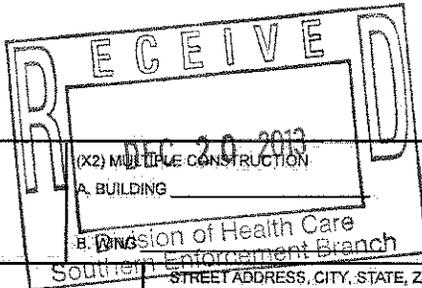


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/12/2013
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/26/2013
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NAME OF PROVIDER OR SUPPLIER BARBOURVILLE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 65 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906
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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	F 000		
F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, facility policy review, and a review of the facility's investigation, it was determined the facility failed to ensure staff provided care in accordance with the written plan of care for one of three sampled residents (Resident #1). A review of an undated Kardex (an individualized guide of resident care needs) revealed the facility had assessed Resident #1 to require the assistance of two staff persons for transfers. A review of a facility investigation dated 11/21/13 revealed State Registered Nursing Assistant (SRNA) #1 transferred Resident #1 from the bed to the wheelchair unassisted and the resident slid to the floor. Documentation revealed Resident #1 sustained no injuries as a result of the incident. The facility's investigation revealed SRNA #1 had failed to provide care in accordance with the resident's Plan of Care and terminated the SRNA's employment at the facility.</p> <p>The findings include:</p>	F 282	See attached	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Janna Parkin</i>	TITLE <i>Administrator</i>	(X6) DATE <i>12/19/13</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 282	Continued From page 1 Review of the facility policy titled, "Care Plan Policy and Protocol," undated, revealed a Kardex would be used as a guide for nursing assistants who provided resident care and would be revised when indicated. Review of the facility policy titled, "Resident Status Kardex," undated, revealed the SRNA was required to review the Kardex to ensure appropriate care was provided to the resident, or any time the SRNA had questions regarding the resident's care. In addition, the policy revealed licensed nurses would also give a verbal report of each resident's care needs to the State Registered Nursing Assistants (SRNAs) at the beginning of their shift. Review of the medical record revealed the facility admitted Resident #1 on 11/09/07, with diagnoses that included Traumatic Brain Injury Secondary to a Motor Vehicle Accident, Seizures, and Degenerative Disc Disease. Review of an annual Minimum Data Set (MDS) assessment for Resident #1 dated 10/07/13, revealed the resident had been assessed by the facility to require the extensive assistance of two persons to transfer the resident. The MDS also revealed the facility had assessed the resident to be severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 7. Review of the undated Kardex for Resident #1 revealed the facility assessed the resident to be a "high fall risk" and noted two persons were required to transfer the resident. Review of the facility's investigation of a fall	F 282			

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F 282	<p>Continued From page 2</p> <p>sustained by Resident #1 on 11/21/13, at 6:45 AM, revealed SRNA #1 attempted to transfer Resident #1 unassisted and the resident slid from the bed to the floor. Documentation revealed the resident sustained no injury as a result of the incident.</p> <p>An interview with Resident #1 was not attempted due to the resident's limited cognition. Observation of Resident #1 on 11/26/13, at 10:15 AM, revealed the resident was in bed and SRNA #2 and SRNA #3 transferred the resident from the bed to a chair.</p> <p>Interview conducted with SRNA #1 on 11/26/13, at 11:27 AM, revealed she had not provided direct care to Resident #1 prior to 11/21/13 and had not reviewed the resident's Kardex at the beginning of the shift on 11/21/13. According to SRNA #1, the nurse had given her a verbal report at the beginning of the shift on 11/21/13 and had instructed her Resident #1 required the assistance of two persons for transfers. The SRNA stated she thought the other SRNAs were busy and felt she could transfer the resident safely by herself.</p> <p>Interview conducted with Registered Nurse (RN) #1 on 11/26/13, at 11:45 AM, revealed she had given SRNA #1 a report on 11/21/13 and had informed the SRNA that two staff persons were required to transfer Resident #1. In addition, the RN stated at the beginning of each shift SRNAs were required to review the Kardex of each resident they were assigned to in order to determine each resident's care needs.</p> <p>Interview conducted with the Director of Nursing (DON) on 11/26/13, at 4:00 PM, revealed a</p>	F 282		

