

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

PRINTED: 03/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2015
NAME OF PROVIDER OR SUPPLIER HART COUNTY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749	
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F 000	INITIAL COMMENTS	F 000	The submission of this plan of correction does not constitute an admission by the provider of any fact or conclusion set forth in the Statement of Deficiency. This plan is being submitted because it is required by law.	
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 observation, interview, record review and facility policy review, it was determined the facility failed to implement the care plans for three (3) of twenty (20) sampled residents (Residents #3, #9 and #11). The facility care planned Resident #9 for a personal alarm to alert staff when the resident was attempting unassisted transfers; however, the facility failed to ensure the alarm was always functioning. Resident #9 sustained a right pelvic fracture during a fall in February 2014 and sustained a second fall with a right hip fracture in June 2014 with indications the alarm was malfunctioning with both falls. Resident #9 had a total of nine (9) unwitnessed falls the facility determined the alarms failed to sound during all nine (9) of the falls. In addition, the facility care planned Resident #3 for heel protectors to be worn at all times; however, the facility failed to consistently apply the heel protectors per the plan of care. The facility also care planned Resident #11 to have palm protectors when the splints were not in use;	F 282	Resident #9 was reassessed for alarms by the care plan team on 3/17/15 for the use of alarms. Resident #11 was reassessed for the use of splints by the care plan team on 3/17/15. The care plans for residents #3, 11 and 9 were reviewed on 3/17/15 to ensure these items were care planned if still applicable. DON will complete a 100% audit of splints, safety devices and alarms to ensure they are on care plans and nurse aide care plans by 3/27/15 Any deficient area will be corrected. Results of audit will be reviewed by QA Committee.	3-28-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *NHA* (X6) DATE *3-27-15*

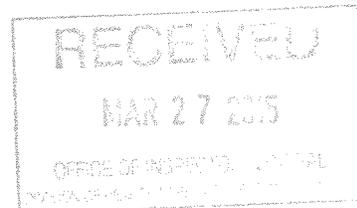
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

MAR 27 2015
OFFICE OF INSPECTION AND SURVEILLANCE
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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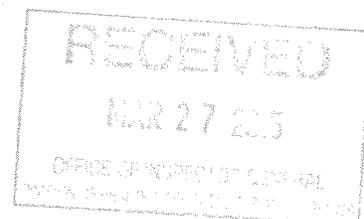
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F 282	<p>Continued From page 1</p> <p>however, the palm protectors were not applied when splints were not in use per the plan of care. The facility did not check and change Resident #11 every two (2) hours as per the plan of care.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding the Resident Assessment Instrument (RAI), dated October 2011, page 4-8, revealed the comprehensive care plan was an interdisciplinary communication tool and described the services being furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. The care planned services provided or arranged must be consistent with each resident's written plan of care. The care plan should reflect the care the resident was receiving.</p> <p>Review of the facility's policy regarding the RAI, dated April 2012, page 4-10 and page 4-11, revealed the overall care plan should be oriented towards preventing avoidable decline in functional levels. The care plan should manage risk factors to the extent possible or indicate the limits of such interventions. It should further address ways to preserve and build upon the resident's strength.</p> <p>Review of the facility's policy regarding the RAI, dated May 2013, page 4-9 and page 4-12 (page 4-10 and 4-11 was not provided by the facility) revealed the care plan was driven not only by identified resident issues and/or conditions, but also by a resident's unique characteristics, strengths and needs.</p> <p>Review of the facility's policy titled Falls Management, dated 01/10/10, revealed the</p>	F 282	<p>Staff education will be completed by 3/27/15 by Staff Development Coordinator on applying alarms, splints and protective devices as well as reporting equipment that isn't functioning. This education will also be done on new hire orientation and annually.</p> <p>The care plan team and nursing administration will be inserviced on 3/27/15 by the corporate nurse consultant in regards to care planning and reviewing interventions for incident and accidents.</p> <p>A 100% audit was completed on 3/4/15 by Environmental services and the nursing unit coordinators to ensure alarms that were ordered were in place and functioning. This will be done weekly and reported to QA Committee monthly.</p> <p>On 3/17/15 the Administrator reviewed a list from pharmacy in regards to alarms, safety devices and splints.</p>	



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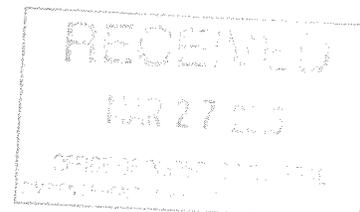
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F 282	<p>Continued From page 2</p> <p>facility was to screen residents, identify resident at risk for falls and implement interventions to reduce those risks.</p> <p>Review of the facility's in-service regarding Care Plans and Confidentiality, dated 01/05/15, revealed the staff was to follow care plans, and check care plans daily for any changes.</p> <p>1. Review of Resident #9's clinical record revealed the facility readmitted the resident on 10/15/13 with diagnoses of Dementia, Mental Disorder, Hypertension, Coronary Artery Disease, Diabetes Mellitus Type II, Anemia and Osteoarthritis.</p> <p>Review of the Post Fall Investigations for Resident #9, revealed unwitnessed falls, alarms that did not sound, and the physician ordered hipsters were not placed on the resident, on 02/08/14 at 4:30 PM, 03/04/14 at 4:15 PM, 04/10/14 at 7:15 PM, 04/12/14 at 4:45 PM, 06/14/14 at 11:40 PM, 09/06/14 at 3:00 PM, 10/15/14 at 10:00 PM, 10/19/14 at 11:15 AM, and 01/17/15 at 12:05 AM.</p> <p>Review of Resident #9's Quarterly Minimum Data Set (MDS) assessment, completed on 01/05/14, revealed the facility assessed the resident during a Brief Interview for Mental Status (BIMS) with a score of three (3) of fifteen (15), indicating the resident was severely impaired cognitively. In addition, the facility assessed the resident as requiring extensive assistance of two (2) persons with bed mobility, transfers and required a wheelchair for mobility.</p> <p>Review of the Physician Orders, dated 02/01/14 through 02/28/14, revealed the staff was to place</p>	F 282	<p>A spreadsheet was developed listing resident and intervention noted.</p> <p>Unit Coordinators will review weekly for one month the placement of safety devices and splints. This will then be done bi-monthly for one month then monthly for 12 months.</p> <p>This will be turned in to the DON for her to review and to initial off. Any deficient practice will be reviewed at the monthly QA meeting.</p> <p>DON will complete a 100% audit of splints and safety devices to ensure they are on care plans and nurse aide care plans by 3/27/15. Any deficient area will be corrected. Results of audit will be reviewed by QA Committee.</p> <p>Each incident/accident will be reviewed at morning department head meeting. These will be noted on a log and reviewed to determine any trend or need to implement a QA.</p>	



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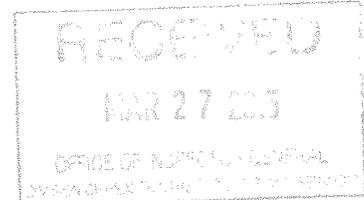
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F 282	<p>Continued From page 3</p> <p>hipsters on the resident at all times.</p> <p>Review of the Physician Orders, revealed a pad alarm to the bed and the chair with placement checks every shift and check function weekly was initially ordered on 10/15/13 and reordered on monthly reorders dated 02/01/14 through 02/28/14.</p> <p>Review of the Comprehensive Care Plan for Resident #9 revealed the facility developed a care plan, dated 01/28/14. Problems on the care plan included a History of Falls related to Hypotension, poor balance, routine use of antidepressant, non compliant behavior and incontinence of bowel and bladder. Interventions included Hipsters on at all times and pad alarm to bed and chair.</p> <p>Review of the February 2014 Medication Administration Record (MAR), revealed a pad alarm to the bed and chair with placement checks every shift and check function weekly. The staff did not initial the checks as completed 02/07/14, 02/08/14, 02/16/14, 02/17/14, 02/25/14, and on 02/28/14 across all three shifts. The medication record did not specify when the pad alarm would be checked weekly for function. Hipsters were not noted on the MAR.</p> <p>Review of the Post Fall Investigations for Resident #9, dated 02/08/14 at 4:30 PM, revealed an unwitnessed fall when the resident was found on the floor. The bed alarm was not sounding and no hipsters were noted. The resident was transferred to the hospital for evaluation. Review of the radiology report, dated 02/08/14, of the right hip revealed, on 10/10/13, Resident #9 underwent surgery for an Open Reduction Internal Fixation (ORIF) to the right hip and now</p>	F 282	<p>Results will be shared and reviewed at monthly QA meeting.</p> <p>Any change to resident care plan will noted in Kiosk for nursing staff to check the residents care plan for any changes.</p>	



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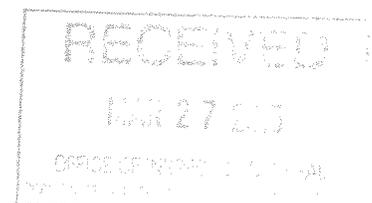
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F 282	<p>Continued From page 4 presented with a new fractured pelvis.</p> <p>Review of the March and April 2014 MARs revealed the pad alarm to the bed and chair with placement checks was not listed for staff to monitor and hipsters were not noted on the MAR. Per the post fall investigation, Resident #9 experienced a fall on 03/04/14 and 04/10/14 and the alarms did not sound and hipsters were not applied.</p> <p>Review of the Falls Alert Progress Notes, dated 06/16/14, revealed the Director of Nurses (DON) documented Resident #9 was found in the doorway on the floor, on 06/14/14 at 11:40 PM, with skin tears in three (3) places on his/her right forearm and complaints of pain in both hips. In addition, the bed alarm was not sounding and there was no evidence the resident was wearing the hipsters as ordered. The resident was transferred to the hospital for evaluation and diagnosed with a right hip fracture.</p> <p>Review of the June 2014 MAR revealed an alarming seatbelt to the wheelchair with placement and function checks to be completed every shift and a pad alarm to bed and check function weekly. This was initiated as completed on 06/14/14. Hipsters were not noted on the MAR.</p> <p>Review of the Physician Orders, dated 09/01/14 through 09/30/14, revealed the hipsters were to be worn at all times by the resident.</p> <p>Review of the September 2014 MAR revealed an alarming seatbelt to the wheelchair with placement and function checks to be completed every shift and a pad alarm to the bed to be</p>	F 282			



