

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

Second SOD

PRINTED: 12/02/2010  
FORM APPROVED  
CMS-0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	RECEIVED DEC - 6 2010 11/03/2010
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NAME OF PROVIDER OR SUPPLIER  MOUNTAIN MANOR OF PAINTSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 40374
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F 000	INITIAL COMMENTS  An abbreviated standard and partial extended survey (KY15496, KY15531) was initiated on October 26, 2010 and concluded on November 3, 2010. Both allegations were substantiated. Immediate Jeopardy related to KY15496 was identified on October 27, 2010, and determined to exist on October 16, 2010. The facility was notified of the Immediate Jeopardy on October 27, 2010. Deficiencies were cited at 483.10 Resident Rights (F157), 483.20 Resident Assessment (F281), 483.25 Quality of Care (F323), and 483.75 Administration (F490 and F520) at a S/S of "J." Substandard Quality of Care (SQC) was identified in the area of 483.25 Quality of Care (F323). Additional deficiencies related to KY15531 were cited at 483.13 Abuse (F225) and 483.60 Pharmacy Services (425) at a S/S of "D."	F 000		
F 157 SS=J	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an	F 157	See Attachment	12/7/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Deborah Fitzgibbon</i>	TITLE Administrator	(X6) DATE 12/6/10
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1</p> <p>existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to notify the physician and responsible party when the resident had a significant change in status and a need to alter treatment for one of seven residents (resident #1).</p> <p>On admission, resident #1 required assistance to get out of bed, but on October 16 and 17, 2010, resident #1 began attempting to get out of bed unassisted. There was no evidence the resident's physician was notified, and no evidence the facility intervened. On October 18, 2010, at 12:35 a.m., resident #1 was found on the floor beside the resident's bed. The resident sustained a right orbital fracture, a fracture of the right zygomatic arch (the orbit and zygomatic arch are</p>	F 157		

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F 157	<p>Continued From page 2</p> <p>bones surrounding the eye), right supra and periorbital hematoma (around the eye), and six rib fractures as a result of the fall. The resident expired on October 26, 2010, as a result of complications from the fall. (Refer to F281, F323, F490, and F520.)</p> <p>The facility's failure to notify the resident's physician placed residents at risk for serious injury, harm, impairment, or death.</p> <p>The findings include:</p> <p>A review of resident #1's medical record revealed the resident was readmitted to the facility on October 14, 2010, with diagnoses that included Sarcoma of the left thigh, Coronary and Peripheral Artery Disease, Dementia, Chronic Pain Syndrome, Osteoporosis, status post right mastectomy, and urinary retention.</p> <p>A review of the nursing notes dated October 16, 2010, at 2:00 p.m., signed by nurse #1, revealed staff found resident #1 "wedged between bedrail and mattress." The nursing note revealed the resident had a slight red "mark" on the upper left thigh. According to the nursing note, resident #1's physician and the resident's family were notified.</p> <p>A review of physician's orders dated October 16, 2010, (no time documented) revealed nurse #1 documented a physician's telephone order for a bed alarm for resident #1's bed. The physician's telephone order stated the resident "continuously attempting to get out of bed by [his/her] self." According to the order, resident #1's family was notified.</p>	F 157		

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F 157	<p>Continued From page 3</p> <p>A review of the Mood &amp; Behavior Summary form for resident #1 revealed on October 16, 2010, on the 11 p.m. to 7 a.m. shift, "Resident tried to climb out of bed;" October 16, 2010, on the 7 a.m. to 3 p.m. shift, "Resident was trying to get out of bed today;" October 17, 2010, (no time/shift documented) "Resident had tried 3 or 4 times to get out of the bed;" October 17, 2010, 11 p.m. to 7 a.m. shift, "I discovered resident laying on bed rail facing the window with [his/her] gown completely off."</p> <p>Interviews with CNA #1 on October 26, 2010, at 4:00 p.m., CNA #2 on October 26, 2010, at 4:20 p.m., nurse #1 on October 26, 2010, at 5:25 p.m., CMA #1 on October 26, 2010, at 10:05 a.m., CNA #4 on October 27, 2010, at 3:53 p.m., CNA #5 on October 27, 2010, at 5:30 p.m., and CNA #7 on November 3, 2010, at 2:20 p.m., revealed resident #1 attempted to get out of bed numerous times on October 16 and 17, 2010. In addition an interview with a family member of unsampled resident #1 on October 26, 2010, at 6:45 p.m., revealed he/she observed resident #1 sitting on the bedside on October 17, 2010. Interviews with unsampled residents #2 and #3 on October 26, 2010, at 6:35 p.m., revealed they observed resident #1 attempting to get out of bed. The residents rang the call light and yelled for staff to assist the resident at least three times after the evening meal on October 17, 2010.</p> <p>According to the facility's investigation, on October 16, 2010, at approximately 5:00 a.m., CNA #8 observed resident #1 attempting to get out of bed. CNA #8's statement revealed, "[Resident #1] was almost out in the floor. [Resident #1] had [his/her] leg stuck in the rail."</p>	F 157			

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F 157	<p>Continued From page 4</p> <p>A review of the facility's policy, Notification of Rights and Services, revised on March 17, 2005, revealed the facility would immediately consult with the resident's physician and notify the resident's legal representative or interested family member when there was an accident which resulted in injury, a significant change in the resident's physical, mental, or psychosocial status, a need to alter treatment significantly, or a decision had been made to transfer or discharge the resident from the facility. According to the facility's policy, if staff was unable to contact the resident's physician, and treatment was urgent, staff should contact the Medical Director. The policy stated if treatment was not urgent, the facility should continue to contact the resident's physician.</p> <p>An interview with nurse #1 on October 26, 2010, at 5:25 p.m., revealed nurse #1 was the nurse responsible for resident #1's care on October 16 and 17, 2010, on the 7 a.m. to 7 p.m. shift. According to nurse #1, resident #1 required assistance with transferring to/from bed. Nurse #1 stated on Saturday, October 16, 2010, that nursing assistants reported resident #1 was "wedged" between the side rail and the mattress. According to the nurse, he/she assessed resident #1 and the resident had a red area on the resident's left thigh. The nurse stated that after speaking with the nurse aides the nurse believed the resident was not "wedged" but was "too close to the side rail." The nurse continued that the resident's "arm may have been wedged." In addition, on at least two occasions on October 16 and 17, 2010, resident #1 was observed with the resident's feet off the side of the bed and sitting on the bedside. The nurse stated the resident across the hall from resident #1 summoned the</p>	F 157		

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F 157	<p>Continued From page 5 nurse to assist resident #1.</p> <p>According to nurse #1, resident #1's physician and responsible party were notified that the resident was wedged between the side rail and the bed, and a physician's order was obtained for a bed alarm. However, a bed alarm was not available and was not implemented for resident #1. The nurse stated he/she did not notify the resident's physician of the resident's continued attempts to get out of bed or the non-availability of the bed alarm.</p> <p>An interview with resident #1's physician on October 27, 2010, at 3:15 p.m., revealed the resident's physician did not recall being notified that resident #1 was attempting to get out of bed or that the resident was caught/wedged in a side rail. However, the physician stated he/she should have been notified. The physician stated he/she did not give an order to implement a bed alarm, but the intervention was appropriate. According to the physician, he/she was not notified by the facility that a bed alarm was not available for resident #1, or that the resident continued to attempt to exit the bed unassisted.</p> <p>A subsequent interview with nurse #1 on October 27, 2010, at 4:10 p.m., revealed a different nurse wrote the physician's order for a bed alarm for resident #1 on October 16, 2010, but nurse #1 signed the order. Nurse #1 stated he/she did not recall if the resident's physician was actually notified. The nurse stated he/she should have notified the resident's physician but "honestly didn't know what to do with [the resident's] situation."</p> <p>According to resident #1's medical record and</p>	F 157		

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F 157	<p>Continued From page 6</p> <p>interviews with staff, on October 18, 2010, at 12:35 a.m., resident #1 was found on the floor by the resident's bed with a large open area on the right forearm and above the resident's right eye. The resident was transferred to the hospital. According to resident #1's hospital record, the resident sustained a right orbital fracture, a fracture of the right zygomatic arch (the orbit and zygomatic arch are bones surrounding the eye), right supra and periorbital hematoma (around the eye), and six rib fractures as a result of the fall.</p> <p>Further interview with resident #1's physician on October 27, 2010, at 3:15 p.m., revealed resident #1 expired on October 26, 2010, as a result of complications from the fall.</p> <p>**An acceptable Allegation of Compliance (AOC) related to the Immediate Jeopardy was submitted by the facility on November 1, 2010, which alleged removal of Immediate Jeopardy effective October 30, 2010. A partial extended survey was conducted on November 3, 2010, which determined the Immediate Jeopardy was removed on October 30, 2010.</p> <p>A review of documentation revealed on October 28, 2010, the facility notified the physicians of all residents who had fallen in the last 15 months with the number of falls and the interventions that were in place to prevent falls.</p> <p>A review of sign-in sheets and interviews with staff on November 3, 2010, revealed the facility conducted in-services with nursing staff on October 28, 2010, related to notifying the resident's physician and legal representative or interested family member when there was a change in a resident's condition, particularly if a</p>	F 157		
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F 157	<p>Continued From page 7</p> <p>resident was trying to get out of bed, or a need to alter treatment and that physician orders had to be obtained from the physician. In addition, according to the in-service sign in sheets dated October 29, 2010, and interviews with staff on November 3, 2010, a log was being kept to further document when physicians were notified and if there were any new orders as a result of the notification.</p> <p>According to the AOC, the in-service information would also be provided to new employees during the orientation process.</p> <p>A review of a call log audit form revealed four resident records were being audited daily to ensure physicians were being notified, and that the facility's policy/procedure for physician notification was being followed.</p> <p>An interview with the Administrator, Assistant Administrator, and Director of Nursing on November 3, 2010, at 4:45 p.m. and 6:40 p.m., revealed all resident physicians were notified in writing with the name of each resident who had fallen, the number of falls, and the interventions the residents had in place. The administrative staff stated four residents' charts were audited daily (two from each floor) for changes in condition and/or a need to alter treatment to ensure the physician was notified in accordance with the facility's policy/procedure for physician notification.</p> <p>Based on the above findings, it was determined on November 3, 2010, the Immediate Jeopardy was removed effective October 30, 2010. Noncompliance continued with the scope and severity lowered to "D" based on the facility's</p>	F 157		
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F 157	Continued From page 8 need to evaluate the implementation of systematic changes and quality assurance activities.	F 157			
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals 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; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse; including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).  The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.  The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance 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	F 225	See Attachment	12/7/10	

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F 225	<p>Continued From page 9 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 ensure all alleged violations of misappropriation of resident property were reported immediately to officials in accordance with State Law. On October 23, 2010, the facility became aware that certified medication aide (CMA) #3 had repeatedly indicated that at least four of seven residents' medications (residents #10, #11, #12, and #13) were being wasted and the CMA allegedly forged another nurse's initials as having witnessed the medications being wasted. The facility failed to report the allegation to the appropriate officials until October 26, 2010.</p> <p>The findings include:</p> <p>A review of the facility's Resident Protection Policy dated July 1999 revealed when an incident of misappropriation was reported an investigation would begin immediately, and the Administrator or Director of Nursing would immediately report the incident to the state licensing agency and to the adult protective services agency.</p> <p>Record review of resident #10's controlled drug record sign-out for Clonazepam 2 milligrams revealed from June 19-October 22, 2010, CMA #3 had wasted the Clonazepam a total of seven times.</p> <p>Record review of resident #11's controlled drug record sign-out for OxyContin 20 milligrams</p>	F 225			

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F 225 Continued From page 10  
revealed from June 27-October 24, 2010, CMA #3 had wasted the OxyContin a total of 13 times.

