

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

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OMB NO. 0938-0391

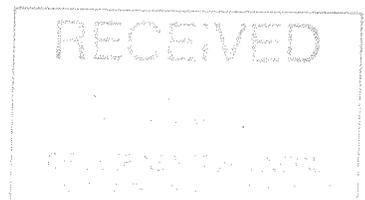
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185342 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 12/07/2012 |
| NAME OF PROVIDER OR SUPPLIER COLONIAL HEALTH AND REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 708 BARTLEY AVENUE BARDSTOWN, KY 40004 | |
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| F 309 | Continued From page 35 address the pain with the nurse again if necessary. 3. The State Agency validated by review of the information presented at the in-service on 11/30/12 with the licensed staff as well as the attendance log to ensure all licensed staff received the information. Interview, on 12/07/12 at 6:40 PM, with RN #1 verified that she did attend the Pain In-Service and understood the role and responsibility of the nurse in the assessment and treatment of pain. RN #1 stated staff were advised the facility updated the Standard of Care to include the assessment and treatment of resident pain, and verbalized understanding the failure of staff to assess and treat pain would constitute resident neglect. 4. The State Agency validated the training of the Nursing Supervisor to ensure the implementation and effectiveness of the Pain Management Program with review of the educational material and discussions with review of the attendance log dated 12/03/12. Interview, on 12/07/12 at 5:45 PM, with Nursing Supervisor #1 revealed she recently attended the Pain In-Service. Nursing Supervisor #1 stated CNAs were trained to document resident pain in the Care Tracker System, and to report the pain at once to the nurse, then at the end of the shift, the Care Tracker System reports would be reviewed by the manager to ensure CNA notifications of resident pain was addressed by nursing with a pain assessment and pain administration as necessary. 5. The State Agency validated that all residents in the facility were assessed on 12/05/12 to | F 309 | | |



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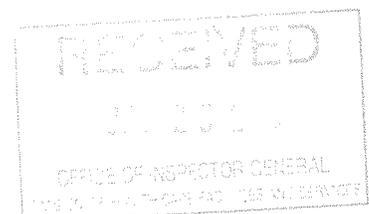
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| F 309 | Continued From page 36 determine any resident who had not been assessed or treated for pain by record review of the Resident Roster provided by the Administrative Core Group on 12/05/12. Interview, on 12/07/12 at 6:30 PM, with the DON revealed that by means of the complete facility resident audit for pain, only one (1) resident was identified to complain of pain that the resident felt had not been assessed or treated. The DON reviewed this resident and provided physician documentation of the nature of the resident's pain, as well as evidence that the resident had pain medication ordered, received the medication, and provided documentation of that the pain was reassessed after treatment, and it was documented the resident's pain was improved upon treatment. | F 309 | | |
| 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 interview, record review, review of the facility's policy for Falls Management, and job descriptions for nursing staff, it was determined the facility failed to ensure one (1) of six (6) sampled residents (Resident #1) was provided adequate supervision and assistive devices to | F 323 | F-323 1. Resident #1 is no longer a resident of the facility. 2. Corporate Consultant and Administrator reviewed all reports of incidents (falls, injury of unknown origin, resident to resident altercation) for past 30 | |



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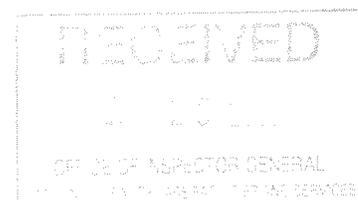
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| F 323 | <p>Continued From page 37</p> <p>ensure the resident was free from accident hazards. Resident #1 was identified by the facility to be dependent for transfers and wheelchair mobility, and required the assist of two (2) staff for transfers, with foot rests on the wheelchair at all times. On 11/15/12 at 5:15 AM, Resident #1 was transferred to a wheelchair without assistance of two (2) staff, and transported by staff in a wheelchair to the shower room for toileting without the use of foot rests. Resident #1 fell from the wheelchair face forward onto the floor and sustained head injuries. Resident #1 was transferred to a local hospital for assessment and treatment, on 11/15/12 at 8:30 AM, and was diagnosed with Left Maxillary Wall Fracture, Bilateral Displaced Nasal Bone Fractures, and Cervical Splne Fracture of the second cervical vertebrae dens. On 11/15/12 at 2:00 PM, Resident #1 was transferred to the regional Level I Trauma Center for further treatment. The resident expired on 11/16/12 at 3:20 PM. The facility's failure to provide adequate supervision and assistive devices to residents to ensure they were free from accident hazards placed residents at risk in a situation that was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 11/29/12 and was found to exist on 11/15/12.</p> <p>The facility provided a Credible Allegation of Compliance (AOC) on 12/07/12 and the state agency verified Immediate Jeopardy was removed on 12/07/12 prior to exit on 12/07/12. The scope and severity was lowered to a D at 42 CFR 483.25 (F323) Residents Free of Accident Hazards while the facility develops and implements the Plan of Correction to establish an effective system to ensure residents receive</p> | F 323 | <p>days to ensure appropriate investigations were completed as evident by completion of post-fall, post- injury and post altercation investigation. Review was to ensure that all reports were reviewed by the falls committee and that there was evidence that a root cause is identified. This was completed 12-5-12.</p> <p>An interdisciplinary Team (Director of Nursing, Restorative Nurse, MDS Coordinator, Therapy Manager, Administrator, Staff Development Director and Director of Social Services) met on Nov 29, 2012 to evaluate all residents utilizing a wheelchair for mobility to determine the need for wheelchair pedals and establish facility policy as it relates to the use of foot pedals. The facility practice will be to have foot pedals on all wheelchairs unless care planned otherwise, such as residents who are self- mobile in the wheelchair who use their feet to</p> | |



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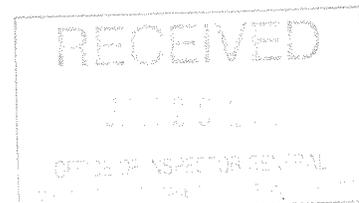
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| F 323 | <p>Continued From page 38</p> <p>adequate supervision and assistive devices to prevent accidents.</p> <p>The findings include:</p> <p>Review of the facility's policy for Falls Management, dated 01/01/10, revealed the facility screened all residents to identify possible risk factors for falls, evaluated the risks to residents, and implemented interventions to reduce risks and monitor interventions to be modified as necessary. The purpose of the facility's Falls Management policy was to identify residents with risk factors that may place the resident at risk for falls, and to manage those residents who experienced a fall to minimize the risk of the further falls, or to minimize the risk of injury related to a fall.</p> <p>Review of the clinical record for Resident #1 revealed an admission date of 07/27/11 with diagnoses of Osteoarthritis, Osteoporosis, Knee Replacement, Dementia, and a surgical history of cervical spine fusion. A physician's order, dated 06/27/12, revealed Resident #1 required an assist of two (2) staff for transfers with the use of the mechanical lift as needed. Review of the Falls Risk Screen for Resident #1, revealed no documented falls; however, review of the facility's Falls Log revealed Resident #1 fell in the shower due to weakness on 05/27/12, and on 08/22/12 the resident fell during an attempt to transfer unassisted by staff. Review of the annual Minimum Data Set for Resident #1, dated 06/12/12, revealed the functional status for transfer was total dependence with a two person physical assist and cited physical limitations of weakness due to recent hospitalization, limited</p> | F 323 | <p>propel the wheelchair. Residents were identified and evaluated as</p> <p>1. Residents who utilize and require foot pedals to be transported safely. 2. Residents who are self-mobile in wheelchair by using their feet to propel the wheelchair and are able to raise their feet for staff assisted transport. 3. Residents who are self-mobile in their wheelchair by using their feet to propel the wheelchair but are unable to raise their feet for staff assisted transport and would require foot pedals for staff assisted transport. 4. Residents who are self-mobile in the wheelchair by using their feet to propel the wheelchair but are unable to raise their feet for staff assisted transport and will not utilize foot pedals so will be walk assisted transport.</p> <p>On December 3, 2012 the Director of Nursing, MDS Coordinator, Director of Social Services, Restorative Nurse, Restorative Aide, Therapy Manager, and Director of Staff Development reviewed all</p> | | |



