

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

Second SOD

PRINTED: 06/05/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185293	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/26/2012
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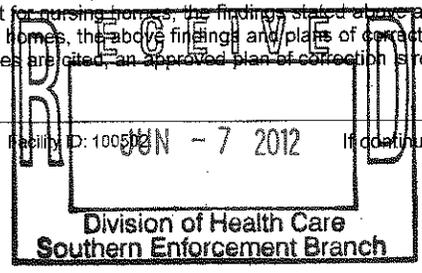
NAME OF PROVIDER OR SUPPLIER  LAUREL CREEK HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1033 NORTH HIGHWAY 11 MANCHESTER, KY 40962
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F 000	INITIAL COMMENTS	F 000	The Maintenance Director began trimming and sanding work on 4-26-12 to correct the rough, protruding edges of doors in resident rooms #106, #121, #128, #129, #130, #132, #144, #146, #147, #156 and #158, and on the East Wing central bathroom door.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of facility policy, the facility failed to provide effective housekeeping/maintenance services to ensure a sanitary, comfortable interior. Rough, splintered edges were observed on several doors throughout the building. The wall across from resident room 157 was missing a portion of wall covering and the drywall was exposed. Lavatories in two resident rooms were stained and discolored. Two toilets were observed to be rusty around the base of the toilets. The toilet in the central bath on the East Wing was out of order and not available for resident use.  The findings include:  A review of the facility's Maintenance Policy, no date given, revealed the Maintenance Department would respond to and correct all identified problems that were reported verbally or in writing within the scope of their operations or arrange for the correction by a qualified individual	F 253	1. Lavatories in resident rooms #128, #140 and #159 will be replaced by 6-1-12. The toilet in resident room #139 was replaced 5-1-12 and the rust around the base was removed.  The Central Shower room toilet on East Wing was replaced on 5-3-12.  Drywall and paint were applied to the wall area across from resident room #157 on 5-7-12.  2. Department Managers make daily rounds utilizing a check-off sheet Monday through Friday to assure Housekeeping and Maintenance provide services necessary to maintain a sanitary, orderly and comfortable interior. Findings are presented to the Executive Director (ED). The ED will follow up with Department Manager, i.e. Maintenance, Housekeeping, etc. responsible for the findings to assure findings are corrected.  Maintenance Director and Housekeeping/Laundry Supervisor found stained and discolored lavatories in resident rooms #151, #145, #143, #119, #115, #113, #106 and #120. Facility will replace by 8-1-12. They checked all resident room toilets and not other problems were found.  Maintenance Director and Housekeeping Supervisor checked all other doors to assure there were no rough, protruding edges and none was found.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Clara Benz</i>	TITLE Director	(X6) DATE 06-06-12
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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F 253	<p>Continued From page 1 in a timely manner.</p> <p>Observations of the facility for 04/24-26/12, revealed the following areas were in need of maintenance services:</p> <ol style="list-style-type: none"> <li>1. Rough, protruding edges were observed on the doors in resident rooms 106, 121, 128, 129, 130, 132, 144, 146, 147, 156, and 158 and on the East Wing central bathroom door.</li> <li>2. Lavatories in resident rooms 128, 140, and 159 were observed to be stained and discolored.</li> <li>3. The toilet in resident room 139 was rusty around the base of the toilet.</li> <li>4. The central shower room toilet on the East Wing was out of order and not available for resident use.</li> <li>5. The wallpaper on the wall across from resident room 157 was missing.</li> </ol> <p>An interview with the East Wing Unit Manager (UM) on 04/24/12, at 1:00 PM, revealed the facility's department heads have assigned areas within the facility to monitor daily for environmental concerns. According to the UM, when a concern is identified, Maintenance and/or Housekeeping was to be notified.</p> <p>An interview with the Maintenance Supervisor (MS) on 04/24/12, at 3:20 PM, revealed he had not been notified of the rough door edges, discolored lavatories, or rusty toilet that needed attention. The MS stated he was aware the toilet in the central bath was out of order but had not</p>	F 253	<p>Maintenance Director checked all central room toilets and there were no other toilets found to be out of order.</p> <p>Executive Director and Maintenance Director checked all the hallways to assure that there were wall coverings on all walls. There were no walls found without covering.</p> <ol style="list-style-type: none"> <li>3. There are plans to replace all resident room doors by 11-1-12. Executive Director and Maintenance Director inserviced all staff on 5-11-12 to be aware and report maintenance problems by completing Maintenance Request forms and turning them in for repair. Examples of problems discussed were door kick plates with rough, protruding edges on resident room doors and other doors, lavatories with stains and discolorations, toilets being out of order. Staff was encouraged to report anything they saw that they considered to be a problem.</li> <li>4. Department Managers make daily rounds (Monday through Friday ongoing) utilizing a check-off sheet to assure Housekeeping and Maintenance provide services necessary to maintain a sanitary, orderly and comfortable interior. Findings are presented to the Executive Director (ED). The ED will follow up with Department Manager, i.e. Maintenance, Housekeeping responsible for the findings to assure findings are corrected.</li> </ol> <p>ED/Maintenance Director and Housekeeping/Laundry Supervisor will conduct audits 3 x per week for 1 month, then 1 x per week ongoing on door kick plates to assure no rough, protruding edges, lavatories to assure no stains and discoloration, toilet bases to assure no rust, Central Shower rooms to assure that all toilets are working, and hallways to assure there are wall coverings.</p>	
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Department Head findings/audits will be reviewed monthly by the Performance Improvement Committee. Improvements will be made as indicated.  
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F 253	Continued From page 2 repaired it. The MS stated he was also aware of the missing wallpaper; however, there was no more left of that particular pattern to finish that section of wall.	F 253	Department Head findings/audits will be reviewed monthly by the Performance Improvement (PI) Committee. Improvements will be made as indicated.	6-1-12
F 281 SS=D	<b>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</b>  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, it was determined the facility failed to follow physician's orders for one of twenty sampled residents (Resident #1). Resident #1 had a physician's order for a gastrostomy tube (G-tube) feeding to be administered for twenty-two hours every day. However, observation and record review on 04/24/12, revealed the tube feeding was observed to be off from 1:56 PM until 6:18 PM, four hours and twenty-two minutes. Resident #1 also had a physician's order dated 03/19/12, for oxygen to be administered at five liters per minute by nasal cannula. However, observation on 04/24/12, 04/25/12, and 04/26/12, revealed the resident was not being administered oxygen at the rate ordered by the physician.  The findings include:  A review of the facility's policy titled "Physician's Orders/Transcription," dated October 2004, revealed proper channels of communication (such as Medication Administration Records, Treatment Administration Records, and shift	F 281  1.a. Resident #1's physician was notified on 4-21-12 that resident was unhooked from tube feeding from 1:56 pm until 6:18 pm. New order obtained to bolus Jevity 1.2 240 ccs to meet dietary needs. Bolus was completed and tube feeding resumed per physician's order. No adverse effects noted.  1.b. Resident #1's physician was notified on 4-26-12 that resident's oxygen flow was not set per physician's order on 4-24-12, 4-25-12 and 4-26-12. New order obtained to resume oxygen per nasal cannula @ 5 liters. No adverse effects noted.  2. 100% audit of all physician orders written in the last 90 days were completed by the DON, ADON, MDS Coordinators on 5-3-12 to ensure all physician orders were being followed.  2.a. 100% audit was completed on 4-27-12 by the Unit Manager for all residents receiving tube feeding to ensure all tube feeding was being administered per physician's order. No problems noted.  2.b. 100% audit was completed by the Unit Managers on 4-27-12 for all residents with orders for oxygen administration to ensure all oxygen was being administered per physician's order. No problems noted.		

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F 281	<p>Continued From page 3 report) were used by the facility to ensure accurate delivery of medications and treatments to all residents. The policy also revealed observation, audits, and monitoring would be performed randomly to ensure compliance with safety.</p> <p>A review of the facility's policy titled "Tube Feeding administration," dated October 2004, revealed tube feedings would be administered as ordered by the resident's physician.</p> <p>An interview conducted on 04/26/12, at 4:30 PM, with the Director of Nursing (DON), revealed the facility did not have a policy related specifically to oxygen administration.</p> <p>A review of the medical record for Resident #1 revealed the facility admitted the resident on 08/27/10, with diagnoses that include Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, Vitamin Deficiency, Anemia, and Decubitus Ulcer.</p> <p>A review of a significant change Minimum Data Set (MDS) for Resident #1 dated 03/25/12, revealed the facility assessed the resident to have moderately impaired cognition.</p> <p>A review of the physician's orders for Resident #1 dated 03/20/12, revealed Speech Therapy was to treat the resident five times a week for twelve weeks for swallowing therapy and neuromuscular electrical stimulation (NMES).</p> <p>A review of the physician's orders for Resident #1 revealed an order dated 04/01/12, for the resident to receive nothing by mouth and the only nutrition</p>	F 281 3.	<p>An inservice was conducted by the Staff Development Coordinator on 4-27-12 for all licensed Nursing staff related to following physician's orders.</p> <p>All telephone orders are received daily, Monday through Friday by the DON, ADON, MDS Coordinator, Rehab Manager and Unit Managers to ensure physician orders are being implemented and followed.</p> <p>All resident charts will be reviewed by the DON, ADON, MDS Coordinator and Unit Managers monthly with physician order change over to ensure orders were implemented and followed.</p> <p>3.a. An inservice was conducted by the Staff Development Coordinator on 4-27-12 for all licensed Nursing staff, Rehab staff, and CNAs related to tube feeding administration and communication to licensed staff of any resident returning to a room unhooked from tube feeding.</p> <p>3.b. An inservice was conducted by the Staff Development Coordinator on 4-27-12 for all licensed staff related to oxygen administration per physician's order.</p> <p>4. Audits will be completed by the DON, ADON, and MDS Coordinator daily, Monday through Friday ongoing for all physician telephone orders to ensure implementation of the order. The DON, ADON and MDS Coordinator will audit 5 resident charts comparing orders to care being provided, weekly x 4 weeks, then 5 resident charts monthly x 4 months to ensure the implementation of the physician orders are being followed. The results of the audits will be reviewed in the monthly Performance Improvement (PI) Committee meeting.</p>	

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F 281	<p>Continued From page 4</p> <p>the resident would be receiving was by gastrostomy tube. A review of the physician's orders also revealed a telephone physician's order dated 04/02/12, for Jevity 1.2 (1.2 calories per milliliter) nutrition to be administered at 55 milliliters per hour by gastrostomy tube for 22 hours every day.</p> <p>A review of the Speech Therapy Treatment Note for Resident #1 dated 04/24/12, at 1:56 PM, revealed the resident was in therapy receiving speech therapy at that time.</p> <p>Observation of Resident #1 on 04/24/12, at 3:20 PM, in the Therapy Department revealed the resident's tube feeding had been disconnected from the resident and was not being administered.</p> <p>Additional observations were conducted of Resident #1 in his/her bedroom on 04/24/12, at 4:35 PM, 5:10 PM, 5:40 PM, 6:00 PM, and 6:15 PM, and revealed the tube feeding continued to be disconnected from the resident and was not being administered.</p> <p>Observation on 04/24/12, at 6:18 PM, revealed Licensed Practical Nurse (LPN) #5 reconnected the tube feeding and programmed the tube feeding to be administered at 55 milliliters per hour through the resident's gastrostomy tube.</p> <p>An interview was conducted on 04/24/12, at 7:45 PM, with LPN #5 and revealed she was responsible for the care of Resident #1 on 04/24/12, from the hours of 3:00 PM to 11:00 PM. The LPN stated the resident had been taken to the Therapy Department on 04/24/12, prior to her</p>	F 281	<p>4.a. Physician orders for all new admit and readmit residents receiving tube feeding will be reviewed daily, Monday through Friday, in the Clinical Meeting by the DON, ADON, and MDS Coordinator to ensure all tube feeding is being administered per order, care plan and care guides updated.</p> <p>Audits will be completed by the DON, ADON, and MDS Coordinator daily, Monday through Friday x 4 weeks, weekly x 4 weeks, then monthly x 4 months on all residents receiving tube feeding to ensure tube feeding is being administered per order. The results of the audits will be reviewed in the monthly Performance Improvement (PI) meeting. Revisions will be made to the systems as indicated.</p> <p>4.b. Physician orders for all new admit and readmit residents receiving oxygen will be reviewed daily, Monday through Friday in the Clinical Meeting by the DON, ADON and MDS Coordinator to ensure all oxygen is being administered per order, care plan and care guides updated.</p> <p>Audits will be completed by the DON, ADON, and MDS Coordinator daily, Monday through Friday x 4 weeks, weekly x 4 weeks, then monthly x 4 months on all residents receiving oxygen to ensure oxygen is being administered per order. The results of the audits will be reviewed in the monthly Performance Improvement (PI) Committee meeting. Revisions will be made in the systems as indicated.</p>	6-1-12

