

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

PRINTED: 03/02/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/17/2012
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NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD CARLISLE, KY 40311
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000 F 157 SS=D	<p>INITIAL COMMENTS</p> <p>An Abbreviated Survey investigating KY#00017811 was conducted on 02/16/12 and 02/17/12. KY#00017811 was substantiated with deficiencies cited.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>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).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.16(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>	F 000 F 157	<p>Johnson Mathers Nursing Home acknowledges receipt of the Statement of Deficiencies and purposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of the quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Johnson Mathers Nursing Home's response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor that any deficiency is accurate. Further, Johnson Mathers Nursing Home reserves the right to refute any of the Deficiencies through Informal Dispute Resolution, formal appeal procedures and/or any other administrative or legal proceeding.</p> <p>F 157 Resident #1's physician and family were notified of resident's injury by LPN #1 at 4:53 PM January 28, 2012.</p> <p>RN#1 was counseled by the DON on January 28, 2012 regarding failure to follow facility fall protocol including failure to document incident and assessment of resident timely and notify physician and responsible party at time of fall.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Admin	(X6) DATE 3/9/2012
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 167	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review it was determined the facility failed to ensure the resident's physician and legal representative were notified immediately of an accident which resulted in injury and admittance to the hospital for one (1) of three (3) sampled residents (Resident #1). Resident #1 was found sitting on the floor of his/her room and the nurses failed to identify this as a fall, as defined by the facility, and follow related facility accident protocol to notify the physician and responsible party.</p> <p>The findings include:</p> <p>Interview, on 02/17/12 at 12:15 PM, with the Director of Nursing (DON) revealed the facility defines a fall as anytime a resident goes unintentionally from one level to another, whether observed or unobserved, or was assisted or unassisted. If the resident is on the floor it would be considered a fall. Further interview revealed the protocol for a fall would include completion of an incident report.</p> <p>Review of the facility's policy "RN Hall Nurse", dated 11/21/06, revealed under Major Duties and Responsibilities subsection fifteen (15) they were to notify the physician of patient accidents/incidents.</p> <p>Review of the facility's policy titled: Reporting and Investigation of Resident Events and Incidents, revised 01/24/12, Section 2 included completion of the Physician notification and</p>	F 167	<p>All residents have the potential to be affected. The Nursing Admin Team including the DON, QI Nurse, MDS Nurses, Treatment Nurse and SDC Nurse reviewed progress notes for the last 30 days on 2/20/2012 for all other residents to identify other residents where notification of changes may be warranted. Any concerns identified were immediately addressed as indicated up to & including a new assessment of the situation and/or MD/RP notification if indicated.</p> <p>All licensed nurses were re-educated on 2/23/12 by the DON regarding the right of all residents to have their physician and family member/legal representative informed when there is an accident/incident, including falls, involving the resident; there is a change in condition or the resident's physical, mental, or psychosocial status; a need to alter treatment significantly or a decision to discharge or transfer the resident.</p> <p>Progress notes will continue to be reviewed by the Nursing Admin Team daily, Monday through Friday, for appropriate notification of physicians and family members/legal representatives. The results of these reviews and actions taken will be</p>	

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F 157	<p>Continued From page 2 Family/Responsible Party notification section.</p> <p>Review of Resident #1's medical record revealed the resident was admitted by the facility on 09/21/11 with diagnoses which included Altered Mental Status, Anemia, Chronic Obstruction Pulmonary Disease, Congestive Heart Failure, and Dementia with Behaviors. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 12/11/11, revealed the facility assessed the resident as moderately impaired in cognitive skills for decision making. Further review revealed the facility assessed the resident as needing one person assistance for ambulation in his/her room. Review of the Care Plan, last revised on 12/11/11, revealed the resident was care planned for being at risk for falls related to impaired balance and unsteadiness.</p> <p>Review of Resident #1's medical record revealed progress notes for 01/28/12 by Licensed Practical Nurse (LPN) #1 at the following times regarding the resident's condition and status:</p> <p>At 4:53 PM, she was called to the resident's room by a Certified Nursing Assistant (CNA) and the resident was noted to have bruising to left ear, left cheek had a small amount of dried blood. The resident complained of left arm pain. Neuro checks were initiated. The physician and family were notified.</p> <p>At 6:04 PM, the resident was noted to not easily be aroused and continues to complain of pain in left arm and left rib area.</p> <p>At 6:47 PM, the resident was sent to the ER for x-rays.</p>	F 157	<p>reported at the weekly QI meeting for four (4) weeks then monthly thereafter.</p> <p>The results of these weekly QI meetings will be reported at the quarterly meeting of the Quality Improvement Executive Committee consisting of the Administrator, DON, ADON, QI Nurse, Medical Director and any other persons required to provide information pertinent to the reports being discussed at the Executive Committee meeting with further action taken as directed by the committee.</p> <p>Completion Date: 3/09/2012</p>	

