STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	185346		C 08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE CARE AND REHABILITATION CENTER	1614 PARRISH AVE, WEST OWENSBORO, KY 42301

(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 Complaints #KY23662 and #KY23683 was conducted on 08/18/15 through 08/21/15. Complaint #KY23662 was unsubstantiated with no deficiencies cited. KY23683 was substantiated with past non-compliance deficiencies cited at the highest Scope and Severity of a "G". The facility failed to provide care in accordance with the resident's care plan; and, failed to provide the resident with the proper assistance of two (2) staff with transfer from his/her bed to a wheelchair, per the facility's assessment of the resident's needs. The facility assessed and care planned Resident #2 as requiring two (2) person assist with a mechanical lift transfer from the bed to a wheelchair. However, on 08/03/15 at approximately 4:00 AM, State Registered Nurse Aide (SRNA) #12 transferred Resident #2 from the bed to the wheelchair without the assistance of another staff and the use of a mechanical lift. The resident did not sustain a fall during the transfer from the bed to the wheelchair by SRNA #12 at approximately 4:00 AM, nor voice any complaint of pain at that time. However, on 08/03/15 at 9:00 AM, SRNA #9 was attempting to get Resident #2's weight and when she moved the resident's right leg, the resident complained of pain. SRNA #9 notified Licensed Practical Nurse (LPN) #4, who assessed the resident's right leg. The resident had pain and swelling to the right knee. LPN #4 contacted the physician and orders were received to obtain an x-ray. The x-ray revealed a fracture of the resident's distal femur. On 08/03/15, Resident #2 was transferred to the hospital Emergency	F 000		

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 000	Continued From page 1 Department (ED) for further evaluation and treatment. The resident underwent a retrograde nailing of the right distal femur for an acute displaced spiral fracture, on 08/04/15.	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, review of the facility's policy and procedure, review of Emergency Department (ED) Examination of the Right Femur Anterior-Posterior and Lateral X-ray, Hospitalist Notes, an Orthopedic Surgery Consult Note and Surgery Operative Note, it was determined the facility failed to ensure services provided or arranged were provided in accordance with each resident's written plan of care for one (1) of three (3) sampled residents (Resident #2). On 08/27/14, Resident #2 was care planned for two (2) person assist, with a mechanical lift, to aid in transfers. However, on 08/03/15 at approximately 4:00 AM, State Registered Nurse Aide (SRNA) #12 transferred Resident #2 from the bed to a wheelchair without the use of a mechanical lift. SRNA assisted Resident #2 to a standing position, pivoted, and assisted the resident to a sitting position in the wheelchair. Resident #2 sustained an acute displaced oblique/spiral fracture of the distal right femur	F 282	Past noncompliance: no plan of correction required.	

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F 282	Continued From page 2 (lower thigh) which required surgical repair on 08/04/15. The findings include: Review of the facility's policy and procedure titled, "Care Plans - Comprehensive", last reviewed 06/01/15, revealed "An individualized comprehensive care plan that includes measurable objectives and timetables to meet the residents' medical, nursing, mental, and psychological needs is developed for each resident". Record review revealed the facility admitted Resident #2 on 03/29/12, with diagnoses which included Anemia, Osteoporosis, Atrial Fibrillation, Hypertension, Arthritis, Non-Alzheimer's Dementia, Hemiplegia Left, Depression, Macular Degeneration, Psychosis, and Degenerative Joint Disease. Review of Resident #2's Minimum Data Set (MDS) Assessment, dated 06/30/15, revealed the facility assessed Resident #2's cognition as moderately impaired with a Brief Interview of Mental Status (BIMS) score of eight (8) which indicated the resident was interviewable. The facility assessed the resident as requiring the extensive assistance of two (2) staff for transfers. Review of the Comprehensive Care Plan for Activities of Daily Living (ADL) Self-Care Performance, dated 08/27/14, and the Nurse Aide Care Plan, last reviewed August 2015, revealed the resident required the assistance of two (2) staff and a mechanical lift to aid in transfers. Interviews on 08/21/15 with SRNA #11 at 1:48 PM, and SRNA #12 at 2:45 PM, revealed on 08/03/15 at approximately 4:00 AM, Resident #2	F 282		