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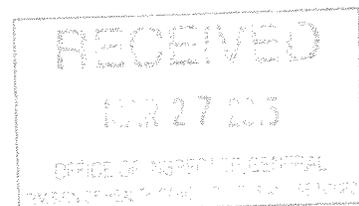
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F 282	<p>Continued From page 5</p> <p>checked for placement and function every shift. This was initialed as being completed on 09/06/14. Hipsters at all times were noted on the MAR as an "FYI" (for your information). However, per the post fall investigation, Resident #9 experienced a fall on 09/06/14 and the alarms did not sound and hipsters were not applied.</p> <p>Review of the October 2014 MAR revealed an alarming seatbelt to the wheelchair with placement and function checks to be completed every shift and a pad alarm to the bed to be checked for placement and function every shift. This was initialed as being completed on 10/15/14 and 10/19/14. However, per the post fall investigations, Resident #9 experienced a fall on 10/15/14 and 10/19/14 and the alarms did not sound and hipsters were not applied.</p> <p>Interview with the CNA #6, on 02/26/15 at 2:20 PM, revealed she routinely cared for Resident #9 and knew the resident well. She stated Resident #9 had some falls when he/she tried to get up without assistance. CNA #6 stated as far as she could remember Resident #9's alarm worked most of the time. CNA #6 stated she had one alarm that did not sound a long time ago; however, she stated she had never been too busy to report alarms not working to the nurse. She reported staff must check to make sure Resident #9's alarms were working. In addition, she stated Resident #9 wore hipsters all the times. However, review of the post fall investigations revealed Resident #9 had nine (9) falls in which no alarm sounded and the resident's hipsters were not applied.</p> <p>Interview with CNA #7, on 02/26/15 at 2:35 PM, revealed she provided care to Resident #9 and</p>	F 282			



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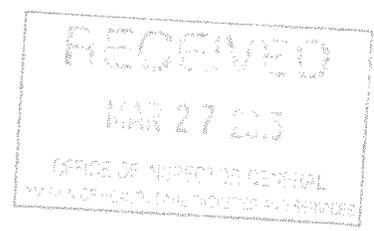
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F 282	<p>Continued From page 6</p> <p>was frequently assigned to the resident. She stated Resident #9 had fallen several times. The resident had a seat belt alarm that he/she released and reconnected behind him/her. They all knew Resident #9 took the alarm off and reconnected the alarm behind him/her and they would have to check on the resident. She further stated the alarms had a light that blinked and a flashing light to show when the battery was low. She stated they changed the batteries on the alarm if the alarm did not work when they get the resident up. Per interview, if the alarms were not working, it must be reported to the nurses.</p> <p>Interview with CNA #8, on 02/26/15 at 2:50 PM, revealed she was familiar with the care for Resident #9. She stated Resident #9 had a self releasing seat belt that he/she took off and would try to get up. All the staff, including Licensed Practical Nurse (LPN) #2 and the Director of Nursing (DON), knew Resident #9 took the seat belt off and would try to get up. She stated she had never put hipsters on Resident #9 since she had been caring for him/her. However, per the resident's plan of care, hipsters should be applied at all times.</p> <p>Observation with CNA #8 of Resident #9 while lying in his/her bed, on 02/26/15 at 2:55 PM, revealed Resident #9 was not wearing any hipsters; however, there were two (2) pair of hipsters in his/her clothing drawer.</p> <p>Interview with LPN #2, on 02/26/15 at 2:00 PM, revealed Resident #9 had a long history of falls in the facility with fractures on a couple of occasions and the resident had an alarming seat belt. LPN #2 stated the resident could self release the alarming seat belt and reconnect it behind his/her</p>	F 282		



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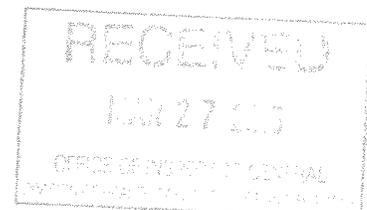
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F 282	<p>Continued From page 7</p> <p>back. She stated they were going to discontinue the self release seat belt, but the family insisted it not be removed since Resident #9 had so many falls. The family felt like it was one more way to alert the staff. The resident currently had two (2) types of alarms, a wheelchair alarm and a bed alarm. LPN #2 stated the resident had numerous falls and everyone knew the minute they heard the alarm, they had to respond because the resident would attempt to get out of the bed. She stated she checked the alarms at the beginning of her shift, and if there was a problem she would correct it at that time.</p> <p>Interview with the DON, on 02/26/15 at 4:40 PM, revealed she had daily morning meetings and falls were discussed at that time. The DON did not specify which interventions were working for Resident #9. She further stated the resident had behaviors, and he/she would take off the seat belt; however, she did not remember what happened.</p> <p>Interview with the Administrator, on 02/26/15 at 1:30 PM, revealed the DON and Unit Managers had daily morning meetings and the falls are discussed during that meeting. He stated the DON informed him during the department head meetings about any falls in the facility. However, it was only during the course of the survey, he had been made aware of Resident #9's falls and the problems with the personal alarms not working. He further stated upon review of the documents of the Post Fall Investigations, he realized he had not been kept abreast of Resident #9's multiple falls.</p> <p>2. Review of Resident #3's clinical record revealed the facility admitted the resident on</p>	F 282		



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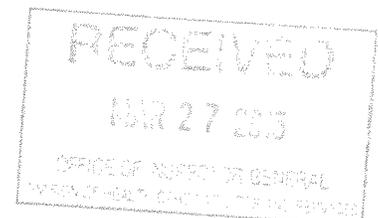
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F 282	<p>Continued From page 8</p> <p>10/16/08 with diagnoses of Type 2 Diabetes, Alzheimer's Disease, Chronic Airway Obstruction, Esophageal Reflux, Depressive Disorder, Hypothyroidism, Oropharyngeal Dysphagia, and Hemolytic Anemia. Review of the physician's admission note, not dated, revealed on admission, the resident was unable to care for himself/herself, and was in a state of general decline.</p> <p>Review of Resident #3's most recent Annual Minimum Data Set (MDS) Assessment, dated 08/06/14, revealed the facility assessed the resident with a score of five (5) out of fifteen (15) on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The facility also assessed the resident as needing extensive assistance with activities of daily living (hygiene, bathing, dressing, and eating); always incontinent of bladder and bowel; and, at risk for the development of pressure ulcers based on intrinsic risk factors which included incontinence, a history of poor nutrition, antidepressant use, Alzheimer's Disease, and severe pulmonary disease.</p> <p>Review of Resident #3's Quarterly MDS Assessment, dated 01/09/15, revealed the facility again scored the resident at a five (5) out of fifteen (15) on the BIMS and assessed the resident continued to be at risk for the development of pressure ulcers. Resident #3 continued to require extensive assistance with activities of daily living (personal hygiene, bathing, dressing, and eating). The facility also assessed the resident to be frequently incontinent of urine, and always incontinent of bowel.</p> <p>Review of an incident report, dated 02/03/15,</p>	F 282			



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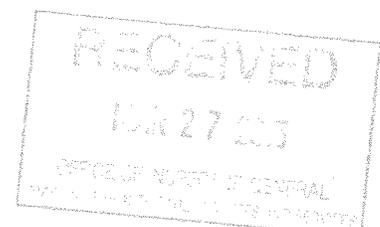
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F 282	<p>Continued From page 9</p> <p>revealed during a skin assessment, conducted on 02/03/15, a small dark area measuring 0.5 x 0.5 centimeters (cm) was identified on the back side of Resident #3's left heel. The nurse notified the physician, and the physician ordered the application of a soft heel boot to the resident's left heel, at all times while he/she was in bed. Daily monitoring of the area was to occur until it was healed. On 02/23/15, the facility assessed the area on Resident #3's left heel and it was measured by Registered Nurse (RN) #1 at 1.0 x 1.0 cm. The physician was notified and he gave an order for the heel boot to be on Resident #3's left heel at all times, with continued daily monitoring of the site until it was healed.</p> <p>Review of Resident #3's Interdisciplinary Care Plan and Certified Nursing Assistant's (CNA's) Care Plan, revealed interventions for the prevention of pressure ulcers, which included the application of a heel boot while in bed, dated 02/04/15 on the initial care plan, and on 02/23/15 it was changed to be on the resident's left foot at all times.</p> <p>Review of the 400 Hallway CNA 24 Hour Report Sheet, revealed Resident #3 was to have a "blue boot" on at all times.</p> <p>Observation, on 02/24/15 at 11:25 AM, revealed Resident #3 was not in his/her room and a blue soft boot was lying on the resident's bed.</p> <p>Observation, on 02/24/15 at 11:50 AM, revealed Resident #3 was seated in his/her wheelchair in the restorative dining area of the facility's Magnolia Unit. The resident was wearing black shoes with Velcro closures. Resident #3 moved his/her feet back and forth with an almost</p>	F 282		



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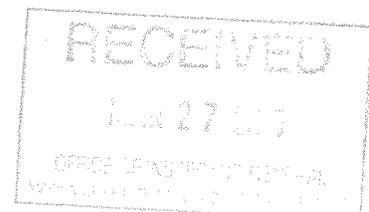
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F 282	<p>Continued From page 10 constant shuffling movement.</p> <p>Observation, on 02/24/15 at 2:20 PM, revealed Resident #3 was seated in his/her wheelchair, in the day area of the facility's Magnolia Unit. The resident continued to wear black shoes with Velcro closures. Resident #3 was not wearing the soft blue boot on his/her left foot.</p> <p>Observation, on 02/25/15 at 7:20 AM, revealed Resident #3 was seated in his/her wheel chair with black shoes with Velcro closures. Resident #3 continued to move his/her feet and legs with an almost constant back and forth movement. Resident #3 did not have the soft blue boot on his/her left foot.</p> <p>Observation, on 02/25/15 at 8:07 AM, revealed Resident #3 continued to be seated in his/her wheelchair, with a clothing protector covering his/her upper torso, while waiting for his/her breakfast meal. Resident #3 was not wearing the soft blue boot on his/her left foot.</p> <p>Continued observation, on 02/25/15 at 8:45 AM, revealed direct care staff assisting Resident #3 with finishing his/her breakfast. The resident was not wearing the soft blue boot on his/her left foot.</p> <p>Interview, on 02/25/15 at 10:25 AM, with CNA #1, revealed she was typically assigned to work on the Magnolia Unit of the facility, and had helped dress Resident #3 earlier in the day, but had not placed the blue soft boot on Resident #3's left foot. CNA #1 stated that the licensed nurse assigned to the hallway where Resident #3 resided had just reminded her of the order to apply the blue soft boot to the resident's left foot. CNA #1 stated she was not exactly sure why</p>	F 282			



