

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

PRINTED: 09/15/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 09/09/2015
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	<p>INITIAL COMMENTS</p> <p>A Revisit Survey was conducted on 09/09/15 and determined the facility was in compliance on 07/28/15, as alleged.</p>	{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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F 000	INITIAL COMMENTS An Abbreviated Survey Investigating Complaints KY#23462 and KY#23453 was conducted on 07/06/15 through 07/09/15. Complaint KY#23462 was substantiated with deficiencies cited at the highest Scope and Severity of a "G". Complaint KY#23453 was unsubstantiated with no regulatory violations identified. On 06/14/15, State Registered Nurse Aide (SRNA) #8 failed to follow the care plan and provide adequate supervision to prevent accidents when she provided incontinent care to Resident #1. SRNA #1 turned Resident #1 over in the bed without assistance, the siderail broke, and the resident fell to the floor sustaining a broken left femur which required surgery and a laceration to his/her left temporal area which required five (5) sutures.	F 000	Disclaimer: Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts alleged or conclusions set forth in the Statement of deficiency. This Plan of Correction is prepared and executed solely because it is required by federal and state law.	
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, facility policy review, and review of the hospital Emergency Room Report, Consultation Report, and Operative Report, it was determined the facility failed to ensure services provided or arranged by the facility were provided by qualified persons in accordance with each resident's written plan of care for one (1) of four (4) sampled	F 282	1. The side rails were immediately replaced on the standard bed of resident #1 on 6/14/15 by the maintenance personnel. The resident was then reassessed for side rail use on 6/14/15 by a licensed nurse. As part of Interdisciplinary Team Review of fall to prevent reoccurrence the resident was reassessed by a licensed nurse on 6/15/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 8/26/15
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F 282	<p>Continued From page 1</p> <p>residents (Resident #1) and one (1) unsampled resident (Resident A). (Refer to F323)</p> <p>On 06/14/15, Resident #1 was care planned for the total assist of two (2) staff for bed mobility; however, on 06/14/15, SRNA #6 failed to follow the Comprehensive and State Registered Nurse Aide (SRNA) Kardex (care plan) for Resident #1 when she provided incontinent care in the bed by rolling the resident over without assistance. When SRNA #1 rolled the resident over, the siderail broke and Resident #1 fell from the bed to the floor sustaining a laceration to the left temporal area requiring five (5) sutures and a broken left hip requiring surgery.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure, titled "Nursing Specific Safety Guidelines", not dated, revealed staff was to always have the appropriate amount of assistance and to refer to the Kardex/care plan for specifics as to how many staff are required to care for a resident safely.</p> <p>Record review revealed the facility admitted Resident #1 on 04/22/11 and readmitted on 07/02/15 with diagnoses which included Multiple Sclerosis, Hypertension, Diabetes Mellitus Type II, Convulsions, Urine Retention, Chronic Osteomyelitis, Neurogenic Bladder, Contracture of hand, Hypothyroidism, Esophageal Reflux, Respiratory Failure, and Left Below Knee Amputation.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 06/01/15, revealed the facility assessed Resident #1's cognitive status as severely impaired with a Brief Interview for Mental</p>	F 282	<p>and placed on a bariatric bed with siderails. The resident's plan of care was updated at that time by a licensed nurse to reflect the addition of the bariatric bed. Resident #1 is provided services by qualified persons in accordance with the written plan of care as determined by care observations conducted by the Administrative nursing team (Director of Nursing, Assistant Director of Nursing, Unit Manger RN, Weekend Manager, Quality Assurance RN, Staff Development Coordinator RN, Assistant Administrator RN, Night Supervisor RN) weekly x4 weeks. These care observations were initiated on 7/27/15.</p> <p>Unsampled Resident A was reviewed by the Director of Nursing on 7/27/15 for amount of</p>		

