



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

PRINTED: 03/08/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185265	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/24/2011
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NAME OF PROVIDER OR SUPPLIER  GRANT MANOR CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 226	<p>Continued From page 1</p> <p>with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to have an effective system to ensure all alleged violations involving abuse, or injuries of unknown source were immediately reported to State Agencies in accordance with state law for one (1) of three (3) sampled residents (Resident #2). Resident #2 was noted to have bruising around the eye on 12/22/10; and was diagnosed with a Hip Fracture on 01/30/11. Although the facility completed investigations related to the injuries; there was no documented evidence state agencies were notified of the injuries of unknown source.</p> <p>The findings include:</p> <p>Review of the facility's policy entitled "Abuse and Neglect Prohibition Program", dated January 2008, revealed the facility ensured all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property were reported immediately to the administrator of the facility and to other officials in accordance with state law. The Policy stated, an Injury should be classified as an "injury of unknown source" when both of the following conditions were met: 1) the source of the injury was not observed by any person, or the source of the injury could not be explained by the resident, and 2) the injury was</p>	F 225	<p>center procedure on abuse, neglect, mistreatment, and misappropriation of resident's property. Residents in attendance were educated by the Social Services Director to report any such concerns to a member of management immediately. Payroll Coordinator also reviewed employee's personnel files to ensure no individuals are employed who have been found guilty of abusing, neglecting or mistreating residents by a court of law or have had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property. Review completed on March 30, 2011. No other residents were identified to be affected.</p> <p>3. The Administrator, Director of Nursing Services, and Social Services Director attended Elder Abuse Training sponsored by the Office of the Inspector General on March 10, 2011. The Administrator and Director of Nursing Services were re-educated by the Regional Director of Clinical Operations on March 16, 2011 regarding reporting allegation of abuse, neglect, mistreatment, or misappropriation of residents' property. Grant Manor employees were re-educated on abuse and neglect by the Administrator and/or Director of Nursing from March 11, 2011 thru March 14, 2011. Education</p>	
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NAME OF PROVIDER OR SUPPLIER  <b>GRANT MANOR CARE AND REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 KIMBERLY LANE</b> <b>WILLIAMSTOWN, KY 41097</b>
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F 225	<p>Continued From page 2</p> <p>suspicious because of the extent of the injury, or the location of the injury. The Policy further stated "Immediately means immediately upon the discovery of a potential incident".</p> <p>1. Record review for Resident #2 revealed diagnoses which included Dementia, Osteoarthritis, and Contractures of Multiple Joints. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 11/27/10, revealed the facility assessed the resident as having moderate impairment in cognitive skills for decision making. Further review of the MDS revealed the facility assessed the resident as requiring total assistance with transfers, dressing, grooming, and bathing, and as being unable to ambulate.</p> <p>Review of the Resident Assessment Protocol Summary (RAPS) dated 09/02/10, revealed the resident was at risk for falls related to the diagnoses of Alzheimer's Disease, and Bilateral Hip/Knee Contractures. Further review revealed the resident was totally dependent on staff for all Activities of Daily Living (ADL's), mobility, and transfers, and was transferred with a mechanical lift.</p> <p>Review of the Comprehensive Plan of Care dated 07/29/10 revealed the resident was at risk for falls related to decreased safety awareness and had self care deficits related to cognitive deficits, Osteoarthritis, and impaired mobility. The interventions included a low bed, assist of two (2) with bed positioning, and use at least two (2) people with a mechanical lift.</p> <p>Review of the Interdisciplinary Progress Notes dated 01/27/11 at 9:05 AM, revealed the resident</p>	F 225	<p>included the criteria for an injury to be "unknown origin," and the center's responsibility of reporting all allegation of abuse, neglect, mistreatment, or misappropriation of residents' property to local and state agencies.</p> <p>4. The Director of Nursing Services or Assistant Director of Nursing Services will complete 5 skin assessments, staff and resident interviews per week times 4 weeks, then monthly for 2 months to ensure there are no injuries of unknown source and or abuse. Identified unknown injuries and or abuse will be reported immediately. The Administrator/Director of Nursing Services/Assistant Director of Nursing Services/Unit Managers/Nursing Supervisor will review all</p>	
	<p>incidents/accidents/grievances daily. In the event that abuse, neglect, mistreatment, or misappropriations are suspected the Administrator/Director of Nursing Services/Assistant Director of Nursing Services/Unit Managers/Nursing Supervisor will report to state and local authorities. The Director of Nursing Services/Assistant Director of Nursing Services will review findings and report to the Performance committee monthly for three (3) months for review and recommendations.</p>			