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F 282	<p>Continued From page 11</p> <p>Resident #3 needed the boot, but she thought it was because he/she had some skin breakdown.</p> <p>Interview, on 02/25/15 at 8:53 AM, with RN #1 revealed Resident #3 had a dark colored spot on his/her left heel and the physician ordered daily monitoring of the area until it was healed. In addition, she stated the resident was to wear the soft blue boot on his/her left foot at all times.</p> <p>Observation, on 02/25/15 at 9:55 AM, revealed Resident #3 was seated in his/her wheelchair with the soft blue boot on his/her left foot. This was immediately prior to a scheduled skin assessment that was performed by RN #1.</p> <p>Interview, on 02/25/15 at 11:10 AM, with RN #1 revealed she had applied the soft blue boot to Resident #3's heel just prior to the scheduled skin assessment, but RN #1 stated the boot had not been applied to the resident's left heel upon his/her rising. RN #1 stated that Resident #3's soft blue boot had been previously ordered for application while the resident was in bed, but on 02/23/15, the order was changed for continuous application of the boot with daily monitoring of the dark spot on the resident's left heel. RN #1 stated the boot was ordered to protect the resident's skin and to promote healing. She further stated the problem with not following the care planned intervention for the protective soft boot was the area could potentially worsen and the resident could experience additional skin breakdown.</p> <p>Further interview with RN #1, on 02/26/15 at 10:45 AM, revealed a new intervention would be reported to the oncoming nurse during the shift change. CNAs were to also report the new care</p>	F 282		

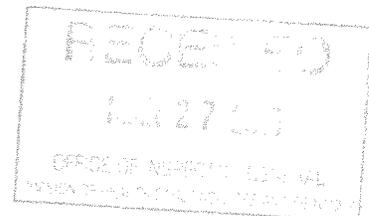


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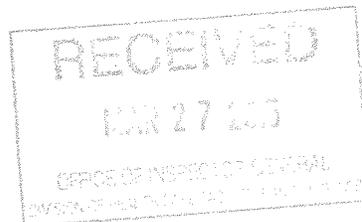
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F 282	<p>Continued From page 12</p> <p>area/intervention to oncoming CNAs during the shift change. RN #1 stated she was the nurse who received the order for Resident #3's blue soft boot on 02/23/15. She stated she updated the CNA care plan and informed the CNA, but she could not remember the CNA who was assigned to care for the resident on that day. RN #1 stated CNAs were to review the CNA care plans every shift. RN #1 stated she was not sure who was responsible for ensuring the CNA Care Plans and the CNA 24-Hour Report Sheets contained the same information about the residents' care needs.</p> <p>Interview, on 02/26/15 at 10:40 AM, with CNA #2 revealed upon reporting to work, she received a report on the residents from the CNA who worked the previous shift. This report included information about any new care interventions, ongoing care needs, and the type of monitoring needed. CNA #2 also stated the CNAs were supposed to review the CNA care plans daily to ensure they knew how to care for their assigned residents, but CNA #2 stated she did not review the CNA care plans daily, as this was just the way the work day flowed for most CNAs. CNA #2 stated she always carried a CNA 24 Hour Report Sheet with her that contained information passed on during the shift change. CNA #2 stated the requirement to apply Resident #3's blue soft boot to his/her left foot was added to the CNA 24 Hour Report Sheet on 02/25/15. CNA #2 stated that prior to 02/25/15, she was not aware Resident #3 was to wear the blue soft boot at all times.</p> <p>Interview, on 02/26/15 at 11:25 AM, with Director of Nurses (DON) revealed at the end of each shift, CNAs were to sign the back of the CNA Care Plans. Their signature verified they had</p>	F 282		



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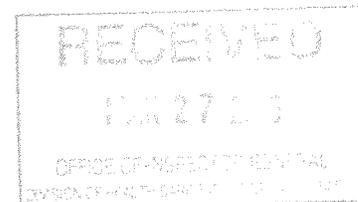
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F 282	<p>Continued From page 13</p> <p>reviewed the care plans and had followed them while providing care to their assigned residents. The DON stated the CNA 24 Hour Report Sheet was turned in to the Unit Managers (UMs) who reviewed them. The DON stated if CNAs were unable to review the care plans or did not understand how to provide resident care, they were to communicate that to the unit's licensed nurses or to her.</p> <p>3. Review of the clinical record for Resident #11 revealed the facility admitted the resident on 09/28/11 with diagnoses of Hypertension, Dementia, Congestive Heart Failure, Hyperlipidemia, Alzheimer's disease, Arthropathy, and Senility without Psychosis, Anxiety, Depression, Psychotic Disorder, Hypo-potassemia, Restless Leg Syndrome, and a history of Intertrochanteric Fracture.</p> <p>Review of Resident #9's quarterly Minimum Data Set (MDS) assessment, completed on 02/15/15, revealed the resident was unable to walk and needed total assistance from staff to toilet, transfer, bed mobility, and for all activities of daily living (ADL) and hygiene needs. The facility completed a Brief Interview for Mental Status (BIMS) examination during the assessment and the resident scored a five (5) out of fifteen (15) indicating moderate cognitive impairment.</p> <p>Review of Resident #11's Care Plan, last updated 12/30/14, revealed the nursing staff would check and change the resident every two (2) hours and as needed. It also revealed that the resident needed total assist to conduct personal hygiene and bathing. The care plan identified the resident was at risk for developing pressure areas due to</p>	F 282		



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F 282	<p>Continued From page 14</p> <p>contractures of the hands, decreased mobility and incontinence. The care plan stated nursing staff should have turned and repositioned Resident #11 every two (2) hours with a two (2) staff assist. The care plan stated the resident would wear palm protectors when not wearing splints and would wear blue heel boots at all times.</p> <p>Review of the Nursing Assistant Care Plan for Resident #11, dated February 2015, revealed staff would ensure the resident's fingernails were not long enough to dig into the palm of the hand and that the resident was to wear palm protectors when the splints were not on. The care plan also stated the resident would wear blue heel boots. The Nursing Assistant Care Plan stated CNAs were to check and change as needed with two assist.</p> <p>Observation of Resident #11, on 02/25/15 at 7:30 AM, revealed CNA #1 and CNA #2, upon going into the resident's room with the CNAs, Resident #11 did not have the float boots on his/her heels. The resident had red, raw, open areas on the tops of his/her toes. The resident was not wearing palm guards. CNA #1 and #2 changed and dressed the resident. The resident's space boots were in his/her closet in the room and CNA #1 retrieved them from the closet. CNA #1 and #2 used a lift to place the resident into the Geri-chair. After the care was completed, the CNAs transported the resident out to a common area near the nurses station. Resident #11 did not have palm protectors on at that time.</p> <p>Continued observation, on 02/25/15 at 9:05 AM, revealed CNA #4 provided restorative care to Resident #11. The CNA took the resident to</p>	F 282		



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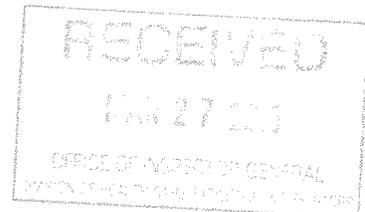
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F 282	<p>Continued From page 15</p> <p>his/her room and provided restorative care and splinting. CNA #4 did not check and change or reposition the resident at that time. CNA #4 returned the resident to the common area after his/her restorative therapy. Interview at this time with CNA #4, revealed she did not check and change the resident during this care.</p> <p>Interview with CNA #2, on 02/26/15 at 9:30 AM, revealed CNA #2 was one of the CNAs responsible for the care of Resident #11 on 02/25/15 during first shift. She stated the resident wore heel boots, Geri-sleeves on his/her legs, palm protectors, and elbow protectors. The CNA stated the resident wore this equipment at all times, both in and out of the bed.</p> <p>CNA #2 also stated CNAs were responsible for repositioning Resident #11 every two hours. She stated Resident #11 was not wearing the heel boots at the time the CNA got the resident up and out of bed on the morning of 02/25/15. The boots were located in another part of the room. She indicated staff had not put the boots on the resident at the last round with the resident during the night shift. The CNA stated not using the heel boots could lead to skin breakdown or injury for Resident #11.</p> <p>The CNA further stated the resident was not wearing palm protectors when the CNA woke the resident. The CNA stated she did not put the palm protectors on the resident. The CNA stated the palm protectors kept the resident from injuring himself/herself due to contractures of the hands. The CNA stated check and change for Resident #11 involved taking the resident to his/her room, using the lift to place the resident onto the bed, and changing the resident's brief.</p>	F 282		



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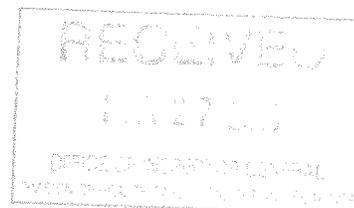
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F 282	<p>Continued From page 16</p> <p>CNA #2 stated she did not provide repositioning or check and change care for Resident #11 between when she provided AM care at 7:30 AM and after lunch at 12:15 PM, on 02/25/15. The CNA stated that by not checking and changing the resident, the resident was at higher risk for skin breakdown.</p> <p>Interview with LPN #1, on 02/26/15 at 9:15 AM, revealed Resident #11 was to wear heel boots at all times, including when in the bed. The LPN stated the heel boots were put in place because the resident had Restless Leg Syndrome that caused him/her to move his/her legs and caused abrasions. The LPN further stated the CNAs were to reposition, check, and change Resident #11 every two (2) hours. She stated this meant the CNAs would take the resident to his/her room, use the Hoyer lift to put the resident in the bed, and check and change the resident's brief. The LPN stated not following the care plan was a problem because not using the proper equipment could lead to skin issues such as abrasions or skin breakdown for the resident.</p> <p>Interview with the Director of Nursing (DON), on 02/26/15 at 10:25 AM, revealed the CNAs had access to the care plans located at the nurses' stations. The CNAs should have looked at the care plans in the mornings at the start of their shift and then must look at the care plan at the end of the shift when they signed off on the care plan. The DON stated she was surprised to hear the CNAs had not followed the care plan by not utilizing palm protectors and heel protectors and not providing incontinent care with Resident #11. The DON stated the resident was at increased risk for skin breakdown if the CNAs did not follow</p>	F 282		



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F 282	Continued From page 17 the care plan. The DON reviewed the resident's care plan and stated it was somewhat confusing because there was a lot of equipment listed and the Nurse Aide Care Plan had a lot of information hand written on it.	F 282			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to provide activities of daily living (ADL) care for one (1) of twenty (20) sampled resident, (Resident #11). CNA #1 and #2 failed to provide oral care and nail care and CNA #4 failed to provide nail care and check and change Resident #11. The findings include: Interview with the Director of Nursing (DON), on 02/26/15 at 10:25 AM, revealed the Clinical Nursing Skills and Techniques, Eighth Edition, was the guide the facility used for providing activities of daily living care. Review of the Clinical Nursing Skills and Techniques, Eighth Edition, revealed daily oral care was essential for preventing oral diseases including inflammation and infection. Oral	F 312			