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F 281	<p>Continued From page 5</p> <p>coming on shift and she was unaware the resident had returned to the room because the speech therapist had failed to notify her when the resident was brought back to the unit. The LPN stated she had been very busy and had not checked the resident's room to see if he/she had returned from therapy. The LPN stated the resident was usually only gone about an hour and she had not thought to call to check with Therapy.</p> <p>An interview conducted with the Speech Language Pathologist (SLP) on 04/25/12, at 8:45 AM, revealed the resident's tube feeding was disconnected by the nursing staff and the resident was then brought to the Therapy Department by the SLP. The SLP stated she does not usually notify the nurse when she brings a resident back to their room and had not notified the nurse when she returned the resident to the room. The SLP stated the resident had been in therapy until around 4:00 PM, when the SLP stated she returned the resident to his/her room and had not notified the nurse of the resident's return.</p> <p>An interview conducted on 04/26/12, at 6:05 PM, with the Director of Nursing (DON) revealed it was the responsibility of the nurses to ensure residents were provided the care they required. The DON stated nurses were expected to make rounds on the residents at least every two hours. In addition, the DON stated Therapy staff was expected to notify the nurse after returning a resident to their room.</p> <p>Continued review of Resident #1's medical record revealed an order dated 03/19/12, for oxygen to be administered at 5 liters per minute by nasal cannula. However, observation of Resident #1</p>	F 281			

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F 281	Continued From page 6 on 04/24/12, at 12:37 PM, 3:20 PM, 4:35 PM, 5:10 PM, 5:40 PM, 6:00 PM, and 6:15 PM, revealed oxygen was being administered at 4.5 liters per minute by nasal cannula.  Observation of Resident #1 on 04/25/12, at 9:05 AM, revealed oxygen was administered at 4 liters per minute per nasal cannula. In addition, observation conducted on 04/25/12, at 10:30 AM, 11:20 AM, 2:15 PM, and 3:20 PM, and on 04/26/12, at 9:00 AM, 10:15 AM, and 11:35 AM, revealed the resident's oxygen was being administered at 4.5 liters per minute by nasal cannula.  An interview conducted with LPN #5 on 04/26/12, at 5:00 PM, revealed she had provided care to Resident #1 on the day shift on 04/24/12, 04/25/12, and 04/26/12. LPN #5 acknowledged she had failed to ensure the resident's oxygen was administered at 5 liters per nasal cannula as prescribed by the physician. The LPN stated she had conducted observations of the resident at east every two hours and had failed to catch the error.  An additional interview conducted with the DON on 04/26/12, at 6:05 PM, revealed nurses were responsible to ensure oxygen was delivered in accordance with physician's orders. The DON stated she makes rounds daily on every resident to ensure they are being provided the care they require but failed to identify the resident's oxygen was not administered in accordance with the physician's order. The DON stated she did not know why the error had not been found.	F 281			
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282			

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F 282	Continued From page 7  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 review of facility policies, it was determined the facility failed to provide services in accordance with four of twenty sampled residents' written plan of care. The facility failed to ensure two staff persons assisted Resident #9 with toilet use and failed to ensure the resident was utilizing a pad alarm for the resident's wheelchair and bed. Resident #9 sustained three falls, two when the resident attempted to transfer independently, and one when the resident was left on the toilet unsupervised. The facility also failed to implement care plans for Residents #3 and #15 related to the number of staff required when transferring the residents. The facility assessed and developed a care plan that required two staff persons to transfer the residents. Observation on 04/26/12, revealed staff failed to assist Resident #15 with transfers and interviews with staff revealed the resident could transfer independently. On 04/19/12, staff transferred Resident #3 with the assistance of one staff member. Resident #3 fell and sustained skin tears (refer to F323). The facility also failed to ensure Resident #1's care plan for hipsters was implemented.  The findings include:	F 282	1. Resident #1's hipsters were placed on resident on 4-26-12 to match care plan and care guide.  Resident #9's pad alarm was placed in use on 4-25-12 to match care plan and care guide.  The Staff Development Coordinator inserviced all Nursing staff related to assistance required for toilet use and transfers per care plan and care guide for resident #9 on 4-27-12.  The Staff Development Coordinator inserviced all Nursing staff related to assistance required for transfers for resident #3 and #15 per care plan and care guides on 4-27-12.  1.a. Care plans for residents #9, #3, #15 and #1 were reviewed by the DON and ADON on 4-27-12 to ensure appropriate interventions were in place. These care plans were found to be appropriate based on the needs of the residents.  2. 100% audit of all resident's care plans was completed on 5-16-12 by the DON, MDS Team, Unit Managers, and ADON to ensure appropriate interventions were in place to reflect the care provided to the residents and that the care plans are being implemented and followed. No problems noted.  3. All licensed staff and Certified Nursing Assistants were inserviced on 5-2-12 by the Staff Development Coordinator related to the implementation and following of resident's care plans.	

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F 282	<p>Continued From page 8</p> <p>A review of the Resident Care Plan Policy, revised December 2008, revealed the resident care plan was a brief written portrait of the resident and an individualized guide of the nursing care needed. The care plan policy stated the essentials of an overall plan of care included the identification of problems and needs, objectives or goals, and methods, approaches, or plan: description of what is actually going to be done for, to, or with the resident in order to achieve the goals.</p> <p>A review of the Daily Care Guidelines (undated) revealed the guidelines were a communication tool to communicate accurate information to the certified nursing assistants relative to maintaining continuity of care for resident and address facility-specific information.</p> <p>Interview with the Director of Nursing (DON) and the Rehabilitation (Rehab) Manager on 04/26/12, at 4:50 PM, revealed on a monthly basis department heads audited a specific number of resident care plans/guides to ensure care was being implemented as planned.</p> <p>1. Observation of Resident #9 on 04/24/12, at 6:05 PM, revealed he/she was sitting on the floor in the bathroom of the resident's room. The resident stated he/she attempted to get off the toilet unassisted and when he/she reached for the wheelchair, the wheelchair slid causing the resident to fall. There were no alarms sounding in the resident's room. Observation revealed a pad alarm (pad for the seat of a chair or bed that alarms when there is no pressure on the pad) was not being utilized for the resident.</p>	F 282	<p>4. All care plans for new admit and readmit residents will be reviewed daily, Monday through Friday in the Clinical Meeting by the DON, ADON, and MDS Coordinator to ensure appropriate interventions are being implemented based on the needs of the residents and being followed. The DON, ADON, and MDS Coordinator will audit 5 resident care plans weekly x 4 weeks, then 5 resident care plans bi-weekly x 4 weeks, then 5 resident care plans monthly x 4 months, to ensure appropriate interventions are being implemented based on the needs of the residents and being followed as listed on the care plan and care guide. The results of the audits will be reviewed in the monthly Performance Improvement (PI) Committee meeting. Revisions will be made to the systems as indicated.</p> <p>Audits will be completed by the DON, ADON, and Unit Managers daily, Monday through Friday x 4 weeks, weekly x 4 weeks, then monthly x 4 months on all residents with care plans requiring a 2 person assist transfer to ensure appropriate interventions are being implemented and followed. The results of the audits will be reviewed in the monthly Performance Improvement (PI) Committee meeting. Revisions will be made to the systems as indicated.</p>	6-1-12	

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F 282	<p>Continued From page 9</p> <p>A review of Resident #9's care plan initially dated 03/08/10, and revised March 2011 revealed the facility identified the resident was at risk for falls. The care plan revealed staff was required to assess the resident's need for assistive/supportive devices, instruct the resident on appropriate use of assistive/supportive devices, and maintain the resident's environment free of clutter and safety hazards.</p> <p>A review of the Daily Care Guide for Resident #9 revealed staff was required to check the alarming bed/chair pad for placement and proper functioning every shift and as needed. The care guide further revealed Resident #9 required assistance of two staff persons for mobility/transfers.</p> <p>An interview with Resident #9 on 04/25/12, at 9:46 AM, revealed the resident did not have a pad alarm in the wheelchair and had not had one since the resident first came to live at the facility approximately two years ago.</p> <p>Further observation of Resident #9 on 04/25/12, at 10:35 AM, revealed SRNA #9 was placing a pad alarm in the resident's wheelchair and had a pad alarm for the resident's bed. An interview with SRNA #9 revealed the resident "used to have one [pad alarm]," but the wires on the alarm became frayed and were taken out of the resident's wheelchair. The SRNA stated it had "been a long time" since the resident had an alarm in the chair. "Since [the resident] first came in I guess," the SRNA stated. The SRNA further stated the resident had lived at the facility for approximately two years.</p>	F 282			

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F 282	<p>Continued From page 10</p> <p>Interviews with State Registered Nursing Assistants (SRNAs) #16 and #17 on 04/25/12, at 10:40 AM, and SRNAs #18 and #19 on 04/25/12, at 4:15 PM, revealed the resident used to have a pad alarm for the chair and bed, but it had been months since the alarm had been used.</p> <p>Licensed Practical Nurse (LPN) #1 on 04/25/12, at 4:12 PM, revealed Resident #9 had not utilized a pad alarm since at least September 2011. An interview with LPN #5 on 04/26/12, at 5:10 PM, revealed Resident #9 had not had a pad alarm for the bed or wheelchair since March 2012.</p> <p>An interview was conducted with LPNs #9 and #10 on 04/26/12, at 10:40 AM. LPN #10 was aware the resident was required to have a pad alarm, but the wires on the alarm became frayed and the facility had to order a new alarm. LPN #10 stated the pad alarm should have been discontinued. According to SRNA #16 on 04/26/12, at 11:50 AM, the SRNA was aware Resident #9's care plan required the resident to have a pad alarm, but the resident had not had one in months. The SRNA stated she was not sure why the resident did not have a pad alarm.</p> <p>Interview with the DON and Rehab Manager on 04/26/12, at 4:50 PM, revealed they investigated the fall sustained by Resident #1 on 04/24/12, and during the investigation realized Resident #9 was not utilizing a pad alarm for the bed/chair. The DON stated she was not aware how long the resident's pad alarm had not been on the resident's bed and chair.</p> <p>Further review of Resident #9's care plan initially dated 03/08/11, and revised March 2011 revealed the facility identified the resident was at risk for</p>	F 282			

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F 282	<p>Continued From page 11</p> <p>falls and required staff to give verbal cues and reminders not to ambulate or transfer without assistance. A review of the Daily Care Guide for Resident #9 revealed two staff persons were required to prompt and assist the resident with toileting every two hours and as needed.</p> <p>Further review of nursing fall assessments for Resident #9 revealed the resident fell on 02/10/12; when SRNAs took the resident to the bathroom toilet, the resident tried to stand up, and slid down to the floor. A review of the facility's investigation dated 02/10/12, revealed a SRNA assisted the resident to the bathroom and instructed the resident to pull the call light when he/she was finished. The investigation further revealed the resident attempted to stand without assistance and fell on the bathroom floor. There was no evidence the facility took action to ensure Resident #9's care plan was implemented and assistance was provided with toileting.</p> <p>Further observation of Resident #9 on 04/26/12, at 10:30 AM, with LPN #9 revealed the resident was in the bathroom, on the toilet, in the resident's room without staff assistance. The resident was bending forward, leaning off the toilet, with a urine collector in his/her hand. An interview with LPN #9 revealed staff had assisted the resident to the toilet and the resident would ring the call light when he/she was finished.</p> <p>Interview with SRNA #9 on 04/26/12, at 12:40 PM, revealed she and another SRNA had transferred Resident #9 to the toilet earlier that morning. The SRNA left the resident on the toilet and instructed the resident to ring the call light when he/she was finished. SRNA #9 stated she</p>	F 282			

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F 282	<p>Continued From page 12</p> <p>was not sure what the resident's care plan stated about assisting the resident with toileting. After the SRNA reviewed Resident #9's care guide, she stated the care guide did not state how much assistance Resident #9 required for toileting.</p> <p>An interview with SRNA #16 on 04/26/12, at 11:50 AM, revealed Resident #9 was not safe to transfer independently and should not be alone in the bathroom by his/her self.</p> <p>An interview with the DON and Rehab Manager on 04/26/12, at 4:50 PM, revealed the facility was aware staff was leaving Resident #9 in the bathroom without staff assistance and had not identified that the resident being left alone on the toilet was a concern, even though the resident was assessed to require the assistance of two staff persons with toileting and the care guide stated staff was required to assist the resident with toileting.</p> <p>2. A review of Resident #3's care plan dated 04/08/12, revealed the facility developed a care plan related to the resident's impaired physical functioning. The care plan revealed the resident required the assistance of one to two staff persons for transfers and ambulation.</p> <p>A review of "Nursing Assessment of Fall" dated 04/19/12, at 12:55 PM, revealed a SRNA (State Registered Nursing Assistant) was attempting to transfer Resident #3 from wheelchair to bed. The resident lost his/her balance and was assisted to the floor by the SRNA. The resident sustained three skin tears to the left arm.</p> <p>A review of the Incident Follow-Up and</p>	F 282			