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NAME OF PROVIDER OR SUPPLIER  <b>GRANT MANOR CARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 KIMBERLY LANE WILLIAMSTOWN, KY 41087</b>		
(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 225	<p>Continued From page 3</p> <p>was in the diningroom and was brought to her/his room due to having a seizure which lasted one (1) minute. Further review of the Notes revealed three (3) persons lifted the resident to the bed and turned the resident on her/his side. At 9:20 AM, a call was placed to the Physician's Office.</p> <p>Review of the Interdisciplinary Progress Notes dated 01/29/11 at 11:15 AM, revealed the nurse attempted one time to start a new intravenous line and was unsuccessful. Further review revealed a call was placed to the physician's office for a possible midline and the resident also complained of right hip pain.</p> <p>The next entry dated 01/29/11 at 2:05 PM, revealed the resident complained of right hip pain and had no signs and symptoms of distress. New Orders were received for an x-ray of the right hip.</p> <p>A late entry note was written on 02/01/11 for 01/29/11 at 6:00 PM, revealed the resident's complaints of right hip pain were reported from the previous shift. The resident's right leg had no discoloration and appeared to be of normal length with comparison to the opposite leg. The resident's bilateral legs were noted to have contractures limiting the range of motion assessment. The resident had no complaints of pain or signs and symptoms of discomfort with the current position but "yelled out" during repositioning for x-ray films placement. Pain was also noted with the assessment of the right hip in the frontal distal area.</p> <p>Review of an entry dated 01/29/11 at 9:15 PM, revealed staff was unable to obtain a hip x-ray in the facility; the physician was notified. New orders were received to send the resident to the</p>	F 225	5. Date of Compliance: March 31, 2011.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 02/24/2011
NAME OF PROVIDER OR SUPPLIER  GRANT MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097		
(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)	(X6) COMPLETION DATE	
F 225	<p>Continued From page 4</p> <p>hospital for a hip x-ray. The resident's family was notified.</p> <p>The next entry dated 01/29/11 at 9:45 PM, revealed the resident was transported to the hospital emergency room for evaluation.</p> <p>Review of the x-ray report of the pelvis obtained on 01/30/11, revealed the resident had a Displaced Transcervical Right Hip Fracture, and Demineralization.</p> <p>Review of the facility's "Fracture Investigation" revealed the date of the event was 01/29/11 at 11:30 PM, the event was a self inflicted injury, and the injury was a fracture. The investigation stated the resident suffered a witnessed violent Grand Mal Seizure lasting over sixty (60) seconds on 01/27/11 while seated in her/his wheelchair. The resident was assisted to bed by three (3) staff members and positioned on his/her left side to keep the airway open. The section entitled; Cause of Injury: revealed the resident suffered a Grand Mal Seizure prior to the discovery of a hip fracture.</p> <p>Interview with the Director of Nursing (DON) on 02/24/11 at 9:45 AM, revealed she had received a phone call from staff on 01/29/11 when the resident was diagnosed with a fracture. She stated the facility was unaware of the cause of the fracture and had to investigate. She further stated all staff were interviewed who were assigned and worked with the resident from 01/26/11, which was the date of re-admission to the facility from the hospital. Further interview revealed the resident had not sustained a recent fall; however, had a "violent" seizure in the dining room on 01/27/11. Continued interview revealed,</p>	F 225			