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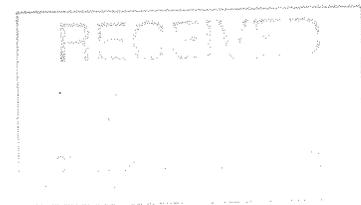
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| F 323 | <p>Continued From page 39</p> <p>range of motion, poor coordination, poor balance, visual impairment, and pain.</p> <p>Review of the Nursing Care Plan for Resident #1 revealed the facility developed a care plan to address falls as related to diuretic medications; however, no intervention was documented to direct staff to ensure foot rests were on the resident's wheelchair at all times to prevent falls. Review of the CNA Care Plan revealed no documentation to direct staff that Resident #1 required an assist of two (2) staff for transfers and foot rests on the wheelchair at all times.</p> <p>Review of the CNA Care Tracker documentation revealed documentation by staff of Resident #1's transfers without the assist of two (2) staff members, on twenty (20) days in October, 2012 and six (6) days in November 2012. During the combined months of October and November, 2012, Resident #1 was transferred without the assist of two (2) staff members by CNA #1 on one (1) day, CNA #3 on two (2) days, CNA #9 on one (1) day, CNA #11 on two (2) days, CNA #12 on four (4) days, CNA #13 on eight (8) days, CNA #14 on three (3) days, CNA #15 on one (1) day, CNA #16 on one (1) day, and CNA #17 on three (3) days.</p> <p>Review of the nursing facility job description for Certified Nurse Aide stated the CNA was responsible to provide direct care to residents in accordance with facility policies and procedures and to report resident needs and concerns to a licensed nurse. Review of the facility job description for Licensed Practical Nurse (LPN) and Registered Nurse (RN) detailed the nurse was responsible to perform acts requiring</p> | F 323 | <p>resident care plans and nurse aide assignment sheets to ensure care plans were reflective of the care and services provided to each resident. Included in this review was transfer status, safety devices, fall prevention strategies, non-use of foot pedals, elopement risk, restraints and toileting programs.</p> <p>2. Nurse Aide Assignment sheet format was updated Dec. 4, 2012 by the Director of Nursing to reflect the use of foot pedals based on the reviews completed Dec 3, 2012. Changes to the nurse aide assignment sheet will be made any time there is a change in the care needs of the resident. It is the responsibility of each nurse to update the assignment sheet for each resident when there is a change. Changes may be initiated by a fall, an incident, a resident request, a change in condition, etc. When a change in the assignment sheet is initiated it is</p> | |



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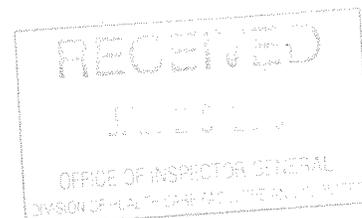
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| F 323 | <p>Continued From page 40</p> <p>knowledge, judgement, and nursing skills in accordance with the scope of practice, and was responsible to supervise unlicensed nursing staff as assigned. Both job descriptions for LPNs and RNs stated supervisory responsibilities were to provide supervision for other assigned licensed and unlicensed nursing personnel. The facility job description for LPNs and RNs also detailed the responsibility to provide supervision, direction, and monitoring of the performance of subordinate staff on an ongoing basis during each shift for completion of tasks and assignments in a manner consistent with the quality standards established by the facility.</p> <p>Review of the facility incident report, dated 11/15/12 which detailed the fall of Resident #1 was witnessed by one (1) staff member, CNA #1, and detailed the injuries, abrasion to the shoulder and right hip, laceration to the bridge of the nose and forehead, and left leg shorter than right. Review of the facility Post Fall investigation tool detailed that Resident #1 was pushed in the hall by CNA #1 without foot rests on the wheelchair and fell face forward out of the wheelchair, and the investigation revealed Resident #1 was wearing non-skid socks at the time of the fall. The facility evaluation of findings and documentation of conclusion was stated as "Resident did not have foot pedals on," and Included an immediate facility response to reiterate the importance of foot rests.</p> <p>Interview by telephone with CNA #1, on 11/27/12 at 11:20 AM, revealed on 11/15/12 at 5:15 AM she transferred Resident #1 without assist of another staff member to a wheelchair. CNA #1 stated she did not remember to place the foot</p> | F 323 | <p>also made on the master assignment sheet and placed on a communication sheet in front of the assignment sheets. Assignment sheets are printed at the end of each shift for the oncoming shift by the Nurse Supervisor or a Nurse in Charge. It is the responsibility of the Nurse Supervisor to Nurse in Charge to compare the communication sheet changes with the master assignment sheet to ensure all changes are made. No less than weekly, the Director of Staff Development will review the master assignment sheet and the communication sheet to ensure all changes were made. The master assignment sheet is also reviewed with each care plan to ensure consistency with care plan interventions. Nursing staff were educated on the process and responsibility to update nurse aide assignment sheets by the Director of Nursing, Nurse Manager and the Director of Staff Development. This was completed on Dec.6, 2012.</p> | | |



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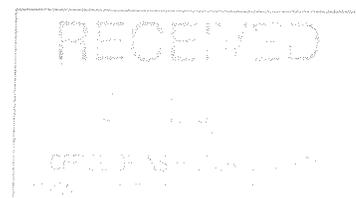
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| F 323 | <p>Continued From page 41</p> <p>rests on the wheelchair before she transported Resident #1 to the shower room for toileting. CNA #1 stated Resident #1 lunged forward from the wheelchair and fell face down on the floor in the hallway and began to bleed from the head and nose. CNA #1 stated she was not aware Resident #1 required an assist of two (2) staff for transfers. CNA #1 stated her shift ended at 6:00 AM, and she was trying to complete her routine duties, and as a result she failed to place the foot rests on the wheelchair. CNA #1 was aware Resident #1 required the use of foot rests on the wheelchair for transportation; however, CNA #1 denied the resident fall was related to her failure to place the foot rests on the wheelchair for safety. CNA #1 stated if Resident #1 had feet on the floor, then she would have experienced resistance while pushing the wheelchair and stopped the forward movement of the chair to avoid a fall from the wheelchair.</p> <p>Interview, on 11/27/12 at 1:25 PM, with CNA #2 revealed she was aware Resident #1 was dependent with the use of the wheelchair and required foot rests on the wheelchair for staff assisted transportation, because the resident was not able to raise and hold his/her feet up. CNA #2 stated Resident #1 leaned back in the wheelchair with his/her feet outstretched on the floor and said she never witnessed the resident attempt to get up or lunge from the wheelchair. CNA #2 stated due to the prone position of Resident #1 in the wheelchair, it would be impossible to safely transport the resident in the wheelchair without the use of the foot rests. CNA #2 stated the fall sustained by Resident #1 on 11/15/12 from the wheelchair was avoidable if the foot rests were in place on the wheelchair.</p> | F 323 | <p>Following the review of the care plans, a list was developed for placement in front of each book of MAR's, TAR's, Care Plans and Nurse Aide Assignment sheets listing residents requiring: Foot Pedals, Foot Pedals for staff assisted transport and residents requiring handheld assisted transport. Included on this list were any resident requiring 2 person assist with transfers and those residents requiring a lift for transfers. This is a quick reference for nurses, aides and other staff.. This list is manually updated whenever there is a change and could be updated by a nurse, Nurse Supervisor, Restorative Nurse, or Director of Nursing. This list is to be reviewed in the weekly falls management meeting to ensure all updates are made. Staff was educated on the use of this list by the Director of Staff development on Dec. 5, 2012. Re-education provided to staff beginning Nov. 16, 2012 and</p> | | |



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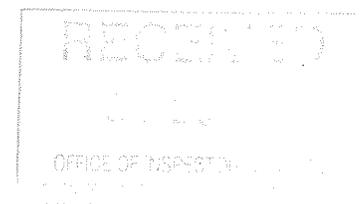
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| F 323 | Continued From page 42 Interview, on 11/27/12 at 7:10 AM, with CNA #3 revealed she was working in a resident room across the hall from where Resident #1 fell out of the wheelchair. She heard a loud 'thud' and what sounded like a wheelchair turned over and found the resident was laying face down on the floor with the resident's arms folded under the body. CNA #3 said she asked CNA #1 why the foot rests were not on the wheelchair and CNA #1 replied, "I forgot." CNA #3 stated Resident #1 required the use of foot rests on the wheelchair at all times because the resident was not able to raise and hold the feet off of the floor for staff assisted wheelchair transportation. CNA #3 said Resident #1 did not have the strength to lunge forward out of the wheelchair, and she knew the only way the resident could have fallen from the wheelchair was as a result of the resident's feet becoming tangled under the wheelchair which cause the resident to fall face forward. CNA #3 also said Resident #1 kept his/her arms folded in their lap when sitting in the wheelchair, and that was the reason the arms were folded under the residents body. Interview, on 11/27/12 at 1:25 PM, with CNA #2, revealed she was aware Resident #1 required an assist of two (2) staff for transfers because the resident was dependent. Interview, on 11/27/12 at 1:40 PM, with CNA #6 revealed she was aware Resident #1 was totally dependent on staff for care and required the assist of two (2) staff for all transfers with the use of foot rests for staff assisted wheelchair mobility. Interview, on 11/27/12 at 2:37 PM, with LPN #3 | F 323 | completed on Dec. 3, 2012 on 1. Following nurse aide care plans 2. Transporting residents in wheelchairs and 3. Use of foot pedals for wheelchair transport. This was completed by the Director of Staff Development. In order to ensure staff education has been effective, MDS Coordinator, Restorative Nurse, Nurse Supervisor, Director of Nursing, Corporate Consultant, Administrator and Director of Staff Development initiated interviews with staff related to the content of education provided. This was initiated on December 6, 2012. This in service will be repeated monthly for 3 months beginning Jan.2013 then quarterly for 3 quarters then include in an annual in-service. All newly hired staff will be educated during orientation. This will be completed by the Director of Staff Development. Re-education provided by Corporate Consultant to all licensed staff beginning on Nov 30, 2012 and completed on Dec. 3, 2012 on Care Plans, including | |