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F 282	Continued From page 3 was already dressed and ready to be transferred to the wheelchair. The SRNAs stated SRNA #12 helped the resident to sit up on the side of the bed, then put his arms around the resident and rotated him/her into the wheelchair with no complaint voiced by the resident at that time. SRNA #11 began wheeling the wheelchair and noted something was brushing the floor so she asked SRNA #12 if he could see anything. SRNA #12 identified the resident's right foot was slightly lower than the left and the shoe was brushing the floor when the wheelchair was rolled. SRNA #11 then placed the right foot pedal on the wheelchair and lifted the resident's foot onto the foot rest without any complaints of pain from the resident and then continued to roll the resident out of the room. Further interview revealed the SRNAs were aware Resident #2 was care planned for the use of a mechanical lift with assistance of two (2) staff; however, they did not use the lift and SRNA #11 did not assist SRNA #12 with the transfer. Review of Nurses' Notes, dated 08/03/15 at 9:00 AM, and interview with SRNA #9, on 08/21/15 at 8:36 AM, revealed she was taking Resident #2 to be weighed when she (SRNA #9) lifted the resident's right leg in an attempt to remove the foot pedal to get an accurate weight the resident yelled out in pain. SRNA #9 reported this information to Licensed Practical Nurse (LPN) #4. Further review of the Nursing Notes dated 08/03/15 at 9:00 AM, 10:30 AM, 2:48 PM, and 3:35 PM and interview with LPN #4, on 08/20/15 at 3:51 PM, revealed LPN #4 assessed the resident's right knee and identified the resident had pain and swelling with range of motion. LPN #4 notified the physician and orders were received to obtain an x-ray; the resident's Power	F 282		

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F 282	Continued From page 4 of Attorney was notified. The resident was transferred to the bed with a mechanical lift for the x-ray to be completed. The results of the x-ray were received and the Physician was notified that the x-ray identified that the resident had a spiral fracture of the distal femur. Orders were received to transfer the resident to the Emergency Department (ED) to be evaluated. The resident was transferred to the hospital at 3:45 PM. Review of the ED Examination of the Right Femur Anterior-Posterior and Lateral x-rays, interpreted on 08/03/15 at 5:10 PM, revealed osteopenia/osteoporosis with an acute displaced oblique/spiral fracture of the distal right femur, "probable rotation at the fracture site." Review of Orthopedic Surgery Consult Notes, dated 08/04/15 at 1:21 PM, revealed the fracture would require surgical repair. Review of the Operative Note, dated 08/04/15 at 4:00 PM, revealed the Surgeon performed retrograde nailing of the right distal femur to repair the fracture. Interview with the Director of Nursing (DON), on 08/21/15 at 10:32 AM, revealed an investigation of the injury was initiated as soon as the x-ray results revealed a spiral fracture and no method of injury was reported. The DON stated any staff who had contact with the resident, for the seventy-two (72) hours prior to discovering the injury, were interviewed in an attempt to discover the probable method of injury. The DON revealed after the fifth (5th) interview with SRNA #12 and the sixth (6th) interview with SRNA #11, on 08/06/15, they both admitted to transferring Resident #2 without using the mechanical lift as care planned. The DON stated the staff should have used the mechanical lift for transfer to	F 282		

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F 282	Continued From page 5 prevent weight bearing which could have caused the resident's injury. Interview with Resident #2's Primary Care Physician, on 08/19/15 at 8:40 AM, revealed the injury may have been prevented if the staff had followed the resident's plan of care. Review of the "Quality Performance/Peer Review, Facility Plan of Action/Continuous Quality Improvement", dated 08/04/15, revealed the steps that were taken from the point of assessment of the resident for an injury of unknown origin. The facility identified other residents who may be affected by the deficient practice; what corrective actions that were to be taken; measures put in to place; the systemic changes to ensure the deficient practice did not reoccur; and, a description of the Quality Assurance Performance Improvement (QAPI) process that will be put into place to track and trend data over time to ensure the action plan met the initial identified goal. The facility implemented the following actions to correct the deficient practice: 1. LPN #4 completed an immediate assessment of Resident #2, notified the Medical Doctor/Medical Director about Resident #2's complaint of pain and assessment findings, obtained an order for the x-ray, and notified the family of a change in the resident's condition. 2. The facility notified the State Survey Agency about the resident's incident. 3. Resident #2 was interviewed about the	F 282		

