

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

PRINTED: 06/25/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 06/13/2013
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NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE AT GLENVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 6000 HUNTING RD. LOUISVILLE, KY 40222
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F 000	INITIAL COMMENTS  An abbreviated survey was initiated on 06/11/13 and concluded on 06/13/13 investigating KY #20300. The Division of Health Care substantiated the allegation with deficiencies cited.	F 000	A. Resident #1- the audit on resident care plan after fall showed that resident did not have a lap tray/pommel cushion in place as care planned. On 6/6/2013 The resident was evaluated by Physical Therapy and the lap tray and pommel cushion was discontinued and a thrust cushion was put in place while the resident is up in wheelchair. The Resident's care plan was reviewed and revised on 6/6/2013 by the Director of Nursing. Also on 6/6/2013 Interventions of the resident's care plan Were Reviewed by the Unit Manager and determined that all interventions were in place and being followed.	
F 282 SS=D	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 record review, interview and policy review it was determined the facility failed to follow the comprehensive plan of care for one (1) of four (4) sampled residents, Resident #1. The facility reported Resident #1 did not have an ordered lap tray or pommel cushion (devices used to prevent falls and for postural support in a wheelchair) affixed to his/her wheelchair and fell from the wheelchair on 06/04/13 sustaining an abrasion to the forehead.  The findings include:  A policy was not provided regarding following a resident's comprehensive plan of care.  Review of Resident #1's record revealed the facility admitted the resident on 11/21/11 with diagnoses of Advanced Alzheimers Dementia	F 282	B. 100% of residents plans of care were audited and direct rounds were made by the Interdisciplinary team on 7/2/13 - 7/19/13 which include the Director of Nursing, Assistant Director of Nursing/SDC, MDS nurse, Social Services and Dietary Manager to insure residents are receiving care as care planned. Any interventions not in place were immediately corrected.  C. In-service of nursing staff from 7/2/2013 - 7/19/13 by the Director of Nursing and Assistant Director of Nursing/SDC on following all care plans and insuring care is being provided to the resident's per their plans of care.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Administrator* (X6) DATE: 7/15/13

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.

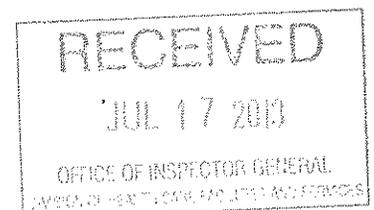
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If continuation sheet Page 1 of 8  
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OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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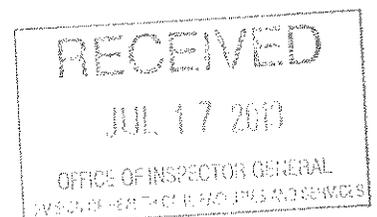
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F 282	Continued From page 1 with Behavior and Hypertension. Review of the comprehensive plan of care for Resident #1, dated 08/21/12, revealed Resident #1 required the on-going use of a lap tray andommel cushion as assistive devices when up in the wheelchair. Review of the Minimum Data Set (a comprehensive assessment tool for nursing facility residents), dated 08/25/12, revealed the facility assessed Resident #1 as having a score of three (3) (severe cognition loss) and on 04/16/13 the facility determined Resident #1 could not be scored due to his/her inability to complete the interview required for scoring cognition. Review of the current Certified Nursing Assistants care report revealed Resident #1 was to have a lap tray and aommel cushion affixed to his/her wheelchair when up in the wheelchair. Review of the nursing notes, dated 06/04/13, revealed Resident #1 fell from the wheelchair on that date and was sent to the emergency department per physician order for an evaluation. Further review of the nursing notes for Resident #1 revealed no lap tray orommel cushion were used at the time of the fall. Review of emergency department notes for Resident #1, dated 06/04/13, revealed a negative scan of the head, a negative cervical spine x-ray and an abrasion to the forehead.  Interview with the Occupational Therapy Aide, on 06/11/13 at 1:20 PM, revealed Resident #1 had been assessed as needing the lap tray and theommel cushion when in the wheelchair prior to the 08/21/12 comprehensive plan of care, but she stated those records were not available as they had been stored away from the facility. The Occupational Therapy Aide revealed the lap buddy would serve to prevent a fall from the	F 282	D. A weekly review of 30% of all care plans and corresponding observation rounds will be completed by the Director of Nursing, Assistant Director of Nursing/SDC and Unit Managers to insure the plans of care/ care plans are being followed in the delivery of residents care. This review will be completed for 4 weeks, then monthly thereafter for 4 months. Results of all reviews will be submitted to the Quality Assurance committee for Further audit or action until ongoing compliance has been determined by the QA committee for three reviews.	07/22/13