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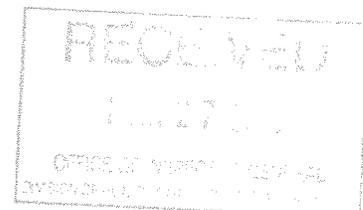
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F 312	<p>Continued From page 18</p> <p>hygiene promotes comfort, nutrition, and verbal communication.</p> <p>Review of the facility's in-service, dated 10/30/14, revealed staff was trained on oral care and grooming. The in-service stated oral care was to be completed each shift per the plan of care.</p> <p>Review of the clinical record for Resident #11 revealed the facility admitted the resident on 09/28/11 with diagnoses of Hypertension, Dementia, Congestive Heart Failure, Hyperlipidemia, Alzheimer's disease, Arthropathy, and Senility without Psychosis, Anxiety, Depression, Psychotic Disorder, Hypopotassemia, Restless Leg Syndrome, and a history of Intertrochanteric Fracture.</p> <p>Review of Resident #11's quarterly Minimum Data Set (MDS) assessment, completed on 02/15/15, revealed the facility assessed the resident as unable to walk and needed total assistance from staff to toilet, transfer, bed mobility, and for all ADLs and hygiene needs. A Brief Interview for Mental Status (BIMS) was conducted during the assessment and the facility scored the resident at a five (5) out of fifteen (15) indicating moderate cognitive impairment.</p> <p>Observation of CNA #1 and CNA #2, on 02/25/15 at 7:30 AM, revealed upon entering the resident's room with the CNAs, Resident #11 was not wearing palm guards. The CNA #1 and CNA #2 performed morning care; however, did not provide oral care or nail care on the resident. Further observation of Resident #11's nails revealed the nails were approximately between one-eighth (1/8) and one-quarter (1/4) inch long. Nursing staff did not place palm protectors on the</p>	F 312	<p>Nursing staff education will be completed by 4/3/15 by SDC in regards to providing oral and nail care as well as checking and changing residents per care plan. Education will be on new hire orientation and annually.</p> <p>A 100% audit will be completed by unit managers by 3/31/15 reviewing oral and nail care.</p> <p>Resident #11 had a 3 day voiding diary completed by 3/27/15 to ensure nothing had changed with current care plan by unit coordinator. Upon completion care plan will be updated if applicable.</p> <p>Each Unit Coordinators will choose a sample of 10 residents per week to review oral and nail care. They will also monitor 10 incontinent residents. This will be done weekly for one month then bi-monthly for one month. This will then be done monthly 12 months. Any deficient practice will be reviewed at monthly QA meeting.</p>	

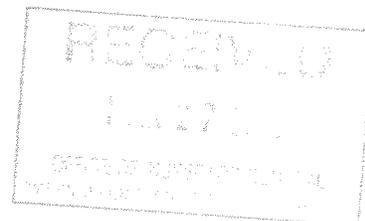
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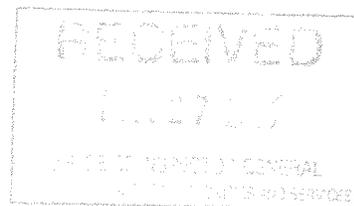
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/26/2015
NAME OF PROVIDER OR SUPPLIER HART COUNTY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749		
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F 312	<p>Continued From page 19</p> <p>resident during morning care. After the care was completed, CNA #1 and CNA #2 transported the resident via Geri-chair to a common area near the nurses station.</p> <p>Observations, on 02/25/15 at 9:05 AM, revealed CNA #4 provided restorative care with Resident #11. The restorative CNA placed splints on Resident #11. The CNA did not perform nail care for Resident #11 or check the resident for an incontinent episode at that time. The CNA assisted the resident to the common area after completing restorative therapy.</p> <p>Observations, on 02/25/15 at 9:35 AM, revealed an unidentified nurse transported Resident #11 to his/her room and administered medications. The nurse did not check Resident #11 for an incontinent episode. The nurse did not provide oral care nor nail care. The unidentified nurse returned the resident to the common area after administration of the medications.</p> <p>Review of Resident #11's Care Plan, last updated 12/30/14, revealed the nursing staff were to check and change the resident every two (2) hours and as needed. It also stated the resident needed total assist to conduct personal hygiene and bathing. The care plan stated the resident wore palm protectors when he/she was not wearing splints.</p> <p>Review of the Nursing Assistant Care Plan for Resident #11, dated February 2015, revealed staff was to ensure the resident's fingernails were not long enough to dig into his/her palms and that the resident wore palm protectors when he/she was not wearing the hand splints. The Nursing Assistant Care Plan stated CNAs were to check</p>	F 312			



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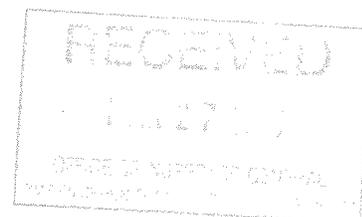
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F 312	Continued From page 20 Resident #11 every two (2) hours for episodes of incontinence and change the resident. It further stated nursing staff provided total care for the resident's oral hygiene. Interview with CNA #2, on 02/26/15 at 9:30 AM, revealed CNA #2 provided the morning care for Resident #11 on 02/25/15. The CNA further stated Resident #11 was not wearing palm protectors when the CNA woke the resident. The CNA stated she did not put the palm protectors on the resident. CNA #2 stated the palm protectors kept the resident from injuring himself/herself due to contractures of the hands. CNA #2 stated she proceeded to provide morning care for Resident #11 on 02/25/15. She stated the CNAs were responsible for providing oral care as part of the morning care for Resident #11. CNA #2 stated she did not provide oral care for the resident. The CNA further stated she had forgotten, and when she thought about it later she was busy providing care to another resident and failed to go back to Resident #11. CNA #2 stated the nursing staff would provide oral care to residents to ensure good mouth hygiene. She also stated the CNA providing morning care checked the resident's fingernails to ensure they were trimmed and this also took place on shower days. CNA #2 stated she did not check Resident #11's nails during his/her morning care on 02/25/15. CNA #2 stated the purpose of clipping Resident #11's nails was to protect the resident from harming himself/herself because he/she had contractures of the hands. CNA #2 stated CNAs were responsible for checking and changing Resident #11 every two hours. The CNA stated check and change for Resident #11 involved taking the resident to his/her room, using the lift to place the resident onto his/her bed, and	F 312		



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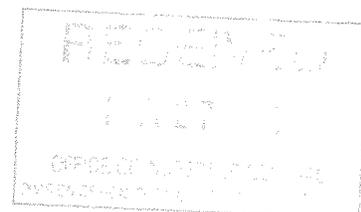
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F 312	<p>Continued From page 21</p> <p>changing the resident's brief. CNA #2 stated she did not provide check and change care for Resident #11 between the time she provided morning care until after lunch on 02/25/15. The CNA stated by not checking and changing the resident, the resident was at a higher risk for skin breakdown. CNA #2 further stated the CNAs were responsible for providing the care indicated in residents' care plans. CNAs signed off on the care plans at the end of each shift. She stated that CNAs had the opportunity to look at the care plans at that time.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 02/26/15 at 9:15 AM, revealed she provided supervision to the CNA staff on her hallway and ensured the CNAs were providing care. The LPN stated she would show up in the resident rooms when the CNAs were providing care in order to observe them to ensure they were giving good care. LPN #1 further stated the CNAs provided check and change care every two (2) hours for Resident #11. She stated this meant the CNAs would take the resident to his/her room, use the Hoyer lift to put the resident in the bed, and check and change the resident's brief. The LPN stated she was surprised to hear that the CNAs did not complete nail or oral care with Resident #11. The LPN stated it was a problem because not providing the proper care and equipment could lead to skin issues such as abrasions or skin breakdown for the resident.</p> <p>Interview with the Director of Nursing (DON), on 02/26/15 at 10:25 AM, revealed the CNAs had access to the care plans located at the nurses' stations. CNAs should have looked at the care plans in the morning at the start of their shift and looked at the care plan at the end of their shift</p>	F 312		



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F 312	Continued From page 22 when they signed off on those care plans. The DON stated she was surprised to hear that the CNAs had not given all of the correct care with Resident #11. The DON stated that the resident was at increased risk for skin breakdown if CNA's did not give correct care. The DON reviewed the resident's care plan and admitted it was somewhat confusing because there was a lot of equipment listed and the Nurse Aide Care Plan had a lot of information hand written on it.	F 312			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record and policy review, it was determined the facility failed to apply heel protectors and palm protector to prevent the development of pressure areas and to promote healing of an identified pressure area for two (2) of twenty (20) sampled residents, (Residents #3 and #11). The staff failed to apply heel protectors to Resident #3's left heel as ordered by the physician. The staff failed to apply palm protectors to Resident #11's hands when splints were not in place.	F 314			

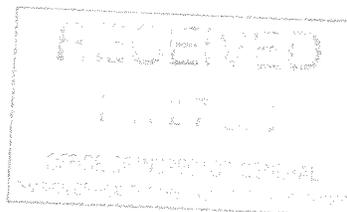


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F 314	Continued From page 23 The findings include: Review, of the facility's policy regarding Pressure Ulcers, dated 02/17/09, revealed it was the policy of the facility to assess each resident for the risk of developing pressure ulcers, identify risk factors and provide care and services to reduce the risk for the development of pressure ulcers. 1. Review of Resident #3's clinical record revealed the facility admitted the resident on 10/16/08 with diagnoses of Type 2 Diabetes, Alzheimer's Disease, Chronic Airway Obstruction, Esophageal Reflux, Depressive Disorder, Hypothyroidism, Oropharyngeal Dysphagia, and Hemolytic Anemia. Upon admission the resident was unable to care for himself/herself, and was in a state of general decline. Review, of Resident #3's most recent Annual Minimum Data Set (MDS) Assessment, dated 08/06/14, revealed the facility assessed the resident with a Brief Interview for Mental Status at a score of five (5) out of fifteen (15). The facility assessed the resident to need extensive assistance with activities of daily living (hygiene, bathing, dressing, and eating). The facility determined the resident was always incontinent of bladder and bowel. In addition, the resident was assessed as at risk for the development of pressure ulcers based on the listed intrinsic risk factors which included incontinence, a history of poor nutrition, antidepressant use, Alzheimer's Disease, and severe pulmonary disease. Review of Resident #3's Minimum Data Set (MDS) Quarterly Assessment, dated 01/09/15, revealed the facility again assessed the resident with a scored a five (5) out of fifteen (15) on the	F 314	The care plans for residents #3 & 11 were reviewed on 3/17/15 by the care plan team to ensure these items were care planned if still applicable. On 3/17/15 the Administrator reviewed a list from pharmacy in regards to safety devices and splints. A spreadsheet was developed listing resident and intervention noted. Unit Coordinators will review weekly for one month the placement of safety devices and splints. This will then be done bi-monthly for one month then monthly for 12 months. This will be turned in to the DON for her to review and to initial off. These will be reviewed at the monthly QA meeting. DON will complete a 100% audit of splints, safety devices and alarms to ensure they are on care plans and nurse aide care plans by 3/27/15 any deficient area will be corrected.	