Record review of resident #12's controlled drug record sign-out for Clonazepam 1 milligram revealed from October 9-22, 2010, CMA #3 had wasted the Clonazepam one time.

Record review of resident #13's controlled drug record sign-out for Lorazepam 1 milligram revealed from June 15-October 2, 2010, CMA #3 had wasted the Lorazepam a total of three times.

According to the facility's investigation, the CMA was observed by facility staff to have slurred speech, disorganized thoughts, and to be unsteady and unable to complete a count of narcotics on October 23, 2010. The facility became aware CMA #3 had wasted residents' medication an unusually high number of times and had allegedly forged staff's initials as having witnessed the medications being wasted.

Interview with the Director of Nursing (DON) and the Administrator on November 3, 2010, at 7:04 p.m., revealed they were unaware the allegation needed to be reported to the state agency. The DON stated the facility had reported the allegation to the Kentucky Board of Nursing, but was unaware the allegation needed to be reported to the State Agency.

F 281 SS-J 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced

F 225

F 281 See Attachment

12/7/10

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F 281	<p>Continued From page 11</p> <p>by:</p> <p>Based on observation, interview, and record review, it was determined the facility failed to ensure services provided by the facility met professional standards of quality. The facility failed to ensure physician's orders were implemented for one of seven sampled residents (resident #1).</p> <p>On October 16, 2010, a physician's order was written for a bed alarm for resident #1; however, there was no evidence the bed alarm was implemented. On October 16 and 17, 2010, resident #1 made attempts to get out of bed unassisted. On October 18, 2010, at 12:35 a.m., resident #1 was found on the floor beside the resident's bed. The resident sustained a right orbital fracture, a fracture of the right zygomatic arch (the orbit and zygomatic arch are bones surrounding the eye), right supra and periorbital hematoma (around the eye), and six rib fractures as a result of the fall. The resident expired on October 26, 2010, as a result of complications from the fall. (Refer to F157, F323, F490, and F520.)</p> <p>The facility's failure to ensure services met professional standards of quality by failing to implement physician's orders placed residents at risk for serious injury, harm, impairment, or death.</p> <p>The findings include:</p> <p>A review of resident #1's medical record revealed the resident was readmitted to the facility on October 14, 2010, with diagnoses that included Sarcoma of the left thigh, Coronary and Peripheral Artery Disease, Dementia, Chronic Pain Syndrome, Osteoporosis, status post right</p>	F 281		

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F 281	<p>Continued From page 12 mastectomy, and urinary retention.</p> <p>A review of the nursing notes dated October 16, 2010, at 2:00 p.m., signed by nurse #1, revealed staff found resident #1 "wedged between bedrail and mattress" and the resident's physician and family were notified.</p> <p>A review of physician's orders dated October 16, 2010, (no time documented) revealed nurse #1 documented a physician's telephone order for a bed alarm for resident #1's bed. The physician's telephone order stated the resident "continuously attempting to get out of bed by [his/her] self."</p> <p>An interview with nurse #1 on October 26, 2010, at 5:25 p.m., revealed on October 16, 2010, resident #1's physician and responsible party were notified that the resident was wedged between the side rail and the bed, and a physician's order was obtained for a bed alarm. The nurse stated a bed alarm was not available and was not implemented for resident #1, as per the physician's orders. According to nurse #1, a bed alarm was not available on Saturday, October 16, 2010, because bed alarms not being used by residents were locked in the facility's stock room and staff did not have access to the stock room.</p> <p>According to resident #1's medical record and interviews with staff, on October 18, 2010, at 12:35 a.m., resident #1 was found on the floor by the resident's bed with a large open area on the right forearm and above the resident's right eye. The resident was transferred to the hospital. According to resident #1's hospital record, the resident sustained a right orbital fracture, a fracture of the right zygomatic arch (the orbit and zygomatic arch are bones surrounding the eye),</p>	F 281			

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F 281	<p>Continued From page 13</p> <p>right supra and periorbital hematoma (around the eye), and six rib fractures as a result of the fall.</p> <p>An interview conducted with resident #1's physician on October 27, 2010, at 3:15 p.m., revealed resident #1 expired on October 26, 2010, as a result of complications from the fall.</p> <p>**An acceptable Allegation of Compliance (AOC) related to the Immediate Jeopardy was submitted by the facility on November 1, 2010, which alleged removal of Immediate Jeopardy effective October 30, 2010. A partial extended survey was conducted on November 3, 2010, which determined the Immediate Jeopardy was removed on October 30, 2010.</p> <p>A review of documentation revealed the facility completed an audit on October 28, 2010, to ensure all physician ordered safety devices, including bed alarms, were being implemented and the devices were documented on the Medication Administration Record (MAR).</p> <p>Interviews with staff on November 3, 2010, and a review of sign-in sheets revealed the facility conducted an in-service on October 28, 2010, related to following physician's orders and the facility's policy for obtaining equipment. According to the facility's Stock Control Policy (updated October 28, 2010), and interviews with staff, a personal alarm and a bed pad alarm were placed in the medication room for use after hours or on the weekends. In addition, staff stated alarms in the medication rooms were being audited at the end of each shift to ensure the alarms were available. The interviews revealed staff was completing a form when an alarm was removed so stock room staff was aware that a</p>	F 281			

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F 281	<p>Continued From page 14</p> <p>replacement alarm was needed. Staff stated they monitored to ensure alarms were being implemented and functional with each contact with the resident. Nursing staff stated devices were documented on residents' Medication Administration Records (MAR) and nurses initialed the MAR once per shift to indicate the devices were present and functioning. Staff explained that a key to the stock room was available and staff would notify the stock control clerk or the Director of Nursing after hours if supplies/equipment were unavailable.</p> <p>Observation revealed one bed alarm and one personal alarm were kept in the medication room on each unit of the facility. Further review of a log revealed staff was monitoring the presence of the alarms once per shift since October 29, 2010.</p> <p>A review of a safety device audit form revealed the facility audited 12 residents daily (three per shift, per floor) to ensure safety devices/alarms were in place, the device was operational, the device was documented on the MAR, and the MAR was initialed.</p> <p>An interview with the Administrator, Assistant Administrator, and Director of Nursing on November 3, 2010, at 4:45 p.m. and 6:40 p.m., revealed 12 charts were being audited daily to ensure that physician ordered safety devices were being implemented. The administrative staff stated any concerns identified were being addressed/corrected immediately.</p> <p>Based on the above findings, it was determined the Immediate Jeopardy was removed effective October 30, 2010. Noncompliance continued with the scope and severity lowered to "D" based on</p>	F 281			

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F 281	Continued From page 15 the facility's need to evaluate the implementation of systematic changes and quality assurance activities.	F 281			
F 323 SS-J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure the resident environment remained as free of accident hazards as is possible for one of three sampled residents (resident #1) and failed to ensure one of seven residents (resident #1) received adequate supervision and assistance devices to prevent accidents.  On October 15, 2010, staff implemented the use of two three-quarter-length raised side rails for resident #1, who was assessed by the facility to be at high risk for falls. On October 16, 2010, resident #1 began attempting to get out of bed unassisted, exiting the bed around the side rails. The resident was observed by staff to be wedged/caught in the side rail. Subsequently a physician's order was written to apply a bed alarm (the alarm alerts caregiver with audio alarm when the resident attempts to get out of bed). However, there was no evidence the bed alarm was implemented. In addition, the facility failed to	F 323	See Attachment	12/7/10	

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F 323	<p>Continued From page 16</p> <p>reassess the safety risks of the raised side rails for resident #1 after the resident was observed wedged/caught in the side rail.</p> <p>Resident #1 continued to attempt to get out of bed on October 17, 2010, without evidence the safety of the side rails was reassessed, nor any interventions implemented to prevent the resident from falling.</p> <p>On October 18, 2010, at 12:35 a.m., resident #1 was found on the floor by the resident's bed with a large open area on the right forearm and above the resident's right eye. The resident was transferred to the hospital. The resident sustained a right orbital fracture, a fracture of the right zygomatic arch (the orbit and zygomatic arch are bones surrounding the eye), right supra and periorbital hematoma (around the eye), and six rib fractures as a result of the fall. The resident expired on October 26, 2010, as a result of complications from the fall.</p> <p>The facility's failure to ensure the resident environment remained as free of accident hazards as is possible and the facility's failure to ensure residents received adequate supervision and assistive devices to prevent accidents placed residents at risk for serious injury, harm, impairment, or death.</p> <p>The findings include:</p> <p>A review of resident #1's medical record revealed the resident was readmitted to the facility on October 14, 2010, with diagnoses that included Sarcoma of the left thigh, Coronary and Peripheral Artery Disease, Dementia, Chronic Pain Syndrome, Osteoporosis, status post right</p>	F 323		

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F 323	<p>Continued From page 17</p> <p>mastectomy, and urinary retention.</p> <p>A review of the admission nursing assessment dated October 14, 2010, revealed resident #1 was alert and oriented to person and place, with periods of confusion. According to the Hospice care face sheet, dated October 14, 2010, resident #1 was "bedbound" and "required total care."</p> <p>A review of the facility's policy titled "Management of Falls" revised in September 2001 revealed the facility would provide a safe environment for residents and would identify residents who were at risk for increased falls. According to the policy, all residents would have a "Fall at Risk" assessment completed upon admission and quarterly thereafter. The policy further addressed procedures for residents who experienced a fall. The policy did not address preventing falls for resident who were at risk.</p> <p>A review of a fall risk assessment dated October 15, 2010, revealed resident #1 was at high risk for falls. A side rail assessment dated October 15, 2010, revealed the resident used two side rails to "help with bed mobility." According to the assessment, there was evidence the resident had or may have a desire to get out of bed, there was no possibility the resident would climb over the side rails, there was no risk to the resident if side rails were used, and side rail alternatives/interventions did not create more risks than side rail usage.</p> <p>A review of the care plan dated October 15, 2010, revealed resident #1 was at risk for falls and fall precautions should be implemented as needed. A review of the CNA care record for October, 2010 revealed resident #1 required the</p>	F 323			