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NAME OF PROVIDER OR SUPPLIER  GRANT MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097		
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F 225	<p>Continued From page 5</p> <p>after staff interviews, the facility felt the seizure was the cause of the fracture. She stated the Administrator was in charge of the abuse investigations.</p> <p>Interview on 02/24/11 at 1:30 PM, with the Administrator revealed she was notified at 9:30 PM on 01/29/11 of the resident complaining of right hip pain and of the resident's transfer to the hospital emergency room for an x-ray. She further stated she was notified at midnight on 01/30/11 of the Hip Fracture and she immediately started interviewing staff. Continued interview revealed, by Sunday Night (01/30/11) she had completed most of the interviews with staff and felt the root cause of the Hip Fracture was the seizure. She stated the staff interviews revealed the resident had not sustained falls, and had not been out of the bed since the seizure on 01/27/11 due to receiving intravenous antibiotics for a Urinary Tract Infection (UTI) and lethargy. Further interview revealed she did not notify the state agencies of the Hip Fracture because after interviews with staff, she felt the Hip Fracture was not an injury of unknown source.</p> <p>2. Further review of the Interdisciplinary Progress Notes dated 12/22/10 at 7:00 AM, revealed there was a bruise noted to the resident's left eye and the resident guarded the eye when touched. The Notes stated, the resident was unable to voice the cause, and the DON was notified.</p> <p>Review of the Interdisciplinary Progress Notes dated 12/22/10 at 7:30 PM written by the DON, revealed completion of interviews with staff revealed the resident had been noted to rub and pick at the face and eyes lately and the discoloration was attributed to this. The</p>	F 225			

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NAME OF PROVIDER OR SUPPLIER  GRANT MANOR CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097
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F 225	<p>Continued From page 6</p> <p>Responsible Party and Physician were notified.</p> <p>Review of the facility's "Skin Investigation" revealed the date of the event was 12/22/10 at 3:00 PM, and the event was a self-inflicted injury. The investigation stated the resident had been noted by staff to pick, scratch, and rub at skin which included the eyes and face. According to the investigation, the resident had a discolored area to the left outer eye as a result.</p> <p>Interview on 02/22/11 at 4:30 PM with Certified Nursing Assistant (CNA) #3 revealed she remembered the resident having black and blue discoloration and swelling of the eye lid. She stated she asked the nurses how the resident got the black eye and the nurses did not give her an answer.</p> <p>Interview on 02/23/11 at 9:45 AM with CNA #1, revealed she sometimes was assigned to the resident and she remembered the resident had a noticeable bruise of the eye around Christmas. She stated "It was a black eye" and no one knew how it happened.</p> <p>Interview on 02/23/11 at 10:00 AM with CNA #2, revealed the resident had a "black eye" and had black discoloration under the eyes around Christmas. She stated she reported it to the nurse who was already aware.</p> <p>Interview with the DON on 02/24/11 at 9:45 AM revealed she was notified of the discoloration of the resident's eye and completed an investigation. She further stated the interviews with staff revealed the resident was noted to pick at her/his eyes non-stop. Continued interview revealed the state agencies were not notified of the bruising</p>	F 225		

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NAME OF PROVIDER OR SUPPLIER  <b>GRANT MANOR CARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 KIMBERLY LANE WILLIAMSTOWN, KY 41097</b>		
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F 225	Continued From page 7 around the eye because she had completed her investigation within hours and felt they had identified the root cause.  Interview on 02/24/11 at 1:30 PM with the Administrator indicated she did not feel the bruising of the resident's eye needed to be called into state agencies because the cause of the bruising was identified during the facility's investigation.  Although the facility had to interview staff and complete investigations in an attempt to find the source of injuries sustained including the right hip fracture, and bruise to the resident's left eye; there was no evidence state agencies were notified immediately of the injuries of unknown source as per state law.	F 225			
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure the "Abuse and Neglect Prohibition Program" Policy, dated January 2008, was implemented for one (1) of three (3) sampled residents (Resident #2). Resident #2 sustained a Right Hip Fracture which was diagnosed on 01/30/11 and was noted to have bruising around the left eye on 12/22/10. The facility failed to ensure the injuries of unknown source were immediately reported to	F 226	F 226  1. Resident #2 was discharged from Grant Manor Care and Rehabilitation Center on date January 30, 2011.  2. The Director of Nursing Services, Assistant Director of Nursing Services, Unit Managers and/or Nursing Supervisors completed skin assessments on current residents March 11, 2011 thru March 14, 2011. Interviews also conducted with residents and staff by the Social Services Director and Administrator on March 30, 2011 with no injuries of unknown source and or abuse identified. Resident Council meeting held on March 30, 2011 reviewed center procedure on prohibition of abuse, neglect, mistreatment, and misappropriation of resident's property. Residents in attendance were educated by the Social Services Director to report any such concerns to a member of		