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| F 323 | <p>Continued From page 43</p> <p>revealed she often cared for Resident #1 and stated the resident required an assist of two (2) staff for transfers and foot rests on the wheelchair at all times to maintain safety of the resident. LPN #3 stated Resident #1's lower extremities were weak and the resident did not have the strength to hold his/her feet up for staff assisted wheelchair transportation. LPN #3 stated it would be dangerous to transport Resident #1 in the wheelchair without the use of foot rests, because the resident's feet could become entangled under the chair and cause the resident to fall from the chair. LPN #3 stated the incident on 11/15/12, when Resident #1 fell from the wheelchair, was avoidable if the foot rests were placed on the resident's wheelchair.</p> <p>Interview, on 11/28/12 at 5:45 AM, with CNA #5 revealed she was aware Resident #1 was dependent with the use of the wheelchair and required an assist of two (2) staff for all transfers.</p> <p>Interview, on 11/28/12 at 9:00 AM, with LPN #4 revealed that she had provided care for Resident #1 since the resident was admitted to the facility and was aware the resident required foot rests on the wheelchair at all times. LPN #4 stated she never observed Resident #1 attempt to lean forward or lunge from the wheelchair and said the resident maintained a backward leaning prone position with legs and feet locked and outstretched in the wheelchair. LPN #4 stated if Resident #1 did not have foot rests on the wheelchair, he/she would be at risk of a fall from the wheelchair, and stated the fall from the wheelchair on 11/15/12 was avoidable if the foot rests were in place on the wheelchair.</p> | F 323 | <p>reviewing and revising, setting measurable goals and utilizing the care Plan as a communication tool, and the facility Falls Management Policy. Opportunity for questions was provided and prior to end of each presentation understanding was evaluated by participants answering questions related to the material.</p> <p>All newly hired licensed nursing staff will be educated on the above during orientation by the Director of Staff Development. Re-education on Care Plans including revision of care plans, provided to the Care Plan Team (MDS Coordinator, Director of Social Service, Dietary manager and Activities Director) by Corporate Consultant on Dec. 3, 2012. Opportunity for questions was provided and prior to end of each presentation understanding was evaluated by participants answering questions related to the material.</p> | |



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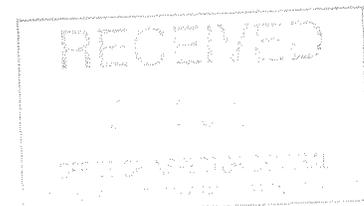
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| F 323 | <p>Continued From page 44</p> <p>Interview by telephone, on 11/28/12 at 8:30 AM, with the Attending Physician revealed Resident #1 was unstable in the wheelchair and was at risk for falls. The Attending Physician said he was told Resident #1 had fallen out of bed and was not aware the resident fell from a wheelchair without the use of foot rests on the wheelchair. The Attending Physician stated it was likely Resident #1 fell from the wheelchair as a result of the lack of foot rests. The Attending Physician stated he was advised by the facility of the death of Resident #1, but was not aware of the cause of death and he did not know if the fall from the wheelchair caused or hastened the resident's death, and said, "the fall did not help."</p> <p>Interview, on 11/30/12 at 2:30PM, with the Vice President of Operations (VPO) revealed Resident #1's fall on 11/15/12 was an accident and should not have happened and was a result of the foot rests not being replaced on the wheelchair. The VPO stated as a result of the facility's investigation, it was understood that Resident #1 did not have the strength or mobility to lunge from the wheelchair as reported by CNA #1, and it was determined the resident's feet became entangled under the wheelchair which caused the resident to be propelled from the wheelchair.</p> <p>Review of the acceptable Allegation of Compliance (AOC), on 12/07/12, revealed the facility took the following immediate actions:</p> <ol style="list-style-type: none"> 1. The Medical Director was advised of immediate Jeopardy notification on 11/29/12 by the Administrator and Corporate Consultant. 2. An Interdisciplinary Team (IDT) met on | F 323 | <p>Therapy Manager instructed on facility practice to have foot pedals on all wheelchairs unless car planned otherwise, ie. self-mobile with feet, at risk for injury related to foot rests, etc.by Corporate Consultant prior to providing education to therapy staff . Re-education provided to therapy staff by therapy manager on use of wheelchairs and facility practice on use of foot pedals on Dec. 3, 2012.</p> <p>Facility to follow the facility policy on Falls Management which includes a Falls Risk Screen, Uponadmission/re-admission, Between days 10-14, Quarterly and With significant change facility will have a weekly Falls Management Meeting to review all resident falls, including the post fall investigation, care plans, and nurse aide assignment sheets to ensure all appropriate safety issues have been identified and</p> | | |



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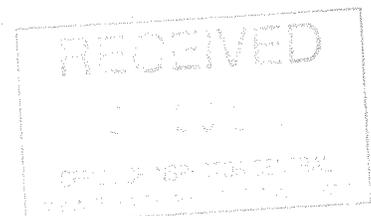
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| F 323 | Continued From page 45 11/29/12 to evaluate all residents who utilized a wheelchair for mobility to determine the need for foot rests, and to determine a policy for the use of foot rests on wheelchairs in the facility. The IDT re-evaluated all residents who used wheelchairs for mobility to identify any needed changes and two (2) residents previously determined to require the use of foot rests refused the foot rests, which were removed by the facility. On 12/01/12 the IDT met to develop an audit tool to ensure residents who required the use of foot rests for wheelchair mobility had foot rests in place on the wheelchair, then met on 12/02/12 and 12/03/12 to evaluate all residents again to determine any necessary changes. On 12/04/12 all newly admitted residents were reviewed for the need for foot rests on the wheelchairs for mobility. 3. Upon completion of the IDT meeting, the Physical Therapy Manager reviewed the wheelchairs of all residents who were determined to need the foot rests which was completed on 11/29/12. 4. Facility Administration developed a quick reference tool for staff, on 12/04/12, located in the MARs binders, TARs binders, Resident Care Plan Binder, and CNA Care Plan Binders to provide staff information regarding specific residents transportation needs with regard to the use of foot rests on wheelchairs to maintain resident safety. 5. The Director of Staff Development provided an in-service on 11/16/12 and was completed on 12/03/12 to educate staff on the use of foot rests on wheelchairs, transporting resident in wheelchairs, and CNA care plans. Future hired staff were to be provided the information during | F 323 | communicated to staff via the care plan and nurse aide assignment sheet. Included in the review will be transfer status, safety devices, fall prevention interventions, elopement risk, restraints, toileting programs and use of foot pedals. Falls Management Meetings will be documented. 3. To ensure residents requiring foot pedals have them during transport Administrative Staff (Director of Nursing, Nursing Supervisor, Administrator, Administrative Nurse, Medical records) completed audits no less than 2 times per day beginning Nov. 30, 2012 and continuing through December 21, 2012. Audits were then completed no less than daily through January 11, 2013. Beginning January 12, 2013 audits will be completed no less than 3 times per week for 4 weeks, then weekly for 4 weeks then will be assigned as a quarterly review for QA. Audits are reviewed by Administrator | |



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| F 323 | Continued From page 46 facility orientation. 6. The Corporate Consultant provided an In-service to licensed staff on 11/30/12 and concluded on 12/03/12 to educate staff on the Notification of Change Policy, Falls Management, Pain Management, Emergency Procedures, and Care Plans. Future hired staff were to be provided the information during facility orientation. 7. The facility developed an audit process for Administration, on 11/30/12, to ensure residents who required foot rests for transportation had the devices in place on the wheelchairs at all times, with audits completed no less that two (2) times daily which began on 11/30/12. Audits were reviewed by the Facility Administrator and necessary staff intervention provided. 8. The Quality Assurance and Assessment Meeting was held on 12/03/12, with the Medical Director in participation by teleconference, to discuss the facility findings and the root cause of the Immediate Jeopardy and to begin the process to develop facility interventions and an Allegation of Compliance. 9. The Facility Administration developed a specific Job Description for the 'Nurse in Charge' on 12/04/12, and licensed staff were educated on the Nurse in Charge responsibilities on 12/04/12, with a copy of the job description placed on the 24 Hour report for staff reference. Future hired staff were to be provided the information during facility orientation. The State Agency validated the AOC on 12/07/12 | F 323 | and direction for re-education given as indicated. To ensure compliance with transfer status, staff nurses and administrative staff are observing a minimum of 10 transfers daily for 4 weeks then 10 weekly for 4 weeks then 10 monthly for 4 months. These observations are recorded for review. Administrator to review observations weekly and direction for re-education given as indicated. Director of Nursing to review Nurse Aide Assignment sheets weekly for 12 weeks, then monthly to ensure all changes have been made and that assignment sheets are reflective of care and services to be provided to the residents. Director of Nursing to review the quick reference related to use of foot pedals, and transfer status located in front of the MAR, TAR, Care Plan and Nurse Aide assignment sheet weekly for 12 weeks then monthly to ensure it is updated appropriately and present in all designated locations. Corporate | |