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F 282	Continued From page 6 incident by the Restorative Supervisor and the Assistant Director of Nursing (ADON) on 08/03/15 at 3:45 PM. 4. Resident #2 was sent to the ED, on 08/30/15 at 3:45 PM, by LPN #4 for an evaluation and treatment per the Physician's Order, dated 08/03/15 at 2:48 PM. 5. An incident report was completed by the ADON on 08/03/15. 6. Staff and family, who had seen the resident in the past seventy-two (72) hours, were interviewed about the resident's reports of pain on 08/03/15. 7. Resident #2's roommate was interviewed by Registered Nurse (RN) #3 about the use of the mechanical lift for his/her roommate on 08/03/15. 8. On 08/04/15, the DON reviewed the orders, the Nurse Aide Care Plans, and reviewed the Comprehensive Care Plan for accuracy. She reviewed the Kiosk documentation used for the current MDS, reviewed the shower sheets used by SRNAs for accuracy and any explanation of injury. The DON reviewed weekly skin evaluations for accuracy and any explanation of injury or complaint of pain. 9. On 08/04/15, the ADON identified other residents who used a mechanical lift, and interviewed those residents with a BIMS' score greater than eight (8); and, performed body audits on those with BIMS below (8). 10. On 08/07/15, the Staff Development Coordinator (SDC) and the MDS Coordinator provided training, and verified skills through	F 282		

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F 282	Continued From page 7 observation and written test of staff who provided transfers by mechanical lifts. 11. Interview with the DON, on 08/21/15 at 9:50 AM, revealed she implemented a Performance Improvement (PI) Audit to monitor for completion of transfers according to the resident's care plan, as well as documentation in the Kiosk, on 08/04/15, to be monitored five (5) times per week for thirty (30) days, then three (3) times per week for thirty days, then weekly for thirty days, and is ongoing. 12. The QA team will meet monthly to review information from the PI Audit. The State Survey Agency validated the corrective actions taken by the facility as follows: 1. Review of Nurses' Notes, dated 08/03/15 at 9:00 AM, and interview with LPN #4, on 08/20/15 at 3:51 PM, revealed Resident #2 was assessed and sent out to the hospital on 08/03/15. Review of the 08/03/15 x-rays, revealed Resident #2 had a Right Femur Anterior-Posterior and Lateral x-rays. 2. Notification of State Agencies, was verified by review of the intake information form and information faxed to the Office of Inspector General (OIG) by the DON. 3. Interview with the ADON, on 08/21/15 at 9:50 AM, revealed she interviewed Resident #2 about the details of the 08/03/15 incident. 4. Transportation of Resident #2 to the ED, was verified by review of the Nurses' Notes, dated 08/03/15 at 3:45 PM. Interview with LPN #4, on	F 282		

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F 282	Continued From page 8 08/20/15 at 3:51 PM, confirmed this information. 5. Completion of the incident report, was verified by review of the "Nursing Assessment", dated 08/03/15 at 2:50 PM. 6. Interview with the DON, on 08/21/15 at 10:32 AM, revealed she conducted interviews with each individual who worked with the resident in the previous seventy-two (72) hours, as well as family, and reviewed the written statements taken by the ADON when an investigation was initiated. Surveyor confirmed this information through review of the documentation of the interviews as well as written statements. 7. Interview with LPN #5, on 08/21/15 at 10:16 AM, revealed she was present when Resident #2's roommate was interviewed by RN #3 about the use of the mechanical lift for his/her roommate. 8. Interview with the DON, on 08/21/15 at 10:32 AM, verified this information was completed. She revealed she identified no concerns. 9. Review of the "Resident Functional Assessment Mechanical Lifts" forms, dated 08/04/15, revealed the forms were used to document interviews and assessments of five (5) identified residents who use a mechanical lift. 10. Review of inservice records and skills check-offs, dated 08/04/15, 08/05/15, 08/06/15, and 08/07/15, revealed facility staff was inserviced on the use of a lift. Interviews on 08/20/15 with SRNA #1 at 9:37 AM, SRNA #2 at 9:55 AM, SRNA #3 at 10:54 AM, SRNA #4 at 1:35 PM, SRNA #5 at 1:58 PM, SRNA #6 at 3:21 PM,	F 282		