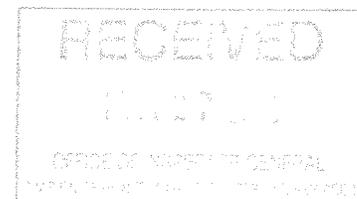
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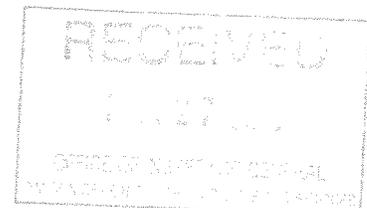
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F 314	<p>Continued From page 24</p> <p>BIMS and continued to be at risk for the development of pressure ulcers. Resident #5 continued to require extensive assistance with activities of daily living (personal hygiene, bathing, dressing, and eating). The resident was assessed to be frequently incontinent of urine, and always incontinent of bowel.</p> <p>Review of an incident report, dated 02/03/15, revealed during a skin assessment conducted on 02/03/15, a small dark area measuring 0.5 x 0.5 cm was identified on the back of Resident #3's left heel. The physician was notified and gave an order for the application of a heel boot to the left heel, at all times, while the resident was in bed. Daily monitoring of the area was to occur until it was healed. On 02/23/15, the area on Resident #3's left heel was assessed and measured by Registered Nurse (RN) #1, and according to the documentation, the area measured 1.0 x 1.0 cms. The physician was notified and gave an order for the heel boot to be on Resident #3's heel at all times, with continued daily monitoring of the site until it was healed.</p> <p>Review, of Resident #3's Interdisciplinary Care Plan and Certified Nursing Assistant's (CNA's) Care Plan, revealed interventions for the prevention of pressure ulcers, which included application of a heel boot, dated 02/23/15. The boot was to be on the resident's left foot at all times.</p> <p>Review, of the 400 Hallway CNA Report Sheet, revealed Resident #3 was to have a "blue boot" on at all times.</p> <p>Observation, on 02/24/15 at 11:25 AM, revealed Resident #3 was not in his/her room and a blue</p>	F 314	<p>Results of audit will be reviewed by QA Committee.</p> <p>The facility staff development coordinator will complete an inservice by 3/27/15 in regards to applying splints and protective devices per care plans. Training will be done on new hire orientation and annually.</p>	



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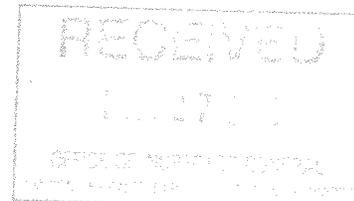
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F 314	<p>Continued From page 25 soft boot was lying on the resident's bed.</p> <p>Observation, on 02/24/15 at 11:50 AM, revealed Resident #3 was seated in his/her wheelchair in the restorative dining area of the facility's Magnolia Unit. The resident was wearing black shoes with Velcro closures. Resident #3 moved his/her feet back and forth with an almost constant shuffling movement.</p> <p>Observation, on 02/24/15 at 2:20 PM, revealed Resident #3 was seated in his/her wheelchair, in the day area of the facility's Magnolia Unit. The resident continued to wear black shoes with Velcro closures. Resident #3 was not wearing the soft blue boot on his/her left foot.</p> <p>Observation, on 02/25/15 at 7:20 AM, revealed Resident #3 seated in his/her wheel chair. He/she was wearing black shoes with Velcro closures. Resident #3 continued to move his/her feet and legs with almost constant back and forth movements. Resident #3 did not have the soft blue boot on his/her left foot.</p> <p>Observation, on 02/25/15 at 8:07 AM, revealed Resident #3 continued to be seated in his/her wheelchair, with a clothing protector covering his/her upper torso, while waiting for the breakfast meal. Resident #3 was not wearing the soft blue boot.</p> <p>Continued observation, on 02/25/15 at 8:45 AM, revealed direct care staff assisting Resident #3 with finishing his/her breakfast. The resident was still not wearing the soft blue boot on his/her left foot.</p> <p>Interview, on 02/25/15 at 8:53 AM, with RN #1</p>	F 314			



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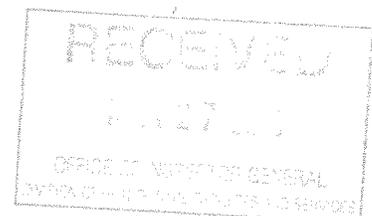
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F 314	<p>Continued From page 26</p> <p>revealed Resident #3 had a dark colored spot on his/her left heel and the physician ordered daily monitoring of the area until it was healed. In addition, she stated staff was to ensure Resident #3 was wearing the soft blue boot at all times.</p> <p>Observation, on 02/25/15 at 9:55 AM, revealed Resident #3 seated in his/her wheelchair with the soft blue boot on his/her left foot. This was immediately prior to a scheduled skin assessment that was to be performed by RN #1.</p> <p>Observation, on 02/25/15 at 10:00 AM, during a skin assessment by RN #1, revealed Resident #3 had a brown/black circular area on the back side of his/her left heel. The site was closed and there was no drainage.</p> <p>Interview, on 02/25/15 at 11:10 AM, with RN #1 revealed she had applied the soft blue boot to Resident #3's heel just prior to the scheduled skin assessment, but RN #1 stated the boot had not been applied to the resident's left heel upon his/her rising. RN #1 stated Resident #3's soft blue boot had been previously ordered for application while the resident was in bed, but on 02/23/15, the order was changed for continuous application of the boot with daily monitoring of the dark spot on the resident's left heel. RN #1 stated the boot was ordered to protect the resident's skin and to promote healing. She further stated the problem with not providing the protective soft boot was the area could potentially worsen and the resident could experience additional skin breakdown.</p> <p>Interview, on 02/25/15 at 10:25 AM, with CNA #1 revealed she was typically assigned to work on the Magnolia Unit of the facility, and had helped</p>	F 314		



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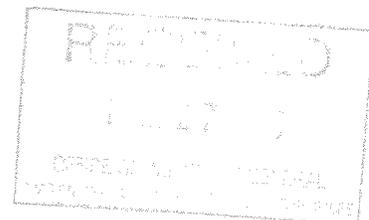
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F 314	<p>Continued From page 27</p> <p>dress Resident #3 earlier in the day, but had not placed the blue soft boot on Resident #3's left foot. CNA #1 stated that the licensed nurse assigned to the hallway where Resident #3 resided had just reminded her of the order to apply the blue soft boot to Resident #3's left foot. CNA #1 stated she was not exactly sure why Resident #3 needed the boot, but she thought it was because the resident had some skin breakdown.</p> <p>Interview, on 02/26/15 at 10:40 AM, with CNA #2 revealed upon reporting to work, she received a report on the residents from the CNA who had worked the previous shift. This report included information about any new care/interventions, ongoing care needs, and requirements for monitoring the residents. CNA #2 also stated the CNAs were supposed to review the CNA care plans daily to ensure they knew how to care for their assigned residents, but CNA #2 stated she did not review the CNA care plans daily, as this was just the way the work day flowed for most CNAs. CNA #2 stated she always carried a CNA 24 Hour Report Sheet with her that contained information that had been passed on during the shift change. CNA #2 stated the requirement to apply Resident #3's blue soft boot to his/her left foot was added to the CNA Report Sheet on 02/25/15. CNA #2 stated that prior to 02/25/15, she was not aware Resident #3 was to wear the blue soft boot at all times.</p> <p>Interview, on 02/26/15 at 11:25 AM, with Director of Nurses (DON) revealed the facility conducted a daily clinical staff meeting which included the facility's Unit Managers (UMs), the Desk Nurses, the MDS Nurse, and herself. During this meeting all new physicians' orders were reviewed and the</p>	F 314		



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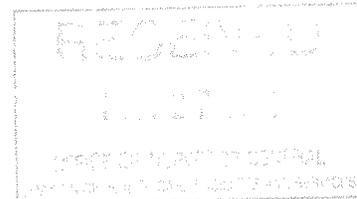
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F 314	<p>Continued From page 28</p> <p>residents' care plans were updated. In addition, staff at these meetings would ensure new orders were placed on the appropriate areas for record keeping such as the Medication Administration Records (MARS) and TARS. But, the DON added all licensed nurses were responsible for ensuring new orders were transcribed to the appropriate records and that care plans were updated. The daily clinical meeting was another venue for ensuring new orders/interventions were transcribed in the appropriate records, recorded accurately, and were accessible to the direct care staff responsible for providing the care.</p> <p>The DON stated at the end of each shift, CNAs were to sign the back of the CNA Care Plans. Their signature verified they had reviewed the care plans and had followed them while providing care to their assigned residents. The DON stated the CNA 24 Hour Report Sheet was turned in to the UMs who reviewed them. The UMs were responsible for ensuring the CNA care plans were updated when new orders were obtained. New orders/interventions were highlighted in yellow, and discontinued orders were highlighted in pink. This system was in place to ensure CNAs were alerted to new orders/interventions. The DON stated if CNAs were unable to review the care plans or did not understand how provide new intervention/care, they were to communicate that to the unit's licensed nurses or to her.</p> <p>2. Review of the clinical record for Resident #11 revealed the facility admitted the resident on 09/28/11 with diagnoses of Hypertension, Dementia, Congestive Heart Failure, Hyperlipidemia, Alzheimer 's disease, Arthropathy, and Senility without Psychosis, Anxiety, Depression, Psychotic Disorder,</p>	F 314		