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F 323	<p>Continued From page 18</p> <p>assistance of two staff for transferring from/to bed/chair. According to the CNA care record, the resident had "other side rails," was a "fall risk."</p> <p>An interview with the Assistant Director of Nursing (ADON) on October 27, 2010, at 10:35 a.m. and 3:50 p.m., revealed the ADON completed the fall risk assessment and the side rail assessment for resident #1 on October 15, 2010. The ADON stated resident #1 required assistance to get in and out of bed and there was no indication the resident would attempt to exit the bed over the side rails, or would get out of bed without assistance. According to the ADON, when the side rail assessment was completed the side rails did not pose any risks to resident #1. In addition, the ADON stated resident #1 was at high risk for falls; however, there were no interventions in place to prevent falls. The ADON stated because the resident had not had any previous falls, staff would "just monitor to see what interventions are needed."</p> <p>A review of the nursing notes dated October 16, 2010, at 2:00 p.m., signed by nurse #1, revealed staff found resident #1 "wedged between bedrail and mattress." The nursing note revealed the resident had a slight red "mark" on the upper left thigh. According to the nursing note, resident #1's physician and the resident's family were notified.</p> <p>A review of an incident report dated October 16, 2010, at 2:00 p.m., revealed nurse #1 documented that an aide entered resident #1's room and the resident was "caught" between the mattress and the side rail. According to the incident investigation, the resident was "at the end of the bed at the opening in the side rail."</p>	F 323		
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F 323	<p>Continued From page 19</p> <p>[The resident] was sitting with [his/her] leg out of the bed against the side rail."</p> <p>A review of physician's orders dated October 16, 2010, (no time documented) revealed nurse #1 documented a physician's telephone order for a bed alarm for resident #1's bed. The physician's telephone order stated the resident "continuously attempting to get out of bed by [his/her] self."</p> <p>An interview with nurse #1 on October 26, 2010, at 5:25 p.m., revealed nurse #1 was the nurse responsible for resident #1's care on October 16 and 17, 2010, on the 7 a.m. to 7 p.m. shifts. According to nurse #1, resident #1 required assistance with transferring to/from bed, but on Saturday, October 16, 2010, nursing assistants reported resident #1 was "wedged" between the side rail on the resident's bed and the mattress. Nurse #1 stated he/she assessed resident #1 and the resident had a red area on the resident's left thigh. The nurse explained the nursing assistants had already assisted resident #1 to bed when the nurse assessed the resident. However, after speaking with the nurse aides, the nurse believed the resident was not "wedged," but was "too close to the side rail." Nurse #1 revealed the resident's "arm may have been wedged." In addition, nurse #1 stated that on at least two occasions on October 16 and 17, 2010, the resident across the hall from resident #1 summoned the nurse to assist resident #1. The nurse stated resident #1 was observed with the resident's feet off the side of the bed and sitting up on the bedside. According to nurse #1 no reassessment was conducted related to the safety of the continued use of side rails for resident #1.</p> <p>Further interview with nurse #1 on October 26,</p>	F 323		
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F 323	<p>Continued From page 20</p> <p>2010, at 5:25 p.m., revealed on October 16, 2010, resident #1's physician and responsible party were notified that the resident was wedged between the side rail and the bed; and a physician's order was obtained for a bed alarm (the alarm alerts caregiver with audio alarm when the resident attempts to get out of bed). However, a bed alarm was not available and was not implemented for resident #1 because the alarms were not available on weekends. The nurse stated bed alarms that were not being used by residents were locked in the facility's stock room and staff did not have access to the stock room. Nurse #1 stated he/she consulted with the other nurses regarding the unavailability of a bed alarm and the staff believed a bed alarm would not be available until the following Monday (October 18, 2010).</p> <p>A review of the Mood &amp; Behavior Summary form revealed staff documented on October 16, 2010, on the 11 p.m. to 7 a.m. shift, "Resident tried to climb out of bed;" October 16, 2010, on the 7 a.m. to 3 p.m. shift, "Resident was trying to get out of bed today;" October 17, 2010, (no time/shift documented) "Resident had tried 3 or 4 times to get out of the bed;" October 17, 2010, 11 p.m. to 7 a.m. shift, "I discovered resident laying on bed rail facing the window with [his/her] gown completely off."</p> <p>Interviews with CNA #1 on October 26, 2010, at 4:00 p.m., CNA #2 on October 26, 2010, at 4:20 p.m., nurse #1 on October 26, 2010, at 5:25 p.m., CMA #1 on October 26, 2010, at 10:05 a.m., CNA #4 on October 27, 2010, at 3:53 p.m., CNA #5 on October 27, 2010, at 5:30 p.m., and CNA #7 on November 3, 2010, at 2:20 p.m., revealed resident #1 attempted to get out of bed numerous</p>	F 323		

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F 323	<p>Continued From page 21</p> <p>times on October 16 and 17, 2010. In addition an interview with a family member of unsampled resident #1 on October 26, 2010, at 6:45 p.m., revealed he/she observed resident #1 sitting on the bedside on October 17, 2010. Interviews with unsampled residents #2 and #3 on October 26, 2010, at 6:35 p.m., revealed they observed resident #1 attempting to get out of bed. The residents rang the call light and yelled for staff to assist the resident at least three times after the evening meal on October 17, 2010.</p> <p>According to the facility's investigation, on October 16, 2010, at approximately 5:00 a.m., CNA #8 observed resident #1 attempting to get out of bed. CNA #8's statement revealed, "[Resident #1] was almost out in the floor. [Resident #1] had [his/her] leg stuck in the rail."</p> <p>According to resident #1's medical record and interviews with staff, on October 18, 2010, at 12:35 a.m., resident #1 was found on the floor by the resident's bed with a large open area on the right forearm and above the resident's right eye. The resident was transferred to the hospital. According to resident #1's hospital record, the resident sustained a right orbital fracture, a fracture of the right zygomatic arch (the orbit and zygomatic arch are bones surrounding the eye), right supra and periorbital hematoma (around the eye), and six rib fractures as a result of the fall.</p> <p>Further review of the facility's investigation dated October 18, 2010, revealed an alarm did not sound and resident #1's alarm was not in the resident's room when the resident fell, even though the resident had an order for an alarm. On October 26, 2010, at 7:10 p.m., an interview was conducted with the nurse who completed the</p>	F 323		
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F 323	<p>Continued From page 22</p> <p>investigation, nurse #5. Nurse #5 stated resident #1's three-quarter-length side rails were raised when the resident fell.</p> <p>Observation of resident #1 on October 26, 2010, at 3:00 p.m., at the hospital, revealed the resident was unresponsive and was having periods of apnea (no breathing). The resident's right eye was observed to be swollen and purple. In addition, the resident's right arm/hand was swollen. An interview with the resident's daughter during the observation revealed the resident was going "to die."</p> <p>An interview with resident #1's physician on October 27, 2010, at 3:15 p.m., revealed the resident's physician did not recall being notified that resident #1 was attempting to get out of bed or that the resident was caught/wedged in a side rail, however, stated he/she should have been notified. The physician stated he/she did not give an order to implement a bed alarm, however, the intervention was appropriate and the resident needed a bed alarm. The physician further stated he/she was not notified by the facility that a bed alarm was not available for resident #1 or that the resident continued to attempt to get out of bed. The physician stated he/she should have been notified so that other interventions could have been implemented to prevent resident #1 from falling. According to resident #1's physician, resident #1 developed mucus plugs and increased secretions in the lungs due to being unable to clear secretions as a result of the rib fractures. According to the physician, rUse zygomatic arch in a Sentence &lt;<a href="http://ask.reference.com/web?q=Use+zygomatic%20arch+in+a+Sentence&amp;qsrc=2892&amp;o=101993">http://ask.reference.com/web?q=Use+zygomatic%20arch+in+a+Sentence&amp;qsrc=2892&amp;o=101993</a>&gt;</p>	F 323			

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F 323	<p>Continued From page 23</p> <p>See images of zygomatic arch &lt;<a href="http://ask.reference.com/pictures?q=zygomatic%20arch&amp;o=102285">http://ask.reference.com/pictures?q=zygomatic%20arch&amp;o=102285</a>&gt;</p> <p>Search zygomatic arch on the Web &lt;<a href="http://ask.reference.com/web?q=zygomatic%20arch&amp;o=102284">http://ask.reference.com/web?q=zygomatic%20arch&amp;o=102284</a>&gt;</p> <p>resident #1 expired on October 26, 2010, at the hospital due to complications as a result of the fall.</p> <p>A subsequent interview with nurse #1 on October 27, 2010, at 4:10 p.m., revealed he/she was unable to recall if the resident's physician was actually notified related to resident #1's continued attempts to exit the bed unassisted. The nurse stated he/she should have notified the resident's physician but "honestly didn't know what to do with [resident #1's] situation."</p> <p>**An acceptable Allegation of Compliance (AOC) related to the Immediate Jeopardy was submitted by the facility on November 1, 2010, which alleged removal of Immediate Jeopardy effective October 30, 2010. A partial extended survey was conducted on November 3, 2010, which determined the Immediate Jeopardy was removed on October 30, 2010.</p> <p>According to documentation on October 28, 2010, the facility completed Fall Risk Assessments and Side Rail Assessments for all residents who had fallen in the last 15 months. On October 28, 2010, the facility also completed reviews of residents' Minimum Data Set (MDS), comprehensive care plan, and nurse aide care plan to ensure that falls or fall risk factors were identified and appropriate prevention measures were being implemented.</p>	F 323		

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F 323	<p>Continued From page 24</p> <p>Further review of documentation revealed the facility conducted an audit on October 28, 2010, to ensure all physician ordered safety devices, including bed alarms, were being implemented and the devices were documented on the Medication Administration Record (MAR).</p> <p>According to documentation, the facility notified the physician of all residents who had fallen in the last 15 months and the interventions that were in place.</p> <p>Interviews with staff on November 3, 2010, and a review of sign-in sheets confirmed the facility had in-serviced staff on October 28, 2010 and October 29, 2010, related to notifying the resident's physician and legal representative or interested family member when there was a change in a resident's condition or a need to alter treatment and that physician's orders had to be obtained from the physician; following physician's orders; the facility's policy for obtaining equipment (Stock Control Policy updated on October 28, 2010); and the facility's fall risk assessment policy (updated on October 28, 2010). According to the in-service sign-in sheets and interviews with nurses, nursing staff was educated on assessing residents and completing a fall risk and/or side rail assessment when there were changes in residents, or as needed. Staff stated they would stay with a resident who was trying to get out of bed or that they felt was not safe to be left alone.</p> <p>According to the facility's Stock Control Policy (updated October 28, 2010) in-service and interviews with staff, a personal alarm and a bed pad alarm were available in the medication room for use after hours or on the weekends. In addition, staff stated alarms in the medication</p>	F 323		