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F 226	<p>Continued From page 8 State Agencies in accordance with state law.</p> <p>The findings include:</p> <p>Review of the facility's policy, "Abuse and Neglect Prohibition Program", dated January 2008, revealed the facility ensured all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property were reported immediately to the administrator of the facility and to other officials in accordance with state law. Further review revealed, "immediately means immediately upon the discovery of a potential incident".</p> <p>1. Review of Resident #2's medical record revealed diagnoses which included Dementia, Osteoarthritis, and Contractures of Multiple Joints.</p> <p>Review of the Interdisciplinary Progress Notes dated 01/29/11 at 11:15 AM revealed the nurse notified the physician that the resident complained of right hip pain.</p> <p>The next entry in the Notes dated 01/29/11 at 2:05 PM revealed the resident complained of right hip pain and had no signs and symptoms of distress. New Physician's Orders were received for an x-ray of the right hip.</p> <p>A late entry in the Notes dated 02/01/11 for 01/29/11 at 6:00 PM revealed the nurse described the resident as having no complaints of pain or signs and symptoms of discomfort with the current position but "yelled out" during repositioning for x-ray films placement. The Note further stated, pain was noted during the</p>	F 226	<p>management immediately. Payroll Coordinator also reviewed employee's personnel files to ensure no individuals are employed who have been found guilty of abusing, neglecting or mistreating residents by a court of law or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property. Review completed on March 30, 2011. No other residents were identified to be affected.</p> <p>3. The Administrator, Director of Nursing Services, and Social Services Director attended Elder Abuse Training sponsored by the Office of the Inspector General on March 10, 2011. The Administrator and Director of Nursing Services were re-educated by the Regional Director of Clinical Operations on March 16, 2011 regarding reporting allegation of abuse, neglect, mistreatment, or misappropriation of residents' property. Grant Manor employees were re-educated on abuse and neglect by the Administrator and/or Director of Nursing from March 11, 2011 thru March 14, 2011. Education included the criteria for an injury to be "unknown origin," and the center's responsibility of reporting all allegation of abuse, neglect, mistreatment, or</p>		