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F 282	Continued From page 9 SRNA #7 at 3:40 PM, SRNA #8 at 4:13 PM, LPN #2 at 10:13 AM, LPN #3 at 10:37 AM, LPN #4 at 3:51 PM; RN #1 at 11:22 AM, and RN #2 at 2:23 PM, and interviews on 08/21/15 with SRNA #9 at 8:36 AM, and SRNA #10 at 8:53 AM, revealed they were re-educated on following the Comprehensive Care Plans, Nurse Aide Care Plans, and using the mechanical lift as specified by the care plans. 11. Review of the PI Audit, "Audit for appropriate Hoyer/Mechanical Lift Transfers", initiated on 08/04/15, and provided via e-mail on 08/27/15 by the Human Resources Director (HRD), revealed an audit to identify any concerns related to the six (6) residents in the facility who use a mechanical lift. 12. Review of an inservice for QA Fracture of Unknown Origin, dated 08/04/15, revealed the initial QA meeting was held with the Medical Director, Administrator, and twenty-one (21) administrative staff to review the plan for Quality Assurance Performance Improvement (QAPI). Interview with the DON, on 08/26/15 at 9:29 AM, revealed QAPI meetings were planned monthly to review PI tools and to make further recommendations as needed.	F 282		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to ensure one (1) of three (3) sampled residents (Resident #2) received adequate supervision and assistance to prevent accidents. On 08/27/14, Resident #2 was care planned for two (2) person assist with a mechanical lift to aid in transfers. On 08/03/15 at approximately 4:00 AM, State Registered Nurse Aide (SRNA) #12 transferred Resident #2 from the bed to a wheelchair without the use of a mechanical lift. SRNA #12 assisted Resident #2 to a standing position, pivoted, and assisted the resident to a sitting position into his/her wheelchair. Later that morning, at 9:00 AM, Resident #2 complained of pain to the right knee, which was reported to Licensed Practical Nurse (LPN) #4 by SRNA #9. LPN #4 completed an assessment and contacted the physician. X-rays were obtained, which revealed the resident had sustained a spiral fracture of the distal right femur (lower thigh). The findings include: Review of the facility's policy/procedure, titled "Resident Lift", undated, revealed "Residents who are unable to transfer themselves independently or with minimum assistance shall be transferred safely with a lift". Record review revealed the facility admitted Resident #2 on 03/29/12 with diagnoses which included Anemia, Osteoporosis, Atrial Fibrillation,	F 323	Past noncompliance: no plan of correction required.	

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F 323	Continued From page 11 Hypertension, Gastroesophageal Reflux Disease, Hyperlipidemia, Arthritis, Non-Alzheimer's Dementia, Hemiplegia Left, Depression, Macular Degeneration, Psychosis, and Degenerative Joint Disease. Review of Resident #2's Minimum Data Set (MDS) assessment, dated 06/30/15, revealed the facility assessed Resident #2's cognition as moderately impaired with a Brief Interview of Mental Status (BIMS) score of eight (8) which indicated the resident was interviewable. The facility assessed the resident to require the extensive assistance of two (2) staff for transfers. Review of the Comprehensive Care Plan for Activities of Daily Living (ADL) Self-Care Performance, last revised 08/27/14, revealed the resident required two (2) staff assist and a mechanical lift to aid with transfers. Review of the Physical Therapy Recertification and Updated Plan of Treatment, dated 11/17/14, revealed "Resident requires lift for bed to chair transfers". Interview with the Physical Therapist (PT), on 08/21/15 at 2:21 PM, revealed Resident #2 was very difficult to transfer from the bed to a wheelchair because he/she did not have enough upper body strength and could not stand up straight. She stated, from previous times working with the resident, he/she had difficulty taking steps, so he/she would have to pivot in order to transfer. Additionally, PT stated the resident had so much tone (stiffness), it took two to three (2 to 3) staff to try to transfer him/her that way, so the mechanical lift was recommended to transfer the resident. Further review of the Care Plan Conference	F 323		