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F 282	<p>Continued From page 2</p> <p>Status (BIMS) score of three (3) which indicated the resident was not interviewable. In addition, the resident required extensive assistance of two (2) staff for bed mobility.</p> <p>Review of Comprehensive Care Plan for bed mobility, dated 07/03/15, and (SRNA) Kardex (care plan) dated 06/20/15, revealed Resident #1 required bed mobility assistance of two (2) staff members.</p> <p>Review of Nursing Notes, dated 06/14/15, the Emergency Room Report, dated 06/14/15 at 10:47 AM, and interviews with SRNA #6, on 07/08/15 at 10:40 AM, and Licensed Practical Nurse (LPN) #1 on 07/07/15 at 2:30 PM revealed on 06/14/15, SRNA #6 asked LPN #1 for assistance and the LPN said "she would be in shorty". SRNA #6 entered Resident #1's room and she noted the resident had feces all over the front and back of him/her. The SRNA went ahead and provided care to the resident when the LPN did not come. The SRNA rolled the resident to his/her side and when the SRNA turned and reached for a wash cloth the resident rolled on over, the side rail broke, and the resident fell to the floor. The SRNA turned on the call light to summon help but no one responded so she went to the hallway and yelled for help. LPN #1 came to the room and assessed the resident who had blood coming from his/her left side of the head. Resident #1 was left on the floor until Emergency Medical Support (EMS) arrived and took the resident to the Emergency Room for evaluation of the laceration to his/her head. Resident #1 returned to the facility on 06/14/15 at 1:35 PM, with five (5) sutures to his/her left temporal area. After return from the hospital, staff identified the resident's left stump began to have swelling. An</p>	F 282	<p>assistance required with activities of daily living and the care plan was reviewed to ensure updated correctly. No changes were necessary. The staff member SRNA #9 was counseled by the Director of Nursing on 7/10/15 on providing assistance to residents according to the plan of care.</p> <p>2. All facility beds with side rails were inspected by the maintenance staff on 6/14/15 for proper function and repaired/replaced as indicated.</p> <p>All residents requiring assistance with turning and repositioning have the potential to be affected. To identify other residents with potential to be affected, care observations were conducted by the Administrative nursing team once weekly x2 weeks, and then once</p>		

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F 282	<p>Continued From page 3</p> <p>x-ray was taken and the resident was sent back to the hospital on 06/14/15 at 8:20 PM.</p> <p>Review of a Consultation Report, dated 06/15/15, revealed radiograph reports showed a fracture of the left femoral shaft. Review of the Operative Report, dated 06/16/15, revealed a postoperative diagnosis of Comminuted Fracture of the left femoral shaft which required a surgical procedure of interlocking intramedullary nailing of the left femur.</p> <p>Further interview with SRNA #6, on 07/08/15 at 10:40 AM, revealed she was aware of the resident's Kardex indicated the resident required two (2) staff assistance for bed mobility, but she did not want to wait any longer for assistance to arrive.</p> <p>Further interview with Licensed Practical Nurse (LPN) #1, on 07/07/15 at 2:30 PM, revealed SRNA #6 expected her to come in the room to provide wound care; however, SRNA #1 did not wait for her to arrive before she provided care to Resident #1 resulting in the resident being injured from a fall from the bed.</p> <p>2. Record review revealed the facility admitted Unsampled Resident A, on 10/03/13 with diagnoses which included Renal Failure, Morbid Obesity, Type II Diabetes Mellitus, Asthma, Osteoarthritis, and Hypertension.</p> <p>Review of the MDS assessment, dated 06/01/15, revealed the facility assessed Unsampled Resident A's cognition as cognitively intact with a BIMS score of fourteen (14) which indicated the resident was interviewable. In addition, the resident required extensive assist of two (2) staff</p>	F 282	<p>monthly x2 months for 10 residents to determine the residents are provided services by qualified persons in accordance with their written plan of care.</p> <p>3. All licensed staff and non-licensed nursing staff have received education by the Staff Development Coordinator RN, Assistant Director of Nursing, Unit Manager RN, Director of Nursing, Night Shift Supervisor RN, or Weekend Manager on the need to provide resident care, including but not limited to the amount of assistance designated, in accordance with the resident plan of care and the disciplinary process that will be utilized if the plan of care is not followed. This education was initiated on 7/13/15 and continued on 7/14/15, 7/15/15, 7/16/15, 7/23/15, 7/24/15, and 7/27/15. No</p>		