Barbourville Nursing Home
Plan of Correction
Abbreviated Survey
November 26th, 2013

F 282 (k) (3) (ii) Comprehensive Care Plans

1. Resident #1 is being transferred with assistance of two staff members as assessed in accordance with the written plan of care.
2. All residents were reviewed and re-assessed to determine the proper amount of assistance required for transfers. The written plan of care & kardex of each resident has been reviewed to ensure accuracy. No other irregularities were found.
3. An in-service was conducted by the Administrator and Director of Nursing on November 27th-30th, 2013 with all nursing staff, including nurse aides and nurses, on following the plan of care/Kardex when providing care and notifying the nurse or Clinical Coordinator if care needs have changed. The staff was also educated regarding transfer techniques, including the importance of utilizing the appropriate number of staff or devices required for transferring.
4. CQI committee designee will select 6 charts at random to review care plan and kardex to ensure the appropriated amount of assistance for transfers has been assessed appropriately. Observations will be conducted on the selected residents to ensure the appropriate number of staff is providing assistance. These audits/observations will be conducted on a weekly basis for one month, then monthly for the next quarter. Any identified concern will be corrected immediately and reported to the CQI Committee for further follow up and review.
5. Completion Date: December 6th, 2013

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F 282	Continued From page 3 licensed nurse was required to give the SRNAs a verbal report at the beginning of each shift and, in addition, the SRNAs were required to review the resident Kardex at the beginning of every shift. The DON stated she made rounds throughout the facility every day to monitor resident care to ensure staff provided care in accordance with each resident's plan of care. According to the DON, she had not identified any concerns related to resident care prior to Resident #1's fall on 11/21/13. The DON stated as the result of the investigation it had been determined the RN had given a verbal report to SRNA #1 at the beginning of the shift on 11/21/13; however, the DON stated SRNA #1 failed to review the resident's Kardex and failed to obtain assistance to transfer Resident #1 on 11/21/13. The DON stated SRNA #1's employment at the facility was terminated on 11/22/13 as a result of the incident.	F 282			
F 323 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, facility policy review, and facility investigation, it was determined the facility failed to ensure adequate supervision and assistance was proved for one of three residents (Resident #1) to	F 323	<i>See attached</i>		

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F 323	<p>Continued From page 4.</p> <p>prevent accidents. Review of an annual Minimum Data Set (MDS) assessment for Resident #1 dated 10/07/13, and a review of an undated Kardex (a guide for the provision of resident care based on the resident assessment) revealed facility staff had assessed Resident #1 to be dependent with transfers and noted the resident required extensive assistance of two persons for transfers. However, a review of documentation revealed State Registered Nurse Assistant (SRNA) #1 attempted to assist Resident #1 from bed to a wheelchair on 11/21/13, without additional assistance, and Resident #1 slid to the floor.</p> <p>The findings include:</p> <p>Interview with the Administrator on 11/26/13, at 12:05 PM, revealed the facility did not have a policy related to providing assistance/supervision to prevent accidents.</p> <p>Review of the undated facility policy entitled "Care Plan Policy and Protocol" on 11/26/13, at 3:15 PM, revealed staff would utilize the information documented in each individualized Kardex as a guide to provide resident care.</p> <p>Continued review of facility policies on 11/26/13, at 3:25 PM, revealed the facility had established a policy entitled "Resident Status Kardex," undated, that indicated a licensed nurse would give a verbal report of each resident's care needs to the State Registered Nursing Assistants (SRNAs) at the beginning of the shift. In addition, the policy also revealed SRNAs were required to review the Kardex (an individualized guide of resident care needs) prior to the beginning of the shift to ensure appropriate care was provided to the residents</p>	F 323			

