

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

PRINTED: 05/21/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185282	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/07/2012
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NAME OF PROVIDER OR SUPPLIER SOUTH SHORE NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE JAMES E. HANNAH DRIVE SOUTH SHORE, KY 41170
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F 000	INITIAL COMMENTS	F 000	To the best of my knowledge and belief, as an agent of South Shore Nursing & Rehabilitation Center, the following plan of correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements.	
F 280 SSRD	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure the Comprehensive Care Plan was revised for one (1) of six (6) sampled residents (Resident #6).</p>	F 280	<p>Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.</p> <p>South Shore Nursing & Rehabilitation Center strives to develop a comprehensive plan of care of each resident that is reflective of their current medical status. The interdisciplinary care plan team strives to develop of comprehensive assessment that is reflective of their current medical status, is reviewed and revised by a team of qualified persons after each assessment and as changes occur with the residents' medical status.</p> <p>The care plan for resident #6 was revised on 5/7/12 by the MDS Coordinator to</p>	6/16/2012

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Scott Willis</i>	TITLE Administrator	(X6) DATE 5/30/12
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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 proper 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 those 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 280	<p>Continued From page 1</p> <p>The findings include:</p> <p>Review of Resident #6's medical record revealed an admission date of 10/21/11, and diagnoses which included a Left Hip Fracture on 03/17/12.</p> <p>Review of the Comprehensive Care Plan, dated 03/21/12, revealed a "problem" entitled resident "has a history of falling, fall with fx (fracture) 03/17/12" and another "problem" entitled resident "has poor safety awareness AEB (as evidenced by) fall 03/17/12". Both care "problems" included an intervention which stated keep walker within resident's reach at all times.</p> <p>Observations, on 05/07/12 at 10:20 AM, 1:00 PM, 1:45 PM, and 5:45 PM revealed no evidence of a walker present near Resident #6. Observation of the resident's room at 5:30 PM revealed no evidence of a walker present in the room.</p> <p>Interview, on 05/07/12 at 4:07 PM, with the Physical Therapy Assistant (PTA) revealed prior to Resident #6's fall he/she had required the use of a rolling walker to ambulate. However, she stated since the fall only Physical Therapy was using a walker with the resident. The PTA stated Resident #6 should not have a walker within reach now because he/she would attempt to ambulate on his/her own which would be unsafe.</p> <p>Interview, on 05/07/12 at 5:10 PM, with State Registered Nursing Assistant (SRNA) #9 revealed Resident #6 did not have a walker and did not use one except in therapy.</p> <p>Interview, on 05/07/12 at 6:07 PM, with the</p>	F 280	<p>specify that the walker should only be used by therapy while working with the resident.</p> <p>All residents' care plans will be reviewed and revised as necessary by the interdisciplinary care plan team to accurately reflect the current status of each individual resident by 6/15/12. Any discrepancies will be corrected by the interdisciplinary care plan team as identified.</p> <p>The Administrator will educate each member of the interdisciplinary care plan team regarding the importance of reviewing and revising care plans as changes occur in order to accurately reflect the residents' current status by 6/1/12.</p> <p>The Director of Nursing will audit ten resident care plans per month for six months for accuracy and to ensure that they have appropriate revisions and are reflective of the residents' current medical status. Thereafter, she will review two care plans per month for one year for compliance. The results of these audits will be forwarded to the monthly Continuous Quality Improvement meeting for further monitoring and continued compliance.</p>	

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F 280	Continued From page 2 Minimum Data Set (MDS) Coordinator revealed the Comprehensive Care Plan should have been revised to discontinue the intervention to have a walker within the resident's reach at all times. She stated this intervention should not have been included on the Comprehensive Care Plan.	F 280		
F 514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>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.</p> <p>The clinical record must contain sufficient 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 interview and record review it was determined the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were accurately documented for one (1) of six (6) sampled residents (Resident #2).</p> <p>The findings include: Review of Resident #2's medical record revealed an admission date of 02/02/12 and diagnoses which included Depression. Review of the</p>	F 514	<p>South Shore Nursing & Rehabilitation Center strives to ensure that clinical records are maintained on each resident that are accepted by professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>A clarification order was written on 5/7/12 by the Director of Nursing clarifying that the 1:1 was discontinued, even though the physician order was written for informational purposes only.</p> <p>The Medical Records Director will audit all medical records by 6/15/12 to ensure that clinical records contain sufficient information to identify the resident; include a record of the resident's assessments; contain the plan of care and services provided; include the results of any preadmission screening conducted by the State; and include progress notes.</p> <p>All licensed staff will be educated by Director of Nursing no later than 6/15/12 regarding the importance of maintaining</p>	6/16/2012

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F 514	<p>Continued From page 3</p> <p>Physician's Orders revealed an order dated 04/25/12 (no time documented), for one on one (1 on 1) observations until further notice. Further review of the Physician's Orders revealed no documented evidence of an order to discontinue the 1 on 1 observations. Continued review of Resident #2's medical record revealed no documented evidence of 1 on 1 observations.</p> <p>Interview on 05/07/12 at 12:38 PM with State Registered Nursing Assistant (SRNA) #10 revealed she had been assigned to perform 1 on 1 observations of Resident #2 on 04/25/12 from 10:00 PM until 6:16 AM on 04/26/12. She stated another SRNA took over for her at that time. She further stated she did not document the 1 on 1 observations as she had not been informed to document it.</p> <p>Interview on 05/07/12 at 6:52 PM with SRNA #9 revealed she had performed the 1 on 1 observations from 4:00 PM until 10:00 PM on 04/25/12. She stated she was not aware she was to document the 1 on 1 observations.</p> <p>Interview on 05/07/12 at 3:45 PM with the Administrator revealed Resident #2 was placed on 1 on 1 observations immediately after receiving the order. She stated however, there was no documented evidence of the 1 on 1 observations in Resident #2's medical record. The Administrator stated there should be documentation of the 1 on 1 observations to prove they had been provided as ordered.</p>	F 514	<p>the clinical record for each resident in accordance with accepted professional standard and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The Director of Nursing will audit two medical records per week for four weeks to ensure that records are maintained in accordance with acceptable standards and practices, are complete, accurately documented and systematically organized. Thereafter, the DON will review one chart per month for one year for compliance.</p> <p>The results of these audits will be forwarded to the monthly CQI Committee meeting for further monitoring and continued compliance.</p>	