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F 282	<p>Continued From page 13</p> <p>Recommendation Form signed by the Director of Nursing and the Administrator on 04/23/12, revealed Resident #3 was being transferred from the chair to bed when the resident lost his/her balance and was assisted to the floor by a SRNA.</p> <p>A review of Resident #3's daily care guide dated 04/25/12, at 6:35 AM, revealed the resident required the assistance of two staff persons for transfers and mobility (walking).</p> <p>Observation of Resident #3 on 04/24/12, at 2:00 PM and 5:00 PM, and 04/26/12, at 10:30 AM, revealed the resident had a dressing to the left lower arm and steri-strips on the resident's left hand. Interview with Licensed Practical Nurse (LPN) #10 on 04/26/12, at 10:30 AM, revealed the resident sustained the skin tears as a result of a fall.</p> <p>An interview with LPN #5 on 04/26/12, at 5:10 PM, revealed Resident #3 required the assistance of two people when transferring because the resident was weak.</p> <p>Interview with SRNA #20 on 04/26/12, at 5:08 PM, revealed she was assisting Resident #3 from the wheelchair to bed when the resident's knees "buckled" and the resident fell. The SRNA stated she tried to catch the resident, but the resident's arm hit the side rail on the bed causing the skin tears to the resident's arm. SRNA #20 further stated that at the time of the fall, staff was transferring the resident with the assistance of one staff member. But after the resident fell, they decided two staff members needed to assist the resident. The SRNA stated she was "pretty sure" the resident care guide stated one person was</p>	F 282		

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F 282	<p>Continued From page 14 required when transferring Resident #3.</p> <p>Interview with the DON and the Rehabilitation Manager on 04/26/12, at 4:50 PM, revealed the DON was aware only one staff member was transferring Resident #3 when the resident fell, but did not identify this as a concern because the resident's care plan stated one to two staff members were required for transfers. The DON stated some days the resident may require two staff members and it was up to the SRNAs to decide how much assistance the resident required. The DON was not aware the Daily Care Guide for Resident #3 required two staff members to assist the resident.</p> <p>3. A review of Resident #15's care plan initially dated 08/02/11 and revised 04/19/12, revealed the facility identified the resident was at high risk for falls and required assistance with Activities of Daily Living (ADLs). The care plan stated the resident required one to two staff members for toilet use, the resident was high risk for falls, and the resident required encouragement to use the call light for assistance.</p> <p>A review of the Daily Care Guide revealed Resident #15 required the assistance of two staff members for mobility, transfers, and toilet use.</p> <p>Observation of Resident #15 on 04/26/12, at 5:24 PM, revealed the resident transferred independently from the bed and walked to the bathroom. The resident was observed to hold on to objects as he/she walked to the bathroom. The resident stated he/she could get up alone.</p> <p>Interview with LPNs #4 and #5 on 04/26/12, at</p>	F 282			

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F 282	<p>Continued From page 15</p> <p>5:26 PM, revealed Resident #15 could transfer independently and go to the bathroom alone.</p> <p>Interview with the Rehab Manager on 04/26/12, at 6:00 PM, and SRNA #21 on 04/26/12, at 7:39 PM, revealed Resident #15 could walk without assistance. SRNA #21 stated if the resident needed assistance to go to the bathroom, he/she would ring his/her call light; otherwise, the resident could go to the bathroom independently.</p> <p>Interview with the DON and nurse consultant on 04/26/12, at 7:30 PM, revealed Resident #15 required one to two staff persons for transfers per the resident's care plan, but the DON believed the resident had improved since admission and could transfer and ambulate independently. However, an interview with the MDS Coordinator on 04/26/12, at 8:00 PM, revealed that based on the ADL tracking for 04/10-16/12 (the assessment reference period), the facility would continue to assess the resident to need extensive assistance of two staff persons for transfers, ambulation, and toilet use.</p> <p>4. A review of a nursing assessment completed after a fall Resident #1 sustained on 04/10/12, at 5:00 PM, revealed the resident had fallen out of bed while turning in the bed. Documentation in the assessment revealed the resident sustained a hematoma to the right side of the head and a skin tear to the left upper arm. A review of the comprehensive care plan for Resident #1 revealed the care plan had been updated on 04/10/12, to include an intervention for the resident to have "hipsters" (hip protectors) on at all times.</p>	F 282			

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F 282	<p>Continued From page 16</p> <p>A review of a Daily Care Guide dated 04/16/12, and utilized by the staff to identify care needs of Resident #1 revealed the resident was required to have hip protectors on at all times.</p> <p>Observation conducted on 04/24/12, at 6:55 PM, revealed State Registered Nursing Assistants (SRNAs) #14 and #16 provided incontinence care for Resident #16. Observation of the resident during the incontinence care revealed the "hipster" was not utilized for Resident #6.</p> <p>An interview conducted with SRNA #16 on 04/24/12, at 7:30 PM, revealed she was required to check the Daily Care Guide at least every shift to find what care was required by the residents. The SRNA acknowledged "hipsters" had been identified on the daily care guide for Resident #1, and stated she had forgotten to put them on the resident.</p> <p>An interview conducted with SRNA #14 on 04/25/12, at 3:30 PM, revealed the SRNA was aware Resident #1 should have had hipsters on. The SRNA stated she was expected to check the Daily Care Guide at the beginning of her shift to find the information regarding the care that was required by the residents. The SRNA stated she was unsure why she had not put the hipsters on the resident.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #5 on 04/24/12, at 6:20 PM, revealed the SRNAs were required to check the Daily Care Guide at the beginning of every shift. The LPN stated she also checks the Daily care Guide as well as the comprehensive care plan. The LPN stated Resident #1 should have had</p>	F 282		

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F 282	Continued From page 17 hipsters. The LPN stated she was required to make rounds at least every two hours to ensure the residents were being given the care they required, but failed to identify that the resident did not have hipsters on.  An interview conducted with the Director of Nursing (DON) on 04/26/12, at 6:05 PM, revealed nurses were required to check the comprehensive care plan and the Daily Care Guide every day. The DON also revealed the SRNAs were also required to check the Daily Care Guide at the beginning of every shift to identify the care needs of each resident. The DON revealed the nurses are expected to make rounds at least every two hours to ensure the residents are getting the care they require. The DON stated she makes rounds on every resident daily to ensure they are getting the care they require. The DON stated Resident #1 should have had hipsters on and was unsure why the nurse had not identified the problem.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the facility failed to ensure appropriate	F 309 I.a.	Resident #6 was started on antibiotic and cough syrup on 4-21-12 for upper respiratory infection. Resident exhibited a change in condition on 4-24-12. Resident was assessed by the Unit Manager and physician was notified and an order received to send the resident to the hospital for an evaluation. Family was notified.  Resident returned to facility on 5-6-12.  Resident #6 care plan was updated to reflect aspiration precautions. A care plan was implemented regarding resident #6 not adhering to aspiration precaution recommendations.	

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F 309	<p>Continued From page 18</p> <p>transfer techniques were utilized for two of twenty sampled residents (Residents #9 and #11). Staff was observed to transfer Residents #9 and #11 without utilizing gait belts and by lifting the residents under their arms. In addition, based on the facility's policy on Aspiration Precautions and a Speech and Language Pathologist's (SLP) recommendations for Aspiration Precautions for Resident #6, the physician had ordered Aspiration Precautions to be utilized for the resident. Resident #6 was observed to be feeding herself unsupervised, and the resident's Head of the Bed (HOB) was not elevated per SLP recommendations.</p> <p>The findings include:</p> <p>A review of the facility's Assisting Resident from Chair to Bed Policy/Procedure, no date given, revealed the staff was to support the resident by placing a belt around the resident's waist to hold and steady the resident. Further review of the facility's Body Mechanics/Transfer Training Demonstration Checklist, dated 11/01/06, revealed staff was to demonstrate appropriate transfer techniques using a gait belt or mechanical lift. The Checklist was to be initialed by the staff member to denote he/she had been instructed on proper procedures, proper use of a gait belt, and not lifting residents under their arms/pulling on arms. According to the Checklist, this is to be completed upon hiring and annually thereafter.</p> <p>An interview with the Director of Nursing (DON) and Rehab Manager on 04/26/12, at 4:50 PM, revealed when new SRNAs were hired, Therapy in-serviced them on proper transfer techniques</p>	F 309	<p>1.b. Head to toe assessment was completed on resident #9 and #11 by the Unit Manager on 4-27-12 and no adverse effects noted related to Certified Nurse's Assistant not utilizing gait belts during transfers. DON interviewed all CNAs to ensure that gait belts were available for use and in use when assisting residents that require gait belts.</p> <p>2.a. 100% audit was completed by the DON and ADON and Unit Managers on 4-27-12 to ensure all residents with an order for aspiration precautions were followed per facility policy. No problems noted.</p> <p>2.b. 100% audit was completed by the Unit Managers on 4-27-12 to ensure all residents with an order for a 2 person assist transfer were being followed per facility policy utilizing gait belts. No problems noted.</p> <p>3.a. An inservice was conducted on 4-30-12 by the Staff Development Coordinator and the Speech and Language Pathologist for all licensed staff, Rehab staff, and Certified Nurse's Assistants related to aspiration precautions and facility's revised system for identifying all residents with aspiration precautions. Once an order is written for a resident to have aspiration precautions, the Nursing staff will place a blue bracelet on the resident, implement a care plan with appropriate interventions, and place on the resident's care guides. If the Speech and Language Pathologist recommends any precautions other than standard aspiration precautions, they will develop a functional maintenance plan and all staff will be educated on it. The plan will be placed in the Restorative Plan Binder for easy access to all staff.</p>		

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F 309	<p>Continued From page 19</p> <p>and the new staff had to complete a demonstration of transfers. According to the DON, if a resident required extensive assistance of two staff persons for transfers, some of the residents would require a gait belt for steadying the resident. The DON stated if a resident required a gait belt, it would be documented on the resident's care guide as a need. According to the Rehab Manager, staff should not pull on residents' arms.</p> <p>A review of the facility's Policy for Aspiration Precautions, dated June 2006, revealed residents placed on Aspiration precautions were to be supervised during all intake, the resident's bed should be positioned upright, to a 90-degree angle, for all intake, and the resident was to be reminded to take small bites of food and small sips of water.</p> <p>1. On 04/24/12, at 1:00 PM, two State Registered Nursing Assistants (SRNAs) were observed to transfer Resident #11 from a chair to the bed. The staff was observed to lift the resident from the wheelchair by placing their arms under Resident #11's armpits and holding the waistband of the resident's clothing to assist the resident to the bed.</p> <p>Interview with State Registered Nursing Assistant #3 (SRNA) on 04/26/12, at 10:37 AM, revealed SRNAs were to review each resident's care guide that had been developed by staff to identify transfer needs for each resident. SRNA #3 stated she did use a gait belt to assist a resident to walk, but not at other times.</p> <p>An interview with SRNA #2 at 10:40 AM on</p>	F 309  3.b.  4.a.	<p>An inservice was conducted on 4-30-12 by the Staff Development Coordinator for all licensed Nursing staff and Certified Nursing Assistants related to the facility policy on gait belt utilization for a 2 person assist transfer.</p> <p>Physician orders for all new admit and readmit residents with an order for aspiration precautions will be reviewed daily, Monday through Friday in the Clinical Meeting by the DON and ADON to ensure all residents with aspiration precautions are identified per facility's revised system and aspiration precautions are being followed per order, care plan and care guides updated and revised as indicated.</p> <p>Five audits will be completed by the DON, ADON, and Unit Managers daily, Monday through Friday x 4 weeks, weekly x 4 weeks, then monthly x 4 months on all residents with order for aspiration precautions to ensure the precautions are being followed by the staff, care plan and care guides are revised as indicated.</p> <p>The results of the audit will be reviewed in the monthly Performance Improvement (PI) Committee meeting. Revisions will be made to the system as indicated.</p>	

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F 309	<p>Continued From page 20</p> <p>04/26/12, revealed she did not use a gait belt to assist residents and stated, "It's [gait belt] in my car."</p> <p>An interview with SRNA #4 on 04/26/12, at 10:45 AM, revealed SRNA #4 asked other SRNAs to assist if a resident required total care. SRNA #4 also stated she did not utilize a gait belt to assist residents with transfers.</p> <p>2. Observation of Resident #9 on 04/26/12, at 10:30 AM, revealed the resident was on the toilet in the resident's bathroom. SRNAs #16 and #9 were observed transferring Resident #9 from the toilet by pulling the resident by the resident's arms. Once the resident was off the toilet, staff held the resident's shirt and underneath the resident's arms to transfer the resident to the toilet.</p> <p>A review of Resident #9's Annual Minimum Data Set (MDS) assessment signed as complete on 07/13/11, and quarterly MDS assessment signed as complete on 03/19/12, revealed the facility assessed the resident to require extensive assistance of two or more people for transfers and walking in the resident's room.</p> <p>A review of Resident #9's Daily Care Guide revealed the resident required the assistance of two staff members for transferring and mobility.</p> <p>Interview with SRNA #9 on 04/26/12, at 11:40 PM, revealed the SRNA "got under [Resident #9's] arm" to help pull the resident up off the toilet. The SRNA stated she did not use a gait belt to transfer the resident, but should have. The SRNA was observed opening a new gait belt and placing</p>	F 309 4.b.	<p>When the care plans are completed on new admit and readmit residents the MDS Coordinator will bring care plans to the daily Clinical Meeting, Monday through Friday, to review for identification of residents requiring 2 person assist transfers, to ensure care guides are updated and followed to reflect resident needs per facility policy.</p> <p>Five audits will be completed by the DON, ADON, and Unit Managers daily, Monday through Friday x 4 weeks, weekly x 4 weeks, then monthly x 4 months on residents with a care plan for a 2 person assist transfer to ensure gait belt utilization per facility policy. The results of the audits will be reviewed in the monthly Performance Improvement (PI) Committee meeting. Revisions will be made to the systems as indicated.</p>	6-1-12	

