

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

RECEIVED  
JUN 28 2012  
Division of Health Care  
Southern Enforcement Branch

PRINTED: 06/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 06/06/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  SUMMIT MANOR HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728
---	--

(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 standard survey (KY18482) was initiated on 06/05/12 and concluded on 06/06/12. The complaint was substantiated. Deficient practice was identified with the highest scope and severity at "G" level, with an opportunity to correct.	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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must record and periodically update	F 157	F 157 Resident #1 has been discharged  DON began auditing on 06-07-12 all reports of incidents, 24 hour reports, wound logs, and MD orders for the past 30 days to ensure that all changes in condition or acute issues identified were reported to the residents physician and responsible party as per the facility policy. She completed the audit on 06-22-12. A head to toe assessment completed on 6-7-12 on all residents by the DON, Wound Care Nurse and two nursing supervisors, to ensure that all skin problems had been identified and reported to the physician and responsible party as per facility policy. Medical Records Coordinator completed an audit on 6-7-12 of all weekly skin assessments for the past 30 days to ensure that they were completed as per facility policy (no less than every 7 days) and to ensure that any changes in condition were reported to the physician and responsible party per facility policy.  F157 continued.....	06-27-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brenda Williams TITLE: Administrator (X6) DATE: 6/28/12

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.

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

PRINTED: 06/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 06/06/2012
NAME OF PROVIDER OR SUPPLIER  SUMMIT MANOR HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728		
(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 157	<p>Continued From page 1</p> <p>the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of facility policy, it was determined the facility failed to notify the physician and the responsible party timely when a significant change in condition occurred for one of four sampled residents (Resident #1). Resident #1 developed a pressure sore identified on 04/22/12; however, the physician was not notified until 04/23/12, and the responsible party was not notified until 04/25/12.</p> <p>The findings include:</p> <p>A review of the facility's Notification of Changes Policy, dated 07/01/08, revealed the facility was to immediately Inform the resident, resident's physician, and the resident's designated family member or resident's legal representative when there was a significant change in the resident's physical, mental, or psychosocial status and/or a need to alter treatment significantly. According to the policy, Clinical Complications that would require notification included the development of a Stage II pressure sore.</p> <p>A review of the medical record for Resident #1 revealed the facility admitted the resident on 01/03/08, with diagnoses that included Hypertension, Coronary Artery Disease, Dementia with Delusions, Renal Failure, Parkinson's Disease, Osteoarthritis, Degenerative Joint Disease, and Emphysema.</p>	F 157	<p>F157 continuation.....</p> <p>The DON and Administrator began conducting in-services with all nurses on 6-6-12 regarding the facility Notification of Change policy and their responsibility to report any change in condition to the physician and responsible party. The procedure for reporting new skin conditions to the Wound Care Nurse was reviewed. Nurses were reminded of the facility policy regarding skin assessments, the use of the new skin problem report, and the facility treatment protocols. All in-services completed by 06-27-12. All nurses will be re-educated on these processes monthly for 3 months then no less than annually.</p> <p>The Quality Assurance Committee met on 6-7-12 and reviewed interventions put in place to ensure that the physician and responsible party is notified of changes in resident condition per facility policy. The Medical Director and the Committee agreed on all interventions and to assign a Unit Coordinator to each unit. Effective 6-21-12 a Unit Coordinator was assigned to each unit to provide additional supervision, coordination and implementation of the residents plan of care. They are to assist the nurses in completing assignments and to ensure that all</p> <p>F157 continued.....</p>		