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F 323	<p>Continued From page 25</p> <p>rooms were being audited at the end of each shift to ensure the alarms were available. The interviews revealed staff was completing a form when an alarm was removed so stock room staff was aware a replacement alarm was needed. Further staff stated they monitored to ensure alarms were being implemented and functional with each contact with the resident. Nursing staff revealed devices were documented on residents' Medication Administration Records (MAR) and nurses initialed the MAR once per shift to indicate the devices were present and functioning properly. In addition, staff stated in interview that a key to the stock room was available and staff would notify the stock control clerk or the Director of Nursing after hours if supplies/equipment was unavailable.</p> <p>According to the AOC, the information will be provided to new employees during their orientation process.</p> <p>A review of a call log audit form revealed four resident records were being audited daily to ensure the facility's policy/procedure for physician notification was being followed and appropriate documentation was in the resident's medical record.</p> <p>A review of a safety device audit form revealed the facility audited 12 residents daily (three per shift per floor) to ensure safety devices/alarms were in place, the device was operational, the device was documented on the MAR, and the MAR was initialed.</p> <p>An interview with the Administrator, Assistant Administrator, and Director of Nursing on November 3, 2010, at 4:45 p.m. and 6:40 p.m.,</p>	F 323		

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F 323	Continued From page 26 revealed the Interdisciplinary Team (IDT) would meet with residents and families on the day of admission to determine the history of falls/injury and identify other potential risk factors for injury and an individualized care plan would be implemented to better meet the resident's needs. In addition, the Fall Risk Assessment Policy was reviewed and updated and two charts would be audited every week to ensure the fall risk assessment and side rail assessment was accurate.  Based on the above findings, it was determined the Immediate Jeopardy was removed effective October 30, 2010. Noncompliance continued with the scope and severity lowered to "D" based on the facility's need to evaluate the implementation of systematic changes and quality assurance activities.	F 323			
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH  The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.  A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.  The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy	F 425	See Attachment	12/7/10	

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F 425	<p>Continued From page 27 services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure a procedure was in place for reconciliation of controlled medication logs. Four (4) sampled residents (residents #10, #11, #12, and #13) were scheduled to receive controlled medications per physician's order. The facility failed to have a procedure to monitor the controlled medication logs for the four residents, and was unaware Certified Medication Aide (CMA) #3 was signing medication as wasted during his/her shifts, and had allegedly forged staff's initials as having witnessed the medications being wasted.</p> <p>The findings include:</p> <p>Review of resident #10's controlled drug record for Clonazepam 2 milligrams revealed on June 24, 2010, August 6 and 13, 2010, and October 21, 2010, CMA #3 documented the medication was wasted because the Clonazepam was either "dropped" or the resident spit out the medication. According to the documentation, a second Clonazepam was then signed out with the same date and time.</p> <p>Review of resident #11's controlled drug record sheet for OxyContin 20 milligrams revealed on July 2, 14, 21, and 29, 2010, August 13 and 31, 2010, September 15 and 29, 2010, and October 3, 4, 5, 9, and 14, 2010, CMA #3 had signed out the OxyContin and documented the medication</p>	F 425		
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F 425	<p>Continued From page 28</p> <p>was wasted because the medication was either dropped, knocked out of the CMA's hand, or spit out by the resident.</p> <p>Review of resident #12's controlled drug record for Clonazepam 1 milligram revealed on October 22, 2010, CMA #3 had signed out the Clonazepam and documented the medication was wasted due to being dropped.</p> <p>Review of resident #13's controlled drug record for Lorazepam 1 milligram revealed on July 14, 2010, August 23, 2010, and September 1, 2010, CMA #3 documented the resident's medication was wasted because the resident refused the medication or medication was knocked out of his/her hand. In addition, according to the controlled drug record, CMA #3 documented that Lorazepam was administered to resident #13 28 times from June 17, 2010 to August 31, 2010; however, no other staff member had administered Lorazepam to resident #13 during that time period.</p> <p>Review of the facility's investigation, initiated after CMA #3 was observed to have slurred speech, disorganized thoughts, to be unsteady and unable to complete a count of narcotics on October 23, 2010, revealed the facility became aware CMA #3 had wasted residents' medication an unusually high number of times. In addition, the investigation indicated the CMA had allegedly forged staff's initials as having witnessed the medications being wasted.</p> <p>Interview with the pharmacist on November 3, 2010, at 4:50 p.m. and 6:58 p.m., revealed each month residents' medications were reviewed, along with lab monitoring, drug interactions, and a</p>	F 425			

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F 425	Continued From page 29 general overview. According to the pharmacist, pharmacy staff conducted a quarterly review of medication administration and reviewed narcotic records to ensure drugs were signed out when they were administered; however, no one reconciled medications or monitored the medication logs for irregularities.  Interview with the Director of Nursing (DON) and the Administrator on November 3, 2010, at 7:04 p.m., revealed that controlled drug records were "occasionally" reviewed for discrepancies, such as staff not signing out medications, but the facility did not have a system for monitoring controlled drug administration.	F 425		
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING  A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to be administered in a manner that enabled the facility to use its resources effectively and efficiently to provide the required care and services to the residents. The facility Administration failed to ensure resident #1's environment remained as free of accident hazards as is possible and failed to ensure resident #1 received adequate supervision and assistance devices to prevent accidents. (Refer to F157, F281, F323, and F490.)	F 490	See Attachment	12/7/10

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F 490	<p>Continued From page 30</p> <p>Resident #1, who was assessed by the facility to be at risk for falling, fell at the facility on October 18, 2010. The facility failed to implement interventions to prevent the resident from falling. In addition, the resident was assessed to need two three-quarter-length side rails on the bed. However, the facility failed to reassess the risks of side rail usage when the resident began attempting to get out of bed around the side rails, and was observed with body parts caught/wedged in the side rails.</p> <p>The facility Administration's failure to ensure adequate supervision and assistive devices were provided and the failure to ensure the environment remained as free of accident hazards as is possible placed residents in the facility at risk for serious injury, harm, impairment, or death.</p> <p>The findings include:</p> <p>Observation of resident #1 on October 26, 2010, at 3:00 p.m., at the hospital revealed the resident was unresponsive and was having periods of apnea (no breathing). The resident's right eye was observed to be swollen and purple, and the right arm/hand was swollen. An interview with the resident's daughter during the observation revealed the resident was going "to die."</p> <p>According to resident #1's medical record and a review of an incident report, on October 18, 2010, at 12:35 a.m., resident #1 was found on the floor by the resident's bed with a large open area on the right forearm and above the resident's right eye. The resident was transferred to the hospital. The resident sustained a right orbital fracture, a</p>	F 490			

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F 490	<p>Continued From page 31</p> <p>fracture of the right zygomatic arch (the orbit and zygomatic arch are bones surrounding the eye), right supra and periorbital hematoma (around the eye), and six rib fractures as a result of the fall. According to an interview with the resident's physician on October 27, 2010, at 3:15 p.m., resident #1 expired on October 26, 2010, as a result of complications from the fall.</p> <p>Review of the resident's medical record revealed the resident had been admitted to the facility on October 14, 2010, four days prior to the fall. A review of the medical record revealed the facility completed a fall risk assessment on October 15, 2010, and determined the resident was at high risk for falling. However, further review of the medical record revealed no interventions were implemented to prevent the resident from falling. In addition, on October 15, 2010, the facility conducted a side rail assessment and determined side rail usage was needed to assist the resident with bed mobility.</p> <p>According to the nursing notes, Mood and Behavior form, and the facility's investigation, on October 16, 2010, resident #1 began attempting to exit the bed or was observed to be sitting on the side of the bed between the bottom of the side rail and the end of the bed. In addition, the resident was observed to be wedged/caught in the side rail on two occasions. There was no evidence the facility notified the resident's physician or reassessed the resident's fall risk or the risks the side rails posed for resident #1. A physician's order was written for a bed alarm on October 16, 2010. However, according to an interview with nurse #1 on October 26, 2010, at 5:25 p.m., the bed alarm was not implemented because bed alarms were locked in the stock</p>	F 490			

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F 490	<p>Continued From page 32 room and were not available to staff.</p> <p>An interview with the Administrator on October 26, 2010, at 8:35 p.m., revealed staff should have notified the Director of Nursing (DON) when they did not have a bed alarm available for resident #1. The Administrator stated the facility had always kept alarms in the stock room because he/she did not want staff to put alarms on everyone without all staff being aware of the intervention. According to the Administrator, the nurse should have called the resident's physician to get medical interventions for resident #1, and should have called the resident's family to possibly visit the resident when the resident was trying to get out of bed. According to the Administrator, a nurse assessed residents' fall risk and side rail usage on admission. In addition, all residents newly admitted to the facility were discussed in a morning meeting with administrative staff and department heads. According to the Administrator, if resident #1 had a history of falls, the facility would have implemented an alarm on admission. However, according to the Administrator, the resident did not have a history of falls or a history of attempting to get out of bed unassisted. The Administrator stated staff nurses should then assess residents and use nursing judgment to provide care for residents. According to the Administrator, the nurse for resident #1 should have used nursing judgment to provide care for resident #1 and the "senior" nurses on the floor should have given the nurse guidance.</p> <p>An interview with the Assistant Administrator on October 27, 2010, at 4:40 p.m., revealed administrative staff monitored care when they were on the living units of the facility. In addition,</p>	F 490			

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F 490	<p>Continued From page 33</p> <p>the nursing supervisors were responsible for monitoring to ensure care was being provided appropriately; however, the supervisor was on sick leave.</p> <p><b>**An acceptable Allegation of Compliance (AOC) related to the Immediate Jeopardy was submitted by the facility on November 1, 2010, which alleged removal of Immediate Jeopardy effective October 30, 2010. A partial extended survey was conducted on November 3, 2010, which determined the Immediate Jeopardy was removed on October 30, 2010.</b></p> <p>A review of documentation and an interview with the Administrator revealed the Medical Director met with the facility Administrator on October 28, 2010, to discuss the facility's plan of action necessary to remedy the Immediate Jeopardy. The Medical Director reviewed all resident falls and interventions that were in place for each resident. According to the AOC, the Medical Director will provide oversight and supervision during the compliance process and during the Quality Assurance process to remove jeopardy.</p> <p>A review of a list of residents who had fallen at the facility and the interventions that were in place for each resident revealed they were signed by the Medical Director.</p> <p>According to documentation and an interview with the facility Administrator, Assistant Administrator, Director of Nursing, and Assistant Director of Nursing on October 28, 2010, Health Care Excel had in-serviced the staff members on fall prevention measures.</p> <p>Based on the above findings it was determined</p>	F 490			