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F 157	<p>Continued From page 3</p> <p>At 10:02 PM, the resident was admitted to the Hospital with a diagnosis of status post fall soft tissue injury to face and scalp. Family at bedside and aware.</p> <p>Review of the Hospital Discharge note for Resident #1, from 01/28/12 admission, revealed no evidence of new injuries to the face or head as well as chest and pelvis. Resident will be transferred back to the nursing home.</p> <p>Interview, on 02/16/12 at 3:25 PM, with LPN #2 revealed she worked the day shift on 01/28/12 and was assigned to Resident #1. She reported she was not informed of a fall. If you find a resident on the floor it was considered a fall even if the resident told you they did not fall. The procedure after a fall was to assess the resident, call the physician, family, and on-call nurse, and DON. Further interview revealed staff was to document the event in the progress note, complete an incident report and put it on the daily report sheet. LPN #2 stated she did not assess Resident #1 because she was not aware of any acute problems. She should have been informed about the fall by the previous shift.</p> <p>Interview, on 02/16/12 at 3:07 PM, with Licensed Practical Nurse (LPN) #1, who worked the evening shift on 01/28/12, revealed she was not told about a fall by staff from the prior shift. The LPN stated falls that occur should be put on the report sheet. She should have been informed of the event and she did not assess the resident for changes at the beginning of her shift. She further stated anytime a resident was found on the floor it was a fall regardless if it was</p>	F 157		

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F 157	<p>Continued From page 4</p> <p>witnessed. Further interview revealed after the CNA informed her the resident had bruising on her face and head she reviewed the report sheet and notes but could not find anything. She assessed the resident, started neuro checks and notified the DON, physician, and family. She followed the fall protocol.</p> <p>Further review of Resident #1's medical record revealed a late entry progress note, on 01/28/12 at 11:48 PM, by RN #1 regarding an unobserved fall on 01/28/12 at 3:15 AM. The resident was found seated on the floor at side of bed on buttocks, with both legs outstretched. The resident stated she did not fall, she was on the floor putting on her shoes. No injuries, no complaints, no problems noted.</p> <p>Interview, on 02/16/12 at 4:40 PM, with RN #1 who cared for the Resident #1 on 01/28/12, revealed she and another nurse (LPN #3) went to the room and found the resident on the floor about 3:15 AM. She assessed the resident for range of motion, vitals, pain, and did a head to toe assessment, but did not see any type of injury. The resident denied falling, but stated she was putting on her shoes. RN #1 felt it should have been reported as a fall. The RN stated the nurse she was with, LPN #3, told her it wasn't a fall so she did not chart it. Further interview revealed she did assess the resident, but did not document the assessment at the time and did not notify the physician or the family of the event.</p> <p>Interview, on 02/16/12 at 8:45 PM, with LPN #3 revealed she went to Resident #1's room with RN #1 and found the resident on the floor. The other nurse, RN #1, assessed the resident. It should</p>	F 157		