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

PRINTED: 06/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 06/06/2012
NAME OF PROVIDER OR SUPPLIER  SUMMIT MANOR HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728	
(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 157	Continued From page 2  A review of the physician's orders for Resident #1, dated 04/22/12, revealed "Duoderm to left inner buttock as needed until healed, telephone order Dr Kiteck." The order was signed by Dr Kiteck on 04/23/12. A review of the nurse's notes dated 04/22/12, revealed "7:00 AM Orders received and noted." However, staff interview revealed the physician was not notified on 04/22/12.  An interview with Registered Nurse (RN) #1 on 06/06/12, at 11:40 AM, revealed RN #1 worked the 7:00 PM to 7:00 AM shift on 04/22/12, and had informed the facility's Wound Nurse (WN) regarding the pressure area identified on 04/22/12, for Resident #1. According to RN #1, she thought the WN had notified the physician and received orders for treatment. RN #1 stated she thought the WN had told RN #1 to write the order on the physician's order sheet as a telephone order. RN #1 stated she did not notify the resident's family regarding the discovery of the pressure sore to Resident #1's coccyx.  An interview with the Wound Nurse (WN) on 06/06/12, at 12:00 PM, revealed the WN had not spoken to the physician to notify him regarding the pressure sore. The WN stated she thought RN #1 had notified the physician and family. According to the WN, it was the responsibility of the nurse who first identified the pressure area to notify the physician and family. The WN further stated she did not tell RN #1 to write an order for treatment.  An interview with RN #2 on 06/05/12, at 3:00 PM, revealed she had visualized Resident #1's	F. 157	F157 continuation.....  residents receive the highest quality of care possible. Unit Coordinators are to review the 24 hour report, all reports of incidents, the wound logs and monitor MD orders to ensure notifications of change are made per the facility policy. They are to report to the DON any issues with notification of change noted. The Medical Records Coordinator will continue to monitor the weekly skin assessments for 30 days to ensure that skin assessments are completed timely and will report her findings to the Quality Assurance Committee after 30 days to evaluate the need to continue the audits. The DON will report the results of the reviews by the Unit Coordinators to the Quality Assurance Committee to identify any trends, need for additional education, or additional audits to ensure sustained compliance.	

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

PRINTED: 06/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 06/06/2012
NAME OF PROVIDER OR SUPPLIER  SUMMIT MANOR HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728	
(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 167	Continued From page 3 pressure sore on 04/25/12, and since it had not improved RN #2 notified the physician to obtain new orders for treatment. RN #2 stated she also notified the resident's responsible party concerning the wound and new orders from the physician.  Further review of the nurse's notes, dated 04/25/12, revealed the physician was notified regarding the size/description of the pressure area on Resident #1's coccyx and new orders were received. Further review of the nurse's notes, dated 04/25/12, revealed the resident's sister/responsible party was notified regarding the pressure sore and the change in physician's orders.  An interview with Resident #1's physician on 06/06/12, at 10:30 AM, revealed the physician stated the pressure area was developing inside with little indication until it was open. According to the physician, the area "looked reddened and then just opened." The cause was multifactorial related to the resident's decline in general health. The physician further stated earlier intervention would have not have made any difference.	F 157		
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review	F 282	F 282  Resident #1 has been discharged  MDS Coordinators reviewed all resident Care Plans to ensure that all care plans reflected the interventions currently in place for all residents, this was completed on 06-07-12. On 6-5-12 all residents on low air loss mattresses were observed by DON and settings evaluated to ensure the bed was in the appropriate position and on the appropriate setting. On 6-5-12 Administrator observed all residents care planned to have their bed in the low position or floor position to ensure that they were positioned according to the care plan.  F282 continued.....	06-27-12