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F 309	<p>Continued From page 21 it around her waist.</p> <p>An interview with SRNA #16 on 04/25/12, at 10:40 AM, revealed the SRNA would use a gait belt to assist with transferring residents. SRNA #16 stated the resident's care plan should state whether or not the resident required a gait belt. At that time, SRNA #16 stated her gait belt was in her locker. Further interview with SRNA #16 on 04/26/12, at 11:50 AM, revealed she had assisted Resident #9 with transferring, but did not use a gait belt because she was told the resident was on the toilet unassisted, so she (SRNA #16) hurriedly went in to assist the resident without a gait belt.</p> <p>3. A review of the physician's orders dated 04/01/12, revealed Resident #6 was to be on Aspiration precautions and the head of the resident's bed was to be elevated at all times. The physician's orders also revealed Resident #6 was never to be left lying flat. In addition, a review of the care plan dated 09/01/11, for Resident #6 revealed the head of Resident #6's bed was to be elevated at all times. The care plan also indicated the resident was on safe swallowing precautions and compensatory strategies were to be utilized.</p> <p>Observation of Resident #6 on 04/24/12, during breakfast and lunch revealed Resident #1 ate breakfast and lunch in his/her room. Facility staff was not observed in attendance during these meals. The head of Resident #6's bed was observed to be elevated at a 15-degree angle at 11:30 AM. Additional observations were conducted at 12:00 PM and 2:15 PM. At 12:00 PM, Resident #6 was observed to be eating</p>	F 309			

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F 309	<p>Continued From page 22</p> <p>unattended with the head of the bed flat. At 2:15 PM, Resident #6 was observed to lying in bed with the head of the bed slightly elevated at 15 degrees.</p> <p>An interview conducted with LPN #9 on 04/24/12, at 10:00 AM, revealed Therapy staff was to notify Nursing if a resident required aspiration precautions.</p> <p>An interview was conducted with the Speech and Language Pathologist (SLP) on 04/25/12, at 11:00 AM. The SLP stated the Therapy Department was responsible to provide staff education for swallowing precautions. The SLP stated Resident #6 was alert and oriented and had received education related to precautions at meals. The SLP stated once the evaluation and education was complete, Therapy staff did not monitor the resident's compliance.</p> <p>An interview was conducted with the Social Services Director on 04/25/12, at 1:25 PM. The Social Services Director stated that different disciplines would receive different education in relation to the staff's educational needs. The Social Services Director stated if aspiration precautions were not followed with a resident requiring aspiration precautions, it could result in the resident's death or pneumonia.</p> <p>An interview was conducted with SRNA #9 on 04/25/12, at 11:00 AM. SRNA #9 stated the head of Resident #6's bed was to be elevated when the resident was eating.</p> <p>An interview was conducted with SRNA #10 on 04/25/12, at 11:15 AM. The SRNA stated staff</p>	F 309			

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F 309	Continued From page 23 was required to monitor residents identified to be at risk for aspiration for signs/symptoms of choking during meals. SRNA #10 stated that he/she was unaware Resident #6 was at risk for aspiration.  An interview was conducted with SRNA #12 on 04/25/12. SRNA #12 stated Resident #6 was to receive small bites of food during meals and the head of Resident #6's bed was to be elevated 90 degrees after meals. SRNA #12 stated resident care guides informed staff of the required treatments/compensatory techniques to be utilized during and after the resident's meal time.  An interview was conducted with SRNA #6 on 04/25/12, at 4:00 PM. SRNA #6 stated residents on swallowing precautions should have their beds elevated at a 45 degree angle after the resident finished a meal. SRNA #6 stated the staff was to monitor each resident during mealtimes.  An interview was conducted with SRNA #1 on 04/25/12, at 4:30 PM. SRNA #1 stated staff had received education on swallowing precautions and there were three residents on swallowing precautions.	F 309		
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	F 314	1.b. Resident #1 was assessed on 5-1-12 by the Unit Manager, no adverse effects were noted related to treatment record being initialed prior to providing treatment as ordered and dressing not being intact per order.  2.a. 100% audit was completed on 5-1-12 by the DON and ADON on all residents with physician orders for wound care to ensure correct hand washing techniques and gloves changed when needed while providing wound care. No problems noted.	

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F 314	Continued From page 24 prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of facility policy, the facility failed to ensure two of twenty residents (Residents #1 and #2) received necessary treatment to promote healing and prevent infections of pressure sores. Observations of wound care for Resident #2 on 04/25/12, revealed staff failed to wash hands/change gloves between wound treatments. In addition, observations on 4/24/12, revealed staff failed to provide treatment as ordered for Resident #1.  The findings include:  A review of the facility's Wound Care Policy/Procedure, no date given, revealed that all treatments were to be documented and the nurse was responsible for the administration and the recording of all treatments according to the physician's orders.  1. Observations of wound care for Resident #2 on 04/25/12, at 11:15 AM, revealed Licensed Practical Nurse (LPN) #7 removed the soiled dressing from the resident's pressure sore on the coccyx with gloved hands, cleansed the wound on the resident's coccyx, changed gloves, and applied a clean dressing to the coccyx wound. However, the nurse failed to wash her hands between the glove changes. LPN #7 then applied skin prep to the resident's heels without washing hands or changing gloves.	F 314	2.b. 100% audit was completed on all residents receiving wound care by the DON and ADON on 5-1-12 to ensure all records were initialed after wound care was completed per facility policy. No problems noted.  3.a. An inservice was conducted by the Staff Development Coordinator on 5-1-12 for all licensed staff related to hand washing, changing gloves, and placement of dressing per order when providing wound care.  The Staff Development Coordinator will perform random observations of all licensed staff and new licensed staff upon hire to ensure correct hand washing techniques, changing gloves, and placement of dressings per order are being followed per facility policy.  3.b. An inservice was conducted by the Staff Development Coordinator on 5-1-12 for all licensed staff related to providing wound care prior to initialing treatment administration record per facility policy.  4.a. The DON, ADON, and Unit Managers will audit all residents receiving wound care to ensure proper hand washing techniques, changing gloves, and placement of dressings per order to follow facility policy daily, Monday through Friday x 4 weeks, weekly x 4 weeks, then monthly x 3 months.  The results of the audits will be reviewed at the monthly Performance Improvement (PI) Committee meeting. Systems will be updated and revisions made as indicated.	

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F 314	<p>Continued From page 25</p> <p>An interview with LPN #7 at 11:30 AM on 04/25/12, revealed the LPN did not think she needed to wash her hands after her gloves were removed because it was not a sterile procedure. LPN #7 acknowledged she should have washed her hands and changed gloves before treating Resident #2's heels.</p> <p>2. A review of the medical record for Resident #1 revealed a physician's order dated 03/28/12, to cleanse the area on the resident's left hip with Hibiclens (antiseptic antimicrobial skin cleanser), rinse the wound with normal saline, pat the area dry, and apply a wet to dry dressing. The procedure was to be performed twice a day.</p> <p>Observation of a skin assessment for Resident #1 on 04/24/12, at 7:05 PM, with the Unit Manager for the West Wing and the Assistant Director of Nursing (ADON) revealed the resident did not have a dressing as ordered by the physician on a pressure sore on the left hip.</p> <p>A review of the Treatment Administration Record (TAR) for Resident #1 revealed staff documented the wound care had been completed on the day shift of 04/24/12.</p> <p>An interview conducted with LPN #5 on 04/26/12, at 4:00 PM, confirmed the treatment had not been completed prior to the skin assessment observation. LPN #5 stated she initials/signs the treatment record prior to the provision of the treatment and acknowledged the treatment to Resident #1's hip had not been completed at the time of the skin assessment on 04/24/12.</p> <p>An interview conducted with the unit Manger on</p>	F 314 4.b.	<p>The DON, ADON, and Unit Managers will audit all residents receiving wound care to ensure the wound care is being completed prior to the treatment administration record being initialed, daily, Monday through Friday x 4 weeks, weekly x 4 weeks, then monthly x 3 months.</p> <p>The results of the audits will be reviewed at the monthly Performance Improvement (PI) Committee meeting. Systems will be updated and revisions made as indicated.</p>	6-1-12	

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F 314	Continued From page 26 04/26/12, at 4:12 PM, revealed the nurses were not supposed to sign the treatment records until the treatments had been provided.  An interview conducted on 04/26/12, at 6:05 PM, with the Director of Nursing (DON) also revealed nurses were not to sign the TARs until the treatments had been provided to the resident.	F 314			
F 323 SS=E	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 observations, interviews, record reviews, policy review, and a review of manufacturer's guidelines, the facility failed to ensure nine of twenty residents received adequate supervision and assistive devices to prevent accidents (Residents #1, #3, #5, #7, #8, #9, #11, #13, and #15). The facility failed to have an effective system to thoroughly investigate falls to determine the possible cause/contributing factors of each fall and failed to implement interventions to prevent further falls. The facility failed to identify Resident #9 was not utilizing a pad alarm for the bed and chair per the resident's care plan and failed to identify staff was not assisting Resident #9 with toileting as assessed	F 323	1. Resident #3 and #15's care guides and care plans were corrected to reflect a 2 person assist with transfers.  Resident #9's pad alarm was placed in use on 4-25-12 to match the care plan and care guides.  All staff was inserviced on 4-27-12 related to the staff assistance required for resident #3's transfers, being followed per the care plan and care guide.  1.a. Resident #1, #3, #5, #7, #8, #9, #11, #13 and #15 personal alarms were attached per manufacturer's recommendations  All personal alarms were reviewed by the Director of Nursing, Assistant Director of Nursing and Unit Managers on 4-30-12 and placed per manufacturer's recommendations.  1.b. The DON, ADON and Rehab Manager reviewed the facility system on investigating falls and implementing intervention to preventing further falls and to revise the system to include reviewing residents care plan, care guides, physician orders, and incident reports to assist the team with implementing care plan interventions.		

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F 323	<p>Continued From page 27</p> <p>and care planned. Resident #9 sustained three falls, two when the resident attempted to transfer to the toilet independently and one fall from the toilet when staff left the resident on the toilet unassisted. The facility also failed to ensure two staff members assisted Resident #3 with transfers as assessed and care planned. Resident #3 fell on 04/19/12, when one staff member assisted the resident to bed. The facility further failed to provide Resident #15 with the assessed and care planned assistance of two staff members for ambulation, transfers, and toilet use. Observation of Resident #15 and interview with staff revealed the resident was transferring, ambulating, and using the toilet independently (refer to F282). In addition, the facility failed to ensure personal alarms for Residents #1, #5, #7, #8, #11, and #13 were being utilized in accordance with manufacturer recommendations.</p> <p>The findings include:</p> <p>A review of the manufacturer's guidelines for the pullstring monitor setup revealed if using the pullstring monitor on a bed, staff was to clip the monitor to the bed mounting bracket. The guidelines also revealed staff was to ensure the pullstring monitor was always free of interference from environmental factors such as sweaters, blankets, and pillows.</p> <p>A review of the facility's policy entitled Chapter 7: Abuse Prevention "Managing Incidents and Fall," (undated) revealed all residents would benefit from a safe environment and an individualized plan of care. Falls and incident management policies included the following: provide timely</p>	F 323	<p>1.c. A therapy screen will be performed by 5-22-12 per therapy for resident #9 to assist and identify appropriate interventions for resident #9 related to falls when toileting. Identified needs for resident #9 per therapy screen will be implemented, care planned and revised as indicated.</p> <p>1.d. A therapy screen will be performed by 5-22-12 per therapy for resident #15 to assess for appropriate interventions related to resident ambulation needs. Identified needs for resident #15 per therapy screen will be implemented, care planned, and revised as indicated.</p> <p>2. 100% review of all care guides and care plans were completed to ensure all physician orders and interventions are being implemented, followed, and carried through. They were assessed to ensure all care guides and care plans matched and was being followed by the staff.</p> <p>2.a. 100% audit of all residents with an order for a personal alarm was completed on 5-2-12 by the Unit Managers to ensure proper placement of personal alarms per manufacturer's recommendations. No problems noted.</p> <p>2.b. 100% audit of all residents experiencing a fall in the past 60 days was completed by the DON, ADON, and MDS team on 5-8-12 to ensure following investigation did include reviewing resident's care plan, care guide, physician orders and incident report to aid in the implementation of appropriate interventions to prevent further falls. No problems noted.</p>		

