

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

PRINTED: 10/14/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185410	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	 (X3) DATE SURVEY COMPLETED C 09/30/2011
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NAME OF PROVIDER OR SUPPLIER RIVER'S BEND RETIREMENT COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 300 BEECH ST. KUTTAWA, KY 42055
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F 000	INITIAL COMMENTS An abbreviated survey (KY #16745) was conducted on 09/27/11 through 09/30/11 and was determined to be unsubstantiated. Unrelated deficiencies were cited with the highest S/S being a "D."	F 000	F157 Criteria #1 Resident #1 is no longer residing in the facility.	
F 157 SS=D	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 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). 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. The facility must record and periodically update the address and phone number of the resident's	F 157	Criteria #2 The facility will identify other residents having the impact to be affected by the same deficient practice by conducting an audit of resident clinical records. Any changes in condition will be reviewed for the last month to ensure that families and M.D. have been notified. Administrative Nursing will be responsible for completion of audit. First full day of compliance will be November 10, 2011. Criteria #3 An inservice will be provided by Administrative Nursing to all licensed nursing staff on the policy for completing notifications to resident/responsible party and appropriate M.D. to include notification of changes of, injury/decline/room/etc). First full day of compliance will be November 10, 2011. Criteria #4 10% of Resident's clinical records will be audited every month for compliance with notification of changes to responsible party/MD. This will be done x 3 months and then quarterly. This will be reviewed as part of the Continuous Quality Improvement meeting. Audits will be completed by Administrative Nursing. First full day of compliance will be November 10, 2011.	
				Criteria #5 11/10/2011 (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Dawn Jeddler, Administrator

10-17-11

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	Continued From page 1 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interviews and record review to include facility policy/procedure, it was determined the facility failed to ensure notification of the physician and/or family for one resident (#1), in the selected sample of three (3), when the resident experienced a change of condition. During an assisted transfer per staff, from a wheelchair to bed, Resident #1 sustained a fall, which resulted in abrasions to both knees. The facility failed to notify the physician and family. The fall was the second fall, sustained by the resident on the evening of 05/25/11. The findings include: A review of the facility's policy/procedure, "Physician/ Legal Representative Notification," undated, revealed nursing staff were to inform the resident, consult with the resident's physician and the resident's legal representative or an interested family member, in the event of an accident involving the resident, which had the potential for requiring physician intervention or a need to alter medical treatment. Closed record review revealed Resident #1 was admitted to the facility, on 03/21/08 with diagnoses which included Dementia and Agitated Behaviors and Osteoarthritis. The resident was discharged on 06/01/11. A review of the quarterly Minimum Data Set	F 157			

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F 157	<p>Continued From page 2</p> <p>(MDS), dated 04/07/11 and the annual MDS dated 01/05/11, revealed the facility assessed Resident #1 as severely cognitively impaired with a short term memory deficit and made poor safety decisions. The resident was identified as having the capability of independent transfers was ambulatory in the room and hallways with supervision and the use of a rolling walker.</p> <p>Review of the "Falls" care plan, dated 01/12/11, revealed interventions included staff to answer call lights promptly and instruct the resident to call for assistance, prior to all transfers and to remove or redirect the resident if he/she placed him/herself in a situation for a possible fall or injury.</p> <p>A review of the Certified Nurse Aide (CNA) Care Plan, dated May 2011, revealed interventions included non-skid socks and staff assurance that the resident's walker was within reach, when the resident was sitting down.</p>	F 157		
	<p>An interview with Certified Medication Aide #1, on 09/27/11 at 4:42 PM and on 09/28/11 at 3:00 PM, revealed that on 05/25/11, Resident #1 fell in the bedroom twice that same evening. The first fall occurred at approximately 7:00 or 7:30 PM. There was a tornado warning issued that night and staff were busy assisting residents to the hallway. The CMA revealed she was not involved with Resident #1 at the time of the fall, but stated the resident #1 sustained a second fall at approximately 9:00-9:30 PM. During this time, residents were being assisted from the hallway to their rooms, after the tornado all clear notice was given. The CMA and another CNA were assisting Resident #1 to transfer from the wheel chair, when the</p>			