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F 226	<p>Continued From page 9</p> <p>assessment to the right hip in the frontal distal area.</p> <p>An entry in the Notes dated 01/29/11 at 9:15 PM, revealed the physician was notified of staff being unable to obtain a hip x-ray in the facility and Physician's Orders were received to send the resident to the hospital for a hip x-ray.</p> <p>The next entry in the Notes dated 01/29/11 at 9:45 PM revealed the resident was transported to the hospital emergency room for evaluation.</p> <p>Review of the x-ray report of the Pelvis completed on 01/30/11 revealed the resident had a Displaced Transcervical Right Hip Fracture, and Demineralization.</p> <p>Review of the facility "Fracture Investigation" revealed the date of the event was 01/29/11 at 11:30 PM and the injury was a fracture. The section entitled; Cause of Injury: revealed the resident suffered a Grand Mal Seizure prior to the discovery of a Hip Fracture.</p> <p>Interview with the Director of Nursing (DON) on 02/24/11 at 9:45 AM revealed the facility was unaware of the cause of the fracture and had to investigate. She further stated the resident had a "violent" seizure in the dining room on 01/27/11 and after staff interviews, the facility felt the seizure was the cause of the fracture.</p> <p>Interview on 02/24/11 at 1:30 PM with the Administrator revealed she was notified at midnight on 01/30/11. Continued interview revealed she did not notify the state agencies of the Hip Fracture because after staff were interviewed, she felt the Hip Fracture was not an</p>	F 226	<p>misappropriation of residents' property to local and state agencies.</p> <p>4. The Director of Nursing Services /Assistant Director of Nursing Services will complete 5 skin assessments, staff and resident interviews per week times 4 weeks, then monthly for 2 months to ensure there are no injuries of unknown source and or abuse. Identified unknown injuries and or abuse will be reported immediately. The Administrator/Director of Nursing Services/Assistant Director of Nursing Services/Unit Managers/Nursing Supervisor will review all incidents/accidents/grievances daily. In the event that abuse, neglect, mistreatment, or misappropriations are suspected the Administrator/Director of Nursing Services/Assistant Director of Nursing Services/Unit Managers/Nursing Supervisor will report to state and local authorities. The Director of Nursing Services/Assistant Director of Nursing Services will review findings and report to the Performance committee monthly for three (3) months for review and recommendations.</p> <p>5. Date of Compliance: March 31, 2011.</p>	
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STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

165285

(X2) MULTIPLE CONSTRUCTION

A. BUILDING \_\_\_\_\_

B. WING \_\_\_\_\_

(X3) DATE SURVEY  
COMPLETED

C

02/24/2011

NAME OF PROVIDER OR SUPPLIER

GRANT MANOR CARE AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

201 KIMBERLY LANE  
WILLIAMSTOWN, KY 41097

(X4) ID  
PREFIX  
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PROVIDER'S PLAN OF CORRECTION  
(EACH CORRECTIVE ACTION SHOULD BE  
CROSS-REFERENCED TO THE APPROPRIATE  
DEFICIENCY)

(X5)  
COMPLETION  
DATE

F 226

Continued From page 10  
Injury of unknown source.

2. Further review of the Interdisciplinary Progress Notes dated 12/22/10 at 7:00 AM, revealed there was a bruise to the resident's left eye and the resident guarded the eye when touched. The Notes stated, the resident was unable to voice the cause, and the nurse notified the DON.

Review of the Interdisciplinary Progress Notes dated 12/22/10 at 7:30 PM written by the DON, revealed interviews were completed with staff. The Note further stated, resident had been noted to rub and pick at the face and eyes of late and discoloration was attributed to this.

Review of the facility "Skin Investigation" revealed the date of the event was 12/22/10 at 3:00 PM. The investigation stated the resident had been noted by staff to pick, scratch, and rub at skin which including the eyes and face. The investigation stated, the resident had a discolored area to the left outer eye as a result.

Interview with the DON on 02/24/11 at 9:45 AM revealed she completed an investigation after being notified of the discoloration of the resident's eye. She stated, interviews with staff revealed the resident was noted to pick at her/his eyes non-stop. Further interview revealed the state agencies were not notified of the bruising around the eye because after her investigation was completed, the facility felt they had identified the root cause.

Interview on 02/24/11 at 1:30 PM with the Administrator indicated she did not feel it was necessary to notify the state agencies of the bruising of the resident's eye because the cause