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F 282	<p>Continued From page 4 for bed mobility.</p> <p>Review of the Comprehensive Care Plan, dated 03/26/14, and the SRNA Kardex, dated 03/26/15, revealed Unsampld Resident A required extensive assist of two (2) staff for bed mobility.</p> <p>Observation on 07/08/15 at 9:45 AM, revealed SRNA #9 was providing care to Unsampld Resident A, who required two (2) staff assist for bed mobility unassisted. SRNA #9 was providing incontinent care for Resident #1 which required the resident to be turned and positioned on his/her side putting the resident at risk for injury related to SRNA #9 providing care unassisted.</p> <p>Interview with SRNA #8, on 07/08/15 at 9:45 AM, revealed Unsampld Resident A required one (1) person assist with bed mobility because the resident was able to hold on to the side rail and assist with turning in bed. SRNA #9 stated she was aware she was supposed to go by the SRNA Kardex; however, the SRNA Kardex revealed the resident required two (2) staff assistance for bed mobility.</p> <p>Interviews with SRNA #5, on 07/07/15 at 3:00 PM, SRNA #7, at 3:08 PM, SRNA #8, at 3:35 PM, SRNA #13 at 7:15 AM, SRNA #11 at 7:14 AM, SRNA #12 at 7:17 AM, and SRNA #10 at 7:05 AM, SRNA #9 on 07/08/15 at 9:45 AM, revealed they were aware of the need to follow the resident's care plan/Kardex to ensure care was provided to meet the resident's needs safely. However, three (3) of the SRNAs interviewed (SRNA #13, SRNA #5, SRNA #9), revealed they provided care with one (1) person assist even though the Kardex indicated the resident required two (2) person assist because other staff</p>	F 282	<p>licensed or non-licensed nursing staff will be allowed to work after 7/27/15 without having first received the education.</p> <p>Maintenance staff received education on 7/24/15, 7/25/15, and 7/27/15 by the Assistant Administrator, Weekend Manager, and Environmental Services Supervisor on the need to inspect all siderails in accordance with the preventative maintenance schedule and manufacturer recommendations.</p> <p>A competency checklist for newly hired nursing staff has been implemented as of 7/22/15 that includes demonstrating how to view the Kardex care plan and determine the amount of assistance required by a resident.</p>		

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F 282	Continued From page 5 members were busy and could not assist them. Interviews on 07/07/15 with Registered Nurse (RN) #3 at 2:20 PM, RN #4 at 2:45 PM, and interviews on 07/08/15 with RN #5 at 12:15 PM, RN #1 at 2:55 PM, RN #2 at 2:22 PM, LPN #2 at 2:12 PM and LPN #3 at 2:34 PM revealed they were responsible to ensure the residents were receiving care that meets safety requirements and the SRNAs were following the Kardex for each resident. The interviews revealed they made rounds on the halls, checked Activities of Daily Living documentation to ensure the correct amount of assistance was being documented and provided, and ensured the SRNAs knew they could ask for assistance from other staff (charge nurses) rather than depending on each other. Interview with the Director of Nursing (DON), on 07/09/15 at 11:45 AM, revealed she expected the SRNAs to follow the resident's Kardex and were not to provide care unassisted if the Kardex indicated otherwise. She stated all licensed staff were responsible for ensuring resident safety and ensuring the care plan/Kardex was being followed.	F 282	An environmental safety audit has been implemented as of 7/27/15. This audit will be completed weekly by the Assistant Administrator or Environmental Services Supervisor. Any identified hazards will be corrected and findings reported to the QAPI (Quality Assurance/ Performance Improvement) monthly meeting for tracking and trending purposes.	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	4. The QAPI (Quality Assurance/ Performance Improvement) indicator for monitoring of resident care provision in accordance with the care plan will be utilized monthly x2 months, then quarterly under the supervision of the Director of Nursing. Any identified concerns will be immediately addressed. Findings of the completed indicators will be reviewed by the QAPI committee to	