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F 323	<p>Continued From page 28</p> <p>analysis of falls/incidents to determine possible contributing factors and/or trends; develop and implement reasonable and appropriate action plans and resident specific care plans in order to identify interventions reducing the potential of future falls/incidents; identify high-risk residents and ensure complete assessment and care planning; provide for analysis of underlying system issues and develop performance improvement plans; and communicate plans to appropriate staff through orientation, in-services, staff meetings, shift report, and care planning.</p> <p>A review of the Falls Management Policy, not dated, revealed all falls would be reviewed by the Interdisciplinary Team (IDT) members following the daily "Stand Up" Meeting. The IDT would review the Incident Report, fall history, the care plan, and other pertinent data to determine the need for further investigation. The policy stated the need for further evaluation of the resident's health condition, the environment, equipment, medications, staff, resident practices, or other factors that may have contributed to the incident would be determined by the IDT in order to promote a comprehensive plan of care. According to the policy, the IDT would determine the need for development of any additional facility-wide or resident specific interventions, staff, resident, and/or family education and training, or other follow-up measures that may be needed to reduce the risk of reoccurrence.</p> <p>An interview with the Director of Nursing (DON) and Rehabilitation (Rehab) Manager on 04/26/12, at 4:50 PM, revealed when a resident fell, Nursing completed an incident report, conducted an investigation of the incident, and notified the</p>	F 323	<p>3. All nursing staff was inserviced on 5-2-12 by the Staff Development Coordinator related to care plan and care guide implementation.</p> <p>All management staff will review and compare care plans and care guides in daily rounds to ensure appropriate interventions are being implemented and followed as listed on the care plan and care guide.</p> <p>3.a. All licensed Nursing staff, Rehab staff, and Certified Nursing Assistants was inserviced on 5-2-12 by the Staff Development Coordinator related to proper placement of personal alarms per manufacturer's recommendations, following care plans, care guides, and reporting if alarm or interventions are not effective.</p> <p>3.b. All licensed Nursing staff, Certified Nursing Assistants and Rehab staff was inserviced on 5-2-12 by the DON, ADON and Rehab Manager related to the revised process of investigating falls to include reviewing the resident's care plan, care guides, physician orders and incident reports to assist in the implementation of appropriate interventions.</p>		

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F 323	<p>Continued From page 29</p> <p>guardian/physician. The IDT reviewed incident reports for falls the next morning, reviewed the resident's care plan, and interventions were reviewed/implemented if needed, including a therapy screen if the resident was not already receiving therapy. The DON stated the IDT met for three days after a fall to follow up and communicate any concerns. Then, seven days after a fall, the IDT collaborated and determined if interventions were working and were appropriate. On 04/26/12, at 5:05 PM, the DON stated the IDT did not review the resident's Daily Care Guides or physician's orders during the IDT meetings for fall investigations, only the resident's care plan.</p> <p>1. A review of Resident #9's medical record revealed the facility admitted the resident to the facility on 08/05/09, with diagnoses that included Alzheimer's Disease and left sided hemiplegia (paralyzed left side).</p> <p>A review of Resident #9's Annual Minimum Data Set (MDS) assessment signed as complete on 07/13/11, and quarterly MDS assessment signed as complete on 03/19/12, revealed the facility assessed the resident to require extensive assistance (resident involved in activity, staff provide weight-bearing support) of two or more people for transfers (how resident moves between surfaces including to or from bed, chair, wheelchair, standing position), walking in the resident's room (how resident walks between locations in his/her room), and toilet use (how the resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses after elimination; changes pad; manages ostomy or catheter; and adjusts clothing).</p>	F 323	<p>4. All residents care guides will be utilized daily, Monday through Friday, in rounds by the Management Team to ensure appropriate interventions and assistance required is being implemented and followed by the staff. Charge nurses will utilize care guides daily, ongoing, to ensure appropriate interventions and assistance required is being implemented and followed by the staff. They will ensure the care plan and care guides match and are being followed by comparing them to the care being provided. This process will be followed daily, Monday through Friday x 4 wks, then 5 resident care guides weekly x 4 weeks, then 5 resident care guides monthly x 3 months. The results of the audits will be reviewed in the monthly Performance Improvement (PI) Committee meeting and revisions will be made to the systems as indicated.</p> <p>4.a. All residents with an order for a personal alarm will be audited by the Unit Managers daily, Monday through Friday x 4 weeks, weekly x 4 weeks, then monthly x 4 months to ensure proper placement is being utilized, proper function and effectiveness per resident per manufacturer's recommendations.</p> <p>Physician orders will be reviewed by the DON, ADON and Unit Managers daily, Monday through Friday in the Clinical Meeting for new orders related to personal alarms. Care plans and care guides will be implemented and revised as indicated.</p>	6-1-12

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F 323	<p>Continued From page 30</p> <p>A review of Resident #9's care plan initially dated 03/08/10, and revised March 2011 revealed the facility identified the resident was at risk for falls. The care plan revealed staff was required to assess the resident's need for assistive/supportive devices, instruct the resident on appropriate use of assistive/supportive devices, maintain the resident's environment free of clutter and safety hazards, and provide verbal cues and reminders not to ambulate or transfer without assistance. A review of the Daily Care Guide for Resident #9 revealed staff was required to check placement and function of the resident's alarming bed/chair pad during every shift and as needed. The Care Guide further revealed Resident #9 required the assistance of two staff members for mobility/transfers and required two staff members to assist and prompt the resident for toileting every two hours and as needed.</p> <p>A review of Resident #9's physician's orders dated 04/01/12, revealed the resident also had orders for an alarming chair pad, an alarming bed pad, and a personal alarm at all times. There were also physician's orders to check the pad alarms for proper placement and function during every shift and as needed.</p> <p>An interview with Resident #9 on 04/25/12, at 9:46 AM, revealed the resident did not have a pad alarm in the wheelchair and had not had one since the resident first came to live at the facility approximately two years prior.</p> <p>Interviews with State Registered Nursing Assistants (SRNAs) #16 and #17 on 04/25/12, at 10:40 AM, and SRNAs #18 and #19 on 04/25/12, at 4:15 PM, revealed the resident used to have a</p>	F 323  4.b.	<p>Audits will be completed by the DON, ADON and Unit Managers on all the residents experiencing a fall daily Monday through Friday x 4 weeks, weekly x 4 weeks, then monthly x 4 months to ensure appropriate interventions are being implemented to prevent further falls with all fall investigations.</p> <p>DON, ADON, and Unit Managers will continue to review all residents with a fall, Monday through Friday ongoing in the Clinical Meeting.</p> <p>The results of the audits will be reviewed in the monthly Performance Improvement (PI) Committee meeting. Revisions will be made to the systems as indicated.</p>	6-1-12

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F 323	<p>Continued From page 31</p> <p>pad alarm for the chair and bed but it had been months since the alarm had been used. Licensed Practical Nurse (LPN) #1 on 04/25/12, at 4:12 PM, revealed the LPN had worked at the facility since September 2011 and during that time Resident #9 had not utilized a pad alarm. An interview with LPN #5 on 04/26/12, at 5:10 PM, revealed Resident #9 had not had a pad alarm for the bed or wheelchair since the LPN started working at the facility in March 2012.</p> <p>An interview was conducted with LPNs #9 and #10 on 04/26/12, at 10:40 AM. LPN #10 was aware the resident was required to have a pad alarm, but the wires on the alarm became frayed and the facility had to order a new alarm. LPN #10 stated the pad alarm should have been discontinued.</p> <p>According to SRNA #16 on 04/26/12, at 11:50 AM, the SRNA was aware Resident #9's care plan required the resident to have a pad alarm, but the resident had not had one in months. The SRNA stated she was not sure why the resident did not have a pad alarm.</p> <p>A review of "Nursing Assessment of Fall" for Resident #9 dated 02/04/12, revealed the resident attempted to stand to go to the bathroom after removing his/her alarm from his/her shirt and fell. The assessment revealed the resident was found lying on his/her back with his/her head on the bedside table leg and sustained a 1 centimeter open area to the back of the head. A review of the Incident Follow-up &amp; Recommendation Form dated 02/04/12, revealed the facility investigated Resident #9's fall and determined the resident removed the personal</p>	F 323			

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F 323	<p>Continued From page 32</p> <p>alarm, got up to go to the bathroom, and fell. The recommendations/actions taken by the facility as a result of the fall were to conduct a therapy screen and reeducate the resident to use the call light for assistance. The facility also checked the resident's blood sugar and offered the resident a snack. The follow-up was to encourage the resident to wear hipsters and reeducate the resident to call for assistance before transfers. There was no evidence the facility identified the resident's pad alarm for the wheelchair and bed were not being utilized as ordered and care planned and no evidence the facility took any action to ensure the devices were being utilized by the resident.</p> <p>On 04/24/12 at 6:05 PM, a visitor summoned the surveyor to Resident #9's room because the resident was yelling for help. Observation of the resident revealed he/she was sitting on the floor in the bathroom of the resident's room with the resident's legs folded behind him/her. The resident's arms were in the seat of the wheelchair. Staff was summoned by another surveyor to assist the resident. The resident stated he/she was not injured. The resident further stated he/she attempted to get off the toilet unassisted and when he/she reached for the wheelchair, the wheelchair slid causing the resident to fall. There were no alarms sounding in the resident's room. Observation revealed a pad alarm (pad for the seat of a chair or a bed that alarms when there is no pressure on the pad) was not being utilized for the resident.</p> <p>A review of the facility's Nursing Assessment of Fall dated 04/24/12, revealed the resident turned off the personal alarm and was transferring</p>	F 323			

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F 323	<p>Continued From page 33</p> <p>independently from the toilet to the wheelchair when the resident fell. The assessment stated the resident was noncompliant with transfers. The alarm was placed back on the resident and the resident was instructed to use the call light for assistance.</p> <p>A review of the facility investigation revealed Resident #9 removed the personal alarm, got up to ambulate to the bathroom (not transferring from the toilet to the wheelchair as stated by the resident and the nursing assessment of the fall), and was found lying on the floor. The recommendations/actions taken were to conduct a therapy screen, encourage the use of hipsters, assist and prompt the resident to use the toilet every two hours, and encourage the resident to go to the nurses' station after meals. The follow-up dated 04/25/12, revealed the facility would remove the resident's personal alarm and place a pad alarm in the wheelchair and bed. There was no evidence the facility identified the resident already had physician's orders and care planned interventions for the pad alarms.</p> <p>Further observation of Resident #9 on 04/25/12, at 10:35 AM, revealed SRNA #15 was placing a pad alarm in the resident's wheelchair and had a pad alarm for the resident's bed. An interview with SRNA #15 revealed the resident "used to have one [pad alarm]," but the wires on the alarm became frayed and the alarm was taken out of the resident's wheelchair. The SRNA stated it had "been a long time" since the resident had an alarm in the chair. "Since [the resident] first came in I guess," the SRNA stated. The SRNA further stated the resident had lived at the facility for approximately two years.</p>	F 323		

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F 323	<p>Continued From page 34</p> <p>Further review of nursing fall assessments for Resident #9 revealed the resident fell on 02/10/12; when SRNAs took the resident to the bathroom toilet, left the room, and when the resident tried to stand up, he/she slid down to the floor. The resident was found lying on the floor in the bathroom. The resident did not sustain any injuries. The resident stated he/she was reaching for the call light. A review of the facility's investigation dated 02/10/12, revealed a SRNA assisted the resident to the bathroom and instructed the resident to pull the call light when he/she was finished. The investigation further revealed the resident attempted to stand without assistance and fell on the bathroom floor. The facility recommendations/actions taken were to bring the resident to the nurses' station to sit, offer a snack, and check the resident's blood sugar. The resident was already receiving therapy. The follow-up actions were to reeducate the resident on using the call light for assistance, to assess the call light in the bathroom to ensure it was within reach, and to educate staff to ensure the call light was within reach at all times. There was no evidence the facility identified Resident #9 was not receiving assistance with toileting when the resident fell from the toilet on 02/10/12. In addition, the facility took no action to ensure staff assisted the resident with toileting in the future.</p> <p>Further observation of Resident #9 on 04/26/12, at 10:30 AM, with LPN #10 revealed the resident was in the bathroom, on the toilet, in the resident's room without staff assistance. The resident was bending forward, leaning off the toilet with a urine collector in his/her hand. An interview with LPN #10 revealed staff had</p>	F 323			

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F 323	<p>Continued From page 35</p> <p>assisted the resident to the toilet and the resident would ring the call light when he/she was finished.</p> <p>Interview with SRNA #9 on 04/26/12, at 12:40 PM, revealed she and another SRNA had transferred Resident #9 to the toilet earlier that morning. The SRNA stated staff left the resident on the toilet and instructed the resident to ring the call light when he/she was finished. SRNA #9 stated she was not sure what the resident's care plan stated about assisting the resident with toileting. After the SRNA reviewed Resident #9's care guide, she stated the care guide did not state how much assistance Resident #9 required for toileting.</p> <p>An interview with SRNA #16 on 04/26/12, at 11:50 AM, revealed Resident #9 was not safe to transfer independently and should not be alone in the bathroom by his/her self.</p> <p>Interview with the DON and Rehabilitation Manager on 04/26/12, at 4:50 PM, revealed they investigated the fall sustained by Resident #9 on 02/04/12, but could not recall if they determined whether or not the resident was utilizing a pad alarm. The DON stated during the investigation of the 04/24/12 fall that they realized Resident #9 was not utilizing a pad alarm for the bed/chair. The DON stated she was not aware how long the resident's pad alarms had not been on the resident's bed and chair. The DON further stated she was aware staff was leaving Resident #9 in the bathroom without staff assistance and had not identified that the resident being left alone on the toilet was a concern, even though the resident was assessed to require the assistance of two staff members with toileting and the care guide</p>	F 323		