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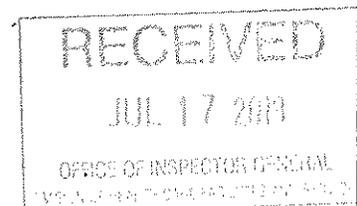
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F 282	<p>Continued From page 2</p> <p>wheelchair for Resident #1. She further stated she was unaware of any other occupational therapy assessments completed for Resident #1 until after his/her 06/04/13 fall from the wheelchair.</p> <p>Interview with Certified Nursing Assistant (CNA) #4, on 06/11/13 at 1:20 PM, revealed she was assigned to Resident #1 on the date of the fall and she knew the lap tray and the pommel cushion were not in use at the time of the fall. CNA #4 revealed she had not seen Resident #1's lap tray and pommel cushion for several months and had assumed they had been discontinued. She stated she was to follow the CNA care report but she was unaware the lap tray and pommel cushion were still on the care report. She further stated she did not remember the facility having trained her on how often to review the resident's care report and she stated she would look at the care report when she felt she needed to.</p> <p>Interview with Registered Nurse (RN) #1 revealed he was passing medications at the time of Resident #1's fall and heard the alarm on his/her chair. He stated when he looked to the alarm he saw Resident #1 on the floor and a lap tray and pommel cushion were not on the wheelchair. RN #1 further stated Resident #1 was awake and alert but had bleeding from an abrasion to the forehead. RN #1 revealed he provided first aid to the resident and called the physician for the order to send the resident to the hospital. He stated he had cared for Resident #1 for several months and had not seen the lap tray or pommel cushion in use. RN #1 revealed he was aware each resident had a comprehensive plan of care and knew it was to be followed, but he did not</p>	F 282			



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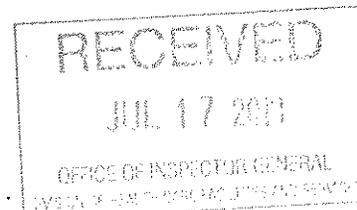
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F 282	Continued From page 3 know Resident #1 had the lap tray and pommel cushion on his/her plan of care.  Interview with CNA #6, on 6/12/13 at 1:30 PM, revealed he had not seen a lap tray or a pommel cushion used for Resident #1 during the past month and he was unaware it was currently on Resident #1's CNA care report. CNA #6 revealed he remembered seeing those assistive devices used for Resident #1 about one year ago.  Interview with the Director of Nursing, on 08/13/13 at 4:55 PM, revealed the nursing staff did not follow the comprehensive plan of care for Resident #1 and they should have. She indicated she was ultimately responsible to ensure the nursing staff followed the comprehensive plans of care for all of the residents; however, she had only been at the facility for four weeks and had not had time to review all of the residents' plans of care.	F 282			
F 323 SS=D	483.26(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 interview and record review, it was	F 323	A. Resident #1 was evaluated by Physical and Occupational Therapy on 6/6/2013. At this time the lap tray and pommel cushion order was discontinued and a thrust cushion was put in place as ordered for fall prevention/wheelchair positioning.		



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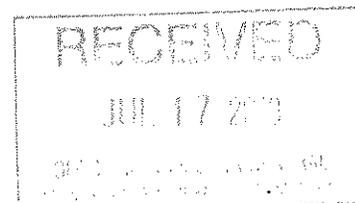
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F 323	<p>Continued From page 4</p> <p>determined the facility failed to ensure assistive devices were utilized to prevent accidents for one (1) of four (4) sample residents. Resident #1 fell from his/her wheelchair on 06/04/13 and sustained a minor injury due to the staff not following the resident's comprehensive plan of care regarding use of assistive devices.</p> <p>The findings include:</p> <p>A policy regarding use of assistive devices and protection of residents from accidents/hazards was not provided.</p> <p>Review of clinical record for Resident #1 revealed the facility admitted the resident on 11/21/11 with diagnoses including Advanced Alzheimer's Dementia with Behavior and Hypertension. Review of the Minimum Data Set (MDS) dated 04/16/13 revealed the facility assessed Resident #1 as not able to be scored due to his/her inability to complete the interview required for scoring cognition. Review of the comprehensive plan of care for Resident #1, dated 08/21/12, revealed Resident #1 required the use of a lap tray andommel cushion as assistive devices when up in the wheelchair. Review of the current Certified Nursing Assistants care report revealed Resident #1 was to utilize a lap tray and aommel cushion when up in the wheelchair. Review of the nursing notes, dated 06/04/13, revealed Resident #1 fell from the wheelchair on that date and was sent to the emergency department for an evaluation per physician order. Further review of the nursing notes revealed no lap tray orommel cushion was used at the time of the fall. Review of the emergency department notes, dated 06/04/13, revealed a negative cervical spine x-ray, a</p>	F 323	<p>B. 100% of residents plans of care Were audited and direct observation rounds were Made on 7/2/13 - 7/19/13 by the IDT team which include the Director of Nursing, ADON, MDS nurse, Social Worker, Dietary Manager to insure residents have devices as ordered in place and are receiving care as care planned and their environment is free of accident hazards. Any interventions not in place/identified were corrected.</p> <p>C. In-service of Nursing staff completed By the Director of Nursing and Assistant Director of Nursing/SDC 7/2/13 - 7/19/12 on following care plans and ensuring care is being provided with assistive devices and interventions as ordered per the plans of care and ensuring environment is free of accident hazards.</p> <p>D. 100% audit by DON/ADON/Unit Manager Of all residents with fall prevention devices daily X5 days, then 2x a week for 1 week, Then 1 time a week for 1 week, then Monthly to insure all ordered devices Are being used and in place. Results will be submitted at the monthly QA meeting until Substantial compliance has been Determined by the QA committee For three consecutive reviews then 10% of residents monthly will be Monitored to insure compliance.</p>	07/22/13	



