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 FORM APPROVED
 OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185332	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/15/2012
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NAME OF PROVIDER OR SUPPLIER GRAND HAVEN NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 105 RODGERS PARK CYNTHIANA, KY 41031
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F 000	INITIAL COMMENTS	F 000		
F 282 SS=D	<p>An abbreviated survey investigating KY#00017810 was initiated on 2/15/12 and concluded on 2/15/12. KY#00017810 was substantiated with unrelated deficiencies cited. 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide services in accordance with the resident's written plan of care for one (1) of four (4) sampled residents (Resident #4). Resident #4 was transferred to his/her wheelchair with a Hoyer lift by one (1) staff person when the Care Plan intervention was for two (2) staff to participate in the transfer.</p> <p>The findings include: Review of the medical record for Resident #4 revealed the resident was admitted by the facility on 04/08/11 with diagnoses which included Debilitation, Degenerative Joint Disease (DJD), History of Falls, Progressive Weakness, Obesity, Fatigue, and Alzheimer's Disease. Review of Resident #4's Comprehensive Care Plan, dated 05/11/11 revealed "staff will maintain highest level of functioning" with and intervention added on 06/26/11 which indicated two (2) staff members</p>	F 282	<p>RECEIVED FEB 29 2012</p> <p>Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Walt Smith</i>	TITLE <i>Administrator</i>	(X8) DATE 2-25-12
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deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 282	<p>Continued From page 1</p> <p>were to perform transfers with the use of a Hoyer mechanical lift. Review of the 02/12 Monthly State Registered Nursing Assistant (SRNA) Care Plan revealed Resident #4 was to be transferred with a mechanical lift with the assistance of two (2) staff.</p> <p>Observation, on 02/15/12 at 10:05 AM, revealed Resident #4 being transferred by SRNA #1 from the bed to the wheelchair via a mechanical lift. No other staff was present when the resident was transferred.</p> <p>Interview, on 02/15/12 at 10:10 AM, with SRNA #1 revealed aide care plans were supposed to be reviewed daily and followed by staff. Resident #4 was care planned for a mechanical lift and two (2) staff. When performing a transfer with the mechanical lift it was supposed to be a two (2) person transfer. SRNA #1 stated the transfer was done by herself. When asked why, she stated other staff were busy at the time.</p> <p>Interview, on 02/15/12 at 1:45 PM, with SRNA #5 revealed aides were supposed to review the care plan daily before they start out on the floor. Aides were supposed to follow the plan of care. Any changes to the care plan were highlighted and flagged. The care plan included safety precautions and how the resident was supposed to be transferred.</p> <p>Interview, on 02/15/12 at 6:10 PM, with the Director of Nursing (DON) revealed when staff was performing mechanical lift transfers two (2) staff should perform the transfer. The DON and nurses monitor aides to ensure care plans were followed. She further stated SRNA #1 admitted to</p>	F 282	<p>F282 Qualified Services in Accordance with the Plan of Care</p> <p>Targeted Resident Resident #4 was evaluated by the Director of Nursing. The staff involved with Resident #4 was disciplined and received one on one re-education by the Director of Nursing regarding following residents care plans.</p> <p>Identification of Other Residents All residents' Comprehensive Care Plans were reviewed and compared to the SRNA Care Plans. These Care Plans were updated as needed to reflect the current care needs of the resident. The DON and designated charge nurses provided and continue to provide in-servicing for all nursing staff on transfers with a mechanical lift. Nursing staff were also in-serviced by the Director of Nursing and designees regarding following the resident's individual care plans while providing care.</p>	

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F 282 F 323 SS=E	<p>Continued From page 2 the DON, she failed to follow the proper procedure with the transfer.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to ensure the residents' safety through monitoring and supervision for one (1) of four (4) sampled residents (Resident #4). The facility failed to provide adequate supervision for Resident #4 as evidenced by a mechanical lift transfer being performed by only one (1) staff person. In addition, the facility failed to provide an environment free from accident hazards over which the facility has control as evidenced by a medication cart being left unlocked and unsupervised on one (1) unit of the facility.</p> <p>The findings include:</p> <p>1. Review of the facility's policy and procedure titled "Mechanical Lift", undated, revealed it was the policy of the facility that all residents were to be transferred without injury to them. Residents</p>	F 282 F 323	<p>Systemic Changes Daily skills check audits are being completed by the Director of Nursing, Assistant Director of Nursing, and Quality Assurance Nurse to monitor staff's delivery of care in accordance with the resident's care plan.</p> <p>Monitoring Daily skills check audits are being completed by the Director of Nursing, Assistant Director of Nursing, and Quality Assurance Nurse to monitor staff's delivery of care in accordance with the resident's care plan. The QA Nurse will audit 10% of residents' care plans monthly. Care Plan audit will include comparing the comprehensive care plan to the SRNA care plan and validating that interventions are carried out as care planned.</p>	2/25/12