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F 323	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review, review of the facility's policy and procedures, and review of the hospital Emergency Room Report, Consultation Report, and Operative Report, it was determined the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for one (1) of four (4) sampled residents (Resident #1) and one (1) unsampled resident (Resident A).</p> <p>Resident #1 was assessed and care planned to require the assistance of two (2) staff with bed mobility to ensure adequate supervision to prevent accidents. On 06/14/15, State Registered Nurse Aide (SRNA) #6 provided incontinent care to Resident #1 with no assistance and when she rolled the resident over to his/her side, the side rail broke and the resident fell to the floor. Resident #1 sustained a broken left femur which required surgery and a laceration to his/her left temporal area which required five (5) sutures.</p> <p>The findings include:</p> <p>Review of the facility's Nursing Specific Safety Guidelines, no date, revealed when moving patients staff should always ask for and wait for help to arrive before attempting to lift or transfer a patient who is unable to assist in moving.</p> <p>Record review revealed the facility admitted Resident #1 on 04/22/11 and readmitted on 07/02/15 with diagnoses which included Multiple Sclerosis, Hypertension, Diabetes Mellitus Type II, Convulsions, Urine Retention; Chronic Osteomyelitis; Neurogenic Bladder; Contracture</p>	F 323	<p>determine if any further action is indicated.</p> <p>The QAPI indicator for monitoring of devices and siderails will be utilized monthly x2 months, then quarterly under the supervision of the Director of Nursing. Any identified concerns will be immediately addressed. Findings of the completed indicators will be reviewed by the QAPI committee monthly to determine if any further action is indicated. The Director of Nursing and the Quality Assurance RN will be responsible to oversee the monitoring.</p> <p>The QAPI (Quality Assurance and Performance Improvement) team at a minimum consists of the Administrator, Assistant Administrator, Director of Nursing, Assistant Director of Nursing,</p>		

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F-323	<p>Continued From page 7</p> <p>of hand; Hypothyroidism, Esophageal Reflux, Respiratory Failure, and Left Below Knee Amputation.</p> <p>Review of Resident #1's Minimum Data Set (MDS) assessment, dated 06/01/15; Comprehensive Care Plan, dated 07/03/15; and State Registered Nurse Aide (SRNA) Kardex (CNA care plan) revealed the facility assessed and care planned Resident #1 required total assist of two (2) staff with bed mobility.</p> <p>Review of Nurse's Note, dated 06/14/15 at 10:34 AM, revealed SRNA #8 came to the nursing station and stated the resident was in the floor and she needed help. The Nurse documented upon entering the room, the resident was in the floor with a moderate amount of blood around his/her head and was found to have a laceration to the left temporal area. 911 was called by another staff member and the resident was sent to the hospital for sutures.</p> <p>Review of the Emergency Room (ER) Report, dated 06/14/15 at 10:47 AM, revealed Resident #1 received sutures to a two (2) centimeter laceration on the left side of the head and departed the ER at 1:37 PM on 06/14/15.</p> <p>Further review of the Nurse's Notes, dated 06/14/15, revealed at 1:35 PM, the resident returned from the Emergency Room with five (5) sutures to his/her left temporal area in no acute distress. Review of a Nurse's Note, dated 06/14/15 at 3:00 PM, revealed the dressing was removed from the resident's left stump area and swelling was noted. The physician was notified of the edema and gave an order for ice to be applied twenty (20) minutes three (3) times. At</p>	F 323	<p>Quality Assurance RN, Staff Development Coordinator RN, Medical Director, and the Environmental Services Supervisor.</p> <p>5. Completion Date 7/28/15</p> <p>F 323</p> <p>1. The side rails were immediately replaced on the standard bed of resident #1 on 6/14/15 by the maintenance personnel. The resident was then reassessed for side rail use on 6/14/15 by a licensed nurse. As part of Interdisciplinary Team Review of fall to prevent reoccurrence the resident was reassessed by a licensed nurse on 6/15/15</p>		