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F 323	Continued From page 12 Summary related to ADLs/Rehabilitation, dated 11/26/14, revealed staff was to, "Assist with all weight bearing, Hoyer lift". Review of the Nurse Aide Care Plan, last reviewed August 2015, revealed transfers were to be conducted with a mechanical lift with the assistance of two (2) staff. Interview with SRNA #11, on 08/21/15 at 1:48 PM, revealed on 08/03/15 at approximately 4:00 AM, Resident #2 was already dressed and ready to be transferred to the wheelchair when she asked SRNA #12 for assistance. She stated SRNA #12 helped the resident to sit up on the side of the bed, then put his arms around the resident and rotated the resident into the wheelchair with no complaint voiced by the resident. Further interview with SRNA #11 revealed she heard something brushing the floor when she started to push the wheelchair. She stated she asked SRNA #12 if he could see anything. SRNA #11 stated SRNA #12 noted that the resident's right foot was slightly lower than the left and the resident's shoe was brushing the floor when the wheelchair was rolled. SRNA #11 stated she then placed the right foot pedal on the wheelchair and lifted the resident's foot onto the foot rest without any complaints voiced and then continued to roll the resident out of the room. Further interview revealed SRNA #11 was aware Resident #2 was care planned for the use of a mechanical lift with assistance of two (2) staff; however, she did not assist SRNA #12 with the transfer. She stated she observed as SRNA #12 reached around Resident #2 and transferred the resident to the wheelchair unassisted. Interview with SRNA #12, on 08/21/15 at 2:45 PM, revealed on 08/03/15 at approximately 4:00 AM, he assisted the resident up to the side of the	F 323		

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F 323	Continued From page 13 bed and transferred the resident to his/her wheelchair. He stated there was no complaints voiced by the resident when he transferred him/her. SRNA #12 stated as he was about to leave the room, when SRNA #11 asked him what was dragging on the wheelchair as it rolled, he could see the resident's right foot rubbing against the floor as the wheelchair was pushed. He stated the resident's right foot was slightly lower than the left foot so they put the foot pedal on the wheelchair and he did not hear any complaints when SRNA #11 lifted Resident #2's leg to place foot on the foot rest. Further interview revealed SRNA #12 revealed he was aware the resident had a care plan for the use of a mechanical lift. He stated he got in a hurry, sat the resident up on the side of the bed, and transferred the resident to the wheelchair. Interview with Registered Nurse (RN) #6, on 08/24/15 at 4:32 PM, revealed she was made aware Resident #2's right leg was dragging the floor on 08/03/15 when the SRNA was pushing him/her in the wheelchair. RN #6 stated it was around 7:00 AM on 08/03/15, when she assessed Resident #2's leg and there was no evidence of swelling at the site or complaints of pain by the resident, so she passed the information on to the oncoming nurse. However, review of the Nurse's Notes revealed there was no documented evidence RN #6 assessed Resident #2 on 08/03/15. Review of Nurses' Notes, dated 08/03/15 at 9:00 AM, revealed SRNA #9 lifted Resident #2's right leg to remove a foot pedal, and he/she yelled out in pain. SRNA #9 reported this information to LPN #4, who assessed the resident's right knee and identified Resident #2 had swelling and pain with	F 323		

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F 323	Continued From page 14 range of motion. LPN #4 notified the Physician and orders were received to obtain an x-ray; the resident's power of attorney was notified. Review of Nurses' Notes, dated 08/03/15 at 2:48 PM, revealed x-ray results were received, and the Physician was notified that the resident had a right femur fracture. A new order was received to send the resident to the Emergency Department (ED) to be evaluated. Further review of Nurses' Notes, dated 08/03/15 at 3:45 PM, revealed the ambulance service arrived and transferred the resident to the hospital. Interview with SRNA #9, on 08/21/15 at 8:36 AM, revealed it was around 9:00 AM on 08/03/15 when she took the resident to be weighed and moved the resident's right leg support on the wheelchair. She stated Resident #2 yelled out in pain, so she took him/her to the nurse for an assessment. Interview with LPN #4, on 08/20/15 at 3:51 PM, revealed Resident #2 was up when she arrived at work at 7:00 AM. She stated SRNA #9 went to obtain the resident's weight and the resident yelled out in pain when they attempted to move his/her right leg from the leg rest. LPN #4 stated when she assessed Resident #2, she found the resident's right knee swollen and complaining of pain with range of motion. She stated she notified the physician to report the results of the assessment, and he ordered an x-ray. LPN #4 stated when the results of the x-ray were returned, the physician was notified about the fracture and an order was obtained to transfer the resident to the ED for further evaluation. Review of the ED Examination of Right Femur Anterior-Posterior and Lateral x-rays, interpreted	F 323		