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F 323	<p>Continued From page 36</p> <p>stated staff was required to assist the resident with toileting.</p> <p>2. Observation of Resident #3 on 04/24/12, at 2:00 PM and 5:00 PM, and on 04/26/12, at 10:30 AM, revealed the resident had a dressing to the left lower arm and steri-strips on the resident's left hand. Observation of a skin assessment on 04/26/12, at 10:30 AM, with LPN #10, revealed steri-strips were present on three areas of the resident's left lower arm. Observation and interview with LPN #10 revealed the areas to Resident #9's arms were skin tears that the resident sustained as a result of a fall. LPN #10 stated the skin tears could not be accurately measured because the steri-strips were covering the wounds.</p> <p>Review of Resident #3's record revealed the facility admitted the resident on 04/02/12, and the resident had diagnoses that included functional decline, arthritis, and diabetes.</p> <p>A review of Resident #3's admission MDS assessment with a completion date of 04/13/12, and 14 Day Medicare A assessment with a completion date of 04/18/12, revealed the facility assessed the resident to require extensive assistance (resident involved in activity, staff provide weight-bearing support) of two or more people for transfers (how resident moves between surfaces including to or from bed, chair, wheelchair, standing position) and for walking in the resident's room (how resident walks between locations in his/her room).</p> <p>A review of the ADL Functional/Rehabilitation Potential Care Area Assessment (CAA)</p>	F 323		

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NAME OF PROVIDER OR SUPPLIER  LAUREL CREEK HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1033 NORTH HIGHWAY 11 MANCHESTER, KY 40962	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 37</p> <p>completed on 04/13/12, revealed the resident had a self-care deficit related to impaired physical functioning secondary to weakness. The CAA revealed Resident #3 was at risk for a fall, impaired skin integrity, and injury related to impaired physical functioning. A review of the fall CAA revealed Resident #3 was at risk for a fall related to impaired physical functioning, incontinence, and use of psychotropic medications. The fall CAA further revealed the resident was at risk for injury.</p> <p>A review of Resident #3's care plan dated 04/08/12, revealed the facility identified the resident had a self-care deficit related to impaired physical functioning. The care plan revealed the resident required the assistance of one to two staff members for transfers and ambulation.</p> <p>A review of Resident #3's daily care guide dated 04/25/12, at 6:35 AM, revealed the resident required the assistance of two staff members for transfers and mobility (walking).</p> <p>A review of "Nursing Assessment of Fall" dated 04/19/12, at 12:55 PM, revealed a SRNA was attempting to transfer the resident from wheelchair to bed. The resident lost his/her balance and was assisted to the floor by the SRNA. The resident sustained three skin tears to the left arm. A review of the Non-Pressure Skin Condition Record dated 04/19/12, revealed one skin tear measured 7 centimeters long, one measured 3 centimeters long, and one measured 2.5 centimeters long.</p> <p>An interview with SRNA #20 on 04/26/12, at 5:08 PM, revealed she was the SRNA who was</p>	F 323		

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F 323	<p>Continued From page 38</p> <p>assisting Resident #3 when he/she fell on 04/19/12. SRNA #20 stated she was assisting the resident to bed from the wheelchair when the resident's knees "buckled" causing the resident to fall. The SRNA stated she tried to catch the resident, but the resident fell, hitting his/her arm on the side rail on the bed causing the skin tears. SRNA #20 further stated that at the time of the fall, staff was transferring the resident with the assistance of one staff member, but after the resident fell, decided two staff members needed to assist the resident. The SRNA stated she was "pretty sure" the resident care guide stated one person was required when transferring Resident #3.</p> <p>A review of the Incident Follow-Up and Recommendation Form signed by the Director of Nursing and the Administrator on 04/23/12, revealed the facility summarized the investigative facts as follows: "Resident was been (being) transferred from chair to bed and lost balance assisted to floor by SRNA assisting." The recommendations/actions taken were to conduct a therapy screen. There was no evidence the facility identified the resident was not being transferred with two staff members as required by the resident's assessment and Daily Care Guide.</p> <p>Interview with LPN #5 on 04/26/12, at 5:10 PM, revealed Resident #3 required two people to assist with transferring because the resident was weak.</p> <p>Interview with the DON and the Rehabilitation Manager on 04/26/12, at 4:50 PM, revealed they did not identify any concerns when investigating Resident #3's 04/19/12 fall. The DON stated she</p>	F 323			

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F 323	<p>Continued From page 39</p> <p>was aware only one staff member was transferring the resident. The DON stated she believed it was appropriate for one person to transfer the resident because the resident's care plan stated one to two staff members were required. According to the DON, when a care plan stated "one or two," staff could use their own judgment and decide whether or not one or two staff members were required to transfer a resident. The DON and Rehabilitation Manager stated when investigating a fall, the Daily Care Guide was not reviewed during the investigation. The DON was not aware the facility assessed Resident #3 and developed a care plan (Daily Care Guide) that required the assistance of two people for transfers.</p> <p>3. Observation of Resident #15 on 04/26/12, at 5:24 PM, revealed the resident got out of bed and walked to the bathroom. The resident was holding onto objects as he/she walked to the bathroom. The resident stated he/she could get up alone.</p> <p>Interview with LPNs #4 and #5 on 04/26/12, at 5:26 PM, revealed Resident #15 could transfer independently and go to the bathroom alone.</p> <p>A review of Resident #15's medical record revealed the resident was admitted to the facility on 07/28/11, and had diagnoses that included altered mental status, hypertension (high blood pressure), history of breast cancer, and chronic obstructive pulmonary disease (COPD).</p> <p>A review the ADL Functional/Rehabilitation Potential CAA completed on 08/02/11, revealed Resident #15 had a self-care deficit related to</p>	F 323			

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F 323	<p>Continued From page 40</p> <p>impaired physical functioning secondary to a recent acute illness and hospitalization. The CAA revealed Resident #15 was at risk for a fall related to impaired physical functioning:</p> <p>A review of Resident #9's quarterly MDS assessment, signed as complete on 01/26/12, revealed the facility assessed the resident to require extensive assistance (resident involved in activity, staff provide weight-bearing support) of two or more people for transfers (how resident moves between surfaces including to or from bed, chair, wheelchair, standing position), for walking in the resident's room (how resident walks between locations in his/her room), and for toilet use (how the resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses after elimination; changes pad; manages ostomy or catheter; and adjusts clothing).</p> <p>A review of Resident #15's care plan, initially dated 08/02/11 and revised 04/19/12, revealed the facility identified the resident as at high risk for falls and required assistance with ADLs. The care plan review revealed the resident required one to two staff members for toilet use, was high risk for falls, and staff was required to encourage the resident to use the call light for assistance.</p> <p>A review of the Daily Care Guide revealed Resident #15 required the assistance of two staff members for mobility, transfers, and toilet use.</p> <p>Interview with the Rehabilitation Manager on 04/26/12, at 6:00 PM, revealed the resident could ambulate without assistance.</p>	F 323		

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F 323	<p>Continued From page 41</p> <p>Interview with SRNA #21 on 04/26/12, at 7:39 PM, revealed if Resident #15 needed assistance to go to the bathroom, he/she would ring his/her call light, otherwise, the resident could go to the bathroom independently.</p> <p>Interview with the DON and Nurse Consultant on 04/26/12, at 7:30 PM, revealed Resident #15 required one to two staff members for transfers per the resident's care plan, but the DON believed the resident had improved since admission and could transfer and ambulate independently. The Nurse Consultant stated an MDS assessment was in progress and they would check the ADL tracking to see what the resident was assessed to require for the current MDS.</p> <p>A review of the Monthly Flow Report for ADLs for Resident #15 for 04/01-26/12, revealed staff documented that Resident #15 was transferred, ambulated, and used the toilet with no assistance, supervision, limited assistance, extensive assistance, and total dependence. Staff also documented the resident required no assistance, one staff member, and two staff members for transfers, ambulation, and toilet use. An interview with the MDS Coordinator on 04/26/12, at 8:00 PM, revealed that based on the documentation, the facility would continue to assess the resident to need extensive assistance of two staff members for transfers, ambulation, and toilet use.</p> <p>4. A review of physician's orders, dated 03/01/12, revealed Resident #11 was to utilize a personal alarm (an alarming device with a string that attaches to the resident's clothing and has a</p>	F 323		

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F 323	<p>Continued From page 42</p> <p>magnet on the end of the string that attaches to a box; when the magnet is disengaged from the box an alarm sounds) when in bed. The Daily Care Guide/Nursing Care Plan for Resident #11, dated 04/25/12, also had an intervention for the resident to use a personal alarm while in bed.</p> <p>Resident #11 was observed on 04/24/12, at 4:12 PM and 5:40 PM, and on 04/25/12, at 10:25 AM, with a personal alarm cord clipped to the resident's clothing, and the personal alarm was lying in the resident's bed. Observation on 04/25/12, at 3:00 PM, revealed the resident to be in bed with a personal alarm tucked under the pillow and not attached to the bed.</p> <p>5. A review of the physician's orders for Resident #5 dated 04/01/12, revealed an order for a personal alarm to be worn by the resident at all times. A review of the Daily Care Guide for Resident #5, dated 04/16/12, revealed staff had identified the need to check the personal alarm for proper placement and proper functioning during every shift for Resident #5.</p> <p>Observation of Resident #5 on 04/24/12, at 3:10 PM, revealed the resident was in bed with the personal alarm under the resident's left cheek.</p> <p>6. A review of the physician's orders for Resident #8 dated 04/01/12, revealed an order for a personal alarm when the resident was in bed. A review of the Daily Care Guide for Resident #8, dated 04/16/12, revealed an intervention for the resident to have a personal alarm on while in the bed.</p> <p>Observation of Resident #8 on 04/24/12, at 3:15</p>	F 323			

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F 323	<p>Continued From page 43</p> <p>PM, revealed the resident was in bed with the personal alarm tucked under the resident's pillow.</p> <p>7. A review of the physician's orders for resident #13 dated 04/01/12, revealed an order for the resident to have a personal alarm on at all times. A review of the Daily Care Guide for Resident #13, dated 04/25/12, revealed an intervention to check the resident's personal alarm for proper placement and proper functioning during every shift.</p> <p>Observation of Resident #13 on 04/26/12, at 3:10 PM, revealed the resident was in bed with the personal alarm tucked under the resident's pillow.</p> <p>8. A review of Resident #7's medical record revealed a physician's order dated April 2012 for Resident #7 to have a personal alarm on at all times. This information was also found on the Nursing and SRNA care plans.</p> <p>Resident #7 was observed on 04/25/12, at 3:15 PM, and again at 5:17 PM, to be in bed with a personal alarm lying on the bed beside the pillow unattached to the bed. No staff members were present in the resident's room.</p> <p>An interview conducted with SRNA #10 on 04/25/12, at 2:25 PM, revealed the SRNA had been responsible for providing care for Residents #5, #8, and #13 on 04/24/12. The SRNA stated she had been told to clip the personal alarm to the resident's clothing and place the monitor next to the pillow where the resident would be unable to reach the monitor. The SRNA stated she obtained the information regarding resident care needs from the Daily Care Guide and was</p>	F 323			

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F 323	Continued From page 44 required to check it at the beginning of every shift.  An interview with SRNA #14 on 04/25/12, at 3:30 PM, revealed the SRNA had been told by the facility to clip the personal alarm string to the resident's clothing and place the monitor under the resident's pillow. The SRNA stated she obtained the information regarding resident care from the Daily Care Guide and was required to review the information at the beginning of every shift.  An interview with SRNA #7 on 04/26/12, at 4:10 PM, revealed she was responsible for the care of Resident #13 on 04/26/12. The SRNA stated she had been instructed to place the personal alarm in bed with the resident out of the resident's reach.  An interview with SRNAs #18 and #19 on 04/25/12, at 4:15 PM, revealed personal alarms should be hooked to the side rail of the resident's bed. The SRNAs stated if the alarm was not hooked to the side rail and the resident fell, the alarm may fall with the resident and not sound.  An interview conducted with the Director of Nursing (DON) on 04/26/12, at 6:05 PM, revealed the DON thought the personal alarm was to be attached to the resident's clothing and out of reach of the resident. The DON stated she was not aware the monitor was to be attached to the bed.	F 323			
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE  Based on a resident's comprehensive assessment, the facility must ensure that a	F 325			