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185285</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C <b>02/24/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GRANT MANOR CARE AND REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 KIMBERLY LANE WILLIAMSTOWN, KY 41097</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 226	Continued From page 11 of the bruising was identified during the facility investigation.	F 226		
F 280 88=D	There was no documented evidence the facility notified state agencies immediately of the injuries of unknown source as per the facility policy. <b>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</b>  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280	F 280  1. Resident #2 was discharged from Grant Manor Care and Rehabilitation Center on date January 30, 2011.	
	A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure Plans of Care were revised for one (1) of three (3) sampled residents (Resident #2). Resident #2 was noted to have a Seizure on 01/27/11; however, there was no documented evidence the		2. Current residents care plans were reviewed, revised and updated as necessary to reflect current resident status by the Administrator, Director of Nursing Services, Assistant Director of Nursing Services, Unit Managers and/or Nursing Supervisors on March 14, 2011 thru March 17, 2011.  3. Resident plans of care are reviewed at minimum quarterly by the interdisciplinary team to ensure they meet the needs of each resident. Licensed Nurses were re-educated by the Administrator and/or Director of Nursing Services on 3/11/2011 through 3/14/2011 on revising and updating care plans with any resident change in condition or treatment. RN #1 was re-educated by the Administrator on 3/14/2011, regarding updating and revising care plans timely as resident condition warrants.	

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F 280	<p>Continued From page 12.</p> <p>Plan of Care was revised to address seizure precautions.</p> <p>The findings include:</p> <p>1. Resident #2's medical record revealed diagnoses which included Alzheimer's Dementia.</p> <p>Review of the Interdisciplinary Progress Notes dated 01/27/11 at 9:05 AM, revealed Resident #2 was brought to her/his room from the diningroom due to having a seizure which lasted one (1) minute. Further review revealed three (3) persons lifted the resident to the bed and turned the resident on her/his side. Vital Signs were obtained; blood pressure was 80/40, pulse was 130, then in one minute pulse was 92 which was difficult to hear, and the resident's oxygen saturation was 98%. The resident was using accessory muscles for breathing, and aroused with painful stimuli. At 9:20 AM a call was placed to the Physician's Office.</p> <p>Review of the Physician's Progress Notes dated 01/28/11, revealed the resident was re-admitted from the hospital on 01/26/11 secondary to a Urinary Tract Infection. Further review revealed the resident had her/his first seizure "yesterday AM" and the Nursing Notes were reviewed.</p> <p>Review of the Comprehensive Plan of Care revealed there was no Plan of Care to address the seizure precautions needed related to the resident's new diagnosis of Seizures.</p> <p>Interview on 02/23/11 at 9:25 AM with Licensed Practical Nurse (LPN) #2 revealed she witnessed the resident to have a seizure on 01/27/11 and indicated the resident was "shaky and jerky"</p>	F 280	<p>4. The Director of Nursing Services, Assistant Director of Nursing Services will review 5 residents per week for 4 weeks then monthly for 2 months to determine care plan reflects current resident status. The Director of Nursing Services will report findings to Performance Improvement Committee meetings for three (3) months for review and recommendations.</p> <p>Date of Compliance: March 31, 2011.</p>	

