

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185112	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	<div style="border: 2px solid black; padding: 5px; text-align: center;"> RECEIVED AUG 19 2011 C 07/15/2011 Division of Health Care Southern Enforcement Branch </div>
NAME OF PROVIDER OR SUPPLIER NIM HENSON GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 420 JETT DRIVE JACKSON, KY 41339	

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F 000	INITIAL COMMENTS	F 000		
F 282 SS=G	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, closed medical record, and incident/accident review, it was determined the facility failed to ensure services were provided to one of three sampled residents (Resident #1) in accordance with the resident's written plan of care. Based on the facility's assessment, Resident #1 required the assistance of two staff persons for bedpan use and bed mobility. However, on 06/18/11, one State Registered Nursing Assistant (SRNA) attempted to assist Resident #1 from a bedpan and the resident fell from the bed. As a result of the fall, the resident sustained a laceration to the head and a left hip fracture. Resident #1 was transferred to the hospital on 06/18/11 and diagnosed with an acute mildly displaced left subtrochanteric fracture (broken left hip). The resident expired on 07/02/11, from a possible pulmonary embolism.</p> <p>The findings include</p> <p>Interview with the Director of Nursing (DON) on</p>	F 282	<p><u>THIS PLAN OF CORRECTION CONSTITUTES MY WRITTEN ALLEGATION OF COMPLIANCE FOR THE DEFICIENCIES CITED. HOWEVER, SUBMISSION OF THE PLAN OF CORRECTION IS NOT AN ADMISSION THAT A DEFICIENCY EXISTS OR THAT ONE WAS CITED CORRECTLY. THIS PLAN OF CORRECTION IS SUBMITTED TO MEET REQUIREMENTS ESTABLISHED BY STATE AND FEDERAL LAWS.</u></p> <p>Resident #1 expired at hospital on July 2, 2011.</p> <p>Any resident may be affected if caregivers fail to comply with care plan. To ensure adherence, so that no other residents may be affected; all C.N.A Care Plans have been checked against physician's orders and treatment sheets as of July 16, 2011. All side rail usage has been re-evaluated on all residents as of August 3 2011, by nursing supervisors/therapy. No other resident was found to be affected.</p>	

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER/REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: Administrator DATE: 8-19-11

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ram participation.

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F 282	<p>Continued From page 1</p> <p>07/15/11, at 10:30 AM, revealed the facility did not have a policy related to resident care plans.</p> <p>A review of the incident/accident report revealed on 06/18/11, Resident #1 rolled over in bed to allow SRNA #6 to remove a bedpan and fell from the bed. The incident/accident report further revealed staff observed a laceration to the left side of Resident #1's head and a hematoma (a collection of blood outside the blood vessel) on the left side of the resident's face. A review of the written Witness Statement from SRNA #6, dated 06/18/11, revealed Resident #1 "had her light on I went in to see what she wanted, she wanted off the bedpan. She rolled over for me to dry her and she rolled to far. I tried to catch her but I could not."</p> <p>A review of the closed medical record for Resident #1 revealed the facility admitted the resident on 10/11/90, with diagnoses that included Epilepsy, Arthritis, Osteoporosis, Scoliosis, Cerebral Vascular Accident with left sided Hemiparesis, Dementia, Osteoarthritis, and Seizure disorder.</p> <p>A review of the Fall Risk Assessment completed on 06/08/11, revealed facility staff had assessed Resident #1 as 12. According to the assessment, a total score of greater than 10 indicated the resident was a high risk for falls.</p> <p>A review of a Quarterly Minimum Data Set (MDS) Assessment, dated 06/08/11, revealed facility staff had assessed Resident #1 to require extensive assistance of two staff persons for bed mobility and bedpan use.</p>	F 282	<p>100% of residents were re-evaluated for fall risk assessments and side-rail usage. These assessments will be completed upon admission, re-admissions, significant change, or a fall if needed. New Care plan policy requires that Care Plans are to be read by nursing assistants each shift. Changes are made timely, and staff is notified immediately to any change. In service on the importance of following CNA Care Plans and transfers were conducted for ALL Nurses, CNA's and CMA's on July 27, 2011. These in-services will be repeated in 3 months. Nursing in-service on fall risk assessment was completed on August 3, 2011.</p> <p>Beginning on July 5, 2011, D.O.N /Nurse supervisor/Designee will be conducting daily monitoring of two selected C.N.A.'s to ensure she/he is knowledgeable of residents current Care Plan and will observe that it is implemented correctly. As of August 1, 2011, CNA Care Plans are monitored monthly for updates and changes. Plans are compared by MDS coordinators to MDS Care Plans. Any issues will be addressed at monthly Q&A.</p>	8/5/11