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PRINTED: 12/02/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 11/03/2010
NAME OF PROVIDER OR SUPPLIER  MOUNTAIN MANOR OF PAINTSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 41240		
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F 490	Continued From page 34 the Immediate Jeopardy was removed effective October 30, 2010. Noncompliance continued with the scope and severity lowered to "D" based on the facility's need to evaluate the implementation of systematic changes and quality assurance activities.	F 490			
F 520 SS=J	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.  The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.  A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.  Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the quality assessment and	F 520	See Attachment	12/7/10	

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F 520	<p>Continued From page 35</p> <p>assurance committee identified issues to which quality assessment and assurance activities were necessary. There was no evidence the facility Quality Assurance Committee identified fall interventions or side rail assessment as quality concerns in the facility.</p> <p>Resident #1 was admitted to the facility on October 14, 2010, and the facility assessed the resident to be at high risk for falls, and to require the use of two three-quarter-length side rails for bed mobility. On October 16 and 17, 2010, resident #1 experienced a change in status and began to exit the bed unassisted. Even though a bed alarm was ordered, the alarm was not implemented. In addition, there was no evidence the side rail usage was reassessed to ensure resident safety. On October 18, 2010, resident #1 sustained a fall at the facility, was transported to the hospital, and expired on October 26, 2010, due to complications from the fall.</p> <p>The facility's failure to ensure a Quality Assurance Committee was in place which identified quality concerns in the facility, and implemented action plans to correct the concerns placed residents at risk for serious injury, harm, impairment, or death.</p> <p>The findings include:</p> <p>A review of the facility's "Quality Control" policy (not dated) revealed the facility had developed a quality control program that identified specific deficiencies, measured the level of the quality of services provided by facility departments, and continually furnished information that would aid the facility in taking corrective action. The Quality Control policy further stated items requiring corrective action would be discussed with the</p>	F 520		

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F 520	<p>Continued From page 36 Administrator "as they arise."</p> <p>A review of the facility's Resident Accident and Incident Review form revealed the facility reviewed resident falls after they occurred. According to the form, the facility reviewed to ensure care after the accident/incident was appropriate, whether or not the accident/incident was avoidable, if measures were taken beforehand to prevent the occurrence, and if there was evidence a plan was implemented to prevent further occurrences.</p> <p>In addition, the facility's Physical Restraint Use Review form revealed the facility monitored restraint use in the facility's CQI program.</p> <p>An interview with the Assistant Administrator, the staff member in charge of Quality Assurance, on October 27, 2010, at 4:40 p.m., revealed the facility monitored resident falls in Quality Assurance. According to the Administrator, the facility monitored side rails that were used as restraints, and if a resident who utilized side rails experienced a fall, the facility would review the side rail usage as a possible causative factor of the fall. According to the interview with the Assistant Administrator, the facility's Quality Assurance program had not identified a concern with interventions not being implemented to prevent falls. In addition, the facility Quality Assurance program had not identified side rails as accident hazards. According to the Assistant Administrator, the facility monitored residents' medical records to ensure physician's orders were on the record, but did not monitor to ensure orders were implemented. Further, the facility's Quality Assurance program had not identified that staff was unaware how to obtain equipment when</p>	F 520			

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F 520	<p>Continued From page 37</p> <p>administrative/stock room staff was not at the facility.</p> <p>Review of resident #1's medical record revealed the resident was admitted on October 14, 2010. Review of the fall risk assessment, dated October 15, 2010, revealed the resident was assessed by the facility to be a high risk for falls. In addition, the facility conducted a side rail assessment, and determined side rail usage was needed to assist the resident with bed mobility.</p> <p>Review of nursing notes, the Mood and Behavior form, and the facility's investigation revealed on October 16 and 17, 2010, resident #1 began to exit the bed unassisted, was observed by staff to be sitting on the edge of the bed between the bottom of the side rail and end of the bed, and had become wedged/caught in the side rail on two separate occasions.</p> <p>Review of the resident's medical record revealed no evidence any interventions were implemented to prevent falls for the resident nor any reassessment of the safety of the side rail usage when the resident began exiting the bed around the side rails on October 16 and 17, 2010. According to the medical record, resident #1 was found on the floor by the resident's bed on October 18, 2010, at 12:35 a.m. The resident was observed to have a large open area on the right forearm and above the resident's right eye. According to hospital records, resident #1 sustained a right orbital fracture, fracture of the right zygomatic arch (bones which surround the eye), right supra and periorbital hematoma (around the eye), and six rib fractures. Interview with the resident's physician, on October 27, 2010, at 3:15 p.m., revealed resident #1 expired</p>	F 520			

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F 520	<p>Continued From page 38 on October 26, 2010, as a result of complications from the fall.</p> <p><b>**An acceptable Allegation of Compliance (AOC)</b> related to the Immediate Jeopardy was submitted by the facility on November 1, 2010, which alleged removal of Immediate Jeopardy effective October 30, 2010. A partial extended survey was conducted on November 3, 2010, which determined the Immediate Jeopardy was removed on October 30, 2010.</p> <p>According to documentation and interviews with the Administrator, the facility had a Continuous Quality Improvement (CQI) meeting on October 28, 2010, with the Medical Director and developed the facility's Allegation of Removal of Immediate Jeopardy. According to the "CQI Problem Follow-Up Forms," the facility obtained a new fall risk and side rail assessment and conducted the assessments for every resident who had fallen in the past 15 months. According to the AOC, the Fall Risk Assessment Policy was reviewed and updated, and two charts would be audited every week to ensure the fall risk assessment and side rail assessment was accurate, and physician notification and documentation was in the nursing notes. According to the CQI, the audits would begin on October 29, 2010.</p> <p>In addition, a review of audits revealed four resident records were audited daily to ensure the facility's policy/procedure for physician notification was being followed and appropriate documentation was in the resident's medical record.</p> <p>Further, a safety device audit was conducted for</p>	F 520			

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F 520	<p>Continued From page 39</p> <p>12 residents daily (three per shift per floor) to ensure safety devices/alarms were in place, the device was operational, the device was documented on the MAR, and the MAR was initialed</p> <p>A review of the audits and interviews with the Administrator, Director of Nursing, and the Assistant Administrator on November 3, 2010, revealed the audits were being conducted and any concerns that were identified were being corrected immediately and the results of the audits would be discussed in the facility's next CQI meeting scheduled for the last week in November 2010.</p> <p>Based on the above findings, it was determined on November 3, 2010, the Immediate Jeopardy was removed effective October 30, 2010. Noncompliance continued with the scope and severity lowered to "D" based on the facility's need to evaluate the implementation of systematic changes and quality assurance activities.</p>	F 520			

Mountain Manor of Paintsville does not believe and does not admit that any deficiencies existed, either, before, during or after the survey. Mountain Manor of Paintsville reserves all rights to contest the survey findings through informal dispute resolution, formal legal appeal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds, nor is it meant to establish any standard of care, contract obligation or position, and Mountain Manor reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance, or self-critical examination privileges which Mountain Manor of Paintsville does not waive, and reserves the right to assert in any administrative, civil, criminal claim, action or proceeding. Mountain Man or of Paintsville offers its responses, credible allegation of compliance, and plan of correction as part of its ongoing effort to provide quality care to its residents.

F 157

483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)

It is the policy of this facility that the resident's family and physician be notified when there is a change in the resident's physical, mental, or psychosocial status. This is evidenced by the following.

1. I cannot correct this as it relates to this resident.
2. The chart of every resident who has had a fall was reviewed. Every attending physician at this facility was notified in writing on October 28, 2010 of each of their residents that has had a fall at this facility in the last 15 months, the number of falls and the safety device/s being used for each resident to prevent falls. They were asked to sign the letter and return it. Anna Caldwell, Robyn Akers and Mary Arms completed this.

A printout (Custom Report for safety tx appliances) was obtained from pharmacy. This report was compared to every resident/resident room to identify if residents had safety devices. The charts were then reviewed and the physicians were notified when necessary to ensure that the physicians are aware of the need for a safety device, that all devices are ordered and are appropriate and that all physician orders related to fall prevention devices/safety devices were implemented and were on the MAR. This was completed on October 28<sup>th</sup>, 2010 by Christy Moore, RN.

The attending physician of all residents having side rails/safety devices/fall prevention devices were notified of the behavior/change in resident condition that was exhibited by the resident before altering the treatment by using a safety device/fall prevention device. This was completed on 12/3/10 by Mary Arms.

In addition the Medical Director, Dr. Charles Hardin was at the facility on October 28, 2010. The IJ and Type A Citation and corrective action was discussed with him by the Administrator, Deborah Fitzpatrick and he reviewed the list of residents, their safety devices and signed each of the physician notification letters as well.

3. On October 28, 2010 Mary Arms, DON and Deborah Fitzpatrick, Administrator inserviced Licensed Nurses on Notification of Changes. Special attention was given to not writing orders without contacting the physician. This inservice also included notification of physician and family concerning changes in resident condition.

Nurse aides were inserviced on reporting changes in resident condition to the nurse on October 28, 2010 by Mary Arms and Deborah Fitzpatrick.

Physician Notification is currently covered during orientation. Additional information was added to the orientation packet on 10/28/10 to reinforce the importance as well as family/responsible party notification. This was completed by Mary Arms/Robyn Akers.

Each nurse was inserviced on and given a copy of nursing "Scope of Practice Guidelines" a brochure from the Kentucky Board of Nursing titled "Assuring Safe Nursing Care in Kentucky" on 10/28/10. These were also added to licensed nurses orientation. A copy of the inservice given on 10/28/10 was placed in the orientation packet and will be covered during orientation. Mary Arms will ensure this is covered during new employee orientation.

Each individual nurse involved was reprimanded.

4. A physician call log was implemented at the suggestion of Dr. Hardin (Medical Director) to monitor physician notification as well as physician response time. Nurses are to log each time they call a physician. The call log will be compared to the nurse's notes and the physician order sheets to verify physician notification.

A maximum of 4 calls will be audited daily (2 calls per floor) from the call log by the DON, ADON or Charge Nurse for 6 weeks. Any problems identified will be corrected immediately and we will continue to monitor.

If no problems are identified we will continue to monitor 4 calls weekly (2 calls per floor) for 6 months.

In addition 10 charts (5 from each floor) will be randomly audited on a weekly basis to ensure that calls are being logged and that physicians are being notified of changes in resident condition. This will continue for 6 weeks. This will be done by the DON, ADON, or Charge nurse. If no problems are identified we will continue to monitor 4 charts per week (2 charts from each floor).