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F 157	<p>Continued From page 3</p> <p>resident stumbled and fell to his/her knees. The CMA alerted the LPN Charge Nurse. The charge nurse responded and assessed the resident, prior to assisting Resident #1 to bed. However, review of the medical record revealed no documented evidence of the fall or notification of the physician or family.</p> <p>Interviews with the LPN Charge Nurse, on 09/27/11 at 1:40 PM and 3:12 PM and on 09/28/11 at 4:30 PM, revealed the LPN did not document the second fall incident or notify the physician or family. She revealed she forgot about the second fall, until the CMA mentioned the incident. She stated, "It was a busy night and I just remember the resident "hunched in the floor and the staff were holding him/her under the arms and did not realize it was a fall."</p> <p>An interview with the Risk Manager, on 09/28/11 at 4:30 PM, revealed the Risk Manager did not interview the CMA regarding the falls and she had only interviewed staff involved in the first fall.</p> <p>An interview with the Director of Nursing (DON), on 09/28/11 at 4:40 PM, revealed she was not employed at the facility at the time the falls occurred, however, she would expect the LPN to assess the resident, call the family and the physician and treat the resident accordingly. The DON revealed she would expect the LPN to complete an incident report and to document in the resident's chart, and to notify the DON, if she was not in the building at the time.</p> <p>An interview with the Administrator, on 09/28/11 at 3:30 PM, revealed the Administrator was unaware of a second fall sustained by Resident</p>	F 157		

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F 157	Continued From page 4 #1. The Administrator revealed the LPN had been provided training regarding the facility policies and procedures related to completion of incident reports and notification of physician and family.	F 157	F514 Criteria #1 Resident #1 no longer resides at the facility.	
F 514 SS=B	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	Criteria #2 The facility will identify other residents having the potential to be affected by the same deficient practice by reviewing all incidences that have occurred in the last month to ensure that the incident is documented in the medical record. This will be completed by Administrative Nursing. First full day of compliance will be November 10, 2011. Criteria #3 Liscensed Nursing Staff will be inserviced on policy for events documentation. This will be completed by Adminlstrative Nursing. First full day of compliance will be November 10, 2011.	

	This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure documentation in the clinical record included incidents such as falls for one resident (#1), in a selected sample of three. A review of the facility's undated policy and procedure, Events/Incident Reports, revealed the facility required all events to be documented involving residents. Incident/accidents were documented in the clinical record and on an incident report per the charge nurse. The charge nurse was responsible for documentation in the medical record and to open the computerized		Criteria #4 The facility has developed the Incident Review Committee which meets at least 3x a week. Events/incidences are reviewed during this time. When events/incidences are reviewed the nurses' notes will be reviewed to ensure appropriate documentation. This will be completed by Administrative Nursing by November 10, 2011.	Criteria #5 11/10/2011
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F 514	Continued From page 5 charting for the review of the Risk Manager, Director of Nursing (DON) and the Administrator. The report should contain the name of the resident, the location of the event, any witnesses and a concise description of the facts observed at the scene and the appropriate follow-up. The findings include: Resident #1 was admitted, on 03/21/08, with diagnoses to include Dementia with Agitated behaviors. The resident was discharged on 06/01/11. Review of the falls care plan, dated 01/12/11, revealed interventions included removal or redirection of the resident if he/she placed him/herself in a situation for a possible fall or injury. A review of the Certified Nurse Aide (CNA) Care Plan, dated May 2011, revealed staff were to ensure the resident's walker was in reach, when the resident was sitting down. An interview with Certified Medication Aide #1, on 09/27/11 at 4:42 PM and on 09/28/11 at 3:00 PM, revealed Resident #1 fell on two occasions, on the evening of 05/25/11. The first fall occurred at approximately 7:00 PM or 7:30 PM. A second fall occurred at approximately 9:00 PM-9:30 PM. The facility staff were in the process of assisting residents back to their rooms after a tornado warning. The CMA and a CNA were assisting Resident #1 with a transfer from the wheelchair to be, when the resident stumbled and fell to his/her knees. The CMA alerted the LPN Charge Nurse, who came and assessed the resident, prior to assisting the resident to bed. Review of the clinical record revealed the incident/fall and actions taken were not	F 514			

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F 514	<p>Continued From page 6</p> <p>documented in the medical record per facility policy and procedures. The results of the nurse's assessment and any actions taken were not recorded. There was no documented evidence the resident was monitored for any potential development of complications, resulting from the second fall.</p> <p>Interviews with the LPN Charge Nurse, on 09/27/11 at 1:40 PM and 3:12 PM and on 09/28/11 at 4:30 PM, revealed the LPN did not document the second fall episode. She revealed she forgot about the resident's second fall, until the CMA mentioned it. She stated she did not document the episode or fill out an event report.</p> <p>An interview with the Director of Nursing (DON), on 09/28/11 at 4:40 PM, revealed she was not employed at the facility at the time of the falls, however, she would expect the LPN to complete an incident report and to document in the resident's chart.</p>	F 514		
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	<p>An interview with the Administrator, on 09/28/11 at 3:30 PM, revealed the Administrator was unaware of a second fall and the LPN had been trained to complete an incident report for all falls.</p>			
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