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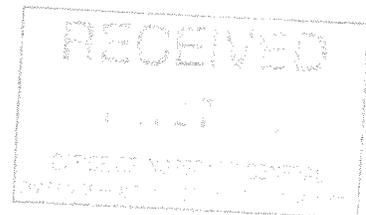
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2015
NAME OF PROVIDER OR SUPPLIER HART COUNTY HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749	
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F 314	<p>Continued From page 29</p> <p>Hypopotassemia, Restless Leg Syndrome, and a history of Intertrochanteric Fracture.</p> <p>Review of Resident #9's quarterly Minimum Data Set (MDS) assessment, completed on 02/15/15, revealed the facility assessed the resident as unable to walk and needed total assistance from staff to toilet, transfer, bed mobility, and for all ADL's and hygiene needs. A Brief Interview for Mental Status (BIMS) was conducted during the assessment and the resident scored a five (5) out of fifteen (15) indicating moderate cognitive impairment.</p> <p>Observation of Resident #11, on 2/25/15 at 7:30 AM, revealed the resident did not have heel protectors on at the time CNA #1 and CNA #2 went into the resident's room to provide morning care. The CNA #1 retrieved the float boots from the resident's closet while providing morning care. Observation of Resident #11 at that time further revealed the resident had red, raw, open areas on the tops of his/her toes.</p> <p>Review of Resident #11's Care Plan, last updated 12/30/14, revealed the resident would wear blue heel boots at all times to protect the resident from skin breakdown and from self-injury due to Restless Leg Syndrome.</p> <p>Review of the Nursing Assistant Care Plan for Resident #11, dated February 2015, revealed staff would ensure the resident wore blue heel boots.</p> <p>Review of the incident reports, dated 09/12/14 at 8:00 AM, revealed the resident had a bruise to his/her right shin. The cause of the injury was unobserved. On 10/23/14 at 1:50 PM, the</p>	F 314	



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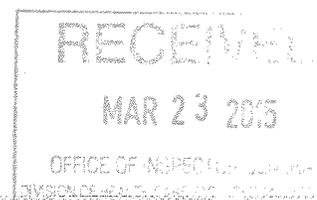
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F 314	<p>Continued From page 30</p> <p>resident had a skin tear to the inside of his/her right foot. On 12/11/14 at 1:50 PM, the resident had a skin shear on the back of his/her right leg. The cause of this injury was unobserved. On 12/26/14 at 8:00 AM, the resident had a scratch to his/her lower right leg. The cause of the injury was unobserved. On 01/07/15 at 10:00 AM, the resident had an abrasion to his/her left ankle at 1.9 centimeters (cm) by 1.4 cm and two (2) smaller abrasions on his/her lower right.</p> <p>Interview with CNA #2, on 02/26/15 at 9:30 AM, revealed CNAs were responsible for providing the care indicated in residents' care plans. CNAs signed off on the care plans at the end of each shift. She stated that CNAs had the opportunity to look at the care plans at that time. CNA #2 stated she was one of the CNAs responsible for the care of Resident #11 on 02/25/15 during first shift. CNA #2 discussed the appropriate care and equipment for Resident #11 including heel boots. CNA #2 stated Resident #11 was care planned to wear the heel boots at all times both in and out of the bed. CNA #2 revealed Resident #11 was not wearing the heel boots when CNA #1 and CNA #2 entered the resident's room to provide morning care on 02/25/15. The boots were located in the resident's closet. CNA #2 stated it was important for Resident #11 to wear the heel boots at all times to prevent skin breakdown and to prevent injury.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 02/26/15 at 9:15 AM, revealed Resident #11 was to wear heel boots at all times, including when in the bed. The LPN stated the nursing staff had put the resident's heel boots in place because the resident had Restless Leg Syndrome that caused him/her to move his/her</p>	F 314		



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F 314	Continued From page 31 legs and caused abrasions. The LPN stated not putting the heel boots on the resident was a problem because not using the proper equipment could have led to skin issues such as abrasions or skin breakdown for the resident.	F 314			
F 323 SS=G	Interview with the Director of Nursing (DON), on 02/26/15 at 10:25 AM, revealed she was surprised to hear the CNAs had not placed the heel boots on Resident #11 and this placed the resident was at increased risk for skin breakdown if CNA's did not use the heel boots. 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 facility policy review, it was determined the facility failed to have an effective system in place to ensure adequate supervision to prevent accidents. The facility failed to assess their fall prevention interventions to determine if they were implemented and effective in promoting a safe environment for one (1) of twenty (20) sampled residents, (Residents #9). The facility had prior knowledge of Resident #9's falls. Resident #9 had a total of nine (9) unwitnessed falls and the facility determined the alarms failed to sound for	F 323			

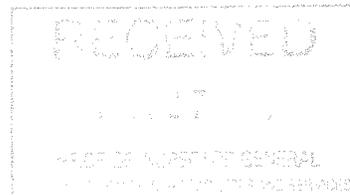


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F 323	Continued From page 32 all nine (9) of the falls. However, there was no documented evidence the alarm failure was addressed. The resident sustained a pelvic fracture during a fall in February 2014 and sustained a second fall in June 2014 resulting in a right hip fracture. (Refer to F282) The findings include: Review of the facility's policy regarding Falls Management, dated 01/10/10, revealed the facility was to screen all residents to identify possible risk factors that may place a resident at risk for falls, to evaluate those risks, implement interventions to reduce those risk, monitor the interventions and modify when necessary. The falls management policy was establish to identify residents with risk factors that may place them at risk for falls and to manage those residents who experienced a fall to minimize the risk of the fall reoccurring or minimize the risk of injury related to a fall. The staff was to review the current plan of care and if necessary revise interventions, or if no plan of care was in place, develop a plan of care to reduce the likelihood that the fall would reoccur and/or minimize the risk of injury related to a fall. Falls tracking was done individually as well as facility wide to analyze trends for Quality Assurance Reporting. The facility was to investigate any resident fails to determine appropriate interventions to put in place to reduce the likelihood that a fall would reoccur and to minimize the risk of injury related to a fall. Review of Resident #9's clinical record revealed the resident underwent surgery for an Open Reduction Internal Fixation (ORIF) to the right hip on 10/10/13. The facility readmitted the resident	F 323	Resident #9 was reassessed for alarms by the care plan team on 3/17/15 for the use of alarms. A 100% audit was completed on 3/4/15 by Environmental services and the nursing unit coordinators to ensure alarms that were ordered were in place and functioning. This will be done weekly by Environmental Services and Unit Coordinators to ensure alarms are on and functioning. This will be turned in weekly to DON for her to monitor and report monthly to QA Committee. Staff education was completed by 3/27/15 by Staff Development Coordinator on applying alarms, splints and protective devices as well as reporting equipment that isn't functioning. Education will be provided on new hire orientation and annually.	

*per 3-28-15
gmm Rec'd
Dnp 3-31-15*



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F 323	<p>Continued From page 33 on 10/15/13 with diagnoses of Dementia, and Mental Disorder.</p> <p>Review of Resident #9's Annual Minimum Data Set (MDS) assessment, completed on 03/05/14, revealed the facility assessed the resident during a Brief Interview for Mental Status (BIMS) score of six (6) of fifteen (15), indicating the resident was severely impaired cognitively. The facility assessed the resident as requiring extensive assistance of two (2) persons with bed mobility, transfers and required a wheelchair for mobility. The facility identified Resident #9 in Section J1800 and J1900, with falls since admission including one (1) major injury since the prior assessment.</p> <p>Review of the Comprehensive Care Plan for Resident #9, dated 01/28/14, with updated goals and target dates for 04/28/14, revealed problems on the care plan included a History of Falls related to Hypotension, poor balance, non-compliant behavior and incontinence of bowel and bladder. Interventions listed included mat on floor next to bed; Hipsters on at all times; perimeter defining mattress; pad alarm to bed and chair; and, high backed wheelchair with rear tilt and elevating leg rest.</p> <p>Review of the Post Fall Investigation for Resident #9, dated 02/08/14 at 4:30 PM, revealed an unwitnessed fall when the resident was found on the floor. The bed alarm was not sounding and no hipsters were noted. Resident #9 was transferred to a local hospital on 02/08/14 for evaluation and diagnosed with a Pelvic Fracture. The care plan for risk of complications of Osteoporosis related to a Pelvic Fracture, dated 02/08/14, revealed interventions were added</p>	F 323	<p>The care plan team and nursing administration will be inserviced on 3/27/15 by the corporate nurse consultant in regards to care planning and reviewing interventions for incident and accidents.</p> <p>Each incident/accident will be reviewed at morning department head meeting. These will be noted on a log and reviewed to determine any trend or need to implement a QA. Results will be shared and reviewed at monthly QA meeting. Any change to resident care plan will noted in Kiosk for nursing staff to check the residents care plan for any changes.</p>	



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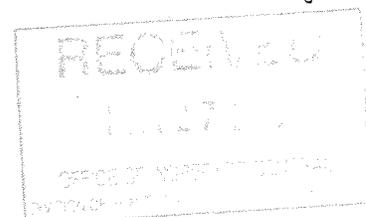
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F 323	Continued From page 34 which included monitor for resident attempting unsafe transfers unassisted, and bed and chair alarms. Further review of Resident #9's Post Fall Investigations revealed an additional eight (8) unwitnessed falls when the resident was found on the floor by staff, the alarm was not sounding, and the physician ordered hipsters were not on the resident. These falls occurred on 03/04/14 at 4:15 PM, 04/10/14 at 7:15 PM, 04/12/14 at 4:45 PM, 06/14/14 at 11:40 PM, 09/06/14 at 3:00 PM, 10/15/14 at 10:00 PM, 10/19/14 at 11:15 AM, and on 01/17/15 at 12:05 AM. Review of the Falls Progress Note, dated 06/16/14, revealed the Director of Nursing (DON) documented on the Falls Progress Note that Resident #9 was found in the doorway on the floor, on 06/14/14 at 11:40 PM, with skin tears in three (3) places on his/her right forearm and complaints of pain in both hips. In addition, the falls progress note stated the bed alarm was not sounding and there was no evidence the resident was wearing the hipsters as ordered. The resident was transferred to the hospital for an evaluation and diagnosed with an acute fracture involving the right hip. Interview with the DON, on 02/25/15 at 1:50 PM, revealed there was no post fall investigation for 06/14/14 found by the facility. Further review of the Post Fall Investigations revealed Resident #9 had tampered with the alarm preventing it from sounding when the resident fell, on 04/10/14 at 7:15 PM and 10/19/14 at 11:15 AM. Interview with the DON revealed, per review of the resident's plan of care,	F 323		