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F 280	<p>Continued From page 13</p> <p>during the seizure. She stated after the resident stopped seizing she/he was only responsive to painful stimuli. Further interview revealed she and two (2) staff members lifted the resident to bed from the wheelchair.</p> <p>Interview on 02/24/11 at 9:30 AM with the Assistant Director of Nursing (ADON) revealed it would have been up to the Unit Manager or the nurse assigned to the resident to revise the Plan of Care to include seizure precautions. She stated the seizure precautions would include assisting the resident to bed or to a safe environment during the seizure, positioning the resident on her/his side, and placing a low bed to the floor. She stated floor mats would need to be placed by the bed. After reviewing the Plan of Care, she stated there was no Care Plan to address seizure precautions.</p> <p>Interview on 02/24/11 at 3:15 PM, with Registered Nurse (RN) #1 revealed she was assigned to the resident on 01/27/11 when the resident had the seizure. She stated staff told her the resident had movements which looked as though she/he was having a seizure. She stated the nurse assigned was responsible for revising care plans as needed; however, she did not think of placing seizure precautions, or revising the Plan of Care. She stated the resident already had a low bed; however, probably would need floor mats.</p> <p>Interview on 02/24/11 at 3:15 PM with the Unit Manager, revealed normally residents have Care Plans to address seizures; however, she could find no Plan of Care to address this residents seizures.</p> <p>Interview on 02/24/11 at 1:30 PM with the</p>	F 280		
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NAME OF PROVIDER OR SUPPLIER  GRANT MANOR CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41087	
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F 280	Continued From page 14 Administrator revealed she was notified of the resident having the seizure on 01/27/10 and it was described to her as a Grand Mal Seizure. She further stated the Plans of Care should be updated for any new Physician's Orders or new diagnoses. She stated the nurse who transcribed the Physician's Orders, or the nurse who was assigned at the time of a new diagnosis such as a seizure was responsible for updating the Care Plans.	F 280		
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 interview and record review it was determined the facility failed to ensure residents received the necessary care and services to maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the Comprehensive Plan of Care for one (1) of three (3) sampled residents (Resident #2). Resident #2 experienced pain with movement on 01/29/11 from breakfast until she/he was transferred to the hospital emergency room at 9:45 PM. There was no documented evidence the resident received analgesics for pain relief. The resident was admitted to the hospital with a diagnosis of a Displaced Transcervical Right Hip Fracture, and Demineralization.	F 309	F 309  1. Resident #2 was discharged from Grant Manor Care and Rehabilitation Center on date January 30, 2011.  2. Current residents were re-assessed for pain management by the Administrator, Director of Nursing Services, Assistant Director of Nursing Services, Unit Managers or Nursing Supervisors on March 15, 2011 thru March 16, 2011. The Administrator, Director of Nursing Services, Assistant Director of Nursing Services, Unit Managers or Nursing Supervisors reviewed all current residents' plan of care on March 14, 2011 thru March 17, 2011 to ensure they were current and reflective of the care needs of each resident. No residents were identified as being affected.  3. Licensed Nurses were re-educated by the Administrator and/or the Director of Nursing Services on March 11, 2011 thru March 14, 2011. Education included	

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F 309	<p>Continued From page 15</p> <p>The findings include:</p> <p>1. Review of Resident #2's clinical record revealed diagnoses which included Dementia, and Osteoarthritis. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 11/27/10, revealed the facility assessed the resident as having moderate impairment in cognitive skills for decision-making. Further review of the MDS revealed the facility assessed the resident as requiring total assistance with Activities of Daily Living (ADL's).</p> <p>Review of the Comprehensive Plan of Care dated 07/29/10 revealed the resident had the potential for pain related to Arthritis. The goals included; will report pain less than daily, pain will decrease within one hour of intervention, and will be free from signs and symptoms of pain such as facial grimacing, moaning, or crying. The interventions included administering pain medication as per the Physician's Orders and note the effectiveness, notify the Physician if pain not reduced, and document and report complaints and non-verbal signs of pain.</p> <p>Review of the re-admission Physician's Orders dated 01/26/11, revealed there was no medication ordered for pain.</p> <p>Review of the Interdisciplinary Progress Notes dated 01/29/11 at 11:15 AM revealed the nurse notified the Physician's Office of the resident's complaints of right hip pain.</p> <p>The next entry dated 01/29/11 at 2:05 PM revealed the resident complained of right hip pain, had no signs and symptoms of distress, and was</p>	F 309	<p>review of the center's Pain Management Program; notification of physician regarding change in condition, administration of pain medication as indicated by resident assessment and/or request, and updating plans of care with new orders, changes in condition or treatment to ensure resident's care needs are being met.</p> <p>4. The Director of Nursing Services/Assistant Director of Nursing Services will complete 5 pain assessments on different residents for 4 weeks, then 3 pain assessments on different residents for 4 weeks, and then pain assessment on 1 resident for 4 weeks. The Administrator, Director of Nursing Services, Assistant Director of Nursing Services, Unit Managers or Nursing Supervisors will utilize the 24 hour change in condition books and review physician daily orders to identify changes in resident's plan of care. The Director of Nursing Services will report findings to Performance Improvement Committee meetings for three (3) months for review and recommendations.</p> <p>5. Date of Compliance: March 31, 2011</p>	

