

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

PRINTED: 10/12/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185412	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/28/2012
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NAME OF PROVIDER OR SUPPLIER LOURDES TRANSITIONAL CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1630 LONE OAK ROAD PADUCAH, KY 42003
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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 was conducted on 09/27/12 through 09/28/12, to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements with deficiencies cited at the highest scope/severity of a "G".	F 000		
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 interview, record review, policy review and Discharge Summary review, it was determined the facility failed to provide ensure the initial care plan was sufficient to meet the needs of newly admitted residents in order to ensure appropriate supervision and assistance to prevent accidents, for one residents (#1) in the selected sample of three residents. The facility failed to ensure staff followed the facility's Fall Prevention Program and failed to ensure the interim care plan reflected the interventions to prevent falls for Resident #1. The facility admitted Resident #1, on 03/07/12 at 9:00 PM, at which time they assessed the Resident as a high risk for falls due to recent history of a fall with hip fracture requiring surgical intervention on 03/04/12. The interim care plan detailed the Resident required assist of two staff to transfer and ambulate with no further interventions detailed related to falls. On 03/07/12 at 10:20 PM, Resident #1 had an unsupervised fall, from the bed. The facility's	F 281	Resident #1 was placed on bed rest following the fall on 3/7/12. The prior fall protocol was continued with assurance from assigned nurse that the personal alarm was on and functioning. Review of this resident's incident and the analysis results were discussed in the March staff meetings on 3/28 and 3/30 /12. All residents are assessed on admission for fall risk using the Morse Fall Risk Assessment. Reinforcement of the following documentation occurred at the staff meeting on 10/18/12: 1. Interim care plan, which includes the Nursing Assistant Care Plan, will be completed and include documentation of bed/personal alarm placement and functionality. 2. Daily Care Record of hourly rounding will include marking the personal/bed alarm as "off" or "on".	11/9/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kelly Bean TITLE: Nursing Home Administrator (X6) DATE: 10/18/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000 INITIAL COMMENTS

An abbreviated survey was conducted on 09/27/12 through 09/28/12, to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements with deficiencies cited at the highest scope/severity of a "G".

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET SS=G 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 interview, record review, policy review and Discharge Summary review, it was determined the facility failed to provide ensure the initial care plan was sufficient to meet the needs of newly admitted residents in order to ensure appropriate supervision and assistance to prevent accidents, for one residents (#1) in the selected sample of three residents. The facility failed to ensure staff followed the facility's Fall Prevention Program and failed to ensure the interim care plan reflected the interventions to prevent falls for Resident #1. The facility admitted Resident #1, on 03/07/12 at 9:00 PM, at which time they assessed the Resident as a high risk for falls due to recent history of a fall with hip fracture requiring surgical intervention on 03/04/12. The interim care plan detailed the Resident required assist of two staff to transfer and ambulate with no further interventions detailed related to falls. On 03/07/12 at 10:20 PM, Resident #1 had an unsupervised fall, from the bed. The facility's

F 000

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Resident #1 was placed on bed rest following the fall on 3/7/12. The prior fall protocol was continued with assurance from assigned nurse that the personal alarm was on and functioning.

Review of this resident's incident and the analysis results were discussed in the March staff meetings on 3/28 and 3/30 /12.

All residents are assessed on admission for fall risk using the Morse Fall Risk Assessment. Reinforcement of the following documentation occurred at the staff meeting on 10/18/12:

1. Interim care plan, which includes the Nursing Assistant Care Plan, will be completed and include documentation of bed/personal alarm placement and functionality.
2. Daily Care Record of hourly rounding will include marking the personal/bed alarm as "off" or "on".

11/9/12



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

TITLE

(X6) DATE

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 281

Continued From page 1
documentation detailed the personal & bed alarms were not sounding as they were unplugged, thus not following the facility's Fall Prevention Program protocol. Furthermore, the facility's documentation of the incident failed to detail any new interventions to prevent further fall for Resident #1. The Discharge Summary revealed Resident #1 sustained a fracture of the right femur requiring surgical repair.

The findings include:

A review of the Fall Prevention Program, dated August 2003 and revised March 2012, revealed the Morse Fall Assessment is to be completed upon admission, patients scoring 45 or greater are determined to be at risk to fall and the Fall Risk Protocol is initiated, personal alarms are used for all patients who score 45 or above on the Morse Fall Assessment. The nursing staff will ensure the Push Button Call Light, over the bed table, and personal alarm is in place before leaving the patient unattended.