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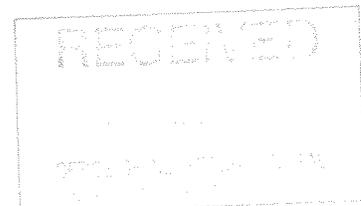
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| F 323 | Continued From page 47 prior to exit as follows: 1. The State Agency validated by interview with the Medical Director, on 12/05/12 at 12:55 PM, which revealed he was contacted by the facility Administrator and Corporate Consultant and advised of the Immediate Jeopardy, but was not certain of the date of notification. 2. The State Agency validated by record review of the IDT meetings on 11/29/12, 12/01/12, 12/02/12, 12/03/12, and 12/04/12 to determine the facility reviewed all facility residents to determine the need for foot rests on wheelchairs to maintain resident safety during transportation. Interview, on 12/07/12 at 7:00 PM, with the Administrator determined there were two (2) residents with impaired mobility of the lower extremities that the facility identified would require foot rests for safety, but both residents, who were cognitively intact refused the foot rests. 3. The State Agency validated by review of the records provided by the Administrator to confirm the Physical Therapy Manager reviewed all facility residents on 11/29/12 for the need of foot rests on the wheelchair to maintain resident safety during wheelchair transportation. 4. The State Agency validated by record review of the MAR, and TAR binders, the Resident and CNA Care Plan binders which were determined to include an updated list of facility residents who required foot rests on wheelchairs to maintain resident safety. 5. The State Agency validated the in-service provided to staff on 11/16/12, which concluded on | F 323 | Consultant to review all reports of falls monthly for completion and identification of root cause of fall. Facility has established a QA sub-committee that will meet monthly to review the implementation of the POC and monitor compliance. This sub-committee is comprised of the Administrator, Director of Nursing, Director of Staff Development, Nurse Supervisor, MDS Coordinator, a staff nurse, a nursing assistant and corporate consultant. Results of all audits, reviews and interviews will be reported to the facility QA Sub-Committee who will then report to the facility QA Committee no less than quarterly for one year. Date of completion 1-7-13 | |

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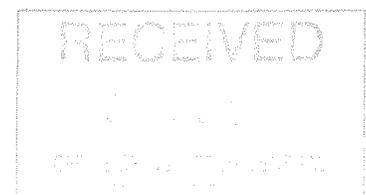
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| F 323 | <p>Continued From page 48</p> <p>12/03/12 to educate staff on the use of foot rests, and CNA Care Plans by review of the educational material discussed, and the attendance log for the in-service. Interview, on 12/07/12 at 6:30 PM, with CNA #10 revealed she participated in the in-service regarding the use of foot rests to maintain resident safety and was told the facility policy stated all residents were to have foot rests on the wheelchair upon admission, until it was determined by the facility that the resident no longer needed the foot rests to maintain safety.</p> <p>6. The State Agency validated the in-service provided to staff by record review of the educational material provided and the attendance log from the in-service on 12/03/12. Interview, on 12/07/12 at 6:30 PM, with CNA #10 revealed she recently attended the Pain In-Service and understood the responsibility of the CNA to report resident pain promptly to the nurse and to document the pain level in the Care Tracker system, as well as her responsibility to follow-up with the resident to ensure the pain was treated. CNA #10 stated she was told the failure to assess and treat resident pain constituted resident neglect.</p> <p>7. The State Agency validated the audit process developed to ensure residents who required foot rests for safe wheelchair transportation, had the foot rests attached to the wheelchair. Observation, on 12/07/12 at 5:00 PM and 5:30 PM, in the facility halls and in the dining areas determined that residents identified to need the foot rests, did have them in place for safe transportation. Interview, on 12/07/12 at 7:00 PM, with the Administrator revealed she had indicated review of the audits by initial and the</p> | F 323 | | | |



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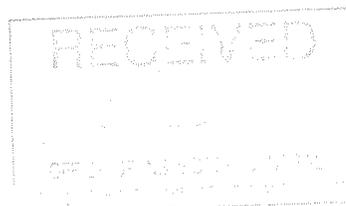
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| F 323 | Continued From page 49 process warranted, and record review determined the audits of residents who required foot rests were done at least twice daily. 8. The State Agency validated the QAA meeting which was held on 12/03/12 with the Medical Director, who participated by teleconference by interview. Interview, on 12/05/12 at 12:55 PM, with the Medical Director revealed that he did participate in the meeting, but was not able to state the cause of the fall. Interview, on 12/07/12 at 6:30 PM, with the DON revealed that the Medical Director was told the root cause of Resident #1's fall on 11/15/12 was a result of foot rests not replaced on the wheelchair during staff assisted transportation. Interview, on 12/07/12 at 7:00 PM, with the Administrator revealed when the Medical Director was told on 12/03/12 of the root cause of Resident #1's fall and when staff asked the Medical Director at the end of the meeting if he had any suggestions to add, he stated he felt all issues had been adequately addressed. 9. The State Agency validated the new Job Description for the 'Nurse in Charge' by review of the statement, and validated by observation that copies of the job description were placed on the 24 Hour report binder for reference on both the East and West Nursing Stations. | F 323 | | |
| F 328 SS=D | 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; | F 328 | | |



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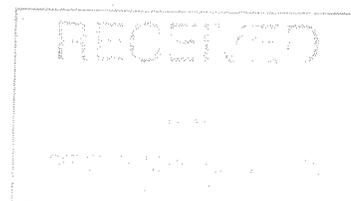
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| F 328 | <p>Continued From page 50</p> <p>Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure one (1) of six (6) sampled residents (Resident #5), received proper treatment of continuous oxygen with humidification treatment to ensure resident compliance and maintain adequate oxygenation of the resident. Resident #5, who was diagnosed with Chronic Airway Obstruction, required continuous oxygen via nasal cannula at a rate of two (2) liters/ minute, per physician order. Multiple observations revealed Resident #5 did not wear the oxygen continuously. Interview revealed Resident #5 complained to staff of the drying effect of the oxygen; however, the facility failed to document, intervene, or determine the root cause of the resident's non-compliance with the oxygen therapy. In addition, the facility failed to intervene and attempt to identify appropriate actions to improve the resident's compliance with the oxygen therapy.</p> <p>The findings include:</p> <p>Review of the clinical record for Resident #5 revealed an admission date of 10/27/12 and diagnoses of Chronic Airway Obstruction, Anemia, and Pulmonary Hypertension. Review of</p> | F 328 | <p>F-328</p> <ol style="list-style-type: none"> 1. On December 11, 2012 the Director of Nursing talked with Resident # 5 regarding the residents non-compliance with utilization of her O2. Oxygen humidifier added to concentrator of resident #5. Facility Oxygen Company advised that humidifier is already built into concentrator and the humidifier was removed. Attempted change in nasal cannula but resident #5 preferred standard nasal cannula. Director of Nursing provided education on risks and benefits of wearing oxygen to Resident #5 on December 11, 2012 2. On December 28, 2012 an interdisciplinary team including the Director of Nursing, Social Services Director, MDS Coordinator, and Administrative Nurse identified any residents in the facility with non-compliance in care including parenteral and enteral fluids, colostomy, ureterosotomy or | |



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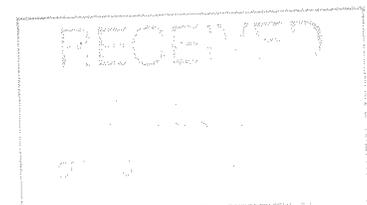
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| F 328 | <p>Continued From page 51</p> <p>the physician orders for Resident #5 detailed an order for oxygen via nasal cannula at a rate of 2 liters/minute continuously (undated), an order for oxygen saturation level documentation every shift, and an order for oxygen saturation level documentation weekly on room air (without oxygen). Review of the Treatment Administration Record documentation for November, 2012, revealed oxygen saturation levels with oxygen therapy was never below 90% (adequate oxygen saturation level greater than 90%); however, the weekly oxygen saturation level on room air ranged between 85-88%. Review of Nurse's Notes revealed no documentation of the refusal of Resident #5 to wear oxygen or the resident's stated reason for non-compliance with oxygen therapy.</p> <p>Observation, on 12/04/12 at 12:30 PM, during the afternoon meal revealed Resident #5 was sitting at the dining room table eating unassisted without use of the oxygen therapy. Observation, on 12/04/12 at 1:30 PM, during a religious activity revealed Resident #5 did not have the oxygen therapy via nasal cannula. Further observation, on 12/04/12 at 2:25 PM, and at 3:30 PM, revealed Resident #5 did not wear oxygen with nasal cannula to maintain adequate oxygenation.</p> <p>Interview, on 12/04/12 at 3:30 PM, with Resident #5 revealed the resident removed the oxygen cannula frequently because it had a drying effect on the nasal passages and was uncomfortable. Resident #5 stated a bottle of sterile water was used on the oxygen concentrator at home to avoid the dryness. Resident #5 said the staff used the sterile water bottle (which was on the bedside table) to improve the humidity of the</p> | F 328 | <p>ileostomy care, tracheostomy care, tracheal suctioning, respiratory services, foot care and prosthesis care. Care plans for those residents identified were reviewed by the Interdisciplinary Team for non-compliance. If resident was non-compliant, further evaluation was conducted to determine the reason for non-compliance. Care plans were developed to address alternative interventions to promote compliance with the plan of care. Nurse aide assignment sheets reviewed and updated as indicated. This was completed on 12-28-12</p> <p>3. Nursing staff educated by Director of Staff Development on reporting all non-compliance to nurse so further investigation can be done to evaluate alternative interventions to promote compliance with the plan of care. This was completed on January 4, 2013. Nurses instructed to note non-compliance on the 24 hour report sheet to ensure communication of same to all nurses. O2 settings are on the resident TAR for nurse to monitor and check every shift.</p> | |