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F 282	<p>Continued From page 2</p> <p>A review of Resident #1's care plan, dated 06/08/11, revealed facility staff assessed Resident #1 to require "limited" to "total" assistance with activities of daily living (ADL) due to a history of Cerebral Vascular Accident (Stroke) with left sided Hemiparesis (weakness on left side of body). A review of interventions revealed staff was required to assist the resident to turn/reposition at least every two hours, assist with peri-care every shift, and to provide assistance with bedpan for toileting needs at the resident's request.</p> <p>A review of the Nurse Aide Care Plan (NACP) for June 2011 revealed facility staff assessed Resident #1 to require the assistance of two staff members for bed mobility and bedpan use.</p> <p>Interview on 07/14/11, at 2:45 PM, with SRNA #6, who assisted Resident #1 on 06/18/11, revealed she went into Resident #1's room to assist the resident off the bedpan. The SRNA stated she asked Resident #1 to roll over to allow the bedpan to be removed, the resident rolled too far, and fell off the bed. SRNA #6 stated she tried to catch the resident but could not get to the resident quick enough to prevent the fall. SRNA #6 stated she reviewed each resident's NACP two to three times a week. However, the SRNA stated she "didn't look closely" when she looked at Resident #1's NACP and was not aware Resident #1 required the assistance of two staff members for bed mobility and bedpan use, or that the resident was a fall risk.</p> <p>Interviews conducted on 07/14/11, with SRNA #4 at 12:05 PM, SRNA #5 at 12:15 PM, and Licensed Practical Nurse (LPN) #1 at 2:30 PM,</p>	F 282		

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F 282	Continued From page 3 revealed staff was required to look at care plans (CPs) to determine each resident's required level of care. SRNA #4 stated staff was required to look at the CP one time a week. SRNA #5 stated CPs were to be looked at every day, and LPN #1 stated the CP was to be looked at two to three times a week. Interview further revealed SRNA #4, SRNA #5, and LPN #1 thought one staff member could assist Resident #1 with the bedpan because the resident could provide assistance with limbs by using the side rails. LPN #1, CNA #4, and CNA #5 stated they were not aware Resident #1 had been assessed to require the assistance of two staff members for bed mobility and bedpan use, and were not aware Resident #1 had been assessed as a fall risk. Interview with Registered Nurse (RN) #1 on 07/15/11, at 10:30 AM, revealed nurses were responsible to update the Comprehensive Care Plan (CCP) and the NACP with any new orders or changes in care for each resident. RN #1 further stated she was aware Resident #1 required the assistance of two staff members for bed mobility and bedpan use. RN #1 stated when she became aware only one staff member had assisted Resident #1 on 06/18/11, the day of the fall, she informed the Unit Manager (JM), and the NA Coordinator "a couple of days later." Interview with the Director of Nursing (DON) on 07/13/11, at 4:15 PM, revealed staff was required to check the Care Plans on a daily basis.	F 282		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323		

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F 323	Continued From page 4 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, closed record review, the facility's incident/accident report, and hospital records, it was determined the facility failed to ensure one of three sampled residents (Resident #1) received adequate supervision and assistance to prevent accidents. Facility staff assessed Resident #1 to be at high risk for falls, and required the assistance of two staff persons for bed mobility and bedpan use. The facility failed to have an effective system to ensure assistance was provided to prevent accident/injuries to Resident #1. On 06/18/11, one staff person attempted to assist Resident #1 to roll over in bed to remove a bedpan, and Resident #1 fell from the bed sustained a laceration to the head and a left hip fracture. On 06/18/11, Resident #1 was transferred to the hospital and assessed to have a laceration and hematoma to the left side of face and scalp, which measured 5.0 cm (centimeters), and an acute, mildly displaced left subtrochanteric fracture (left hip fracture). Further review of Resident #1's hospital record revealed the resident was transferred to another hospital to undergo surgery to correct the hip fracture on 06/22/11, and expired on 07/02/11, from a possible pulmonary embolism. The findings include:	F 323	Resident #1 expired at hospital on July 2, 2011. Any resident may be affected by a fall if not properly supervised or if assessment devices are improperly utilized. Fall risk and hi-low assessments were completed on all residents on July 15 and August 3, 2011. All CNA care plans were compared with MDS care plans on August 1, 2011. No other residents were identified as being affected. MDS staff will be comparing MDS Care Plans to CNA Care Plans. A record of all safety devices will be kept by risk management team and compared with physician's orders including treatment sheets and CNA Care Plans. In-service for all Nurses and CNA's and CMA's on the importance of following CNA Care Plans and transfers were completed on July 27, 2011; to be repeated in 3 months.	