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F 157	<p>Continued From page 5</p> <p>have been treated as an unobserved fall, if a resident is found on the floor it is considered a fall. They are supposed to assess the resident, complete an incident report, notify the physician, family, and administrator. They are supposed to report to the next shift. Further interview, revealed because the other nurse was caring for the resident she would be expected to complete the progress note.</p> <p>Continued interview, on 02/17/12 at 12:15 PM, with the DON revealed the nurse, RN #1, failed to understand the resident had a fall per the facility's definition of a fall. Per the fall protocol, an incident report should have been completed immediately upon discovery of the fall. It should have been documented in the progress note which would include who was notified. The nurse failed to follow the documentation protocol and failed to notify the proper persons.</p> <p>Interview, on 02/17/12 at 11:45 AM, with the Administrator revealed a fall was defined as anytime a resident goes from one level to another unintentionally. After a fall the facility protocol was staff should assess the resident as soon they knew there had been a fall. When staff ensured the resident was safe, staff should document the event and call the physician to possibly get orders. The nurses taking care of Resident #1 did not follow protocol.</p>	F 157		
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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</p>	F 323		

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F 323	<p>Continued From page 6 prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide an environment that is free from accident hazards of which the facility has control and provide supervision and assistive devices to each resident to avoid accidents for one (1) of three (3) sampled residents (Resident #1). Resident #1 was found sitting on the floor of her room and the nurses failed to identify this as a fall, as defined by the facility's policy, and follow related facility accident protocol to initiate preventive measures.</p> <p>The findings include:</p> <p>Review of the facility's policy titled: Reporting and Investigation of Resident Events and Incidents, revised 01/24/12, revealed upon becoming aware of an event, the nurse or nursing supervisor is to complete the Quality Improvement (QI) reporting form. It includes the event date/time, assessments and interventions. Further review revealed on completion of the QI form it is to be routed to the Director of Nursing (DON) or designated administrative nurse to determine if interventions were to be initiated.</p> <p>Interview, on 02/17/12 at 12:15 PM, with the Director of Nursing (DON) revealed the facility defined a fall as anytime a resident goes unintentionally from one level to another, whether</p>	F 323	<p>F 323 Resident # 1 was provided with an assistive device by LPN #1 at 4:53 PM on 1/28/2012 when she assessed the resident, she placed a pressure cushion under the resident to alert staff when she got up. Resident #1 was transferred to the hospital on 1/28/2012 at 6:47PM for diagnostic tests per physician order. A new fall risk assessment was completed on 1/28/2012 for Resident #1 and upon her return from the hospital on 2/1/2012, the following interventions were put in place: high/low bed adjusted to appropriate height for the resident; winged mattress; and pressure cushion alarm under resident at all times to alert staff that she is up.</p> <p>RN#1 was counseled by the DON on 2/28/12 regarding failure to identify a resident sitting on the floor as a fall even though unobserved and thus failed to follow the facility fall protocol which includes completing a new fall risk assessment and initiating appropriate interventions.</p> <p>All residents have the potential to be at risk. A review of fall risk assessments</p>	

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F 323	<p>Continued From page 7</p> <p>observed or unobserved, or assisted or unassisted. If the resident was on the floor it would be considered a fall. Further interview revealed the protocol for a fall would include completion of a fall risk assessment and initiation of preventive measures.</p> <p>Review of Resident #1's medical record revealed the resident was admitted by the facility on 09/21/11 with diagnoses which included Altered Mental Status, Anemia, Chronic Obstruction Pulmonary Disease, Congestive Heart Failure, and Dementia with Behaviors. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 12/11/11, revealed the facility assessed the resident as moderately impaired in cognitive skills for decision making. The facility assessed the resident as one person assistance for ambulation in his/her room. Review of the Care Plan, revised on 12/11/11 revealed the resident was care planned for being at risk for falls related to impaired balance and unsteadiness. The care plan included assist during transfer and mobility, encourage the resident to wear glasses, have commonly used articles within easy reach, proper and non slip footwear, and wheelchair when out of bed.</p> <p>Further review of Resident #1's medical record revealed a late entry progress note, on 01/28/12 at 11:48 PM, by Registered Nurse (RN) #1 regarding an unobserved fall on 01/28/12 at 3:15 AM. The resident was found seated on the floor at side of bed on buttocks, with both legs outstretched. Asked if he/she fell, the resident stated, no he/she was pulling on his/her shoes. No injuries, no complaints, no problems noted.</p>	F 323	<p>for all residents including review of assistive devices in place was completed by the DON and MDS Nurses on 3/8/2012. No additional residents were identified as being at risk for falls and no new assistive devices were identified as being needed through this review.</p> <p>A visual round of the facility was conducted by the Administrator, DON, & Environmental Services on 3/8/2012 to identify hazards or risks in the resident's environment and to implement interventions to reduce any hazards or risks identified.</p> <p>In-services for nursing staff regarding the following:</p> <ul style="list-style-type: none"> - Definition of a fall - Assessment of resident after a fall and completion of new fall risk assessment - Completion of incident report - Identification of cause of fall and implementation of appropriate interventions - Completion of wandering risk assessments <p>were conducted by the DON, QI Nurse and SDC Coordinator on 2/23/2012.</p> <p>To identify any changes in condition or behavior that could potentially indicate</p>	