A record review revealed Resident #1 was admitted, on 03/07/12 at 9:00 PM, with diagnoses to include Rehabilitation after a Traumatic Hip Fracture, Diabetes Mellitus, Parkinson's Disease and Coronary Artery Disease. A review of the Admission History, Evaluation and Interim Care Plan, dated 03/07/12, revealed the admitting diagnoses was status post right hip fracture with bipolar fixation. The history detailed that Resident #1 stated he/she fell and broke his/her hip. The facility evaluated the resident to require two person assist with transfers and ambulation, having had a fall in the last 30 days. Further review of this document revealed no evidence of

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3. Documentation on the Post-Fall Protocol will include specific interventions put in place after a fall. These interventions will be recorded in the section: "steps taken to reduce risk of additional falls".

4. Bedside report at shift change will include all pertinent safety and risk information for each resident.

In order to assure that further incidents did not occur, there was a review of the Fall Prevention Policy and Protocol in the March 28 and 30, 2012 staff meeting. Mandatory "Education Day" was held in June and September, 2012 where there was a Fall Prevention poster and information that all clinical staff was required to read and sign their understanding. In June, 2012, a request was made to the Cabinet to convert Room 610 from private to semi-private in order to provide two beds instead of one in the room closest to the nurses' station so that high risk patients could be closely monitored. Approval was received on 9/19/12.

In order to monitor performance and assure solutions are sustained, weekly audits of all residents will be conducted each Friday, for four weeks, to determine compliance with documentation practices regarding interventions for risk to fall residents and implementation of the Fall Prevention policy. Random monthly audits will be conducted for the next six months on 25% of residents. All results will be reported to staff at unit meetings and to QA members at quarterly meetings.

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F 281	<p>Continued From page 2</p> <p>interventions related to the resident's history of fall. Review of the Morse Fall Assessment completed on 03/07/12 revealed the facility assessed Resident #1 as at risk for falls based on history of falls, use of an ambulatory aid, intravenous therapy, impaired gait, mental status limitations, and medication use (scoring 120). Further review of the interim care plan, dated 03/07/12, revealed no evidence the facility had initiated the use of the personal/bed alarms as specified in their policy due to Resident #1's assessed risk for falls.</p> <p>An interview with Registered Nurse (RN) #1, on 09/27/12 at 4:11 PM, revealed she ensure Resident #1 upon admission at 9:00 PM on 03/07/12 had personal and bed alarms applied and that the staff was aware the resident had a previous fall with resulting hip fracture. RN#1 described Resident #1 as very confused, not knowing where he/she was or the time. The RN stated she told the resident and the spouse, the resident was not to get out of bed until evaluated by the Physical Therapist (PT), in the morning. She stated she ensured the bed alarm and personal alarm were functioning prior to leaving the resident's room as she had tested them and plugged them into the call light. An interview with Licensed Practical Nurse (LPN) #1, on 09/28/12 at 9:30 AM, revealed the LPN was sure the resident had both alarms on the bed, as these were in place, prior to admitting the resident. However, continued review of the interim care plan revealed no evidence of the intervention of alarms, instruction for the resident not to get out of bed until PT evaluation, or the level of supervision required to prevent a fall for Resident #1.</p>	F 281		

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F 281	<p>Continued From page 3</p> <p>Review of the medical record and interview with LPN #1 revealed the LPN had documented the resident received pain medication at 9:40 PM and remembered seeing Resident #1 sitting on the side of the bed, when she left the room, but stated the spouse was staying with the resident, in the room and knew the LPN was leaving the room. However, an interview with the spouse, on 09/27/12 at 5:05 PM and 09/29/12 at 4:40 PM, revealed the staff had assisted the resident to the bed side commode and then transferred him/her to sit on the side of the bed. The spouse was in the bathroom, brushing his/her teeth when he/she heard a staff member say they would be right back. The spouse walked out of the bathroom to see the resident take a step at the bedside and fall. The spouse stated there were no alarms sounding.</p> <p>Further interviews with RN #1 and LPN #1 revealed RN #1 revealed at approximately 10:20 PM, they heard the spouse call out for help, as the resident had fallen. The alarms did not sound and RN #1 checked to see why they were not sounding and they were unplugged. The spouse said he/she had set the resident up, to sit on the side of the bed and the spouse had gone to the bathroom. When the spouse got back, the resident was in the floor.</p> <p>Review of the Nursing Progress Record, dated 03/07/12 at 10:20 PM, revealed the resident's spouse call out for help as the resident had fallen. Upon staff entering the room, Resident #1 was found lying on the floor, "no bed alarm or personal alarm was going off." The note further detailed</p>	F 281		
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F 281	Continued From page 4 Resident #1's right leg was turned outward in a lax position. The staff transferred Resident #1 to the bed and the resident complained of "a lot of pain". The facility notified the physician and an xray was ordered. Review of the facility's Post Fall Protocol document, dated 3/08/12 at 12:30 AM, revealed Resident #1 had fallen, at 10:20 PM on 03/07/12, with a probable cause of the fall determined and corrected; however, there was no documented evidence of action taken by the facility related identifying the probably cause. The document specified that Fall Prevention Protocol was in place and followed; however, interviews with RN #1, LPN #1 and the spouse revealed that the personal/bed alarms were not sounding and interview with RN #1 revealed that the alarms were unplugged. Further review of the protocol revealed "same orders" was detailed related to steps taken to reduce risk of additional falls and Morse Fall Assessment and initiate Fall Risk Protocol was marked. Further review of the interim care plan, after the fall, revealed there was no change to the interim care plan as the alarms had not been marked, no specific detail related to supervision the resident required and no new interventions were detailed to prevent further fall recurrence. Review of the Physician's Discharge Summary, dated 04/18/12, revealed Resident #1 was discharged from the facility transferred to the hospital where x-rays confirmed Resident #1 had sustained a "comminuted periprosthetic fracture of the right femur" (hip fracture) which required surgical repair.	F 281			
F 323	483.25(h) FREE OF ACCIDENT	F 323			