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

PRINTED: 06/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 06/06/2012
NAME OF PROVIDER OR SUPPLIER  SUMMIT MANOR HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728	
(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 282	<p>Continued From page 4</p> <p>of facility policy, it was determined the facility failed to ensure services were provided according to the plan of care for one of four sampled residents (Resident #1). On 06/01/12, the facility failed to lower Resident #1's bed to the floor in accordance with the resident's plan of care. Resident #1 sustained a fall resulting in a pelvic fracture and bruise to the resident's head.</p> <p>The findings include:</p> <p>A review of facility's care plan policy, dated 04/20/12, revealed all residents were to be "Care Planned" according to the Resident Assessment Instrument (RAI) per the RAI manual. A review of the Falls Management Policy, dated 01/01/02, revealed the facility was to screen all residents for their risk for falls, evaluate those risks, implement interventions to reduce those risks, and monitor those interventions.</p> <p>A review of the medical record for Resident #1 revealed the resident was admitted to the facility on 01/03/08, with diagnoses that included Parkinson's Disease, Renal Failure, Osteoarthritis, Osteopenia, Emphysema, Dementia with Delusions, Anxiety, Depression, and Coronary Artery Disease. A comprehensive significant change assessment completed on 05/21/12, revealed the facility assessed the resident was at risk for falls due to impaired mobility, weakness, and impaired cognitive status, the utilization of antidepressants, cardiovascular medications, and diuretics. In addition, internal risk factors for falls included cardiac dysrhythmias, Parkinson's Disease, Depression, and Dementia. A care plan, dated 05/22/12, was reviewed/revised to address the</p>	F 282	<p>F282 continuation.....</p> <p>In services were conducted beginning 6-6-12 by the DON and Administrator for SRNA's, Nurses and the Housekeeping Department regarding the safety of all residents including the potential for falls, following the care plans, and assuring all residents who are identified at risk for falls have appropriate interventions in place. Emphasis was placed on the responsibility of everyone to observe and assure that residents who have been identified with a potential to fall have all interventions in place per the care plan. Staff were reminded of the urgency to provide safety for all our residents and the responsibility to follow through with all safety interventions. All in-services completed by 06-27-12. This education will be repeated monthly for 3 months then no less than annually and will be included in new employee orientation.</p> <p>The Quality Assurance Committee met on 6-7-12 and recommended assigning a Unit Coordinator to each unit. Effective 6-21-12 a Unit Coordinator was assigned to each unit to provide additional supervision, coordination and implementation of the residents plan of care. They are</p> <p>F282 continued.....</p>	

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

PRINTED: 06/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 06/06/2012
NAME OF PROVIDER OR SUPPLIER  SUMMIT MANOR HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728		
(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 282	<p>Continued From page 5 resident's risk for falls.</p> <p>A review of the plan of care for Resident #1 revealed interventions that included placing the resident's bed on the floor and a body alarm.</p> <p>An interview with State Registered Nurse Aide (SRNA) #1 on 06/05/12, at 2:10 PM, revealed SRNA #1 had been an employee of the facility for eleven years and had received education regarding nurse aide care plans. SRNA #1 stated SRNAs were required to check the nurse aide care plan at the beginning of the shift to ensure they were aware of each resident's care needs. SRNA #1 stated she had not checked the nurse aide care plan for Resident #1 on 06/01/12, although she knew she was supposed to review it. SRNA #1 stated she and SRNA #2 checked Resident #1's brief for incontinence and then turned and repositioned the resident. SRNA #1 stated the two nurse aides had completed care for Resident #1 and SRNA #2 left the room. SRNA #1 stated she began caring for Resident #1's roommate when she heard a loud noise and when she looked, Resident #1 was on the floor. SRNA #1 stated she had not checked the nurse aide care plan and was not aware the bed was to be lowered to the floor and she failed to lower Resident #1's bed to the floor.</p> <p>An interview with SRNA #2 on 06/05/12, at 2:00 PM, revealed SRNA #2 had been employed by the facility for twelve years and had been educated in the use of the nurse aide care plan and that she was to check it daily at the beginning of the shift. SRNA #2 stated she helped SRNA #1 to provide care for Resident #1. SRNA #2 stated she had checked the nurse aide care plan</p>	F 282	<p>F282 continuation.....</p> <p>to assist the nurses in completing assignments and to ensure that all residents receive the highest quality of care possible. Unit Coordinators are to review the 24 hour report, all reports of incidents, the wound logs and monitor MD orders to ensure notifications of change are made per the facility policy. They are to make walking rounds to ensure safety interventions are followed and will allow for additional supervision of staff performance. The Unit Coordinators will meet with the Quality Team and report any noted problems or concerns regarding quality of care, following the plan of care and any safety issues observed. They will review all reports of incidents and will be responsible to see that the committee's recommendations and directions are implemented. The DON will report the results of the reviews by the Unit Coordinators to the Quality Assurance Committee to identify any trends, need for additional education, or additional audits to ensure sustained compliance. For the next 30 days, the Administrator and DON will make walking rounds each day to observe all residents who require low beds or floor beds to ensure that they are in fact positioned according to the plan of care.</p>		