The results will be reported monthly to the Medical Director and quarterly through CQI by Robyn Akers.

5. DOC 12/07/2010

F 225

483.13 ( c ) ( 1 ) ( ii ) - ( iii ) , ( c ) ( 2 ) - ( 4 ) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

It is the policy of this facility to report all allegations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property immediately to the State survey and certification agency and other state officials as required by state law. This is evidenced by the following.

1. This incident was reported to the state survey and certification agency on October 26<sup>th</sup>.
2. An audit of all current resident narcotic sign out sheets was completed on 11/19/10 by Mary Arms, DON. Narcotic sign out sheets were audited for excessive wasting or other discrepancies. There were no other incidents of suspected misappropriation of resident medication.
3. All licensed staff were inserviced concerning misappropriation of resident property related to medication as part of the Abuse Prevention Policy and proper reporting procedures on 11/19/10 by Mary Arms, DON. See attachment #1.

The CMA is no longer employed by this facility.

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A special incident report has been developed and will be required when wasting a narcotic. This must be signed by both nurses and reported to the DON/ADON. The DON/ADON will investigate each instance of medication wasting and report any suspected misappropriations as stated in the abuse prevention policy. Licensed staff were inserviced on 11/19/10 by Mary Arms, DON/ADON.

A narcotic wasting policy has been developed and staff were inserviced on 11/19/10 by Mary Arms, DON.

Enclosed is a copy of the Narcotic Wasting Policy, Wasted Narcotic Incident Report, Misappropriation of Resident Property from the Abuse Prevention Policy and the sign in sheet. All licensed nurses attended. See Attachment #1.

4. The narcotic sheets will be audited bi-weekly for three (3) months by the DON/ADON and/or designee for improper wasting of narcotics. All instances of wasted narcotics on the narcotic sign out sheets will be compared to the Wasted Narcotic Incident Reports.

During this audit the DON will randomly select 6 residents (3 from each floor) and count narcotics with the nurse to monitor proper counting procedures.

If no significant problems are identified then the monitoring will continue on a monthly basis.

This will be reported monthly to the Medical Director and quarterly through CQI by Robyn Akers

5. DOC 12/07/2010

F 281

483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

It is the policy of this that services provided or arranged by the facility must meet professional standards of quality. This is evidenced by the following.

1. I cannot correct this as it relates to this resident.
2. A printout (Custom Report for safety tx appliances) was obtained from pharmacy. This report was compared to every resident/resident room to identify if residents had safety devices that were not ordered or had orders but did not have safety devices. The charts were then reviewed and the physicians were notified when necessary to ensure that the physicians are aware of the need for a safety device, that all devices are ordered and are

appropriate and that all physician orders related to fall prevention devices/safety devices were implemented and were on the MAR. This was completed on October 28<sup>th</sup>, 2010 by Christy Moore, RN.

3. Licensed Nurses were inserviced on 10/28/2010 by Mary Arms and Deborah Fitzpatrick. Special emphasis was placed on physician notification for orders, noting orders and implementation of orders.

All Licensed Nurses were inserviced on 10/28/10 by Mary Arms and Deborah Fitzpatrick concerning their responsibility as nurses. Each was given a copy of "Scope of Practice Determination Guidelines" and a brochure titled "Assuring Safe Nursing Care in Kentucky". These will be added to the licensed nurses orientation.

Alarms were placed in the medication room along with a sign out sheet to ensure that alarms can be replaced as used. Nurses are to count at the end of their shift and sign indicating that alarms are available. Madge Arnett, Mary Arms completed this on 10/18/10.

All Licensed Nurses were inserviced on 10/28/10 by Mary Arms and Deborah Fitzpatrick concerning alarms being placed in the med room, signing them out, counting at shift change and on the facility policy concerning how to obtain supplies if not readily available. This inservices was started again for licensed nurses on December 3, 2010 and will be completed by 12/6/2010.

4. A safety device audit form was developed and implemented to monitor the proper use of safety devices as ordered. A calendar was developed to include all residents who have safety/fall prevention devices. Three residents per shift per floor or twelve (12) per day will be audited to ensure that the proper safety device is in place and is operational. These audits are being completed by Administration/Nursing Administration. This audit will continue daily for six (6) weeks. If no problems are identified the audit will decrease to six (6) residents per week for 6 months. These audits will be completed by Deborah Fitzpatrick, Robyn Akers, Mary Arms, Anna Caldwell and charge nurse/s as designated.

A physician call log was implemented at the suggestion of Dr. Hardin (Medical Director) to monitor physician notification as well as physician response time. Nurses are to log each time they call a physician. The call log will be compared to the nurse's notes and the physician order sheets to verify physician notification and that orders have been carried out as ordered. These audits will be completed by a designated charge nurse, Anna Caldwell or Mary Arms.

In addition 10 charts (5 from each floor) will be randomly audited on a weekly basis to ensure that calls are being logged and that physicians are being notified of changes in resident condition. This will continue for 6 weeks. This will be done by the DON, ADON,

or Charge nurse. If no problems are identified we will continue to monitor 4 charts per week (2 charts from each floor).

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The results of the audits will be reported monthly to the Medical Director and quarterly through CQI by Robyn Akers.

5. DOC 12/07/10

F 323

483.25 (h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

It is the policy of this facility that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This is evidenced by the following.

1. I cannot correct this as it relates to this resident.
2. All residents/rooms with fall prevention measures were audited to ensure that all safety devices were in place and care planned per physician order and that all devices were operational. This audit was completed by Christy Moore, RN on 10/28/10.

The MARs were audited to ensure that all devices ordered are on the MAR. This was completed by Christy Moore, RN on 10/28/10.

An updated version of our current fall risk assessment was obtained and completed on all residents who have had a fall within the last 15 months by Anna Caldwell, Mary Arms and Roberta Thompson on 10/28/10. All other residents had their current fall risk assessment reviewed on 10/29/10 by Anna Caldwell and Christy Moore. All other residents current fall risk assessment was reviewed again on 12/01/10 and 12/02/10 by Christy Moore and Anna Caldwell. Currently 66 residents have been evaluated using the updated fall risk assessment. The remainder of the residents will have their fall risk assessment updated using the updated assessment with their next MDS or sooner if indicated.

An updated version of our current side rail assessment was obtained and completed on all residents who have had a fall within the last 15 months on 10/28/10 by Anna Caldwell, Roberta Thompson and Mary Arms. All of the other residents had their

current side rail assessment reviewed on 10/29/10 by Anna Caldwell and Christy Moore.

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All other residents had their current side rail assessment reviewed again on 12/01/10 and 12/02/10 by Christy Moore and Anna Caldwell. Currently 66 residents have been evaluated using the updated side rail assessment. The remainder of the residents will have their side rail assessment updated using the updated assessment with their next MDS or sooner indicated.

A side rail review was completed on 11/15/10 on all residents to ensure that the appropriate side rail length was in use as ordered. This was completed by Anna Caldwell.

The MDS, Comprehensive Care Plan and Nurse Aide Care Plan of all residents was reviewed to ensure that falls or fall risk factors was identified and appropriate prevention measures are care planned and being implemented. This was completed by Roberta Thompson, MDS Coordinator on 10/28/10.

On 10/29/10 Anna Caldwell and Christy Moore reviewed the Comprehensive Care Plan and the Nurse Aide Care Plan of all the other residents to ensure that fall or fall risk factors and side rails were identified and appropriate prevention measures are being implemented.

Anna Caldwell and Christy Moore reviewed comprehensive care plans and Nurse Aide Care Plans on 12/01/10 and 12/02/10 for fall risk factors and fall prevention measures.

On 11/10/10 and 11/15/10 Anna Caldwell reviewed all resident records for side rails and compared them to what they had on their beds. Physicians were notified of any discrepancies and clarification orders were received.

3. Both nurses and nurse aides were inserviced on 10/28/10 by Mary Arms and Deborah Fitzpatrick to assess the safety devices/fall prevention devices used by the resident to see if they are on the bed/person or are in the specified location in the room and are operational. The MAR should be initialed to indicate devices are in place and operational.

Nursing staff were inserviced on resident supervision and accident prevention on 10/28/10 by Deborah Fitzpatrick and Mary Arms. Nurses should make rounds between med passes at a minimum. If working with a CMA the nurse should make rounds on all the patients the CMA is giving medication to. The CMA should make rounds between

med passes also and assist the nurse aides in providing direct patient care if necessary.

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Nurse aides should make rounds between turn and change. Staff were inserviced that if residents are exhibiting unsafe behavior such as climbing out of bed, the nurse should be notified, the physician should be notified and someone should stay with the resident until precautions can be put in place to protect the resident.

Health Care Excel provided inservice training for all staff on facility wide falls prevention program on November 2<sup>nd</sup>, 3<sup>rd</sup>, and 11<sup>th</sup> of 2010. One hundred and five (105) employees attended over a three day period. See Addendum #2

Inservices were started for all Licensed Nurses on December 3, 2010 by Mary Arms concerning fall risk and side rail assessments policies, why these assessments are necessary, how to complete the assessments, when they should be completed and who should complete them. The inservices will be completed by December 6, 2010 by Mary Arms

Pad and personal alarms were placed in each med room with a sign out sheet on 10/18/10. When an alarm is used per physician order the alarm should be signed out and the slip sent to stock control so it can be replaced. The alarms are counted at shift change to ensure that alarms are available. Mary Arms began inservicing on 10/18/10. All licensed were inserviced on 10/28/10 Deborah Fitzpatrick and Mary Arms.

Licensed staff were inserviced on stock control policy and how to obtain supplies not readily available on 10/28/10 by Deborah Fitzpatrick and Mary Arms. See Addendum #3.

The stock control employee relabeled all the cabinets in the supply room on each floor. There is a list of items that is available in the supply room on each floor. Each nurse will be inserviced on the list, the door labels and the supplies in the room by Mary Arms.

A key is available to the main stock room at each nurses station. Employees were inserviced by Mary Arms on 12/3/10

All alarm pads and personal alarms were replaced with new alarms. This was completed by Madge Arnett on 11/12/10.

4. Three residents per shift per floor (12 per day) are being audited daily to determine if they have the appropriate safety devices as ordered by the physician and if the device is operational and if the nurse has initialed that she checked the device. This audit will continue for six (6) weeks. If no problems are identified the frequency will decrease to six (6) residents once a week for 6 months. The audits are being completed by Mary Arms, Anna Caldwell, Robyn Akers, Deborah Fitzpatrick and charge nurses as designated by the DON.

The charts of all new residents or residents returning from a hospital stay will be audited during the morning CQI meeting to ensure that side rail and fall risk assessments were completed timely and accurately, that the physician was notified if necessary to alter treatment to prevent injury and that physician orders were implemented. Mary Arms, Anna Caldwell, or designated charge nurse will complete this.

