the nurse aide. She stated the resident complained of left hip pain and she had requested an x-ray.</p>	F 514	<p>3. The facility has initiated the following corrective measures to assure the identified deficient practice does not reoccur as follows:</p> <ul style="list-style-type: none"> <li>• Documentation- General Policy was developed and approved by QA Committee on 7/18/14 (see attachment #13)</li> <li>• The QA Audit tool "Clinical Documentation of Falls" was developed by DON and is being utilized on all new falls beginning 7/31/14 (see attachment #10).</li> <li>• A comprehensive education program on documentation containing policies on the fall program, accident reporting, and a new fall audit tool for documentation was presented by DON to ADONs, and Nurse Leaders on 7/24/2014 and to all Nursing Staff on 7/30/14, 7/31/14, and 8/5/14 (see attachment 7 &amp; 8).</li> <li>• Licensed nurse orientation will include the new policy "Documentation-General" (see attachment #11) and "Falls Documentation Audit Tool"(see attachment #12).</li> <li>• New falls documentation after 7/31/2014 will be reviewed for accuracy using "Clinical Documentation of Falls audit tool" by nurse leaders under supervision of DON (see attachment #10).</li> <li>• A 100% sample of current residents were assessed utilizing the new falls risk assessment by DON, ADONs, Nurse Leaders completed on 7/31/2014 and will be utilized ongoing to ensure other resident's medical records regarding falls are complete, accurate, accessible and organized.</li> </ul> <p>4. The facility has implemented the following interventions to monitor the corrective action to ensure that performance is sustained as follows:</p> <ul style="list-style-type: none"> <li>• An indicator was added to the facility's QA Committee "Clinical Documentation of Falls" The reports will be presented to the Quality Assurance Committee for monitoring of effectiveness and recommendation,</li> </ul>		



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F 514	<p>Continued From page 21</p> <p>Continued record review revealed documentation by a Clinical Coordinator, on 06/13/14 at 9:56 AM, that stated she was called to Resident #1's room regarding the resident's fall. The Clinical Coordinator documented she had spoken with the daughter regarding the fall. A physical assessment was conducted, with the resident complaining of mild pain during range of motion (ROM) to the left hip. She suggested to LPN #1 to notify the Advanced Registered Nurse Practitioner (ARNP) and request a left hip x-ray. She documented to continue to do neuro checks. However, there was no documented evidence in the clinical record the neuro checks had been conducted.</p> <p>Review of a late entry that was documented, on 06/15/14 at 5:56 PM, by LPN #1, documented the fall under the category of accident/incident on 06/13/14. This report stated the resident was on the commode and the nurse aide left him/her to answer another resident's call light. The daughter, who was in the resident's room, heard the resident fall and hit the bathroom floor. Further review revealed the daughter requested an x-ray be obtained to rule out injury. The nurse documented she called the ARNP and obtained an order to get a portable x-ray of the left hip. However, further review revealed no documentation in the record of when the x-ray was obtained or when the results were available to the facility. A telephone order, dated 06/13/14 at 7:20 PM, revealed an order to send the resident to the emergency room. The late entry revealed the ambulance arrived at 9:00 PM. The record did not contain documentation as to when the resident left the facility.</p> <p>Review of the portable x-ray final report revealed</p>	F 514	<p>monthly beginning at the August 2014 QA Committee meeting. The Clinical Documentation of Falls auditing schedule and QA reporting will be maintained for six months and then reevaluated.</p> <ul style="list-style-type: none"> <li>The DON and Nurse Leaders are conducting reviews of all new falls to monitor that the falls documentation process performed accurately. DON is submitting all reviews to the Quality Assurance Committee monthly for review to ensure effectiveness of the audit.</li> </ul> <p>5. The Quality Assurance will review required audits and supportive documentation to ensure effectiveness of the compliance plan and make revisions as necessary on an ongoing basis completed by</p>	8/6/2014	



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F 514	<p>Continued From page 22</p> <p>a finding of a left femur neck fracture. Review of the requested documentation from the Mobile Diagnostic Express X-ray Service revealed the x-ray results were faxed to the facility, on 06/13/14 at 6:00 PM. This information was not in the closed clinical record.</p> <p>Continued review of the closed record revealed no documented evidence the resident was monitored for pain. Review of the medication administration record revealed on 06/13/14 at 11:00 AM, Tylenol (pain medication) 650 milligrams was given. However, there was no documented evidence the resident's pain was relieved.</p> <p>Interview with CNA #2, on 07/16/14 at 3:27 PM, revealed she cared for Resident #1 during the evening hours before the resident was transferred to the hospital. At the start of her shift (around 2:30 PM), she went into the resident's room and the spouse looked sad and told her of the resident's fall. At 4:00 PM, she performed an incontinence check and found the resident to be a little wet. When she turned the resident, he/she stated his/her leg hurt. She informed the nurse and the nurse told the CNA she was already aware. However, the clinical record revealed no written documentation the nurse assessed the resident's pain or administered any pain medication.</p> <p>Attempts were made to contact the nurse three (3) times via telephone requesting a return call. The nurse did not work at the nursing facility anymore and she did not return any calls to the State Survey Agency.</p>	F 514			