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

PRINTED: 08/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 08/06/2012
NAME OF PROVIDER OR SUPPLIER  SUMMIT MANOR HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728		
(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 282	Continued From page 6 and was aware that Resident #1's bed was required to be on the floor, but SRNA #2 stated she "just forgot" and left the resident's room without lowering the bed.  An interview with Registered Nurse (RN) #2 on 06/05/12, at 3:00 PM, revealed she was called to Resident #1's room immediately following the fall. The RN stated when she assessed the resident and attempted range of motion, the resident complained of pain. The RN notified the physician and the resident was transported to the Emergency Department of the hospital.  A review of the Emergency Department record revealed Resident #1 sustained a pelvic fracture and a bruise to the head.	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.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of facility policy, it was determined the facility failed to provide adequate supervision to prevent accidents for one of four sampled residents (Resident #1). Resident #1 was assessed to be at risk for falls and required the	F 323	F 323  Resident #1 has been discharged  On 6-5-12 all residents on low air loss mattresses were observed by DON and settings evaluated to ensure the bed was in the appropriate position and on the correct setting. On 6-5-12 Administrator observed all residents care planned to have their bed in the low position or floor position to ensure that they were positioned according to the care plan.  In services were conducted beginning 6-6-12 by the DON and Administrator for SRNA's, Nurses and the Housekeeping Department regarding the safety of all residents including the potential for falls, following the care plans, and assuring all residents who are identified at risk for  F323 continued.....	06-27-12	

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

PRINTED: 06/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 06/06/2012
NAME OF PROVIDER OR SUPPLIER  SUMMIT MANOR HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728	
(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 323	<p>Continued From page 7</p> <p>bed to be lowered to the floor. On 06/01/12, staff failed to lower the resident's bed to the floor and the resident fell from the bed and sustained a fractured pelvis and bruise to the head.</p> <p>The findings include:</p> <p>A review of the facility's Fall Management Policy, dated 01/01/10, revealed the facility would screen all residents to identify fall risk, evaluate those risks, implement interventions to reduce risks, and monitor the interventions.</p> <p>A review of the medical record for Resident #1 revealed the resident was admitted to the facility on 01/03/08, with diagnoses that included Parkinson's Disease, Renal Failure, Osteoarthritis, Osteopenia, Emphysema, Dementia with Delusions, Anxiety, Depression, and Coronary Artery Disease. A comprehensive significant change assessment completed on 05/21/12, revealed the facility assessed the resident to be totally dependent on staff for all activities of daily living and was at risk for falls due to impaired mobility, weakness, and impaired cognitive status, the utilization of antidepressants, cardiovascular medications, and diuretics. In addition, internal risk factors for falls included cardiac dysrhythmias, Parkinson's Disease, Depression and Dementia. A care plan, dated 05/22/12, was developed to address the resident's risk for falls which included an intervention to place the resident's bed on the floor.</p> <p>A review of the nurse's notes dated 06/01/12, at 3:45 PM, revealed Registered Nurse (RN) #2 was called to the resident's room and found the</p>	F 323	<p>F323 continuation.....</p> <p>falls have appropriate interventions in place. Emphasis was placed on the responsibility of everyone to observe and assure that residents who have been identified with a potential to fall have all interventions in place per the care plan. Staff were reminded of the urgency to provide safety for all our residents and the responsibility to follow through with all safety interventions. Nurses were reminded that they are responsible for the care and safety of their residents at all times and are to monitor the staff's performance while on duty to ensure that the plan of care is being followed. All in-services completed by 06-27-12. This education will be repeated monthly for 3 months then no less than annually and will be included in new employee orientation. The Quality Assurance Committee met on 6-7-12 and recommended assigning a Unit Coordinator to each unit. Effective 6-21-12 a Unit Coordinator was assigned to each unit to provide additional supervision, coordination and implementation of the residents plan of care. They are to assist the nurses in completing assignments and to ensure that all residents receive the highest quality of care possible. They are to provide additional supervision to ensure the environment is safe and that all safety</p> <p>F323 continued.....</p>	