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| F 328 | <p>Continued From page 52</p> <p>oxygen and it helped, but water condensation built up in the oxygen tubing and had begun to drip from the nasal cannula onto his/her face which was uncomfortable. Resident #5 said removed the sterile water humidification and said the oxygen concentrator provided by the facility was equipped with a built-in humidifier and told the resident the sterile water was not necessary to improve humidification. Resident #5 stated therefore, he/she removed the oxygen cannula frequently because of the continued drying effect of the oxygen therapy without the additional humidification.</p> <p>Interview, on 12/04/12 at 3:15 PM, with LPN #3 revealed that she was aware Resident #5 often removed the oxygen cannula, but did not know why the resident did not wear the oxygen continuously, and stated Resident #5 had the right to refuse the oxygen therapy. LPN #3 was not aware Resident #5 did not have continuous oxygen therapy for a period of nearly three (3) hours during the current shift. LPN #3 stated she obtained an oxygen saturation level for Resident #5 earlier today on room air, which was 96% and did not think that the lack of oxygen therapy would have any negative effect on the resident's ability to maintain adequate oxygenation. Further interview, on 12/04/12 at 3:40 PM, with LPN #3 revealed she was not aware that the resident complained of nasal passage dryness and did not know why the sterile water bottle at the bedside was not used to provide humidification.</p> <p>Interview, on 12/05/12 at 12:38 PM, with True Air Technologies contracted Registered Respiratory Therapist (RRT) revealed some of the oxygen concentrators used in nursing facilities were</p> | F 328 | <p>4. Beginning December 11, 2012 Director of Nursing or Nurse Manager to audit TAR's no less than 3 times per week for 4 weeks, then weekly for 4 weeks and then monthly to ensure O2 settings are on the TAR and signed to indicate setting is checked every shift. Beginning January 4, 2013 DON or MDS Coordinator to review all residents noted by nurses on 24 hour report as being non-compliant with any care need, to ensure alternative interventions have been evaluated, that the physician has been notified of non-compliance if indicated, that resident family/responsible party have been informed, and that resident is aware of risks related to the noted non-compliance and that there is a care plan related to the non-compliance. All reviews will be reported to the QA Committee.</p> <p>Facility has established a QA sub-committee that will meet monthly to review the</p> | |



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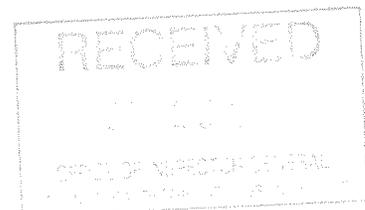
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| F 328 | <p>Continued From page 53</p> <p>equipped with a humidifier; however, some of the residents who were used to getting more humidification at home could require the addition of the sterile water humidification to avoid nasal passage dryness. The RRT stated that if a resident who required continuous oxygen therapy, such as Resident #5, diagnosed with Chronic Airway Obstruction complained of nasal passage dryness the staff should use the sterile water to improve the humidity and resident compliance with continuous oxygen therapy. When the RRT was advised that Resident #5 was observed without oxygen therapy for three (3) hours on 12/04/12, with documentation of weekly room air oxygen saturation levels below 90%, the RRT stated it would be dangerous for the resident to be without oxygen as the resident could decompensate and develop respiratory distress. The RRT stated if the sterile water created a problem with condensation in the oxygen tubing, the staff should have consulted the RRT and a condensation/water trap could be installed on the oxygen delivery system to improve resident compliance with continuous oxygen therapy.</p> <p>Interview, on 12/07/12 at 11:30 AM, with the Director of Nursing (DON) revealed she was aware that Resident #5 often removed the oxygen cannula, and was contacted on 12/05/12 by the RRT regarding Resident #5's complaints of dry nasal passages, and non-compliance with the continuous oxygen therapy. The DON stated that staff should have documented the non-compliance of Resident #5 with the continuous oxygen therapy in the Nurse's Notes, and included the concern on the twenty-four (24) hour report to ensure the issue was discussed in the daily morning meeting. The DON stated she</p> | F 328 | <p>implementation of the POC and monitor compliance. This sub-committee is comprised of the Administrator, Director of Nursing, Director of Staff Development, Nurse Supervisor, MDS Coordinator, a staff nurse, a nursing assistant and corporate consultant. Results of all audits, reviews and interviews will be reported to the facility QA Sub-Committee who will then report to the facility QA Committee no less than quarterly for one year.</p> <p>Date of completion 1-7-2013</p> | |



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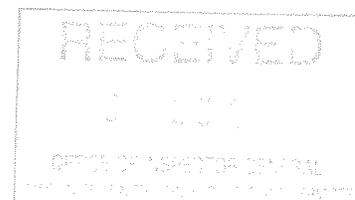
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| F 328 | Continued From page 54 observed Resident #5 to remove the oxygen cannula on 12/07/12 during lunch. The DON stated Resident #5's non-compliance with the oxygen therapy could have a negative impact on the resident's ability to maintain adequate oxygenation. | F 328 | | | |
| 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, record review, and review of the facility's policy, it was determined the facility failed to provide effective administration to ensure resources were effectively and efficiently managed to provide the highest practicable physical, mental, and psychosocial well-being of each resident. Resident #1 fell from the wheelchair, on 11/15/12 at 5:15 AM, after a staff member transferred the resident without assistance of two (2) staff and failed to replace the foot rests on the wheelchair. Resident #1 demonstrated verbal and non-verbal signs of pain on 11/15/12 after the fall from the wheelchair and did not receive a pain assessment or treatment for the pain. Resident #1 sustained significant injuries as a result of the fall from the wheelchair on 11/15/12 at 5:15 AM, and was not transferred to an acute care facility until 7:30 AM. The facility failed to identify other residents at risk for injury without the use of foot | F 490 | F-490 1. Resident #1 is no longer a resident of the facility. 2. Corporate Consultant and Administrator reviewed all reports of incidents (falls, injury of unknown origin, resident to resident altercation) for past 30 days to ensure appropriate investigations were completed as evident by completion of post-fall, post- injury and post altercation investigation. Review was to ensure that all reports were reviewed by the falls committee and that there was evidence that a root cause is identified. This was completed 12-5-12. An interdisciplinary Team (Director of Nursing, Restorative Nurse, MDS | | |



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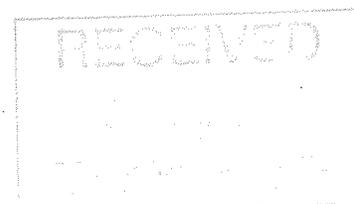
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| F 490 | <p>Continued From page 55</p> <p>rests on wheelchairs. The facility failed to ensure staff were adequately supervised and knowledgeable of safety interventions to ensure provision of safe resident care. The facility failed to ensure staff were trained to recognize and treat pain, and failed to implement a procedure to ensure all residents were assessed and treated for pain. The facility failed to ensure staff recognized the failure to treat pain and obtain emergency treatment for Resident #1 constituted neglect, and failed to ensure facility Administration identified staff neglect when pain medication and the need for emergency medical treatment was not emergently provided to Resident #1 on 11/15/12. The facility's failure to provide effective administration to ensure resources were effectively and efficiently managed to provide the highest practicable physical, mental, and psychosocial well-being of each resident placed residents at risk in a situation that was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 11/29/12 and was found to exist on 11/15/12.</p> <p>The facility provided a Credible Allegation of Compliance (AOC) on 12/07/12 and the State Agency verified Immediate Jeopardy was removed on 12/07/12 prior to exit on 12/07/12. The scope and severity was lowered to a D at 42 CFR 483.75 (F490) Administration, while the facility's Quality Assurance monitors the effectiveness of implementation of action plans and training to achieve and maintain compliance.</p> <p>The findings include:</p> <p>Review of the facility's policy for Notification of</p> | F 490 | <p>Coordinator, Therapy Manager, Administrator, Staff Development Director and Director Of Social Services) met on Nov 29, 2012 to evaluate all residents utilizing a wheelchair for mobility to determine the need for wheelchair pedals and establish facility policy as it relates to the use of foot pedals. The facility practice will be to have foot pedals on all wheelchairs unless care planned otherwise, such as residents who are self- mobile in the wheelchair who use their feet to propel the wheelchair. Residents were identified and evaluated as 1. Residents who utilize and require foot pedals to be transported safely.2. Residents who are self -mobile in wheelchair by using their feet to propel the wheelchair and are able to raise their feet for staff assisted transport.3. Residents who are self-mobile in their wheelchair by using their feet to propel the wheelchair but are unable to raise their feet for staff assisted transport and</p> | | |