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F 325	<p>Continued From page 45</p> <p>resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, it was determined the facility failed to ensure one of twenty sampled residents received a therapeutic diet as prescribed by the physician (Resident #1). Resident #1 had a physician's order for Jevity (gastrostomy tube feeding) 1.2 calories per milliliter, to be administered by means of a gastrostomy tube at 55 milliliters per hour for twenty-two hours every day. Observation of Resident #1 on 04/24/12, and medical record review revealed the tube feeding (Jevity) had been turned off and disconnected and Resident #1 had not received the prescribed amount of tube feeding (Jevity) for four hours and twenty-two minutes.</p> <p>The findings include:</p> <p>A review of the facility's policy titled, "Tube Feeding Administration," dated October 2004, revealed tube feedings would be administered as ordered by the physician.</p> <p>A review of the medical record for Resident #1 revealed the resident was admitted by the facility</p>	F 325	<ol style="list-style-type: none"> <li>Resident #1's physician was notified on 4-24-12 that resident did not receive tube feeding from 1:56 p.m. to 6:18 p.m., new order obtained to bolus Jevity 1.2 240 cc's to meet dietary needs. Family notified, no adverse effects noted.</li> <li>100 audit was completed on 4-30-12 by the Unit Managers to ensure all residents with an order for g-tube feeding was receiving the feeding per physician's order. No problems noted.</li> <li>All licensed Nursing staff was inserviced on 4-30-12 by the Staff Development Coordinator related to interal feeding administration, communications between departments, to ensure notification to a licensed staff of any resident returning to their room with tube feeding unhooked so tube can be resumed as ordered.</li> </ol> <p>All Rehab and Nursing staff inserviced on 4-30-12 by Staff Development Coordinator related to new process of residents receiving g-tube feedings will not be unhooked for therapy services.</p> <ol style="list-style-type: none"> <li>Physician's order for all new admit and readmit residents receiving tube feeding will be reviewed daily, Monday through Friday in the Clinical Meeting by the DON, ADON, and Unit Managers to ensure all tube feeding is being administered per order, care plan and care guides revised as indicated.</li> </ol> <p>All residents receiving interal feeding via feeding tube will be audited to ensure tube feeding is being administered per order, daily, Monday through Friday x 4 weeks, weekly x 4 weeks, then monthly x 4 months by the DON, ADON and Unit Managers.</p>	

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F 325	<p>Continued From page 46</p> <p>on 08/27/10, with diagnoses that include Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease, Vitamin deficiency, and Decubitus Ulcer. A review of the Registered Dietitian (RD) notes dated 03/26/12, revealed a significant change assessment was completed after the resident had been admitted to the hospital on 02/29/12, and discharged back to the facility on 03/19/12, with a diagnosis of pneumonia and after having a gastrostomy tube inserted. A review of the weight record for Resident #1 revealed the resident's weight was documented on 04/03/12, at 132 pounds, which was a usual weight for the resident.</p> <p>Documentation in the medical record revealed physician's orders dated 04/02/12, for Jevity 1.2 calories per milliliter to run at a rate of 55 milliliters per hour for 22 hours every day via Resident #1's gastrostomy tube.</p> <p>Documentation in the medical record revealed Resident #1 had been taken to the Therapy Department on 04/24/12, at 1:56 PM, for speech therapy services.</p> <p>On 04/24/12, at 3:20 PM, Resident #1 was observed sitting in a wheelchair in the Therapy Department with the speech therapist and was receiving therapy services. The resident was observed to be disconnected from the tube feeding at that time.</p> <p>Observations conducted of Resident #1 on 04/24/12, at 4:35 PM, 5:10 PM, 6:00 PM, and 6:15 PM, revealed the resident to be in his/her room and the tube feeding continued to be disconnected from the resident.</p>	F 325	The results of the audits will be reviewed at the monthly Performance Improvement (PI) Committee meeting. Revisions will be made to the systems as indicated.	6-1-12	

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F 325	<p>Continued From page 47</p> <p>On 04/24/12, at 6:18 PM, Licensed Practical Nurse (LPN) #5 was observed to reconnect the resident's tube feeding to a feeding pump in the resident's room and continued the tube feeding of Jevity 1.2 at 55 milliliters an hour.</p> <p>Based on documentation, from 1:56 PM to 6:18 PM on 04/24/12, the resident's tube feeding was not connected and the resident did not receive the tube feeding as required, a timeframe of four hours and twenty-two minutes.</p> <p>An interview conducted with LPN #5 on 04/24/12, at 7:45 PM, revealed the LPN had been unaware the resident had been returned to his/her room on 04/24/12, following the speech therapy treatment and as a result there was a delay in reconnecting and administering the resident's tube feeding. The LPN stated she had the responsibility on 04/24/12, to ensure the resident received the prescribed amount of tube feeding. The LPN stated it was the responsibility of the Therapy Department to notify the nurse when returning the residents to their rooms after therapy and they had failed to notify the nurse of the resident's return. The LPN stated she had been busy and had not checked to see if the resident had returned nor had she checked with the Therapy Department to see why the resident had not returned.</p> <p>An interview conducted with the Speech Language Pathologist (SLP) on 04/25/12, at 8:45 AM, revealed the resident's tube feeding had been disconnected by Nursing staff and taken to the Therapy Department by the therapist. The SLP acknowledged she had failed to notify the</p>	F 325			

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F 325	Continued From page 48 nurse after returning the resident to his/her room and stated she had not been told it was her responsibility to tell the nurse after returning residents to their rooms after therapy.  An interview conducted on 04/26/12, at 6:05 PM, with the Director of Nursing (DON) revealed it had been the responsibility of the nurses to ensure the residents were being provided the care they require. The DON stated nurses were expected to observe/assess the residents at least every two hours. The DON revealed Therapy staff was expected to notify the nurse after returning a resident to his/her room.	F 325			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431	1. The temperature of the West Wing medication room and refrigerator did not meet regulation. The Maintenance Director immediately removed the refrigerator and replaced it with a new one. Nursing discarded all medications in the refrigerator and called Pharmacy to replace the temperature sensitive medications. Nursing staff moved medication carts into the hallway.  2. DON, ADON, and Unit Managers audited 100% of medications in the medication cart and refrigerator to ensure temperatures were in compliance with regulations. No additional problems were found.  3. The facility will repair air conditioner units by 8-1-12.  Licensed Nursing staff was inserviced on 4-26-12 to relocate medication carts outside medication rooms until air conditioning is repaired, therefore, there will be no medication stored until air conditioning is repaired.		

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F 431	Continued From page 49  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.  This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and a review of facility policies, the facility failed to ensure temperatures in both the East and West Wing medication storage rooms and refrigerators utilized to store medications were maintained at proper temperatures. Observations of the East Wing on 04/26/12, at 5:30 PM, revealed the medication room temperature was 80 degrees Fahrenheit and the West Wing medication room temperature was 84 degrees Fahrenheit at 6:00 PM. Observations of the West Wing medication refrigerator at 6:00 PM, revealed the temperature inside the refrigerator was 56 degrees Fahrenheit.  The findings include:  A review of the facility's medication storage policy revealed the medication room temperature was required to be maintained between 59 and 77 degrees Fahrenheit and the temperature of the refrigerator was required to be maintained between 36 and 46 degrees Fahrenheit.	F 431	4. DON and ADON will audit the temperature in the storage area daily, Monday through Friday x 4 weeks, then 3 x per week for 2 months. Findings will be presented to the monthly Performance Improvement (PI) Committee meeting. Revisions will be made per findings.	6-1-12	

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F 431	Continued From page 50  Observations of the West Wing medication room on 04/26/12, at 6:00 PM, revealed the room temperature was 84 degrees Fahrenheit and the medication room refrigerator was 56 degrees Fahrenheit.  Medications stored in the West Wing medication room included:  1. Two vials of Piperacillin and Tazobactam with storage requirements of 68 to 77 degrees Fahrenheit.  2. One vial of Ceftriaxone with storage requirements of 68 to 77 degrees Fahrenheit.  3. Two vials of Vancomycin with storage requirements of less than 77 degrees Fahrenheit.  4. One vial of Primaxin with storage requirements of a temperature not to exceed 77 degrees Fahrenheit.  5. Two vials of Invanz required to be stored at a temperature not to exceed 77 degrees Fahrenheit.  6. Three vials of Tazicef with storage requirements of 68 to 77 degrees Fahrenheit.  7. Two vials of Cefazolin required to be stored between 68 and 77 degrees Fahrenheit.  8. Two vials of Promethazine with storage requirements between 68 and 77 degrees Fahrenheit.	F 431		

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F 431	Continued From page 51 9. One vial of Klonex required to be stored between 68 and 77 degrees Fahrenheit.  An interview with Licensed Practical Nurse (LPN) #4 on 04/26/12, at 6:00 PM, revealed staff recorded the room temperature on a daily temperature log. Review of the log revealed the highest temperature recorded during the month of May 2012 for the West Wing medication room was 78 degrees Fahrenheit. Observations of the East Wing on 04/26/12, at 5:30 PM, revealed the medication room temperature was 80 degrees Fahrenheit. There were no medications stored in the East Wing medication refrigerator and no temperature sensitive antibiotics stored in the East Wing medication room.  An interview with the Corporate Consulting Registered Nurse on 04/26/12, at 6:00 PM, revealed the Maintenance Supervisor had been notified and would replace the refrigerator on the West Wing immediately. In addition, the nurse stated the pharmacy would be notified and would replace the temperature sensitive medications immediately.	F 431			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441	1. Resident #8 was assessed by the Unit Manager on 4-26-12. No adverse effects were noted related to nurse #4 not washing hands not washing hands prior to delivering meal tray.  2. 100% meal tray observation on 5-2-12 by DON and ADON to ensure proper hand washing techniques were being followed per policy. No problems noted.		

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F 441	Continued From page 52 in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, it was determined the facility failed to ensure the environment was sanitary for one of twenty sampled residents (Resident #8). Observation of the evening meal service on 04/24/12, revealed Licensed Practical Nurse (LPN) #4 was observed to drop two drinking glasses on the floor, pick the glasses up from the	F 441	3. All associates inserviced on 5-2-12 by the DON and ADON on infection control and hand washing. Staff Development Coordinator performs observations and hand washing competencies on all Nursing staff annually, randomly and upon hire to ensure proper hand washing techniques are being followed during meal delivery.  4. The DON, ADON, and Unit Manager will perform audits on 5 associates during meal tray pass to ensure hand washing compliance daily, Monday through Friday x 2 weeks, weekly x 2 weeks, then monthly x 2 months. These audits will be reviewed in the monthly Performance Improvement (PI) Committee meetings. Revisions will be made to the systems as indicated.	6-1-12

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F 441	<p>Continued From page 53</p> <p>floor, place them onto a cart, and proceed to set up and deliver a meal tray to Resident #8 without washing/sanitizing her hands.</p> <p>The findings include:</p> <p>A review of the facility's policy titled, "Hand Hygiene," with a revision date of 05/21/94, revealed staff was required to use an alcohol based hand rub for routinely decontaminating hands in all clinical situations unless hands are visibly dirty or contaminated. According to the policy, if staff hands were visibly dirty or contaminated, staff was required to wash their hands with either a non-antimicrobial soap or an antimicrobial soap and water.</p> <p>Observation of the evening meal service in the West Wing dining room on 04/24/12, at 5:12 PM, revealed Licensed Practical Nurse (LPN) #4 dropped two glasses on the floor, picked the glasses up from the floor, and placed them on the lower shelf of a meal cart. The LPN proceeded to set up a meal tray for Resident #8 without washing/sanitizing her hands. The meal tray was observed to be delivered to the resident.</p> <p>An interview conducted with LPN #4 on 04/24/12, at 6:25 PM, revealed the LPN was aware she should have washed/sanitized her hands after picking up the glasses from the floor and was unsure why she had not.</p> <p>An interview conducted with the Director of Nursing (DON) on 04/26/12, at 6:05 PM, revealed staff was required to wash/sanitize their hands prior to any interaction with a resident's tray. The DON stated the LPN should have</p>	F 441			

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F 441	Continued From page 54 washed/sanitized her hands after picking the glasses up from the floor. The DON also revealed staff was required to attend an in-service on handwashing upon hire, quarterly, and as needed. The DON revealed LPN #4 had attended a handwashing and infection control in-service on 01/13/12. The DON stated all staff is required at least annually to provide a return demonstration for handwashing, and LPN #4 had provided the return demonstration on 01/14/12.	F 441			
F 460 SS=D	483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY  Bedrooms must be designed or equipped to assure full visual privacy for each resident.  In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of facility policy, the facility failed to ensure every bedroom was designed to assure full visual privacy. Observations during the initial tour on 04/24/12, 04/25/12, and 04/26/12, revealed resident room 151 was not equipped with privacy curtains to ensure privacy for the resident in room 151, bed 1.  The findings include:  A review of the facility's Resident Rights Policy, no date given, revealed staff was to screen and	F 460	1. On 4-26-12 the Maintenance Director installed a privacy track and curtain in room #151 to provide for resident in bed #1. A privacy curtain was also installed in rooms #127, #131, and #148, all private rooms.  2. Maintenance Director and Housekeeping Director checked all other rooms to ensure there were privacy curtains. No other resident rooms were found without privacy curtains.  3. The Maintenance Director and the Executive Director (ED) inserviced all staff on 5-11-12 to complete Maintenance Request forms and turn in so that the facility is informed if there is a maintenance issue that needs attention. Staff was encouraged to report anything they saw as a problem.  4. The ED, Maintenance Director and Housekeeping Director will complete audits 2 x per week for 1 month and 1 x per week for 1 month to assure privacy curtains are placed in all resident rooms.  Audits will be reviewed by the Performance Improvement (PI) Committee monthly. Revisions will be made as indicated.	6-1-12	

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F 460	Continued From page 55 drape residents for maximum privacy when delivering care.  Observations on 04/24/12, 04/25/12, and 04/26/12, revealed resident room 151 did not have a privacy curtain that enclosed the resident bed to provide privacy. Based on observations, a mirror was located on the wall across from the foot of bed 1 and there was a privacy curtain between bed 1 and bed 2. Observation revealed even when the privacy curtain between the beds was closed, individuals on the bed 2 side of the room were able to look in the mirror across from the foot of bed 1 and have full view of the resident in bed 1. In addition, if the entrance door was opened to room 151, there was no way to provide privacy for the resident in bed 1.  An interview with the Unit Manager on 04/25/12, at 2:05 PM, revealed she was unaware the privacy curtain was missing for bed 1.  An interview with the facility Administrator on 04/25/12, at 3:00 PM, revealed she was unaware of the lack of a privacy curtain and thought the curtain track must have been removed during remodeling and had not been reinstalled.	F 460			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient	F 514 I.a.	Resident #9's personal alarm was removed on 4-26-12 by the Unit Manager and the Certified Nursing Assistant and replaced with a pad alarm to reflect current physician's order, care plan and care guide.		