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F 323	<p>Continued From page 8</p> <p>3:20 PM, the stump appeared more edematous and the physician was notified and at 5:11 PM, the nurse noted the dressing to the stump appearing more snug and the physician was notified again with an order received for an x-ray of the left stump at 5:17 PM. At 7:17 PM, Mobile X-Ray arrived at the facility and x-rays were obtained and at 8:20 PM, the physician was notified of the x-ray results and an order was obtained to send the resident to the Emergency Room. Review of a Nurse's Note, dated 06/15/15 at 3:57 AM, revealed the nursing facility called the hospital to check on Resident #1 and he/she had been admitted to the medical unit and a consult was requested with an orthopedic surgeon.</p> <p>Review of a Consultation Report, dated 06/15/15, revealed radiograph reports showed a fracture of the left femoral shaft. Review of the Operative Report, dated 06/16/15, revealed a postoperative diagnosis of Comminuted Fracture of the left femoral shaft which required a surgical procedure of interlocking intramedullary nailing of the left femur.</p> <p>Interview with SRNA #6, on 07/08/15 at 10:40 AM, revealed on 06/14/15 she told the Charge Nurse, Licensed Practical Nurse (LPN) #1, she was going into Resident #1's room to provide care and was told by LPN #1 "she would be in shortly to assist her". She stated when she entered the resident's room, the resident had feces all over the front and back of him/her, she waited for assistance, but when no one came, she proceeded to clean the resident rolling him/her to his/her right side facing the window. She said she had her left hand placed on Resident #1's right hip and reached around to</p>	F 323	<p>and placed on a bariatric bed with siderails. The resident's plan of care was updated at that time by a licensed nurse to reflect the addition of the bariatric bed. Resident #1 is provided services by qualified persons in accordance with the written plan of care as determined by care observations conducted by the Administrative nursing team (Director of Nursing, Assistant Director of Nursing, Unit Manger RN, Weekend Manager, Quality Assurance RN, Staff Development Coordinator RN, Assistant Administrator RN, Night Supervisor RN) weekly x4 weeks. These care observations were initiated on 7/27/15.</p> <p>Unsampled Resident A was reviewed by the Director of Nursing on 7/27/15 for amount of</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/09/2015
NAME OF PROVIDER OR SUPPLIER REDBANKS			STREET ADDRESS, CITY, STATE, ZIP CODE 851 KIMSEY LANE HENDERSON, KY 42420		
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F 323	<p>Continued From page 9</p> <p>obtain a clean wash cloth and she felt the resident's body give and he/she rolled out of the bed onto the floor. She stated the side rail was up on the side of the bed she rolled the resident towards, but it gave way. Further interview revealed she turned the resident's call light on to summon help and when no one came, she went to the hallway and yelled for help. She stated LPN #1 came to the room and assessed Resident #1 who was found to have blood coming from his/her left side of the head and the resident was transferred to the Emergency Room for evaluation of the laceration to his/her head. She revealed she was aware of the resident's Kardex indicated the resident required two (2) staff assistance for bed mobility, but she did not want to wait any longer for assistance to arrive.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 07/07/15 at 2:30 PM, revealed she was working on 06/14/15 when Resident #1 fell from the bed causing harm to the resident. She stated SRNA #8 expected her to come in the room to provide wound care; however, SRNA #1 did not wait for her to arrive before she provided care to Resident #1 resulting in the resident being injured from a fall from the bed.</p> <p>Interview with the Maintenance Technician, on 07/08/15 at 1:35 PM, revealed the side rail that broke on Resident #1's bed was on the bed via a universal side rail kit from a different manufacturer than that of the bed. He revealed he had never seen a side rail give way resulting in a resident being injured until 06/14/15 when the incident occurred with Resident #1. Additional observation and interview revealed the bar under the bed mattress, which was part of the universal side rail kit, broke and not the side rail. He was</p>	F 323	<p>assistance required with activities of daily living and the care plan was reviewed to ensure updated correctly. No changes were necessary. The staff member SRNA #9 was counseled by the Director of Nursing on 7/10/15 on providing assistance to residents according to the plan of care.</p> <p>2. All facility beds with side rails were inspected by the maintenance staff on 6/14/15 for proper function and repaired/replaced as indicated.</p> <p>All residents requiring assistance with turning and repositioning have the potential to be affected. To identify other residents with potential to be affected, care observations were conducted by the Administrative nursing team once weekly x2 weeks, and then once</p>		