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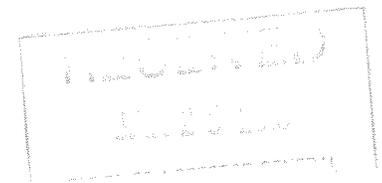
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| F 490 | <p>Continued From page 56</p> <p>Changes, dated 07/01/08 revealed staff would immediately inform the resident, consult with the resident's physician, and notify the resident's responsible party in the case of an accident with the potential to require physician intervention, a significant change in resident condition, need to alter treatment, or a decision to transfer or discharge the resident from the facility. Further review of the policy revealed no staff direction for circumstances to report a change in condition to the Facility Administration, or circumstances which may require staff consultation with the Medical Director.</p> <p>Observation during the survey on 11/28/12 of both East and West Nursing Stations, revealed the facility maintained a copy of the Lippincott Manual, Volume Five (5) for staff reference; however, staff were not able to identify a specific binder or manual that included the facility's adopted Policy and Procedures.</p> <p>Interview, on 11/26/12 at 2:35 PM, with CNA #1 revealed on 11/15/12 at 5:15 AM she assisted Resident #1 to stand, pivot, and sit in a wheelchair without assistance and transported the resident to the shower room for toileting. CNA #1 stated she was not aware of a physician order that required staff to utilize an assist of two (2) when transferring Resident #1; however, she was aware that the resident needed foot rests on the wheelchair for safety.</p> <p>Interview, on 11/26/12 at 3:30 PM, with LPN #1 revealed she was not aware that she could have consulted the Medical Director by telephone to discuss the care and treatment of Resident #1 on 11/15/12 after she was told by the Attending</p> | F 490 | <p>would require foot pedals for staff assisted transport.4. Residents who are self-mobile in the wheelchair by using their feet to propel the wheelchair but are unable to raise their feet for staff assisted transport and will not utilize foot pedals so will be walk assisted transport.</p> <p>2. Nurse Aide Assignment sheet format was updated Dec. 4, 2012 by the Director of Nursing to reflect the use of foot pedals based on the reviews completed Dec 3, 2012. Changes to the nurse aide assignment sheet will be made any time there is a change in the care needs of the resident. It is the responsibility of each nurse to update the assignment sheet for each resident when there is a change. Changes may be initiated by a fall, an incident, a resident request, a change in condition, etc. When a change in the assignment sheet is initiated it is also made on the master assignment sheet and placed on a communication sheet in front of the assignment sheets.</p> | | |



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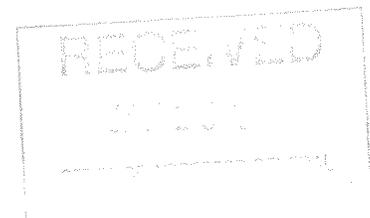
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| F 490 | <p>Continued From page 57</p> <p>Physician to return the resident to bed. LPN #1 was not aware of any emergency protocol or Policy and Procedure manual in the facility.</p> <p>Interview, on 11/26/12 at 4:03 PM, with RN #1 revealed she was the Charge Nurse on 11/15/12 during third shift when Resident #1 fell from the wheelchair and was injured. RN #1 stated she was not advised of the injury by LPN #1 and overheard other staff describe the incident involving the resident's fall. RN #1 stated she went to observe Resident #1, and advised LPN #1 the resident needed to "go out (to the hospital)," but took no further action to assist LPN #1 with the transfer of the resident. RN #1 stated she was not aware that she could consult the Medical Director by phone if staff deemed it necessary for the resident's well-being.</p> <p>Interview, on 11/27/12 at 11:00 AM, with the Director of Nursing (DON) revealed the facility did not have a policy for Emergency Protocols in case of a resident emergency. The DON stated staff were trained to call her anytime a resident sustained a fall with major injuries and said she was not advised that Resident #1 fell on 11/15/12, until 12:00 PM that afternoon. The DON stated that LPN #1, who was assigned to the care of Resident #1 on 11/15/12, knew she could call the Medical Director if she needed to do so, because LPN #1 had been advised by the DON to call the Medical Director in the past. The DON was not aware LPN #1 did not advise RN #1 (Charge Nurse) of Resident #1's fall on 11/15/12, and stated that staff were trained to notify the Charge Nurse and the DON when a fall occurred in the facility. The DON stated she was not sure if there was a Policy and Procedure manual in the facility,</p> | F 490 | <p>Assignment sheets are printed at the end of each shift for the oncoming shift by the Nurse Supervisor or a Nurse in Charge. It is the responsibility of the Nurse Supervisor or Nurse in Charge to compare the communication sheet changes with the master assignment sheet to ensure all changes are made. No less than weekly, the Director of Staff Development will review the master assignment sheet and the communication sheet to ensure all changes were made. The master assignment sheet is also reviewed with each care plan to ensure consistency with care plan interventions. Nursing staff were educated on the process and responsibility to update nurse aide assignment sheets by the Director of Nursing, Nurse Manager and the Director of Staff Development. This was completed on Dec. 6, 2012. Following the review of the care plans, a list was developed for placement in front of each book of MAR's, TAR's, Care Plans and Nurse Aide Assignment sheets listing residents</p> | | |



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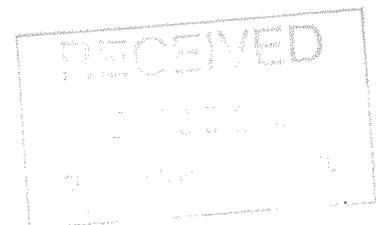
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| F 490 | <p>Continued From page 58 but stated the Standard of Practice was the Lippincott Manual.</p> <p>Interview, on 12/05/12 at 2:28 PM, with LPN #2 revealed there had previously been a Policy and Procedure manual in the facility which staff referred to as "The Bible," but it was removed because it was determined the manual contained many different and conflicting instructions.</p> <p>Interview, on 11/28/12 at 8:45 AM, with the Staff Development Coordinator (SDC) revealed the facility relied on critical thinking and nursing judgement to respond to emergency situations in the facility. The SDC reported there was no Emergency Policy and Procedure at the facility, and stated that staff were trained to use their critical thinking and nursing judgement to function independently. The SDC also stated staff was trained to notify the Administrator or Director of Nursing when a resident was injured or sent to the hospital.</p> <p>Interview, on 11/30/12 at 2:30 PM, with the Vice President of Operations (VPO) revealed the facility did have a Policy and Procedure Manual that was available in the DON's office and stated the DON most likely wasn't aware the manual was there because the previous DON did not share that information with the current DON.</p> <p>Further interview, on 12/07/12 at 12:30 PM, with the DON revealed she was aware there was a Policy and Procedure Manual for the facility that was located in her office. The DON stated her office was locked when she was out of the facility and said staff was aware that they could use the Lippincott Manual for reference after normal</p> | F 490 | <p>requiring: Foot Pedals, Foot Pedals for staff assisted transport and residents requiring handheld assisted transport, also included on the list are residents requiring 2 person assisted transfer and residents requiring use of a lift for transfers. This is a quick reference for nurses, aides and other staff.. This list is manually updated whenever there is a change and could be updated by a nurse, Nurse Supervisor, Restorative Nurse, or Director of Nursing. This list is to be reviewed in the weekly falls management meeting to ensure all updates are made. Staff was educated on the use of this list by the Director of Staff development on Dec. 5, 2012. Re-education provided to staff beginning Nov. 16, 2012 and completed on Dec. 3, 2012 on 1. Following nurse aide care plans 2. Transporting residents in wheelchairs and 3. Use of foot pedals for wheelchair transport. This was completed by the Director of Staff Development. This in service will be repeated monthly for 3 months beginning Jan.2013 then quarterly for 3 quarters then include in an annual in-service. All newly hired staff will be educated</p> | |



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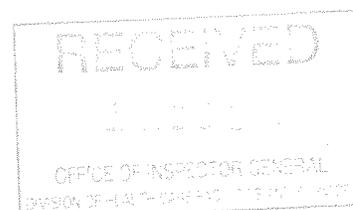
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| F 490 | <p>Continued From page 59 business hours.</p> <p>Interview, on 12/05/12 at 1:43 PM, with the Medical Director revealed he did not know what the facility's Standard of Practice was and did not know if he had been requested to review and authorize by signature the adoption of a Policy and Procedure Manual for the facility. The Medical Director was not aware the staff could not access the Nursing Policy and Procedure Manual and said that should be available to staff working all shifts. The Medical Director said he participated in a Quality Assurance and Assessment meeting by phone during the prior week to determine facility interventions to prevent recurrence of falls, such as the fall sustained by Resident #1. The Medical Director stated when possible head trauma was suspected, it would be prudent to transfer the resident to the hospital for an evaluation as soon as possible to ensure the best resident outcome.</p> <p>Interview, on 12/07/12 at 12:55 PM, with the Administrator revealed that she was aware the Policy and Procedure manuals at the nursing stations were not complete and stated a complete copy of the Policy and Procedure manual was maintained in the DON's office, which was locked at night. The Administrator was not sure why the staff did not have access to the entire Policy and Procedure manual, but said if staff had a question after hours, they could call the DON at home. The Administrator was not sure if the Medical Director reviewed and documented acceptance of the Policy and Procedure manual.</p> <p>Interview, on 12/07/12 at 4:15 PM, with the Senior Vice President (SVP) revealed he was not sure if</p> | F 490 | <p>during orientation. This will be completed by the Director of Staff Development.</p> <p>Re-education provided by Corporate Consultant to all licensed staff beginning on Nov 30, 2012 and completed on Dec 3, 2012 on Care Plans, including reviewing and revising, setting measurable goals and utilizing the care Plan as a communication tool, and the facility Falls Management Policy. All newly hired licensed nursing staff will be educated on the above during orientation by the Director of Staff Development. Re-education on Care Plans including revision of care plans, provided to the Care Plan Team (MDS Coordinator, Director of Social Service, Dietary manager and Activities Director) by Corporate Consultant on Dec. 3, 2012. Therapy Manager instructed on facility practice to have foot pedals on all wheelchairs unless car planned otherwise, ie. self-mobile with feet, at risk for injury related to foot rests, etc. by Corporate Consultant prior to providing education to therapy staff. Re-education provided to therapy staff by therapy manager on use of</p> | | |