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F 514	<p>Continued From page 56</p> <p>information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation, interview, and a review of facility policy, the facility failed to ensure accurate clinical records were maintained for four of twenty sampled residents (Residents #9, #1, #11, and #16). Resident #9's Treatment Administration Record was initialed by staff to indicate the resident was utilizing a pad alarm to the bed and chair, however, no pad alarm was observed in use by the resident. Resident #1's medical record indicated the resident had received wound care on 04/24/12, however, observation and interviews revealed wound care had not been provided at the time of the observation on 04/24/12. A review of the Minimum Data Set (MDS) assessment indicated there were no restraints in use for Resident #11; however, observations revealed the resident did utilize restraints. A review of the documentation by Speech Therapy indicated Resident #16 required thickened liquids; however, the resident did not require thickened liquids and had physician's orders for thin liquids.</p> <p>The findings include:</p> <p>A review of the medical record policy, revised 01/22/08, revealed all medical records were to be systematically organized. The policy did not address accuracy.</p>	F 514	<p>1.b. Treatment was completed on resident #1 by the Unit Manager and and ADON on 4-24-12. No adverse effects noted to resident #1 related to nurse #5 initialing treatment administration record prior to providing treatment.</p> <p>Licensed nurse #5 was educated on 4-24-12 by the DON concerning signing treatment administration record before providing treatment. An education acknowledgment was signed by nurse #5.</p> <p>1.c. On 4-26-12 resident #11 medical records was reviewed by the DON. The MDS Coordinator completed an MDS to reflect the resident's use of a restraint.</p> <p>1.d. The Rehab Manager reviewed resident #16's record on 5-2-12 with Speech Therapy. Documentation was completed to reflect resident no longer required thickened liquids.</p> <p>2.a. 100% audit of residents with an order for pad alarms was completed by the Unit Manager on 5-6-12 to ensure correct devise is being utilized and functioning properly per order.</p> <p>2.b. 100% audit of all treatment administration records and treatments per observation was completed by the DON and ADON on 5-6-12 to ensure treatment was being provided prior to treatment administration being initialed by licensed nurse.</p> <p>2.c. 100% audit of all residents with a restraint order was completed on 5-7-12 by the MDS Team to ensure all medical records reflect the use of a restraint. No other records revealed restraint missing from an MDS.</p>		

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F 514	<p>Continued From page 57</p> <p>1. Observation of Resident #9 on 04/24/12, at 6:05 PM, revealed a pad alarm (pad for the seat of a chair or a bed that alarms when there is no pressure on the pad) was not being utilized for the resident.</p> <p>An interview with Resident #9 on 04/25/12, at 9:46 AM, revealed the resident did not have a pad alarm in the wheelchair and had not had one since the resident first came to live at the facility approximately two years ago.</p> <p>Review of Resident #9's Treatment Administration Records (TARs) for March and 04/01-24/12, revealed staff documented during every shift that an alarming bed pad was in use while the resident was in bed and an alarming chair pad was in use while in a chair, including 04/24/12, when the alarming pads were observed not being utilized for Resident #9. Further review of the TAR revealed staff had also documented during every shift that the alarming chair/bed pad was properly placed and properly functioning and the batteries had been checked and replaced every month and as needed.</p> <p>An interview was conducted with LPNs #9 and #10 on 04/25/12, at 10:40 AM. Review of the TAR revealed LPN #9 signed Resident #9's TAR on 04/24/12, indicating the resident was utilizing an alarming pad. LPN #9 stated she could not remember if the pad alarm was present or not. LPN #10 stated Resident #9 had an order for a pad alarm at one time, but the wires were frayed and the alarm was removed until a new alarm was ordered. LPN #10 stated the resident had not had a pad alarm for about three weeks and</p>	F 514	<p>2.d. 100% audit of all residents receiving Speech Therapy was completed by the Rehab Manager and Speech Therapist on 5-7-12 to ensure Speech documentation accurately reflects the physician's order related to liquid consistency. No problems noted.</p> <p>3.a./b. An inservice was conducted on 5-7-12 by the Staff Development Coordinator for all licensed staff related to following the treatment administration records and documenting treatments being provided and alarms being utilized per facility policy.</p> <p>3.c. The MDS Team was inserviced on 5-7-12 regarding care plan and MDS revisions by the DON.</p> <p>3.d. Rehab staff was inserviced on 5-7-12 by the Rehab Manager regarding the medical record documentation to reflect the physician's order</p> <p>4.a./b. 5 treatment administration audits will be completed by the DON, ADON, and Unit Managers Monday through Friday x 4 weeks, weekly x 4 weeks, then monthly x 4 months to ensure all treatment administration records for residents with orders for wound care are being signed after treatment has been provided and correct alarm on treatment administration record is being utilized.</p> <p>4.c. Audits will be completed by the DON, ADON, and Unit Managers Monday through Friday x 4 weeks, weekly x 4 weeks, then monthly x 4 months on all residents with an order for a restraint to ensure the MDS and the medical record reflect the use of the restraint.</p>	

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NAME OF PROVIDER OR SUPPLIER  <b>LAUREL CREEK HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1033 NORTH HIGHWAY 11 MANCHESTER, KY 40962</b>	
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F 514	<p>Continued From page 58</p> <p>the pad alarm should have been discontinued from the TAR. LPN #10 stated she had signed the TAR by mistake.</p> <p>An interview with LPN #5 on 04/26/12, at 5:10 PM, revealed Resident #9 had not had a pad alarm for the bed or wheelchair since the LPN started working at the facility in March 2012. Review of the TAR revealed the LPN had documented the bed and chair alarms were in place and functioning properly. The LPN sated she was not paying attention and signed the TAR by mistake.</p> <p>2. Observation of a skin assessment conducted on 04/24/12, at 7:05 PM, for Resident #1 with the Unit Manager (UM) for the West Wing and the Assistant Director of Nursing (ADON) revealed the resident had a pressure sore on the left hip which was observed not to be covered by a dressing.</p> <p>A review of Resident #1's medical record revealed a physician's order dated 03/28/12, for staff to cleanse the area on the left hip with Hibiclens (antiseptic antimicrobial skin cleanser), rinse the area with normal saline, pat the area dry, and apply a wet to dry dressing to the area. The physician requested the treatment to be performed two times a day.</p> <p>A review of the Treatment Administration Record (TAR) for Resident #1 revealed the nurse had signed the TAR on the day shift of 02/24/12, indicating the wound care had been provided.</p> <p>An interview conducted with LPN #5 on 04/26/12, at 4:00 PM, revealed the LPN had signed the</p>	F 514  4.d.	<p>Audits will be completed by the Rehab Manager and a Speech Therapist Monday through Friday x 4 weeks, weekly x 4 weeks, then monthly x 4 months on all residents receiving Speech Therapy to ensure documentation reflects current physician orders.</p> <p>The results of the audits will be reviewed in the monthly Performance Improvement (PI) Committee meeting and revisions will be made to the systems as indicated.</p>	6-1-12

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F 514	<p>Continued From page 59</p> <p>TARs with intentions to provide the treatments at a later time. LPN #5 acknowledged she had not yet completed the treatment for Resident #1 on 04/24/12, and was aware she should not have documented (by signature on the TAR) that the treatment had been completed and was unsure why she had done this.</p> <p>An interview conducted with the Unit Manager on 04/26/12, at 4:12 PM, revealed the nurses were not supposed to sign the TAR until the treatments had been provided.</p> <p>An interview conducted on 04/26/12, at 6:05 PM, with the Director of Nursing (DON) also revealed nurses were not to sign the TARs until the treatments had been provided to the resident.</p> <p>3. A review of the MDS assessment, dated 03/08/12, revealed no physical restraints were in use for Resident #11. However, observations throughout the survey on 04/24-26/12, revealed Resident #11 utilized an alarming seat belt when sitting in the wheelchair. Further review of Resident #11's medical record revealed the informed consent to physical restraint use was signed by the resident's family on 11/01/11, and Resident #11's care plan included the use of the alarming seat belt.</p> <p>An interview with State Registered Nurse Aide (SRNA) #3 on 04/26/12, at 10:35 AM, revealed Resident #11 has used the seat belt for "quite a while" and before that he/she used a lap buddy.</p> <p>An interview on 04/25/12, at 3:10 PM with LPN #6 who was responsible for Resident #11's MDS assessment completed on 03/08/12, revealed he</p>	F 514		

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F 514	<p>Continued From page 60 "just missed it on the March assessment."</p> <p>4. A review of the physician's orders for Resident #16 dated 04/12/12, revealed the physician had ordered a regular, mechanical soft diet with pureed meats and thin liquids. However, a review of the Speech Therapy notes dated 04/13/12, revealed Resident #16 required thickened liquids.</p> <p>An interview with the Rehabilitation Manager on 04/26/12, at 7:00 PM, revealed that the computer system automatically included the thickened liquid requirement if the resident was assessed to eat less than 25 percent of meals and that the staff has no capability to correct it. According to the Rehabilitation Manager, it is a "drop down" box and while it is inaccurate since the resident does not require thickened liquids, the staff was unable to change it.</p>	F 514			

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Division of Health Care  
Southern Enforcement Branch  
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FORM APPROVED  
OMB NO. 0938-0391  
04/25/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185293</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/25/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LAUREL CREEK HEALTH CARE CENTER</b>	STREET ADDRESS <b>1033 NORTH HIGHWAY 11 MANCHESTER, KY 40962</b>
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K 000	INITIAL COMMENTS  CFR: 42 CFR 483.70(a)  BUILDING: 01  PLAN APPROVAL: 1976  SURVEY UNDER: 2000 Existing  FACILITY TYPE: SNF/NF  TYPE OF STRUCTURE: One story, Type V(000)  SMOKE COMPARTMENTS: Five  FIRE ALARM: Complete automatic fire alarm system  SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system  GENERATOR: Type II diesel generator  A life safety code survey was initiated and concluded on 04/25/12. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid.  Deficiencies were cited with the highest deficiency identified at "E" level.	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Olivia E. Bevers* TITLE: *Debra R. Duck* (X6) DATE: *5/18/12*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 018	<p>Continued From page 1</p> <p>those constructed of 1½ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that corridor doors were maintained according to NFPA standards. This deficient practice affected two of five smoke compartments, staff, and approximately forty-five residents. The facility has the capacity for 106 beds with a census of 98 on the day of the survey.</p> <p>During the Life Safety Code tour on 04/25/12, at 9:50 AM, with the Director of Maintenance (DOM), a corridor door to resident room 104 would not latch. Corridor doors must close and latch to help resist the passage of smoke and fire in a fire situation. During the survey, doors to resident rooms 131, 134, and 136 would not</p>	K 018	<ol style="list-style-type: none"> <li>1. Maintenance Director will make adjustments to corridor door, to resident room #104, #131, #134 and #136 by 6-1-12 to assure they latch.</li> <li>2. Maintenance Director and Executive Director made rounds through the facility to assure there were no other doors that did not latch. None were found.</li> <li>3. There are plans to replace all resident room doors by 11-01-12. Maintenance Director and Executive Director inserviced all staff to be aware and report maintenance problems by completing Maintenance Request forms and turning them in for repair. Staff were encouraged to report any resident room doors that did not latch.</li> <li>4. Maintenance Director/ED will audit doors 3 x per week for 1 month, 1 x per week for 1 month to assure all resident room doors latch. Audits will be reviewed by the Performance Improvement (PI) Committee monthly. Revisions will be made as indicated.</li> </ol>	06-01-12	

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K 018	Continued From page 2 latch.	K 018			
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain an exit according to NFPA standards. This deficient practice affected one of five smoke compartments and staff. No residents were directly affected by this practice. The facility has the capacity for 106 beds with a census of 98 on the day of the survey.  The findings include:  During the Life Safety Code tour on 04/25/12, at 9:35 AM, with the Director of Maintenance (DOM) an exterior exit located in the dining room of the facility was observed not to have a durable surface to the public way as required. An interview with the DOM on 04/25/12, at 9:35 AM, revealed the facility had plans to put a sidewalk in but had not as of yet.	K 038	<ol style="list-style-type: none"> <li>No residents were directly affected by this practice.</li> <li>An exterior exit located in the facility dining room was observed to not have a durable surface to the public as required.</li> <li>By 6-8-12 the facility will install a sidewalk from the exterior exit located in the dining room to a public way.</li> <li>The sidewalk will provide all occupants with a safe access to a public way.</li> </ol>	6-8-12	

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K 038	Continued From page 3  Reference: NFPA 101 (2000 Edition).  7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way.  CMS Ref: S&C-05-38	K 038			