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F 323	<p>Continued From page 5 assigned to the SRNA.</p> <p>Documentation in the medical record revealed the facility admitted Resident #1 on 11/09/07. At the time of the visit on 11/26/13, Resident #1's diagnoses included Traumatic Brain Injury Secondary to a Motor Vehicle Accident, Seizures, and Degenerative Disc Disease.</p> <p>Review of an annual Minimum Data Set (MDS) assessment, dated 10/07/13, revealed facility staff had assessed Resident #1 and noted two staff persons were required to provide extensive assistance to transfer the resident. Continued review of the MDS revealed, based on the facility's assessment, Resident #1 had a Brief Interview for Mental Status (BIMS) score of 7 which indicated the resident had severely impaired cognition.</p> <p>Documentation reviewed on 11/26/13, at 3:30 PM from an undated Kardex also revealed the facility had assessed Resident #1 to be at a "high" risk for falls and noted two persons were required to transfer the resident.</p> <p>Based on a review of the facility's investigation of a fall sustained by Resident #1 on 11/21/13, at 6:45 AM, SRNA #1 had attempted to transfer Resident #1 unassisted and the resident slid from his/her bed to the floor. Documentation revealed the resident sustained no injury as a result of the incident.</p> <p>Due to Resident #1's limited cognition, an interview with the resident was not attempted. Observation of Resident #1 on 11/26/13, at 10:15 AM, revealed the resident was assisted from the bed to a chair by SRNA #2 and SRNA #3.</p>	F 323			

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F 323	<p>Continued From page 6</p> <p>Interview conducted with SRNA #1 on 11/26/13, at 11:27 AM, revealed she had not provided care to Resident #1 prior to 11/21/13 and had not reviewed the resident's Kardex at the beginning of the shift on 11/21/13. Although SRNA #1 stated the nurse had given her a verbal report at the beginning of her shift and told her the resident needed two people to assist with transfer, the SRNA stated she failed to obtain assistance when she transferred Resident #1 on 11/21/13. The SRNA stated she thought the other SRNAs were busy and felt she could transfer the resident safely by herself.</p> <p>Registered Nurse (RN) #1 stated in an interview conducted on 11/26/13, at 11:45 AM, that she had given SRNA #1 a verbal report of Resident #1's care needs, including the number of staff required to assist the resident with transfers, prior to the beginning of the shift on 11/21/13. The RN also stated the resident's Kardex contained information related to his/her individual care needs and that the SRNAs were required to review the Kardex at the beginning of their shift to determine the resident's care needs.</p> <p>Interview conducted with the Director of Nursing (DON) on 11/26/13, at 4:00 PM, revealed staff had informed her on 11/21/13 of the fall sustained by Resident #1 on 11/21/13 at 6:45 AM. The DON stated all SRNAs were required to review the Kardex at the beginning of every shift to determine the care needs of each resident and the assistance they required to ensure the resident's safety. In addition, the DON stated licensed nurses were also required to give the SRNAs a verbal report at the beginning of each shift of the resident's care needs and any</p>	F 323			

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F 323	Continued From page 7 assistance the residents required. The DON stated she conducted observations of resident care throughout the day in an effort to ensure each resident's care needs were met and that staff provided assistance and/or supervision of the residents based on their assessed needs/plan of care. According to the DON, she had not identified any concerns related to staff's failure to provide assistance or care in accordance with the plan of care prior to the incident with Resident #1's fall. The DON also stated SRNA #1's employment at the facility was terminated on 11/22/13 due to the SRNA's failure to review and follow the Kardex for Resident #1 on 11/21/13.	F 323			

Barbourville Health & Rehabilitation Center

Plan of Correction

Abbreviated Survey

November 26th, 2013

F-323

1. Resident #1 is being transferred with assistance of two staff members as assessed per the written plan of care.
2. All residents were reviewed and assessed to determine the proper amount of assistance required for transfers. Observations were made of residents being transferred that require two or more staff members to assist. No other irregularities were found.
3. An in-service was conducted by the Administrator and Director of Nursing on November 27th-30th, 2013 with all nursing staff, including nurse aides and nurses, regarding transfer techniques, including the importance of utilizing the appropriate number of staff or devices required for transferring. The staff was also educated on following the plan of care/kardex when providing care and notifying the nurse or Clinical Coordinator if care needs have changed.
4. CQI Committee designees will conduct 6 random observations per week of residents to ensure the appropriate number of staff is providing assistance. The observations will also include a review of the kardex to ensure the appropriate amount of assistance was used during the transfer. The audits/observations will be conducted on a weekly basis for one month, then monthly for one quarter. Any identified concern will be corrected immediately and reported to the CQI committee for further follow-up and review.
5. Date of Completion: December 6th, 2013