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F 323 SS=G	<p>Continued From page 5 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, policy review and Discharge Summary review, it was determined the facility failed to provide appropriate supervision and assistance to prevent accidents, for one residents (#1) in the selected sample of three residents. The facility failed to ensure staff followed the facility's Fall Prevention Program and failed to ensure the care plan reflected the interventions to prevent falls for Resident #1. The facility admitted Resident #1 on 03/07/12 at 9:00 PM at which time they assessed the Resident as a high risk for falls due to recent history of a fall with hip fracture requiring surgical intervention on 03/04/12. On 03/07/12 at 10:20 PM, Resident #1 had an unsupervised fall, from the bed. The facility's documentation detailed the personal & bed alarms were not sounding as they were unplugged, thus not following the facility's Fall Prevention Program protocol. Furthermore, the facility's documentation of the incident failed to detail any new interventions to prevent further fall for Resident #1. The Discharge Summary revealed Resident #1 sustained a fracture of the right femur requiring surgical repair.</p>	F 323	<p>Resident #1 was placed on bed rest following the fall on 3/7/12. The prior fall protocol was continued with assurance from assigned nurse that the personal alarm was on and functioning.</p> <p>Review of this resident's incident and the analysis results were discussed in the March staff meetings on 3/28 and 3/30 /12.</p> <p>All residents are assessed on admission for fall risk using the Morse Fall Risk Assessment. Reinforcement of the following documentation occurred at the staff meeting on 10/18/12:</p> <ol style="list-style-type: none"> Interim care plan, which includes the Nursing Assistant Care Plan, will be completed and include documentation of bed/personal alarm placement and functionality. Daily Care Record of hourly rounding will include marking the personal/bed alarm as "off" or "on". Documentation on the Post-Fall Protocol will include specific interventions put in place after a fall. These interventions will be recorded in the section: "steps taken to reduce risk of additional falls". Bedside report at shift change will include all pertinent safety and risk information for each resident. 	11/9/12
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F 323	<p>Continued From page 6</p> <p>The findings include:</p> <p>A review of the Fall Prevention Program, dated August 2003 and revised March 2012, revealed the Morse Fall Assessment is to be completed upon admission, patients scoring 45 or greater are determined to be at risk to fall and the Fall Risk Protocol is initiated, personal alarms are used for all patients who score 45 or above on the Morse Fall Assessment. The nursing staff will ensure the Push Button Call Light, over the bed table, and personal alarm is in place before leaving the patient unattended.</p> <p>A record review revealed Resident #1 was admitted, on 03/07/12 at 9:00 PM, with diagnoses to include Rehabilitation after a Traumatic Hip Fracture, Diabetes Mellitus, Parkinson's Disease and Coronary Artery Disease. A review of the Admission History, Evaluation and Interim Care Plan, dated 03/07/12, revealed the admitting diagnoses was status post right hip fracture with bipolar fixation. The history detailed that Resident #1 stated he/she fell and broke his/her hip. The facility evaluated the resident to require two person assist with transfers and ambulation, having had a fall in the last 30 days. Further review of this document revealed no evidence of interventions related to the resident's history of fall. Review of the Morse Fall Assessment completed on 03/07/12 revealed the facility assessed Resident #1 as at risk for falls based on history of falls, use of an ambulatory aid, intravenous therapy, impaired gait, mental status limitations, and medication use (scoring 120). Further review of the interim care plan, dated 03/07/12, revealed no evidence the facility had</p>	F 323	<p>In order to assure that further incidents did not occur, there was a review of the Fall Prevention Policy and Protocol in the March 28 and 30, 2012 staff meeting. Mandatory "Education Day" was held in June and September, 2012 where there was a Fall Prevention poster and information that all clinical staff was required to read and sign their understanding. In June, 2012, a request was made to the Cabinet to convert Room 610 from private to semi-private in order to provide two beds instead of one in the room closest to the nurses' station so that high risk patients could be closely monitored. Approval was received on 9/19/12.</p> <p>In order to monitor performance and assure solutions are sustained, weekly audits of all residents will be conducted each Friday, for four weeks, to determine compliance with documentation practices regarding interventions for risk to fall residents and implementation of the Fall Prevention policy. Random monthly audits will be conducted for the next six months on 25% of residents. All results will be reported to staff at unit meetings and to QA members at quarterly meetings.</p>	11/9/12
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Continued From page 7