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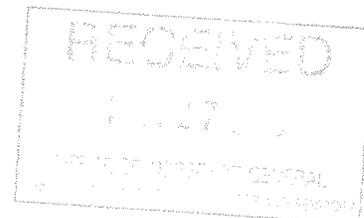
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F 323	<p>Continued From page 35</p> <p>it could not be determined which changes on the care plan were initiated or discontinued related to these two (2) falls.</p> <p>Per the investigation report for 01/17/15, CNA #6 and #7 got Resident #9 out of bed that morning and the alarm did not go off in the morning and they were too busy getting people up to let the nurse know.</p> <p>Review of facility's In-service Training on Resident Alarms, revealed the Unit Manager and CNA #8 had attended training regarding the placement of the bed alarm under Resident #9, dated 10/19/14, and also had attended an inservice on 10/25/14.</p> <p>Further review of the facility In-service Training on Bed Alarms, dated 12/10/14, revealed CNA #6, #7 and #8 attended. The in-service agenda revealed staff was to ensure alarms sounded when the resident was gotten up. Also, if the alarm was not in proper working order, then immediately notify the nurse. In addition, the staff was to make sure all chair alarms and bed alarms were attached, plugged in and in working order.</p> <p>Interview with CNA #6, on 02/26/15 at 2:20 PM, revealed she routinely cared for Resident #9 and knew the resident well. Resident #9 had some falls, when he/she tried to get up without assistance. When they heard the alarm they had to go to the resident right then. CNA #6 stated as far as she could remember Resident #9's alarm worked most of the time. She stated she recalled having an in-service to report any alarms not working. CNA #6 stated she had one alarm that did not sound a long time ago; however, she</p>	F 323		



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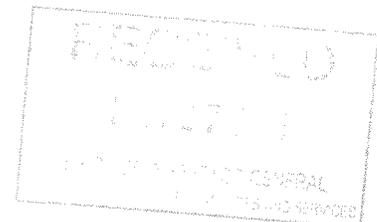
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F 323	<p>Continued From page 36</p> <p>stated she had never been to busy to report alarms not working to the nurse. She stated Resident #9's alarms usually worked. She stated staff must check to make sure Resident #9's alarms were working. The staff made rounds every one (1) to two (2) hours and checked on the alarms. In addition, she stated Resident #9 wore hipsters all the time.</p> <p>Interview with CNA #7, on 02/26/15 at 2:35 PM, revealed she provided care to Resident #9 and was frequently assigned to the resident. Resident #9 had fallen several times and the falls occurred when Resident #9 tried to find his/her children and other times it had been when he/she tried to get back in bed. Resident #9 had a seat belt alarm that he/she released and reconnected behind him/her. They all knew Resident #9 took the alarm off and reconnected the alarm behind him/her. She stated they would have to check on him/her right then. She stated the alarms had a light that blinked and a flashing light to show when the battery was low. She stated, she found the resident when he/she fell and broke his/her hip several months ago, back in June. The alarm was not sounding at that time. She stated they change the batteries or the alarm if the alarm did not work when they got the residents up. Alarms not working must be reported to the nurses.</p> <p>Interview with CNA #8, on 02/26/15 at 2:50 PM, revealed she had attended the in-service on checking the alarms and making sure they were working. She stated Resident #9 had a self releasing seat belt that he/she took off and would try to get up. All the staff knew the resident had several falls. The nurses, Licensed Practical Nurse (LPN) #2 and the DON, knew the resident repeatedly took the seat belt alarm off and tried to</p>	F 323			



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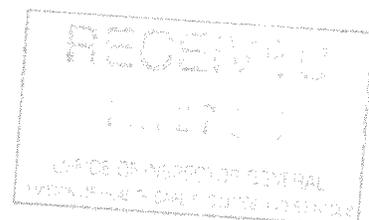
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F 323	Continued From page 37 get up. The resident also had a bed alarm and fall mats at the bedside in the floor. She stated she had never put hipsters on Resident #9 since she had been caring for him/her. Interview with the LPN #2, on 02/26/15 at 2:00 PM, revealed Resident #9 had a long history of falls in the facility with fractures on a couple of occasions. The resident could roll around the facility while in the wheelchair and utilized an alarming seat belt. LPN #2 stated the resident could self release the alarming seat belt and reconnect it behind his/her back. She stated they were going to discontinue the self release seat belt, but the family resisted it being removed since Resident #9 had so many falls. The family felt like it was one more way to alert the staff. The resident currently had two (2) types of alarms, a wheelchair alarm and a bed alarm. LPN #2 stated the resident had numerous falls and everyone knew the minute they heard the alarm, they had to respond because the resident would attempt to get out of the bed. She stated she checked the alarms at the beginning of her shift, and if there was a problem she would correct the problem at that time. Interview with the DON, on 02/26/15 at 4:40 PM, revealed she held morning meetings with falls discussed. She stated during the meeting they looked at the care plans and if an inappropriate intervention was added, then they would add an appropriate intervention; however, the inappropriate intervention may not be discontinued. The DON stated twenty-six (26) of ninety-six (96) residents were assigned bed and/or chair alarms. The pad alarm batteries were changed every one (1) year. They documented when they started using them, when	F 323			



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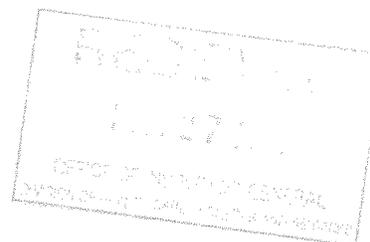
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F 323	Continued From page 38 the alarm is opened, then they document that it needed to be changed in one (1) year. She stated they had disciplined two (2) CNAs for not reporting to the nurse that an alarm was not functioning and they provided an in-service for checking the alarms and any alarms not working must be reported to the nurse. She stated they would throw away any alarms that did not work. She stated the alarms were included on the Medication Administration and Treatment Administration Records with staff ensuring the function of the alarm and the placement of the alarms; however, she did not do any monitoring of the system to ensure the staff was compliant. Interview with the Administrator, on 02/26/15 at 1:30 PM, revealed the DON and Unit Managers had daily morning meetings and the falls are discussed during that meeting. The falls were tracked and trended by the DON. In addition, the falls were followed by the DON and she was supposed to look for patterns with the time of the falls. He stated the falls had not been monitored based on an injurious and non-injurious fall; therefore, the QA Committee had not identified any trends. He stated the DON informed him during the department head meetings about any falls in the facility. However, only during the course of the survey, he had been made aware of Resident #9's falls and the problems with the personal alarms not working. He further stated upon review of the documents of the Post Fall Investigations, he realized he had not been kept abreast of Resident #9's multiple falls.	F 323			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from	F 329			



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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	
F 329	<p>Continued From page 39</p> <p>unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to ensure Gradual Dose Reductions were attempted for residents to ensure they were free from unnecessary drugs for one (1) of twenty (20) sampled residents (Resident #15).</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Use of</p>	F 329	<p>Parkview Psychiatric is scheduled to be at the facility on 3/26/15 and will review resident #15 to see if a GDR can be recommended to the MD. If so, the MD will approve/decline the GDR for resident #15.</p> <p>A 100% audit will be completed by DON by 3/27/15 for the past 3 months, December-February to ensure that any recommended GDR has been approved/declined by MD.</p> <p>After the monthly visit by Parkview the facility have an anti-psychotic review team consisting of DON, Administrator, Unit Coordinators and Social Service to review the recommendations and to ensure the MD has approved/declined the GDR.</p> <p>These meetings will take place monthly for 12 months. The results of the meetings will be shared with the QA Committee.</p>	3/28/15	



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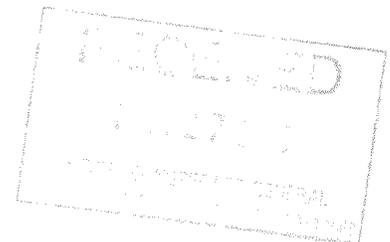
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F 329	Continued From page 40 Unnecessary Drugs, no revision date, revealed the purpose of the policy was to allow each resident's drug regimen to be free from unnecessary drugs. Under the section policy it stated an unnecessary drug was defined as any drug used at an excessive dose (including duplicate therapy), for an excessive duration, without adequate monitoring or adequate indications for its use, or in the presence of adverse consequences which indicate the dose should be reduced or discontinued, or any combinations of the reasons above. Under the section Procedure the policy stated the facility Pharmacy Consultant would review each resident's drug regimen for the use of unnecessary drugs, recommendations for gradual dose reductions or discontinuations would be reported to the facility and the recommendations would be addressed with the resident's Physician, and a response documented in the clinical record. Review of Resident #15's clinical record revealed the facility admitted the resident on 07/17/09 and re-admitted the resident on 08/08/14 with diagnoses of Anemia, Hypertension, Gastroesophageal Reflux Disease, Alzheimer's Disease, Parkinson's Disease, Anxiety Disorder and Depressive Disorder. Review of the resident's admission medications dated 08/08/14 included Celexa 20 milligram (mg) 1(one) tablet daily, Hydralazine 25 mg three (3) times a day, Lopressor 50 mg 1 tablet two (2) times a day, Zyprexa 5 mg 1 (one) tablet daily and Exelon 6 mg 1 (one) capsule 2 (two) times a day. Review of the resident's Psychiatric evaluation, dated 06/17/14, from a local Psychiatric Services agency revealed the resident had a history of behaviors and staff did advise that the resident was doing all right at the present time and had no	F 329		
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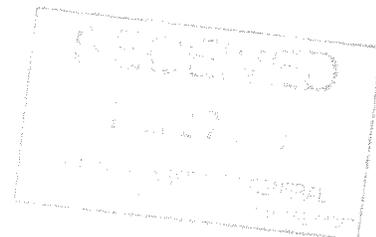
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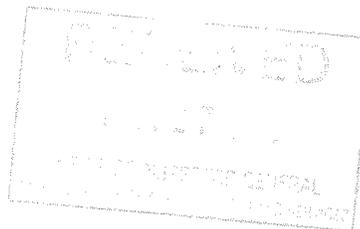
F 329	<p>Continued From page 41</p> <p>current issues or concerns. The evaluation revealed the resident had no Psychotic features at the time of the evaluation and to Rule out Bipolar Disorder with Psychotic features. At that time a reduction attempt was noted on Zyprexa to decrease to 5 mg 1 (one) tablet daily. Review of the Consultant Pharmacist Drug Review for the resident revealed a Gradual Dose Reduction (GDR) noted for 06/17/14. On the drug review dated for 11/24/14 the pharmacy recommended a GDR with follow up pending.</p> <p>Review of Resident #15's Annual Minimum Data Set (MDS) assessment completed, on 08/15/14, revealed the facility assessed the resident as non interviewable with a Brief Interview for Mental Status (BIMS) score of five (5), severely impaired.</p> <p>Review of the Comprehensive Care Plan for Resident #15 revealed the facility developed a care plan on 08/19/14, with updated goals and target dates for 05/10/15. The facility initiated a care plan for Behaviors and Moods related to episodes of hitting and cursing at staff on 08/20/14. The approaches included a pharmacy review of psychotropic medications. The facility initiated a care plan for Antipsychotic and Antidepressant Drugs on 08/19/14. The approaches included monitor for adverse side effects from antipsychotic medications and review and attempt gradual dosage reduction quarterly and as needed.</p> <p>Review of the facility report Compressed Behavior Report, dated 08/30/14-02/26/15, revealed the resident had zero (0) days of episodes of wandering, zero (0) days of episodes of rejection of care, five (5) days of episodes of impact on others, six (6) days of episodes of</p>	F 329		
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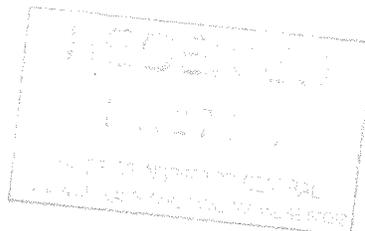
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F 329	<p>Continued From page 42</p> <p>impact on self and nine (9) days of symptoms in the last six (6) months. The report also revealed for three (3) months straight, September 2014 thru November 2014, the resident had no episodes of any types of behaviors.</p> <p>Observation of Resident #15 on 02/25/15 at 4:00 PM and on 02/26/15 at 6:45 AM, 8:30 AM, 9:30 AM, 11:00 AM, 2:55 PM and 4:00 PM revealed the resident was up and about in his/her room and other common areas without assistance. The resident was calm and cooperative with no tremors or behaviors noted.</p> <p>Interview with Certified Nursing Assistance (CNA)#2, on 02/26/15 at 10:30 AM, revealed the resident only had behaviors of yelling out periodically. CNA #2 stated the resident never hit staff or any other residents that she knew of and was a nice person who liked to be around other people and loved to take showers. CNA #2 stated that if any residents had any type of behaviors, herself or other nursing staff, would document the behaviors in the kiosks on the wall in the hallways.</p> <p>Interview with CNA #5, on 02/26/15 at 10:40 AM, revealed the resident did have behaviors of yelling out, but that was periodically. CNA #5 stated she didn't know of any other type of behaviors for the resident. CNA#5 stated that staff did not document yelling out as a behavior and they did not document that at all in the computer, but any other types of behaviors are documented in the computer system in the hallways.</p> <p>Interview with the Assessment Nurse, on 02/26/15 at 11:00 AM, revealed she kept all the</p>	F 329			