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F 323	Continued From page 15 on 08/03/15 at 5:10 PM, revealed osteopenia/osteoporosis with an acute displaced oblique/spiral fracture of the distal right femur, "probable rotation at the fracture site." Review of Hospitalist Notes, dated 08/03/15 at 8:06 PM, revealed Resident #2 was admitted to the Hospitalist service for evaluation and medical clearance for surgical intervention by the Orthopedic Surgeon. Review of the Orthopedic Surgery Consult Notes, dated 08/04/15 at 1:21 PM, revealed the fracture would require surgical repair. Review of the Operative Note, dated 08/04/15 at 4:00 PM, revealed the Surgeon performed retrograde nailing of the right distal femur to repair the fracture. Interview with the Director of Nursing (DON), on 08/21/15 at 10:32 AM, revealed an investigation of the injury was initiated as soon as the x-ray results revealed a spiral fracture and no method of injury was reported. The DON stated any staff who had contact with the resident, for the seventy-two (72) hours prior to discovering the injury, were interviewed in an attempt to discover the probable method of injury. The DON revealed after the fifth (5th) interview with SRNA #12 and the sixth (6th) interview with SRNA #11, on 08/06/15, they both admitted to transferring Resident #2 without using the mechanical lift as care planned. The DON stated the staff should have used the mechanical lift for transfers to prevent weight bearing which could have caused the resident's injury. SRNA #11 and SRNA #12 were terminated from employment on 08/07/15. Interview with Resident #2's Primary Care Physician, on 08/19/15 at 8:40 AM, revealed the injury may have been prevented if the staff had	F 323		

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F 323	Continued From page 16 followed the resident's plan of care. Review of the "Quality Performance/Peer Review, Facility Plan of Action/Continuous Quality Improvement", dated 08/04/15, revealed the steps that were taken from the point of assessment of the resident for an injury of unknown origin. The facility identified other residents who may be affected by the deficient practice; what corrective actions that were to be taken; measures put in to place; the systemic changes to ensure the deficient practice did not reoccur; and, a description of the Quality Assurance Performance Improvement (QAPI) process that will be put into place to track and trend data over time to ensure the action plan met the initial identified goal. The facility implemented the following actions to correct the deficient practice: 1. LPN #4 completed an immediate assessment of Resident #2, notified the Medical Doctor/Medical Director about Resident #2's complaint of pain and assessment findings, obtained an order for the x-ray, and notified the family of a change in the resident's condition. 2. The facility notified the State Survey Agency about the resident's incident. 3. Resident #2 was interviewed about the incident by the Restorative Supervisor and the Assistant Director of Nursing (ADON) on 08/03/15 at 3:45 PM. 4. Resident #2 was sent to the ED, on 08/30/15 at 3:45 PM, by LPN #4 for an evaluation and	F 323		

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F 323	Continued From page 17 treatment per the Physician's Order, dated 08/03/15 at 2:48 PM. 5. An incident report was completed by the ADON on 08/03/15. 6. Staff and family, who had seen the resident in the past seventy-two (72) hours, were interviewed about the resident's reports of pain on 08/03/15. 7. Resident #2's roommate was interviewed by Registered Nurse (RN) #3 about the use of the mechanical lift for his/her roommate on 08/03/15. 8. On 08/04/15, the DON reviewed the orders, the Nurse Aide Care Plans, and reviewed the Comprehensive Care Plan for accuracy. She reviewed the Kiosk documentation used for the current MDS, reviewed the shower sheets used by SRNAs for accuracy and any explanation of injury. The DON reviewed weekly skin evaluations for accuracy and any explanation of injury or complaint of pain. 9. On 08/04/15, the ADON identified other residents who used a mechanical lift, and interviewed those residents with a BIMS' score greater than eight (8); and, performed body audits on those with BIMS below (8). 10. On 08/07/15, the Staff Development Coordinator (SDC) and the MDS Coordinator provided training, and verified skills through observation and written test of staff who provided transfers by mechanical lifts. 11. Interview with the DON, on 08/21/15 at 9:50 AM, revealed she implemented a Performance Improvement (PI) Audit to monitor for completion	F 323		