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| F 490 | <p>Continued From page 60</p> <p>the Standard of Practice was reviewed and acknowledged as adopted by the Medical Director, but thought that the facility Administrator would know if this was accomplished. The SVP was not aware that multiple nursing staff was not aware if the facility had a Policy and Procedure Manual available for staff to reference, and that some staff stated the Policy and Procedure Manual was kept locked in the DON office. The SVP stated, without question, all staff should have access to the Policy and Procedure Manual at all times.</p> <p>Review of the acceptable Allegation of Compliance (AOC), on 12/07/12, revealed the facility took the following immediate actions:</p> <ol style="list-style-type: none"> 1. The Medical Director was advised of the Immediate Jeopardy notification on 11/29/12 by the Administrator and Corporate Consultant. 2. Facility Administration, on 12/04/12, developed a quick reference tool for staff, located in the MARs binders, TARs binders, Resident Care Plan Binder, and CNA Care Plan Binders to provide staff information regarding specific residents transpiration needs with regard to the use of foot rests on wheelchairs to maintain resident safety. 3. The facility Nursing Policy and Procedure Manuals with current policies were placed in binders at both the East and West Nursing Stations on 12/02/12. 4. The Director of Staff Development provided an in-service on 11/16/12 and was completed on 12/03/12 to educate staff on the use of foot rests on wheelchairs, transporting resident in | F 490 | <p>wheelchairs and facility practice on use of foot pedals on Dec. 3, 2012.</p> <p>Facility to follow the facility policy on Falls Management which includes a Falls Risk Screen, Upon admission/re-admission, Between days 10-14, Quarterly and With significant change facility will have a weekly Falls Management Meeting to review all resident falls, including the post fall investigation, care plans, and nurse aide assignment sheets to ensure all appropriate safety issues have been identified and communicated to staff via the care plan and nurse aide assignment sheet. Included in the review will be transfer status, safety devices, fall prevention interventions, elopement risk, restraints, toileting programs and use of foot pedals.</p> <p>Nursing Policy and Procedure Manuals placed in binders at each nurses' station.</p> <p>Administrator and Corporate Consultant verified that all</p> | |



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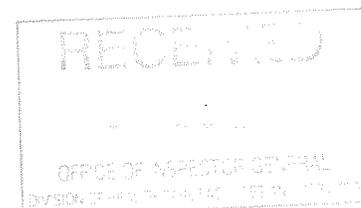
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| F 490 | Continued From page 61 wheelchairs, and CNA care plans. Future hired staff were to be provided the information during facility orientation. 5. The Corporate Consultant provided an in-service to licensed staff on 11/30/12 and concluded on 12/03/12 to educate staff on the Notification of Change Policy, Falls Management, Pain Management, Emergency Procedures, and Care Plans. Future hired staff were to be provided the information during facility orientation. 6. The facility developed an audit process for Administration to ensure residents who required foot rests for transportation had the devices in place on the wheelchairs at all times, with audits completed no less that two (2) times daily which began on 11/30/12. Audits were reviewed by the Facility Administrator and necessary staff intervention provided. Audits were completed by administrative staff, the DON, East and West House Supervisors, and the Nurse Supervisor. 7. The Quality Assurance and Assessment Meeting was held on 12/03/12, with the Medical Director in participation by teleconference, to discuss the facility findings and the root cause of the immediate Jeopardy and to begin the process to develop facility interventions and an Allegation of Compliance. 8. The Facility Administration developed a specific Job Description for the 'Nurse in Charge' and licensed staff were educated on the Nurse in Charge responsibilities on 12/04/12, with a copy of the job description placed on the 24 Hour report for staff reference. Future hired staff were to be provided the information during facility | F 490 | policies were current and required no changes. This was completed on Dec. 2, 2012. Reference books with phone numbers and emergency policies and procedures were placed at both nurses' stations. Administrator and Corporate Consultant reviewed contents of the reference books to ensure policies and procedures were current and required no changes. This was completed on Dec. 2, 2012. Nursing Staff educated by Director of Staff Development on the Policy and Procedure Manual and the Reference Binder. This was completed on Dec. 3, 2012. Administrator and Corporate Consultant developed a job description for "Nurse in Charge". Included in the job description is a specific responsibility as it relates to emergencies. DON and Director of staff Development educated all licensed staff on the job description on Dec. 4, 2012. A copy of the job description was placed on the 24 hour report for all licensed staff to reference. All newly hired licensed staff will be educated during | | |



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| F 490 | <p>Continued From page 62 orientation.</p> <p>9. The Corporate Consultant provided an in-service for the Administrator, DON, MDS Coordinator, Restorative Nurse, Nurse Supervisors, and the Director of Staff Development on 12/04/12 to ensure the Administrative staff was able to identify and investigate allegations of reported or suspected abuse and neglect.</p> <p>10. The Director of Staff Development provided an In-service on 12/04/12 for all staff regarding the facility Abuse Policy and Procedure. The staff was not permitted to return to work without completion of the in-service.</p> <p>The State Agency validated the AOC on 12/07/12 prior to exit as follows:</p> <p>1. The State Agency validated by interview with the Medical Director on 12/05/12 at 12:55 PM, that he was contacted by the facility Administrator and Corporate Consultant and advised of the Immediate Jeopardy, but was not certain of the date of notification.</p> <p>2. The State Agency validated the quick reference tool for staff by observation on 12/07/12 of the presence and accuracy of the tool on all MAR binders on the medication carts, TAR binders on the treatment carts, the Resident Care Plan Binders and the CNA Care Plan Binders in both the East and West Nursing Stations. Interview, on 12/07/12 at 6:40 PM, with RN #3 verified that if a staff member was not sure if a resident required foot rests on the wheelchair for</p> | F 490 | <p>orientation by the Director of Staff Development. Quality Assurance meeting held on Dec. 3, 2012 with Medical Director to review the Immediate Jeopardy and the Allegation of Compliance. Medical Director participated via conference phone. All were apprised of the facts and events that resulted in the Immediate Jeopardy. Participants discussed the education that had been and was being provided and the QA monitoring that had been implemented. Medical Director was asked for suggestions, and voiced his agreement to the plan. No additional recommendations were made.</p> <p>Re-education provided by Corporate Consultant to all licensed staff beginning Nov. 30 and completed Dec. 3, 2012 on Notification of Change Policy, Pain Management Policy, including assessment of pain, verbal and non-verbal indicators of pain, and that not assessing and treating pain can be considered neglect. Emergency Procedures, including response.</p> | |



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| F 490 | Continued From page 63 safe transportation, staff could readily access this information on the MAR or TAR cart or in the Resident and CNA Care Plan binders. 3. The State Agency validated the provision of Nursing Policy and Procedure Manuals with current policies, by observation on 12/07/12 which determined the presence of the Manuals on both the East and West Nursing Stations. Interview, on 12/07/12 at 6:40 PM, with RN #3 revealed that she was aware Policy and Procedure Manuals were located at both Nursing Stations for staff reference, and that information regarding Emergency procedures and notification were contained in the manuals. Interview, on 12/07/12 at 5:45, with RN #2 revealed that she was aware the Nursing Policy and Procedure Manuals were located in a black binder on both Nursing Stations. 4. The State Agency validated the in-service provided to staff by the Director of Staff Development on 11/16/12, which concluded on 12/03/12 to educate staff on the use of foot rests, and CNA Care Plans by review of the educational material discussed, and the attendance log for the in-service. Interview, on 12/07/12 at 6:30 PM, with CNA #10 revealed she participated in the in-service regarding the use of foot rests to maintain resident safety and was told the facility policy stated all residents were to have foot rests on the wheelchair upon admission, until it was determined by the facility that the resident no longer needed the foot rests to maintain safety. 5. The State Agency validated the in-service provided to staff by record review of the educational material provided and the attendance | F 490 | treatment, notifications and resources. Attendees voiced understanding of material and time for questions was provided. This education will be repeated no less than quarterly for 4 quarters then annually. All newly hired licensed staff will be educated on the facility Pain Management Policy during orientation. This will be the responsibility of the Nurse responsible for the Pain Management Program or the Director of Staff development. Re-education provided to all non-licensed nursing staff beginning Dec. 1 and completed on Dec. 3, 2012 on identifying, documenting and reporting pain, including non-verbal indicators of pain and use of CareTracker. In order to ensure that staff education has been effective non-licensed staff were interviewed by MDS Coordinator, Restorative Nurse, Nurse Supervisor, DON, Corporate Consultant, Administrator, and Director of Staff Development related to the education provided. This was initiated on December 6, 2012. | | |