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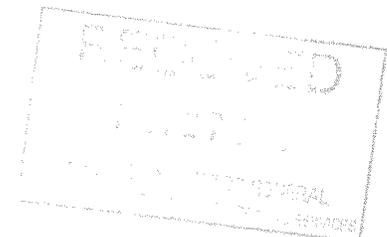
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F 329	<p>Continued From page 43</p> <p>Psychotropic Medication review forms for the entire facility. The Assessment Nurse stated she completed the review forms at each resident's annual and quarterly assessments. The Assessment Nurse stated if she had seen a resident on a as needed medicine and it hadn't been used for over a period of time then she would talk with the Unit Manager about discontinuing the medication. The Assessment Nurse stated she didn't have anything to do with keeping up with GDR's or talking with the pharmacist or making recommendations. The Assessment Nurse stated the Unit Managers and Director of Nursing did all the recommendations to and from the pharmacy and doctor.</p> <p>Interview with Social Services, on 02/26/15 at 12:15 AM, revealed she ran a behavior report each day for all residents. Social Services stated she tracked what behavior occurred, how and why it happened. Social Services stated she tracked the care plan and document notes in the social services notes in the chart. Social Services stated the resident did yell out periorally, but couldn't recall documenting any behaviors recently for the resident. Social Services stated she didn't have anything to do with recommendations for GDR's and that was handled by the nursing staff.</p> <p>Interview with the Director of Nursing (DON), on 02/26/15 at 12:50 PM, revealed the facility's process for GDR's relied on the pharmacy to make GDR recommendations for the entire facility. The DON stated herself and the Unit Managers could and would make recommendations to the pharmacist for GDR's for any resident. The DON stated they had a system process where nursing staff met and</p>	F 329		



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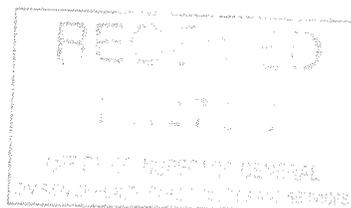
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F 329	Continued From page 44 discussed changes on all residents including GDR's and Psychoactive drugs. The DON stated they had not had a meeting concerning Resident #15 and that a GDR should had been attempted for the resident in November 2014. The DON stated the process had failed and they had failed the resident. An attempted interview, on 02/26/15, was made with the Pharmacist and a voice mail was left, but no phone call was returned as of 02/26/15. Interview with the Administrator, on 02/26/15 at 1:30 PM, revealed Pharmacy attended the quarterly Quality Assurance (QA) meetings. The Pharmacy provided information regarding residents on antipsychotic medications and the need for GDR. He reported the facility was below the state and national averages. He stated he was not involved in recommendations for the GDR or monitoring of these medications. The DON was responsible for follow up with the recommendations. He said the only monitoring of psychoactive medications during QA meetings was what Pharmacy reported to him.	F 329			
F 520 SS=G	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify	F 520			



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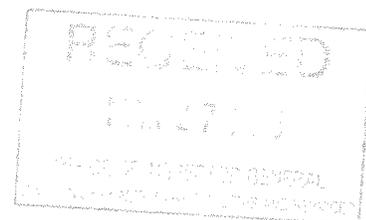
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F 520	<p>Continued From page 45</p> <p>issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to have an effective system in place to ensure the Quality Assurance (QA) Committee identified quality deficiencies, developed plans of action, and monitored for effectiveness. Resident #9 sustained multiple falls, two (2) that resulted in injuries and nine (9) that the alarm did not sound. The QA Committee failed to track and trend the falls to identify patterns and ensure appropriate plans of action were developed and monitored to prevent further falls.</p> <p>The findings include:</p> <p>Review of the clinical record for Resident #9 revealed the resident sustained a pelvic fracture during a fall in February 2014 and sustained a second fall in June 2014 resulting in a right hip fracture. Resident #9 had a total of nine (9)</p>	F 520	<p>Each incident/accident will be reviewed Monday-Friday at the facility morning meeting by Administrator, DON, Activity Director, Social Services, Maintenance, Environmental Services Director and Therapy.</p> <p>The facility is scheduled to have a QA meeting on 3/31. At this time the results of the survey will be reviewed as well as the facilities plan of correction.</p> <p>At the morning meeting which occurs Monday-Friday the QA Falls Tracking Log or the QA Incident Tracking Log will be reviewed.</p> <p>The falls tracking log will review date, time, location of fall, any injury, treatment, cause and interventions put in place. The incident tracking log will review date, time, type of injury, where did the event occur, cause, any injury and interventions put in place.</p>	4315	



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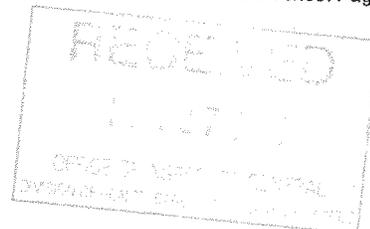
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F 520	<p>Continued From page 46</p> <p>unwitnessed falls which the facility determined the alarms failed to sound.</p> <p>Interview with the Director of Nursing (DON), on 02/26/15 at 4:40 PM, revealed she tracked and trended the falls in the facility and reported the findings to the Quality Assurance (QA) Committee for analysis. She stated they talked about the falls in the QA committee; however, they had not identified any patterns with the falls.</p> <p>However, review of the falls tracking information provided by the facility revealed the following:</p> <p>January 2014, Dogwood Court residents (where Resident #9 resided) had two (2) falls on Sunday, two (2) falls on Monday, two (2) falls on Tuesday, one (1) fall on Wednesday, one (1) fall on Thursday, three (3) falls on Friday, four (4) falls on Saturday. The DON identified five (5) falls occurred on the 11:00 PM-7:00 AM shift, six (6) falls occurred on the 7:00 AM-3:00 PM Shift and four (4) falls occurred on the 3:00 PM-11:00 PM Shift for a total of fifteen (15) falls.</p> <p>January 2014, Magnolia Court residents had one (1) fall on Sunday, two (2) falls on Monday, two (2) falls on Tuesday, no fall on Wednesday, two (2) falls on Thursday, one (1) fall on Friday, two (2) falls on Saturday. The DON identified three (3) falls occurred on the 11:00 PM-7:00 AM shift, five (5) falls occurred on the 7:00 AM-3:00 PM Shift and two (2) falls occurred on the 3:00 PM-11:00 PM Shift for a total of ten (10) falls. The summarization revealed there were three (3) residents with repeated falls, two (2) residents with three (3) falls each and one (1) resident fell two times.</p>	F 520	<p>The resident will be added to the Falls Alert Master List at this time. A Falls Alert team consisting at minimum of the DON, Unit Coordinators and Administrator will meet weekly to determine if interventions put in place are effective or need revision. Each resident will be followed for one month after their last fall to ensure interventions are appropriate. Documentation will be written in the falls alert progress note.</p> <p>Facility QA members will be inserviced by regional nurse consultant on 3/27/15 in regards to the Falls Management program.</p> <p>The corporate nurse consultant will review on a monthly basis for 3 months the facilities falls program prior to the QA meeting to ensure the program is being followed correctly and that falls are being tracked and trended. The corporate nurse consultant will also attend facility QA</p>		



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F 520	Continued From page 47 Further review of the fall tracking information revealed the residents with repeated falls were all identified to reside on Dogwood Court. In addition, the DON documented she would continue to monitor fall patterns to identify any patterns of falls. The January 2014 report did not distinguish falls with or without injury, or falls involving equipment/assistive devices. No current information related to fall tracking and trending was provided. Interview with the Administrator, on 02/26/15 at 1:30 PM, revealed the DON and Unit Managers brought clinical issues to the Quality Assurance (QA) meeting, developed action plans to address the problems and then evaluated the effectiveness. He stated the DON and Unit Managers had daily morning meetings and the falls were discussed during that meeting. The DON informed the Administrator during the department head meeting about any falls in the facility. The falls were tracked and trended by the DON. The falls were followed by the DON and she was supposed to look for a pattern and the time of the falls. He stated the QA Committee had not identified any trends. He stated the falls tracking report had not distinguished between injurious and non-injurious falls. He stated the QA committee did not know of the multiple falls and the problems with the personal alarms, therefore, no action plan had been developed, implemented, or monitored.	F 520	meetings monthly for 3 months then no less than quarterly for one year.		



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{F 000}	INITIAL COMMENTS An on-site revisit survey was initiated and concluded on 04/07/15. The facility was found to be in compliance as of 04/04/15 as alleged in their Plan of Correction.	{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.