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F 323	Continued From page 18 of transfers according to the resident's care plan, as well as documentation in the Kiosk, on 08/04/15, to be monitored five (5) times per week for thirty (30) days, then three (3) times per week for thirty days, then weekly for thirty days, and is ongoing. 12. The QA team will meet monthly to review information from the PI Audit. The State Survey Agency validated the corrective actions taken by the facility as follows: 1. Review of Nurses' Notes, dated 08/03/15 at 9:00 AM, and interview with LPN #4, on 08/20/15 at 3:51 PM, revealed Resident #2 was assessed and sent out to the hospital on 08/03/15. Review of the 08/03/15 x-rays, revealed Resident #2 had a Right Femur Anterior-Posterior and Lateral x-rays. 2. Notification of State Agencies, was verified by review of the intake information form and information faxed to the Office of Inspector General (OIG) by the DON. 3. Interview with the ADON, on 08/21/15 at 9:50 AM, revealed she interviewed Resident #2 about the details of the 08/03/15 incident. 4. Transportation of Resident #2 to the ED, was verified by review of the Nurses' Notes, dated 08/03/15 at 3:45 PM. Interview with LPN #4, on 08/20/15 at 3:51 PM, confirmed this information. 5. Completion of the incident report, was verified by review of the "Nursing Assessment", dated 08/03/15 at 2:50 PM.	F 323		

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F 323	Continued From page 19 6. Interview with the DON, on 08/21/15 at 10:32 AM, revealed she conducted interviews with each individual who worked with the resident in the previous seventy-two (72) hours, as well as family, and reviewed the written statements taken by the ADON when an investigation was initiated. Surveyor confirmed this information through review of the documentation of the interviews as well as written statements. 7. Interview with LPN #5, on 08/21/15 at 10:16 AM, revealed she was present when Resident #2's roommate was interviewed by RN #3 about the use of the mechanical lift for his/her roommate. 8. Interview with the DON, on 08/21/15 at 10:32 AM, verified this information was completed. She revealed she identified no concerns. 9. Review of the "Resident Functional Assessment Mechanical Lifts" forms, dated 08/04/15, revealed the forms were used to document interviews and assessments of five (5) identified residents who use a mechanical lift. 10. Review of inservice records and skills check-offs, dated 08/04/15, 08/05/15, 08/06/15, and 08/07/15, revealed facility staff was inserviced on the use of a lift. Interviews on 08/20/15 with SRNA #1 at 9:37 AM, SRNA #2 at 9:55 AM, SRNA #3 at 10:54 AM, SRNA #4 at 1:35 PM, SRNA #5 at 1:58 PM, SRNA #6 at 3:21 PM, SRNA #7 at 3:40 PM, SRNA #8 at 4:13 PM, LPN #2 at 10:13 AM, LPN #3 at 10:37 AM, LPN #4 at 3:51 PM; RN #1 at 11:22 AM, and RN #2 at 2:23 PM, and interviews on 08/21/15 with SRNA #9 at 8:36 AM, and SRNA #10 at 8:53 AM, revealed they were re-educated on following the	F 323		

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F 323	Continued From page 20 Comprehensive Care Plans, Nurse Aide Care Plans, and using the mechanical lift as specified by the care plans. 11. Review of the PI Audit, "Audit for appropriate Hoyer/Mechanical Lift Transfers", initiated on 08/04/15, and provided via e-mail on 08/27/15 by the Human Resources Director (HRD), revealed an audit to identify any concerns related to the six (6) residents in the facility who use a mechanical lift. 12. Review of an inservice for QA Fracture of Unknown Origin, dated 08/04/15, revealed the initial QA meeting was held with the Medical Director, Administrator, and twenty-one (21) administrative staff to review the plan for Quality Assurance Performance Improvement (QAPI). Interview with the DON, on 08/26/15 at 9:29 AM, revealed QAPI meetings were planned monthly to review PI tools and to make further recommendations as needed.	F 323		