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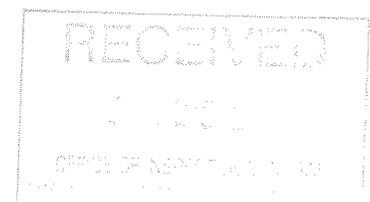
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| F 490 | Continued From page 64 log from the in-service on 12/03/12. Interview, on 12/07/12 at 6:30 PM, with CNA #10 revealed she recently attended the Pain In-service and understood the responsibility of the CNA to report resident pain promptly to the nurse and to document the pain level in the Care Tracker system, as well as her responsibility to follow-up with the resident to ensure the pain was treated. CNA #10 stated she was told the failure to assess and treat resident pain constituted resident neglect. 6. The State Agency validated the audit process developed to ensure residents who required foot rests for safe wheelchair transportation, had the foot rests attached to the wheelchair. Observation, on 12/07/12 at 5:00 PM and 5:30 PM in the facility halls and in the dining areas determined that residents identified to need the foot rests, did have them in place for safe transportation. Interview, on 12/07/12 at 7:00 PM, with the Administrator revealed she had indicated review of the audits by initial and the process warranted, and record review determined the audits of residents who required foot rests were done at least twice daily. 7. The State Agency validated the QAA meeting was held on 12/03/12 with the Medical Director, who participated by teleconference by interview. Interview, on 12/05/12 at 12:55 PM, with the Medical Director revealed that he did participate in the meeting, but was not able to state the cause of the fall. Interview, on 12/07/12 at 6:30 PM, with the DON revealed that the Medical Director was told the root cause of Resident #1's fall on 11/15/12 was a result of foot rests not replaced on the wheelchair during staff assisted | F 490 | This re-education will be repeated monthly for 3 months then will be part of the annual in-service schedule. All newly hired non-licensed nursing staff will be educated during orientation. This will be completed by the Director of Staff Development. Corporate Consultant reviewed the facility Pain Management Program with the Nursing Supervisor responsible for program to ensure all components of the program are being followed, including review of CareTracker reports, MAR's for pain medication usage and acute pain assessments. Knowledge and understanding was validated by the Corporate Consultants review of the Pain Management Program. This was completed on Dec. 3, 2012. A mandatory in-service on the Abuse Policy and Procedure was provided to all staff on 12-4-12 by the Director of Staff Development and no staff was permitted to work prior to completion of the mandatory | |



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| F 490 | Continued From page 65 transportation. Interview, on 12/07/12 at 7:00 PM, with the Administrator revealed she was aware that the Medical Director was told on 12/03/12 of the root cause of Resident #1's fall and when staff asked the Medical Director at the end of the meeting if he had any suggestions to the add, he stated that he felt all issues had been adequately addressed. 8. The State Agency validated the new Job Description for the 'Nurse in Charge' by review of the statement, and validated by observation that copies of the job description were placed on the 24 Hour report binder for reference on both the East and West Nursing Stations on 12/04/12. 9. The State Agency validated the in-service that was provided to the Administrative staff of the facility on 12/04/12 by review of the results of the post-test provided by the Corporate Consultant and validated the understanding of all Administrative staff and their responsibility to identify and investigate all reported and suspected incidents of abuse and neglect. 10. The State Agency validated by review of the Abuse and Neglect Policy provided to staff at the in-service provided by the Director of Staff Development on 12/04/12, and by review of the attendance log to ensure all staff were required to attend the in-service prior to return to work and it was determined the facility had 100% compliance with the mandatory staff in-service. Interview, on 12/06/12 at 6:30 AM, with CNA #8 revealed she was aware that staff failure to provide the services needed to meet the needs of any resident could be determined to be neglect. CNA #8 stated she was aware the failure of staff to | F 490 | education. To evaluate understanding of the facility policy on Abuse staff were asked to complete a questionnaire related to the policy. These were reviewed by the Director of Staff Development for accuracy. Corporate Consultant reviewed the Abuse Policy and Procedure including identification of abuse or neglect, types of abuse and neglect, investigation of abuse or neglect, including conducting staff interviews, the initial report, the 5 day report and need to arrive at a conclusion, also discussed protection of residents during the investigation., with the facility Administrator, Director of Nursing, MDS Coordinator, Restorative Nurse, Nurse Supervisor and Director of Staff Development on 12-4-12. A post test was administered to those attending to evaluate understanding of the Abuse Policy. In-service for staff on Abuse Policy and Procedure will be repeated monthly for 3 months | | |



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| F 490 | Continued From page 66 assess and treat pain was a form of resident neglect. Interview, on 12/06/12 at 10:00 AM, with CNA #11 revealed she recently attended an abuse and neglect in-service and verbalized understanding the failure to assess and treat pain constituted resident neglect. | F 490 | then quarterly for 3 quarters then no less than annually. All newly hired employees will be educated on the Abuse Policy during orientation. This will be the responsibility of the Director of Staff Development. 4. All reports of Abuse will be reviewed by the Corporate Consultant monthly to ensure appropriate investigation and if indicated reporting is completed. All reports of incidents will be reviewed by the Administrator weekly to ensure any incident that appropriate investigation occurs. Director of Social Services to interview each resident or if resident not interviewable, a family member or responsible party, quarterly on if they have observed or experienced any form of abuse or neglect that they have not reported. Director of Social Services to review the facility Policy on Abuse in the monthly Resident Council meeting and request feedback regarding any concerns related to abuse or neglect. Any | | |



concerns voiced will be immediately investigated and if appropriate reported to the appropriate agencies.

Administrative Staff (Director of Nursing, Weekend Nursing Supervisor, Administrator, Nurse Supervisor, Medical records) completed audits no less than 2 times per day beginning Nov. 30, 2012 and continuing through December 21, 2012. Audits were then completed no less than daily through January 11, 2013. To ensure residents requiring foot pedals have them during transport. Beginning January 12, 2013 audits will be completed 3 times per week for 4 weeks then weekly for 4 weeks then will be assigned to the MDS

Coordinator as a quarterly review by the facility QA Committee. Audits are reviewed by Administrator and direction for re-education given as indicated. Corporate Consultant to review 25% of CAA's monthly for 3 months then 25% quarterly to ensure they are completed appropriately and timely and that if indicated a Care Plan is developed related to the CAA.



Director of Nursing to review Nurse Aide Assignment sheets weekly for 12 weeks, then monthly to ensure all changes have been made and that assignment sheets are reflective of care and services to be provided to the residents.

Director of Nursing to review the quick reference related to use of foot pedals located in front of the MAR, TAR, Care Plan and Nurse Aide assignment sheet weekly for 12 weeks then monthly to ensure it is updated appropriately and present in all designated locations.

Corporate Consultant to review the facility Pain Management Program monthly for 3 months then no less than quarterly to ensure resident pain is appropriately assessed, treated and evaluated. This review will include review of the initial pain assessment, caretracker reports, MAR's, acute pain assessments and the Pain Management Logs.

Director of Staff Development to review CareTracker report related to Pain weekly for 4 weeks to ensure compliance with completing the daily assessment of pain indicators.

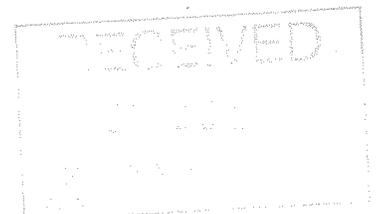


To ensure compliance with transfer status, staff nurses and administrative staff are observing a minimum of 10 transfers daily for 4 weeks then 10 weekly for 4 weeks then 10 monthly for 4 months. These observations are recorded for review. Administrator to review observations weekly and direction for re-education given as indicated.

Corporate Consultant to review all reports of falls monthly for completion and identification of root cause of fall.

Beginning December 11, 2012
Director of Nursing or Nurse Manager to audit TAR's no less than 3 times per week for 4 weeks, then weekly for 4 weeks and then monthly to ensure O2 settings are on the TAR and signed to indicate setting is checked every shift.

Beginning January 4, 2013
DON or MDS Coordinator to review all residents noted by nurses on 24 hour report as being non-compliant with any care need, to ensure alternative interventions have been



evaluated, that the physician has been notified of non-compliance if indicated, that resident family/responsible party have been informed, and that resident is aware of risks related to the noted non-compliance and that there is a care plan related to the non-compliance. All reviews will be reported to the QA Committee.

Facility has established a QA sub-committee that will meet monthly to review the implementation of the POC and monitor compliance. This sub-committee is comprised of the Administrator, Director of Nursing, Director of Staff Development, Nurse Supervisor, MDS Coordinator, a staff nurse, a nursing assistant and corporate consultant.

Results of all audits, reviews and interviews will be reported to the facility QA Sub-Committee who will then report to the facility QA Committee no less than quarterly for one year.

Date of completion 1-7-2013

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