Ten (10) resident records (5 per floor) will be audited weekly for 6 weeks to ensure that side rail and fall risk assessments are updated as necessary and the physician is notified if it is necessary to alter treatment based on these assessments. If no problems are identified then the audits will decrease to 4 records (2 per floor) per month for 6 months. Mary Arms, Anna Caldwell or designated charge nurse will complete this.

The results of the audit will be reported monthly to the Medical Director and quarterly through CQI by Robyn Akers.

5. DOC 12/07/10

F 425

483.60(a),(b) PHARMACEUTICAL SERVICES-ACCURATE PROCEDURES. RPH

It is the policy of this facility to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological) to meet the needs of each resident. This is evidenced by the following.

1. The narcotic records of those residents identified during the survey as being affected were audited for inaccuracies or excessive wasting on 11/19/10 by Mary Arms.
2. All current narcotic sign out sheets of all residents were reviewed on 11/19/10 for excessive wasting or other discrepancies by Mary Arms, DON. There were no other suspected misappropriation of resident medication.

3. All licensed staff were inserviced concerning misappropriation of resident property related to medication as part of the Abuse Prevention Policy and proper reporting procedures on 11/19/10 by Mary Arms, DON. See Attachment/Addendum #1.

A special incident report has been developed and will be required when wasting a narcotic. This must be signed by both nurses and reported to the DON/ADON. The DON/ADON will investigate each instance of medication wasting and report any suspected misappropriations. Licensed staff were inserviced on 11/19/10 by the DON. See Attachment/Addendum #1.

A narcotic wasting policy has been developed and staff were inserviced on 11/19/10 by Mary Arms, DON. See Attachment/Addendum #1.

4. The narcotic sheets will be audited bi-weekly for three (3) months by the DON/ADON and/or designee for improper wasting of narcotics. All instances of wasted narcotics on the narcotic sign out sheets will be compared to the Wasted Narcotic Incident Reports.

During this audit the DON will randomly select 6 residents (3 from each floor) and count narcotics with the nurse to monitor proper counting procedures.

If no significant problems are identified then the monitoring will continue on a monthly basis.

5. DOC 12/07/2010

F 490

#### 483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING

It is the policy of this facility that it be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This is evidenced by the following.

1. F157, F281, F323, F490, F520 cannot be corrected as it relates to this resident.

F225 - The incident concerning the misappropriation of narcotics was reported to the state survey and certification agency on October 26<sup>th</sup>, 2010.

F425 - The narcotic records of those residents identified during the survey as being affected were audited for inaccuracies or excessive wasting on 11/19/10 by Mary Arms.

2. The chart of every resident who has had a fall was reviewed. Every attending physician at this facility was notified in writing on October 28, 2010 of each of their residents that has had a fall at this facility in the last 15 months, the number of falls and the safety device/s being used for each resident to prevent falls. They were asked to sign the letter and return it. Anna Caldwell, Robyn Akers and Mary Arms completed this.

A printout (Custom Report for safety tx appliances) was obtained from pharmacy. This report was compared to every resident/resident room to identify if residents had safety devices. The charts were then reviewed and the physicians were notified when necessary to ensure that the physicians are aware of the need for a safety device, that all devices are ordered and are appropriate and that all physician orders related to fall prevention devices/safety devices were implemented and were on the MAR. This was completed on October 28<sup>th</sup>, 2010 by Christy Moore, RN.

The attending physician of all residents having side rails/safety devices/fall prevention devices were notified of the behavior/change in resident condition that was exhibited by the resident before altering the treatment by using a safety device/fall prevention device. This was completed on 12/3/10 by Mary Arms.

In addition the Medical Director, Dr. Charles Hardin was at the facility on October 28, 2010. The IJ and Type A Citation and corrective action was discussed with him by the Administrator, Deborah Fitzpatrick and he reviewed the list of residents, their safety devices and signed each of the physician notification letters as well.

An updated version of our current fall risk assessment was obtained and completed on all residents who have had a fall within the last 15 months by Anna Caldwell, Mary Arms and Roberta Thompson on 10/28/10. All other residents had their current fall risk assessment reviewed on 10/29/10 by Anna Caldwell and Christy Moore. All other residents current fall risk assessment was reviewed again on 12/01/10 and 12/02/10 by Christy Moore and Anna Caldwell. Currently 66 residents have been evaluated using the updated fall risk assessment. The remainder of the residents will have their fall risk assessment updated using the updated assessment with their next MDS or sooner if indicated.

An updated version of our current side rail assessment was obtained and completed on all residents who have had a fall within the last 15 months on 10/28/10 by Anna Caldwell, Roberta Thompson and Mary Arms. All of the other residents had their current side rail assessment reviewed on 10/29/10 by Anna Caldwell and Christy Moore. All other residents had their current side rail assessment reviewed again on 12/01/10

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and 12/02/10 by Christy Moore and Anna Caldwell. Currently 66 residents have been evaluated using the updated side rail assessment. The remainder of the residents will have their side rail assessment updated using the updated assessment with their next MDS or sooner indicated.

A side rail review was completed on 11/15/10 on all residents to ensure that the appropriate side rail length was in use as ordered. This was completed by Anna Caldwell.

The MDS, Comprehensive Care Plan and Nurse Aide Care Plan of all residents was reviewed to ensure that falls or fall risk factors was identified and appropriate prevention measures are care planned and being implemented. This was completed by Roberta Thompson, MDS Coordinator on 10/28/10.

On 10/29/10 Anna Caldwell and Christy Moore reviewed the Comprehensive Care Plan and the Nurse Aide Care Plan of all the other residents to ensure that fall or fall risk factors and side rails were identified and appropriate prevention measures are being implemented.

Anna Caldwell and Christy Moore reviewed comprehensive care plans and Nurse Aide Care Plans on 12/01/10 and 12/02/10 for fall risk factors and fall prevention measures.

On 11/10/10 and 11/15/10 Anna Caldwell reviewed all resident records for side rails and compared them to what they had on their beds. Physicians were notified of any discrepancies and clarification orders were received.

An audit of all current resident narcotic sign out sheets was completed on 11/19/10 by Mary Arms, DON. Narcotic sign out sheets were audited for excessive wasting or other discrepancies. There were no other incidents of suspected misappropriation of resident medication.

3. Dr. Hardin (Medical Director) was consulted on October 28, 2010 concerning our survey resulting in deficiencies and Type A citation. The plan of correction was discussed with him.

On November 24, 2010 a meeting was held with Dr. Hardin to discuss his participation in CQI and oversight in quality of care.

On October 28, 2010 Mary Arms, DON and Deborah Fitzpatrick, Administrator inserviced Licensed Nurses on Notification of Changes. Special attention was given to not writing orders without contacting the physician and implementation of physician orders. This inservice also included notification of physician and family concerning changes in resident condition.

Nurse aides were inserviced on reporting changes in resident condition to the nurse on October 28, 2010 by Mary Arms and Deborah Fitzpatrick.

Physician Notification is currently covered during orientation. Additional information was added to the orientation packet on 10/28/10 to reinforce the importance as well as family/responsible party notification. This was completed by Mary Arms/Robyn Akers.

Each nurse was inserviced on and given a copy of nursing "Scope of Practice Guidelines" a brochure from the Kentucky Board of Nursing titled "Assuring Safe Nursing Care in Kentucky" on 10/28/10. These were also added to licensed nurses orientation. A copy of the inservice given on 10/28/10 was placed in the orientation packet and will be covered during orientation. Mary Arms will ensure this is covered during new employee orientation.

Each individual nurse involved was reprimanded.

All licensed staff were inserviced concerning misappropriation of resident property related to medication as part of the Abuse Prevention Policy and proper reporting procedures on 11/19/10 by Mary Arms, DON. See attachment #1.

The CMA involved in the medication misappropriation for residents #10, #11, #12, and #13 is no longer employed by this facility.

A special incident report has been developed and will be required when wasting a narcotic. This must be signed by both nurses and reported to the DON/ADON. The DON/ADON will investigate each instance of medication wasting and report any suspected misappropriations as stated in the abuse prevention policy. Licensed staff were inserviced on 11/19/10 by Mary Arms, DON/ADON. See attachment #1

A narcotic wasting policy has been developed and staff were inserviced on 11/19/10 by Mary Arms, DON. See attachment #1.

Enclosed is a copy of the Narcotic Wasting Policy, Wasted Narcotic Incident Report, Misappropriation of Resident Property from the Abuse Prevention Policy and the sign in sheet. All licensed nurses attended. See Attachment #1.

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The stock control employee (Madge Arnett) relabeled and rearranged the supply room on each floor on 11/19/10. A list of items found in the stock room is available in the supply room. All nurses were inserviced on the supplies and their location by Mary Arms December 3, 2010.

A copy of the stock control policy will be included in new orientation for nursing staff.

Pad and personal alarms were placed in each med room with a sign out sheet on 10/18/10. When an alarm is used per physician order the alarm should be signed out and the slip sent to stock control so it can be replaced. The alarms are counted at shift change to ensure that alarms are available. Mary Arms began inservicing on 10/18/10. All licensed staff were inserviced on 10/28/10 Deborah Fitzpatrick. Attachment #3

Mary Arms inserviced licensed staff again December 3, 2010 concerning supplies, what is in the supply room on each floor, the location of the main stock room, the stock control policy and the location of the key to the main stock room. Attachment #4

All alarm pads and personal alarms were replaced with new alarms. This was completed by Madge Arnett on 11/12/10.

Both nurses and nurse aides were inserviced on 10/28/10 by Mary Arms and Deborah Fitzpatrick to assess the safety devices/fall prevention devices used by the resident to see if they are on the bed/person or are in the specified location in the room and are operational. The MAR should be initialed to indicate devices are in place and operational.

Nursing staff were inserviced on resident supervision and accident prevention on 10/28/10 by Deborah Fitzpatrick and Mary Arms. Nurses should make rounds between med passes at a minimum. If working with a CMA the nurse should make rounds on all the patients the CMA is giving medication to. The CMA should make rounds between med passes also and assist the nurse aides in providing direct patient care if necessary. Nurse aides should make rounds between turn and change. Staff were inserviced that if residents are exhibiting unsafe behavior such as climbing out of bed, the nurse should be notified, the physician should be notified and someone should stay with the resident until precautions can be put in place to protect the resident.

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Health Care Excel began inservice training for all staff on facility wide falls prevention program on 11/2/10. One hundred and five (105) employees attended over a three day period (November 2, 3 and 11 of 2010). See Addendum #2 for education material.

Inservicing began for all Licensed Nurses on December 3, 2010 concerning fall risk and side rail assessments policies, why these assessments are necessary, how to complete the assessments, when they should be completed and who should complete them. These inservices will be completed on December 6, 2010 by Mary Arms.