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F 323	<p>Continued From page 8</p> <p>Interview, on 02/16/12 at 4:40 PM, with RN #1 who cared for the Resident #1 on 01/28/12, revealed she and another nurse, Licensed Practical Nurse (LPN) #3, went to the room and found the resident on the floor about 3:15 AM. The resident denied falling and stated he/she was putting on his/her shoes. RN #1 stated she did not put anything in the progress notes about the event and it should have been documented. Further interview revealed RN #1 did not complete an incident report until after being called on 01/28/12 at 9:00 PM by the DON. It should have been reported as an incident and she had requested help to complete the report but LPN #3, told her the resident sat down and it wasn't a fall.</p> <p>Interview, on 02/16/12 at 8:45 PM, with LPN #3 revealed she went to Resident #1's room with RN #1 and found the resident on the floor. The other nurse, RN #1, assessed the resident. It should have been treated as an unobserved fall, because Resident #1 was found on the floor. She stated staff was supposed to assess the resident, complete an incident report, do a twenty-four hour note to alert other staff and notify the physician, family, and administrator.</p> <p>Continued interview, on 02/17/12 at 12:15 PM, with the DON revealed the RN #1 failed to understand the resident had a fall per the facility's definition of a fall. The assessment should have been documented at the time of the fall and subsequent neuro checks should have been performed. She failed to notify the day shift nurse so no fall assessments were done. They should have put it on the twenty-four (24) hour report and the resident should have been assessed for injury</p>	F 323	<p>an increased risk for falls in all residents, including those not currently identified as at risk for falls; and to ensure that for any resident(s) identified as being at risk for falls, the fall risk assessment has been completed properly and assistive devices have been put in place as appropriate, the DON, MDS Nurses, QI Nurse, SDC Nurse and/or Facility Registered Nurse Consultant will read nurse's notes, review 24 hour nursing reports, talk to direct care staff and observe residents during rounds, daily, Monday - Friday.</p> <p>To monitor facility performance to ensure that solutions are sustained through the QI process, the progress notes and 24 hour reports for all residents, including Resident #1, will continue to be read by the DON, QI Nurse, SDC Nurse and/or MDS Nurses daily, Monday - Friday to ensure that interventions implemented for a resident identified at risk for falls remain effective. The results of these audits and action taken will be reviewed weekly for four weeks, then monthly thereafter by the QI Committee, consisting of the Administrator, DON, QI Nurse, Treatment Nurse, SDC Nurse and/or MDS Nurses. Trends & any accompanying actions from these</p>	

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F 323	Continued From page 9 and if appropriate neuro checks should have been performed. The nurse failed to follow the fall protocol and failed to notify the proper persons. The nurse did not initiate a preventive measures as per the facility's policy.	F 323	audits in additions to reports from the Falls, Wandering Residents, Restraints, Safety, Event & Incident, and the Physical Plant Quality Improvement Committees will be reviewed quarterly by the QI Executive Committee, consisting of the Administrator, DON, ADON, QI Nurse, Treatment Nurse, MDS Nurse, Medical Director, &/or any other persons required to provide information pertinent to the reports being discussed, with further retraining or other such interventions implemented as directed by the committee. Completion Date: 3/09/2012	