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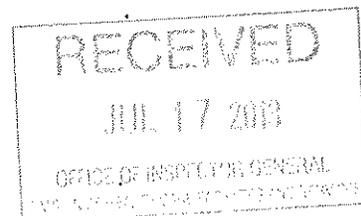
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F 323	<p>Continued From page 5</p> <p>negative scan of the head and an abrasion to the forehead.</p> <p>Interview with the Occupational Therapy Aide, on 06/11/13 at 1:20 PM, revealed Resident #1 had been assessed as requiring the use of a lap tray and a pommel cushion when in the wheelchair prior to the 08/21/12 comprehensive plan of care. However, those records were not available as they had been stored away from the facility. The Occupational Therapy Aide revealed the lap buddy would serve to prevent a fall from the wheelchair for Resident #1 and a pommel cushion would serve to keep the resident from sliding out of a wheelchair.</p> <p>Interview with Certified Nursing Assistant (CNA) #4, on 06/11/13 at 1:20 PM, revealed she was assigned to Resident #1 on the date of the fall, she knew the lap tray and the pommel cushion were not in use at the time of the fall. CNA #4 revealed she had not seen Resident #1's lap tray and pommel cushion for several months and had assumed they had been discontinued. CNA #4 stated she thought the resident could not fall from the wheelchair if the lap tray was in place and she was unaware of any other falls for Resident #1 from the wheelchair. She did however reveal Resident #1 had been sliding in the wheelchair on several occasions in the past couple of months and she had reported that to the charge nurse. CNA #4 stated she had been trained by the facility in accident prevention.</p> <p>Interview with Registered Nurse (RN) #1, on 06/11/13 at 2:46 PM, revealed he saw Resident #1 on the floor after the fall on 06/04/11 and a lap tray and pommel cushion were not on the</p>	F 323			



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F 323	<p>Continued From page 6</p> <p>wheelchair at that time. He stated he had cared for Resident #1 for several months and had not seen the lap tray or pommel cushion in use. RN #1 stated he completed the Situation, Background, Assessment and Request form used by the facility after an incident/accident and gave that to the Director of Nursing. He stated that was a document used to reduce accidents in the facility and he also stated he had been trained on accident prevention by the facility upon hire.</p> <p>Interview with CNA #6, on 6/12/13 at 1:30 PM, revealed he had not seen a lap tray or a pommel cushion used for Resident #1 during the past month and he was unaware it was currently on the resident's CNA care report. CNA #6 revealed he remembered seeing those assistive devices used for Resident #1 about one year ago. He indicated he thought the pommel cushion and the lap tray would help prevent a resident's fall and he had been trained by the facility to utilize residents' assessed assistive devices to help prevent falls.</p> <p>Interview with the Director of Nursing, on 06/13/13 at 4:55 PM, revealed the nursing staff did not follow the comprehensive plan of care for Resident #1 which might have prevented the resident's fall. She indicated the nursing staff were trained on accident prevention to include use of assistive devices and the Situation, Background, Assessment and Request forms were reviewed each day in a 'clinical meeting' which would assist in accident prevention. She indicated she was ultimately responsible to ensure the nursing staff did everything possible to prevent resident accidents; however, she had only been at the facility for four weeks and had</p>	F 323			



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F 323	Continued From page 7 not had time to review all of the residents' plans of care.	F 323			