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

PRINTED: 06/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 06/06/2012
NAME OF PROVIDER OR SUPPLIER  SUMMIT MANOR HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728		
(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 323	<p>Continued From page 8</p> <p>resident lying on the floor between the bed and the wall with the resident's upper body noted to be lying on the stand for the overbed table. Resident #1 was alert and oriented to name only and screamed when the right leg was touched. The RN noted the right foot displayed an outward rotation. The physician and the responsible party were notified and orders were received to transport the resident to the Emergency Department for evaluation.</p> <p>A review of the hospital admission history and physical revealed Resident #1 sustained a pelvic fracture and a bruise to the head.</p> <p>Observation of Resident #1 at the hospital on 06/06/12, at 12:00 PM, revealed the resident was awake and alert but nonverbal and was turned to the left side with bilateral half side rails in the elevated position. A hospital staff member was sitting with the resident at the bedside.</p> <p>An interview conducted with the Registered Nurse Manager at the hospital on 06/05/12, at 11:30 AM, revealed the resident was being discharged to another long term care facility and there was a sitter with the resident at all times until transfer.</p> <p>An interview with State Registered Nurse Aide #1 (SRNA #1) on 06/05/12, at 2:10 PM, revealed SRNAs were required to check the nurse aide care plan at the beginning of the shift to ensure they were aware of each resident's care needs. SRNA #1 stated she had not checked the nurse aide care plan on 06/01/12, although she knew she was supposed to review it. SRNA #1 stated she and SRNA #2 checked Resident #1's brief for incontinence and then turned and repositioned</p>	F 323	<p>F323 continuation.....</p> <p>interventions are in place according to the residents plan of care. Unit Coordinators are to review the 24 hour report, all reports of incidents, the wound logs and monitor MD orders to ensure notifications of change are made per the facility policy. They are to make walking rounds to ensure safety interventions are followed and will allow for additional supervision of staff performance. The Unit Coordinators will meet with the Quality Team and report any noted problems or concerns regarding quality of care, following the plan of care and any safety issues observed. They will review all reports of incidents and will be responsible to see that the committee's recommendations and directions are implemented. The MDS Coordinators office was moved on 6-21-12 to provide for additional supervision on the unit. They are frequently out of the office completing assessments. They have been instructed to observe for any safety issues and to conduct random audits (a minimum of one per day) to ensure staff are following the plan of care in regards to bed position. These audits will be completed for the next 30 days. The DON will report the results of the reviews by the Unit Coordinators, and MDS Coordinators to the Quality Assurance</p> <p>F323 continued.....</p>		

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

PRINTED: 06/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 06/06/2012
NAME OF PROVIDER OR SUPPLIER  SUMMIT MANOR HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 BOMAR HEIGHTS COLUMBIA, KY 42728	
(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 323	<p>Continued From page 9</p> <p>the resident. SRNA #1 stated the two nurse aides had completed care for Resident #1 and SRNA #2 left the room. SRNA #1 stated she began caring for Resident #1's roommate when she heard a loud noise and when she looked, Resident #1 was on the floor. SRNA #1 stated she was not aware the bed was to be lowered to the floor and she failed to lower Resident #1's bed to the floor.</p> <p>An interview with SRNA #2 on 06/05/12, at 2:00 PM, revealed SRNA #2 was aware she was to check the nurse aide care plan daily at the beginning of the shift. SRNA #2 stated she helped SRNA #1 to provide care for Resident #1. SRNA #2 stated she had checked the nurse aide care plan and was aware that Resident #1's bed was required to be on the floor, but SRNA #2 stated she "just forgot" and left the resident's room without lowering the bed.</p> <p>An interview conducted with the Director of Nursing (DON) on 06/05/12, at 1:30 PM, revealed the nurses on the floor were responsible to update the nurse aide care plan as needed and to check them daily. The DON further stated the SRNAs were to check their residents' nurse aide care plans prior to beginning the shift to obtain information related to each resident's care needs and to check for any changes that may have been added. According to the DON, the nurses were required to ensure SRNAs cared for residents as directed by the nurse aide care plan and the DON was responsible to ensure nurses followed the resident's plan of care. The DON stated she made frequent rounds daily throughout the facility.</p>	F 323	<p>F323 continuation.....</p> <p>Committee to identify any trends, need for additional education, or additional audits to ensure sustained compliance. For the next 30 days, the Administrator and DON will make walking rounds each day to observe all residents who require low beds or floor beds to ensure that they are in fact positioned according to the plan of care.</p>	