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F 323	<p>Continued From page 10--</p> <p>unsure how the break occurred and review of the audit logs conducted monthly on all of the universal side rail adapter kits, revealed Resident #1's side rails and kit were checked on 06/01/15 with no concerns noted.</p> <p>Interview with a Representative from the Manufacturer of Resident #1's bed, on 07/09/15 at 8:35 AM, revealed the universal kit was appropriate for the bed; however, they recommended use of side rails they sold to go on their beds.</p> <p>2. Record review revealed the facility admitted Unsampled Resident A, on 10/03/13 with diagnoses which included Renal Failure, Morbid Obesity, Type II Diabetes Mellitus, Asthma, Osteoarthritis, and Hypertension.</p> <p>Review of the MDS assessment, dated 06/01/15; Comprehensive Care Plan, dated 03/26/14; and the SRNA Kardex, dated 03/26/15, revealed Unsampled Resident A required extensive assist of two (2) staff assistance for bed mobility.</p> <p>Observation on 07/08/15 at 9:45 AM, revealed SRNA #9 was providing incontinent care for Unsampled Resident A. SRNA #9 was turning and repositioning the resident on his/her side without the assistance of another staff to ensure adequate supervision was provided which placed the resident as risk for injury.</p> <p>Interview with SRNA #9, on 07/08/15 at 9:45 AM, revealed Unsampled Resident A required one (1) person assist with bed mobility because the resident was able to hold on to the side rail and assist with turning in bed; however, the SRNA Kardex revealed the resident required two (2)</p>	F 323	<p>monthly x2 months for 10 residents to determine the residents are provided services by qualified persons in accordance with their written plan of care.</p> <p>3. All licensed staff and non-licensed nursing staff have received education by the Staff Development Coordinator RN, Assistant Director of Nursing, Unit Manager RN, Director of Nursing, Night Shift Supervisor RN, or Weekend Manager on the need to provide resident care, including but not limited to the amount of assistance designated, in accordance with the resident plan of care and the disciplinary process that will be utilized if the plan of care is not followed. This education was initiated on 7/13/15 and continued on 7/14/15, 7/15/15, 7/16/15, 7/23/15, 7/24/15, and 7/27/15. No</p>		

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F-323	Continued From page 11 staff assistance for bed mobility. Interviews on 07/07/15 with Registered Nurse (RN) #3 at 2:20 PM and RN #4 at 2:45 PM; and interviews on 07/08/15 with RN #5 at 12:15 PM, RN #1 at 2:55 PM, RN #2 at 2:22 PM, LPN #2 at 2:12 PM and LPN #3 at 2:34 PM revealed they were responsible to ensure the residents were receiving care with the adequate amount of supervision. Interview with the Director of Nursing (DON), on 07/09/15 at 11:45 AM, revealed she expected the SRNAs to follow the resident's Kardex and to ask for and wait for assistance to arrive before putting a resident in harms way.	F 323	licensed or non- licensed nursing staff will be allowed to work after 7/27/15 without having first received the education. Maintenance staff received education on 7/24/15, 7/25/15, and 7/27/15 by the Assistant Administrator, Weekend Manager, and Environmental Services Supervisor on the need to inspect all siderails in accordance with the preventative maintenance schedule and manufacturer recommendations. A competency checklist for newly hired nursing staff has been implemented as of 7/22/15 that includes demonstrating how to view the Kardex care plan and determine the amount of assistance required by a resident.		

An environmental safety audit has been implemented as of 7/27/15. This audit will be completed weekly by the Assistant Administrator or Environmental Services Supervisor. Any identified hazards will be corrected and findings reported to the QAPI (Quality Assurance/ Performance Improvement) monthly meeting for tracking and trending purposes.

- 4. The QAPI (Quality Assurance/ Performance Improvement) indicator for monitoring of resident care provision in accordance with the care plan will be utilized monthly x2 months, then quarterly under the supervision of the Director of Nursing. Any identified concerns will be immediately addressed. Findings of the completed indicators will be reviewed by the QAPI committee to**

determine if any further action is indicated.

The QAPI indicator for monitoring of devices and siderails will be utilized monthly x2 months, then quarterly under the supervision of the Director of Nursing. Any identified concerns will be immediately addressed. Findings of the completed indicators will be reviewed by the QAPI committee monthly to determine if any further action is indicated. The Director of Nursing and the Quality Assurance RN will be responsible to oversee the monitoring.

The QAPI (Quality Assurance and Performance Improvement) team at a minimum consists of the Administrator, Assistant Administrator, Director of Nursing, Assistant Director of Nursing,

**Quality Assurance RN,
Staff Development
Coordinator RN, Medical
Director, and the
Environmental Services
Supervisor.**

5. Completion Date 7/28/15