initiated the use of the personal/bed alarms as specified in their policy due to Resident #1's assessed risk for falls.

An interview with Registered Nurse (RN) #1, on 09/27/12 at 4:11 PM, revealed Resident #1 was admitted at 9:00 PM. The bed was set up with a personal alarm, as the staff was aware the resident had a previous fall with resulting hip fracture. RN#1 described Resident #1 as very confused, not knowing where he/she was or the time. The RN stated she told the resident and the spouse, the resident was not to get out of bed until evaluated by the Physical Therapist, in the morning. She stated she ensured the bed alarm and personal alarm were functioning prior to leaving the resident's room as she had tested them and plugged them into the call light.

An interview with Licensed Practical Nurse (LPN) #1, on 09/28/12 at 9:30 AM, revealed the LPN was sure the resident had both alarms on the bed, as these were in place, prior to admitting the resident. The LPN had documented the resident receiving a pain medication at 9:40 PM and remembered seeing Resident #1 sitting on the side of the bed, when she left the room, but stated the spouse was staying with the resident, in the room and knew the LPN was leaving the room.

An interview with the spouse, on 09/27/12 at 5:05 PM and 09/29/12 at 4:40 PM, revealed the staff had assisted the resident to the bed side commode and then transferred him/her to sit on the side of the bed. The spouse was in the bathroom, brushing his/her teeth when he/she heard a staff member say they would be right

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F 323	<p>Continued From page 8</p> <p>back. The spouse walked out of the bathroom to see the resident take a step at the bedside and fall. The spouse stated there were no alarms sounding.</p> <p>Further interviews with RN #1 and LPN #1 revealed RN #1 revealed at approximately 10:20 PM, they heard the spouse call out for help, as the resident had fallen. The alarms did not sound and RN #1 checked to see why they were not sounding and they were unplugged. The spouse said he/she had set the resident up, to sit on the side of the bed and the spouse had gone to the bathroom. When the spouse got back, the resident was in the floor.</p> <p>Review of the Nursing Progress Record, dated 03/07/12 at 10:20 PM, revealed the resident's spouse call out for help as the resident had fallen. Upon staff entering the room, Resident #1 was found lying on the floor, "no Bed alarm or personal alarm was going off." The note further detailed Resident #1's right leg was turned outward in a lax position. The staff transferred Resident #1 to the bed and the resident complained of "a lot of pain". The facility notified the physician and an xray was ordered.</p> <p>Review of the facility's Post Fall Protocol document, dated 3/08/12 at 12:30 AM, revealed Resident #1 had fallen, at 10:20 PM on 03/07/12, with a probable cause of the fall determined and corrected; however, the document did not detail what the probably cause of the fall was nor did it detail action that was taken to correct the problem. The document specified that Fall Prevention Protocol was in place and followed; however, interviews with RN #1, LPN #1 and the</p>	F 323		

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185412	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/28/2012
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NAME OF PROVIDER OR SUPPLIER LOURDES TRANSITIONAL CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1530 LONE OAK ROAD PADUCAH, KY 42003
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F 323	<p>Continued From page 9</p> <p>spouse revealed that the personal/bed alarms were not sounding and interview with RN #1 revealed that the alarms were unplugged. Further review of the protocol revealed "same orders" was detailed related to steps taken to reduce risk of additional falls and Morse Fall Assessment and initiate Fall Risk Protocol was marked. Further review of the interim care plan revealed the alarms had not been marked and no changes had been made to prevent further fall recurrence.</p> <p>Review of the Physician's Discharge Summary, dated 04/18/12, revealed Resident #1 was discharged from the facility transferred to the hospital where x-rays confirmed Resident #1 had sustained a "comminuted periprosthetic fracture of the right femur" (hip fracture) which required surgical repair.</p>	F 323		