4. Alarm pads and personal alarms are available and their availability is monitored at shift change. A form will be filled out when an alarm is used so that it can be restocked. This will be monitored by the stock control employee Madge Arnett. Any problems will be corrected immediately and monitored through CQI.

A safety device audit form was developed and implemented to monitor the proper use of safety devices as ordered. A calendar was developed to include all residents who have safety/fall prevention devices. Three residents per shift per floor or twelve (12) per day will be audited to ensure that the proper safety device is in place and is operational. These audits are being completed by Administration/Nursing Administration. This audit will continue daily for six (6) weeks. If no problems are identified the audit will decrease to six (6) residents per week for 6 months. These audits will be completed by Deborah Fitzpatrick, Robyn Akers, Mary Arms, Anna Caldwell and charge nurse/s as designated.

The charts of all new residents or residents returning from a hospital stay will be audited during the morning CQI meeting to ensure that side rail and fall risk assessments were completed timely and accurately, that the physician was notified if necessary to alter treatment to prevent injury and that physician orders were implemented. Mary Arms, Anna Caldwell, or designated charge nurse will complete this.

Ten (10) resident records (5 per floor) will be audited weekly for 6 weeks to ensure that side rail and fall risk assessments are updated as necessary and the physician is notified if it is necessary to alter treatment based on these assessments. If no problems are identified then the audits will decrease to 4 records (2 per floor) per month for 6 months. Mary Arms, Anna Caldwell or designated charge nurse will complete this.

Break times are being monitored daily to ensure that adequate staff remains in patient care areas to provide resident supervision. This will be completed by the charge nurse, DON, ADON or Assistant Administrator.

A physician call log was implemented at the suggestion of Dr. Hardin (Medical Director) to monitor physician notification as well as physician response time. Nurses are to log

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each time they call a physician. The call log will be compared to the nurse's notes and the physician order sheets to verify physician notification and that orders have been carried out as ordered. These audits will be completed by a designated charge nurse, Anna Caldwell or Mary Arms.

A maximum of 4 calls will be audited daily (2 calls per floor) from the call log by the DON, ADON or Charge Nurse for 6 weeks. Any problems identified will be corrected immediately and will be monitored through CQI.

If no problems are identified we will continue to monitor 4 calls weekly (2 calls per floor) for 6 months.

In addition 10 charts (5 from each floor) will be randomly audited on a weekly basis to ensure that calls are being logged and that physicians are being notified of changes in resident condition. This will continue for 6 weeks. This will be done by the DON, ADON, or Charge nurse. If no problems are identified the audit will decrease to 6 charts per month for 6 months.

Written orders will be compared to the call log for 6 weeks. Nursing Administration will monitor.

The narcotic sheets will be audited bi-weekly for three (3) months by the DON/ADON and/or designee for improper wasting of narcotics. All instances of wasted narcotics on the narcotic sign out sheets will be compared to the Wasted Narcotic Incident Reports.

During this audit the DON will randomly select 6 residents (3 from each floor) and count narcotics with the nurse to monitor proper counting procedures.

If no significant problems are identified then the monitoring will continue on a monthly basis.

The results of all audits will be reported monthly to the Medical Director and quarterly through CQI by Robyn Akers.

5. DOC 12/07/10

## 483.75(O)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS

It is the policy of this facility to maintain a quality assessment and assurance committee that identifies deficiencies and develops and implements appropriate plans of action to correct the quality deficiencies. This is evidenced by the following.

1. F157, F281, F323, F490, F520 cannot be corrected as it relates to this resident.

F225 - The incident concerning the misappropriation of narcotics was reported to the state survey and certification agency on October 26<sup>th</sup>, 2010.

F425 - The narcotic records of those residents identified during the survey as being affected were audited for inaccuracies or excessive wasting on 11/19/10 by Mary Arms.

2. The chart of every resident who has had a fall was reviewed. Every attending physician at this facility was notified in writing on October 28, 2010 of each of their residents that has had a fall at this facility in the last 15 months, the number of falls and the safety device/s being used for each resident to prevent falls. They were asked to sign the letter and return it. Anna Caldwell, Robyn Akers and Mary Arms completed this.

A printout (Custom Report for safety tx appliances) was obtained from pharmacy. This report was compared to every resident/resident room to identify if residents had safety devices. The charts were then reviewed and the physicians were notified when necessary to ensure that the physicians are aware of the need for a safety device, that all devices are ordered and are appropriate and that all physician orders related to fall prevention devices/safety devices were implemented and were on the MAR. This was completed on October 28<sup>th</sup>, 2010 by Christy Moore, RN.

The attending physician of all residents having side rails/safety devices/fall prevention devices were notified of the behavior/change in resident condition that was exhibited by the resident before altering the treatment by using a safety device/fall prevention device. This was completed on 12/3/10 by Mary Arms.

In addition the Medical Director, Dr. Charles Hardin was at the facility on October 28, 2010. The IJ and Type A Citation and corrective action was discussed with him by the Administrator, Deborah Fitzpatrick and he reviewed the list of residents, their safety devices and signed each of the physician notification letters as well.

An updated version of our current fall risk assessment was obtained and completed on all residents who have had a fall within the last 15 months by Anna Caldwell, Mary Arms

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and Roberta Thompson on 10/28/10. All other residents had their current fall risk assessment reviewed on 10/29/10 by Anna Caldwell and Christy Moore. All other residents current fall risk assessment was reviewed again on 12/01/10 and 12/02/10 by Christy Moore and Anna Caldwell. Currently 66 residents have been evaluated using the updated fall risk assessment. The remainder of the residents will have their fall risk assessment updated using the updated assessment with their next MDS or sooner if indicated.

An updated version of our current side rail assessment was obtained and completed on all residents who have had a fall within the last 15 months on 10/28/10 by Anna Caldwell, Roberta Thompson and Mary Arms. All of the other residents had their current side rail assessment reviewed on 10/29/10 by Anna Caldwell and Christy Moore. All other residents had their current side rail assessment reviewed again on 12/01/10 and 12/02/10 by Christy Moore and Anna Caldwell. Currently 66 residents have been evaluated using the updated side rail assessment. The remainder of the residents will have their side rail assessment updated using the updated assessment with their next MDS or sooner indicated.

A side rail review was completed on 11/15/10 on all residents to ensure that the appropriate side rail length was in use as ordered. This was completed by Anna Caldwell.

The MDS, Comprehensive Care Plan and Nurse Aide Care Plan of all residents was reviewed to ensure that falls or fall risk factors was identified and appropriate prevention measures are care planned and being implemented. This was completed by Roberta Thompson, MDS Coordinator on 10/28/10.

On 10/29/10 Anna Caldwell and Christy Moore reviewed the Comprehensive Care Plan and the Nurse Aide Care Plan of all the other residents to ensure that fall or fall risk factors and side rails were identified and appropriate prevention measures are being implemented.

Anna Caldwell and Christy Moore reviewed comprehensive care plans and Nurse Aide Care Plans on 12/01/10 and 12/02/10 for fall risk factors and fall prevention measures.

On 11/10/10 and 11/15/10 Anna Caldwell reviewed all resident records for side rails and compared them to what they had on their beds. Physicians were notified of any discrepancies and clarification orders were received.

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An audit of all current resident narcotic sign out sheets was completed on 11/19/10 by Mary Arms, DON. Narcotic sign out sheets were audited for excessive wasting or other discrepancies. There were no other incidents of suspected misappropriation of resident medication.

3. Dr. Hardin (Medical Director) was consulted on October 28, 2010 concerning our survey resulting in deficiencies and Type A citation. The plan of correction was discussed with him. He will review the plan of correction prior to submission. He will also be more involved with CQI and provide oversight as necessary during the correction process as well as the CQI process to prevent further incidents.

The care plan team will meet with all new residents/family members on admission to identify history of falls and potential risk factor. An initial care plan will be developed that is individualized to meet the residents needs.

On October 28, 2010 Mary Arms, DON and Deborah Fitzpatrick, Administrator inserviced Licensed Nurses on Notification of Changes. Special attention was given to not writing orders without contacting the physician and implementation of physician orders. This inservice also included notification of physician and family concerning changes in resident condition.

Nurse aides were inserviced on reporting changes in resident condition to the nurse on October 28, 2010 by Mary Arms and Deborah Fitzpatrick.

Physician Notification is currently covered during orientation. Additional information was added to the orientation packet on 10/28/10 to reinforce the importance as well as family/responsible party notification. This was completed by Mary Arms/Robyn Akers.

Each nurse was inserviced on and given a copy of nursing "Scope of Practice Guidelines" a brochure from the Kentucky Board of Nursing titled "Assuring Safe Nursing Care in Kentucky" on 10/28/10. These were also added to licensed nurses orientation. A copy of the inservice given on 10/28/10 was placed in the orientation packet and will be covered during orientation. Mary Arms will ensure this is covered during new employee orientation.

Each individual nurse involved was reprimanded.

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All licensed staff were inserviced concerning misappropriation of resident property related to medication as part of the Abuse Prevention Policy and proper reporting procedures on 11/19/10 by Mary Arms, DON. See attachment #1.

The CMA involved in the medication misappropriation for residents #10, #11, #12, and #13 is no longer employed by this facility.

A special incident report has been developed and will be required when wasting a narcotic. This must be signed by both nurses and reported to the DON/ADON. The DON/ADON will investigate each instance of medication wasting and report any suspected misappropriations as stated in the abuse prevention policy. Licensed staff were inserviced on 11/19/10 by Mary Arms, DON/ADON. See attachment #1

A narcotic wasting policy has been developed and staff were inserviced on 11/19/10 by Mary Arms, DON. See attachment #1.

Enclosed is a copy of the Narcotic Wasting Policy, Wasted Narcotic Incident Report, Misappropriation of Resident Property from the Abuse Prevention Policy and the sign in sheet. All licensed nurses attended. See Attachment #1.

The stock control employee (Madge Arnett) relabeled and rearranged the supply room on each floor on 11/19/10. A list of items found in the stock room is available in the supply room. All nurses were inserviced on the supplies and their location by Mary Arms December 3, 2010.

A copy of the stock control policy will be included in new orientation for nursing staff.

Pad and personal alarms were placed in each med room with a sign out sheet on 10/18/10. When an alarm is used per physician order the alarm should be signed out and the slip sent to stock control so it can be replaced. The alarms are counted at shift change to ensure that alarms are available. Mary Arms began inservicing on 10/18/10. All licensed staff were inserviced on 10/28/10 Deborah Fitzpatrick. Attachment #3

Mary Arms inserviced licensed staff again December 3, 2010 concerning supplies, what is in the supply room on each floor, the location of the main stock room, the stock control policy and the location of the key to the main stock room. Attachment #4

All alarm pads and personal alarms were replaced with new alarms. This was completed by Madge Arnett on 11/12/10.