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F 323	<p>Continued From page 3</p> <p>requiring more assistance with transfers than two (2) people can safely provide by themselves will be transferred by means of a mechanical lift. Under "Procedure" subsection ten (10): Using the control, lift resident off the bed/chair with one (1) SRNA at the control and the other SRNA behind the resident.</p> <p>Review of the medical record for Resident #4 revealed the resident was admitted by the facility on 04/08/11 with diagnoses which included Debilitation, Degenerative Joint Disease (DJD), History of Falls, Progressive Weakness, Obesity, Fatigue, and Alzheimer's Disease. Review of Resident #4's Comprehensive Care Plan, dated 05/11/11 revealed "staff will maintain highest level of functioning" with and Intervention added on 06/26/11 which indicated two (2) staff members were to perform transfers with the use of a Hoyer mechanical lift. Review of the 02/12 Monthly State Registered Nursing Assistant (SRNA) Care Plan revealed Resident #4 was to be transferred with a mechanical lift with the assistance of two (2) staff.</p> <p>Observation, on 02/15/12 at 10:05 AM, revealed Resident #4 was being transferred by State Registered Nursing Assistant (SRNA) #1 from the bed to the wheelchair via mechanical lift.</p> <p>Interview, on 02/15/12 at 10:10 AM, with SRNA #1 revealed aide care plans were supposed to be reviewed daily and followed by staff. Resident #4 was care planned to be transferred with a mechanical lift and two (2) staff. When performing a transfer with the mechanical lift it was supposed to be a two (2) person transfer. SRNA #1 stated she performed the transfer by</p>	F 323	<p>F323 Free of Accident Hazards/Supervision/Devices</p> <p>Targeted Resident</p> <p>Resident #4 was evaluated by the Director of Nursing. The staff involved with Resident #4 was disciplined and received one on one re-education by the Director of Nursing regarding following on residents care plans. The employee responsible for the medication cart was re-educated and counseled by the DON per the facility policy.</p> <p>Identification of Other Residents</p> <p>All resident Comprehensive Care Plans were reviewed and compared to the SRNA Care Plans. Both Care Plans were updated as needed to reflect the current care needs of the resident. Daily skills check audits are being completed by the Director of Nursing and Assistant Director of Nursing, to monitor staff's delivery of care in accordance with the</p>	

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F 323	<p>Continued From page 4 herself. When asked why, she stated other staff was busy.</p> <p>Interview, on 02/15/12 at 6:00 PM, with SRNA #3 revealed if other staff was not available, they were supposed to wait until someone was available. Further interview revealed they always had other SRNAs to assist or nurses would help with transfers when needed. Two (2) people should always do a mechanical lift transfer. SRNA #3 reported staff had been trained on the mechanical lift.</p> <p>Interview, on 02/15/12 at 6:10 PM, with the Director of Nursing (DON) revealed when staff was performing mechanical lift transfers, two (2) staff should perform the transfer. It was important to have two (2) staff present for resident safety. Staff was inserviced on how to perform the transfers. The DON and nurses were supposed to monitor aides to ensure care plans were followed. Further interview with the DON revealed, SRNA #1 informed her of the incident and explained she was in a hurry and did the transfer and did it without asking for assistance. The aide admitted to the DON, she failed to follow the proper procedure with the transfer.</p> <p>2. Review of the facility's policy titled "Storage of Medications", undated, revealed the medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Under Procedures subsection B. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access.</p>	F 323	<p>resident's care plan and facility policy. All residents have the potential to be affected by storage of the medication cart.</p> <p>Systemic Changes The DON and designated charge nurses provided and continue to provide inservicing for all nursing staff on proper transfers. The DON, and ADON provided and continue to provide inservicing for all licensed nursing staff regarding safe storage of medication.</p> <p>Monitoring Daily skills check audits are being completed by the Director of Nursing and Assistant Director of Nursing to monitor staff's delivery of care in accordance with the facility policy and the resident's care plan. Daily audits have and will continue to occur to monitor safe storage of medication. The QA Nurse will audit 10% of residents' care plans monthly. Care Plan audit will include</p>	

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F 323	<p>Continued From page 5</p> <p>Observation on Hall 200, on 02/15/12 from 10:54 AM to 10:59 AM, revealed a medication cart was unlocked and unsupervised. Licensed Practical Nurse (LPN) #2 returned to the cart at 10:59 AM and locked the cart. No residents or other staff were present when the unlocked cart was observed.</p> <p>Interview, on 02/15/12 at 10:59 AM, with LPN #2 revealed she always locked her cart, but forgot at that time. Further interview with LPN #2 revealed she understood why the cart should be locked - for safety. LPN #2 also acknowledged it was the facility's policy to always lock the cart when walking away.</p> <p>Interview, on 02/15/12 at 11:30 AM, with the Administrator revealed all medication carts should be locked anytime a nurse walks away from the cart. Pharmacy had inserviced all staff about locking the cart and staff should be familiar with the facility's policy.</p> <p>Interview, on 02/15/12 at 1:15 PM, with the DON revealed medication carts should always be locked if not performing a task at that time. The facility had conducted inservices on medication carts needing to be locked and on medication storage. The DON continued to state, Pharmacy also provided inservices to staff.</p>	F 323	<p>comparing the comprehensive care plan to the SRNA care plan and validating that interventions are in place as care planned. The QA nurse and or pharmacy representative will conduct medication administration skills checks including safe storage of medication.</p>	2-25-12