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F 309	<p>Continued From page 16</p> <p>on antibiotics for a Urinary Tract Infection (UTI). New Orders were received for an x-ray of the right hip.</p> <p>A late entry written on 02/01/11 for 01/29/11 at 5:00 PM, revealed the resident's complaints of right hip pain was reported from the previous shift. The resident had no complaints of pain or signs and symptoms of discomfort with the current position but "yelled out" during repositioning for x-ray films placement. Pain was also noted with the assessment of the resident's right hip in the frontal distal area.</p> <p>An entry dated 01/29/11 at 9:15 PM, revealed staff were unable to obtain a hip x-ray in the facility and the physician was notified. New orders were received to send the resident to the hospital for a hip x-ray.</p> <p>The next entry dated 01/29/11 at 9:45 PM revealed the resident was transported to the hospital emergency room for evaluation.</p> <p>Review of the x-ray report of the Pelvis obtained on 01/30/11 revealed the resident had a Displaced Transcervical Right Hip Fracture, and Demineralization.</p> <p>Interview on 02/23/11 at 10:30 AM with Certified Nursing Assistant (CNA) #4 revealed she was assigned to the resident on the day shift on 01/29/11. She stated when she went to assist the resident up for breakfast, the resident guarded her/his hip and would not roll over in the bed. She stated it took two (2) staff to log roll the resident in the bed due to the resident's pain with movement. She stated the resident would say "my hip hurts". The CNA stated she reported the</p>	F 309			

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F 309	<p>Continued From page 17</p> <p>resident's pain to Registered Nurse (RN) #2 and was instructed to leave the resident in the bed.</p> <p>Interview on 02/23/11 at 11:00 AM and 1:30 PM with Registered Nurse (RN) #2 revealed she was assigned to Resident #2 on 01/29/10 and was told by CNA #4 the resident complained of pain. Further interview revealed she notified the Physician's office of the resident's right hip pain about 11:15 AM and received a call back from the office about 12:30 PM. She reviewed the Medication Administration Record for 01/11 and stated the resident had no scheduled pain medication and had Tylenol ordered for fever. She stated the resident was in no distress, or she would have obtained an order to administer pain medication. Further interview revealed she may not have thought of obtaining an order for pain medication because she was busy.</p> <p>Interview on 02/22/11 at 5:30 PM with CNA #5 revealed she was assigned to the resident on the evening of 01/29/11. She stated when the resident was turned and repositioned in the bed she/he would "scream out" and complain of pain in the hips. She stated she informed the nurse; however, she was unsure of which nurse she told. Continued interview revealed the resident had not complained of pain with turning and positioning until 01/29/11.</p> <p>Interview on 02/22/11 at 2:00 PM with Licensed Practical Nurse (LPN) #2 revealed she was assigned to the resident on 01/29/11 and started her shift at 3:00 PM. She stated she was informed by the previous shift, there was an x-ray ordered due to the resident's hip pain. She further stated she assessed the resident and the resident complained of pain when repositioned or</p>	F 309		
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F 309	<p>Continued From page 18</p> <p>when being turned for perineal care. Continued interview revealed she crushed Tylenol 650 milligrams (medication used for pain or fever) and administered the medication to the resident with applesauce around 5:30 PM; however, after review of the Medication Administration Record (MAR), she stated she did not document it on the MAR.</p> <p>Review of the Pain Evaluation completed on 01/29/11 by LPN #2 revealed the resident was guarding the right hip and groaning/moaning with repositioning. Further review revealed the resident was assessed as having internal, acute, frequent pain at a rating of a seven (7) on a scale of zero (0) to ten (10) which was described as severe/horrible. The Evaluation stated the resident received diversion activities for pain management and pain medications as needed.</p> <p>Review of the Pain Management Program, dated 01/08, revealed pain was the fifth (5th) vital sign. "The team has the responsibility to treat those symptoms based on the reportable or noticeable signs of pain for all of our residents-especially those who are unable to tell us they are in pain. By effectively managing pain, the team continues to provide the highest quality of care while helping residents maintain their maximum level of independence".</p>	F 309		