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F 323	Continued From page 5 Interview with the Director of Nursing (DON) on 07/14/11, at 4 15 PM, revealed the facility did not have a policy related to falls or accidents. A review of the incident/accident report dated 06/18/11, revealed staff attempted to assist Resident #1 from a bedpan, the resident rolled over to the side, and fell from the bed. Documentation revealed staff observed a laceration to the left side of the resident's head and a hematoma on the left side of the resident's face. The incident/accident report further revealed one staff person had assisted the resident at the time of the incident. A review of the facility Witness Statement Form, dated 06/18/11, written by State Registered Nurse Aide (SRNA) #6, revealed the SRNA responded to Resident #1's call light and the resident requested assistance off a bedpan. Documentation revealed Resident #1 rolled over to allow SRNA #6 to provide incontinence care, and the resident fell from the bed. The witness statement revealed SRNA #6 was unable to prevent the resident's fall. A review of the closed medical record revealed the facility admitted Resident #1 on 10/11/90, with diagnoses that included Epilepsy, Arthritis, Osteoporosis, Scoliosis, and Cerebral Vascular Accident with left sided Hemiparesis, and Seizure Disorder. A review of the quarterly Minimum Data Set (MDS) dated 07/08/11, revealed facility staff assessed Resident #1 to require extensive assistance of two staff persons for all bed mobility and bedpan use.	F 323	Fall risk assessments and side rail usage have been reevaluated on 100% of residents. Nursing staff attended in-service detailing the correct procedures for completing fall risk form on August 3, 2011. New policies on fall and accident/incident have been put in place. Risk management meets daily to discuss any issues. A list of safety devices will be evaluated weekly and compared to CNA Care Plans by the risk management team. This list will be updated as needed. Risk management team will monitor and re-evaluate the safety devices with any incident once weekly. D.O.N./Nurse/designee will monitor on a daily basis, two selected CNA's to ensure she/he is knowledgeable of residents current Care Plan and will observe that it is implemented correctly. Any problems will be discussed at monthly Q&A.	8/5/11	

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F 323	Continued From page 6 A review of the Fall Risk assessment dated 06/08/11, revealed facility staff assessed Resident #1 to be at high risk for falls. Based on the assessment, a score of 10 and above indicated a resident was a high risk for falls. Staff assessed Resident #1 as a 12 on the assessment. A review of Resident #1's Care Plan (CP) dated 06/08/11, revealed the facility identified Resident #1 at risk for falls and/or injury due to an unsteady gait when assisted with transfers, diagnosis of epilepsy, osteoporosis, scoliosis and a history of a Cerebral Vascular accident with left sided hemiparesis. A goal on the care plan was for Resident #1 to experience no injuries related to falls. The facility's planned approach to the goal included to assess the resident for safety, to use a bed with a high/low position, and two side rails. A review of the Nurse Aide Care Plan (NACP) for June 2011 revealed Resident #1 required the assistance of two staff persons for bed mobility and bedpan use. A review of the Post Fall Analysis completed by the SRNA Supervisor (who is also the Risk Manager for falls) dated 06/20/11, revealed the resident rolled out of the bed on 06/18/11, while receiving care. The analysis revealed SRNA #6 was assisting Resident #1 from the bedpan, the resident rolled over, and fell from the bed. The report indicated the resident preferred for the bed to be in a high position at all times and refused for side rails to be raised. The Post Fall Analysis also revealed SRNA #6 attempted to stop the	F 323			

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F 323	<p>Continued From page 7</p> <p>resident but failed to prevent the fall.</p> <p>Interview with SRNA #6 on 07/14/11, at 2:48 PM, revealed on 06/18/11, she responded to Resident #1's request to be taken off the bed pan. The SRNA stated she asked the resident to roll over and when the resident rolled over the resident rolled too far and fell from the bed. SRNA #6 stated that she was not aware Resident #1 had been assessed to require the assistance of two staff members for bed mobility and bedpan use or that the resident was a fall risk. The SRNA stated one staff member provided care for Resident #1 on a daily basis.</p> <p>Interview on 07/14/11, at 12:05 PM, 12:15 PM, and 2:30 PM, with SRNAs #4 and #5, and Licensed Practical Nurse (LPN) #1, revealed the daily care provided to each resident was based on each resident's written CP. Interview further revealed SRNA #4, SRNA #5, and LPN #1 thought one staff member could assist Resident #1 with the bedpan because the resident could provide assistance with turns by using the side rails. LPN #1, CNA #4, and CNA #5 stated they were not aware Resident #1 had been assessed to require the assistance of two staff members for bed mobility and bedpan use, and were not aware Resident #1 had been assessed as a fall risk. However, review of the Nurse Aide Care Plan (NACP) for June 10/11 revealed Resident #1 required the assistance of two staff persons for bed mobility and bedpan use.</p> <p>Interview with the DON on 07/14/11, at 4:15 PM, revealed the facility did not have a system in place to ensure CNAs reviewed the nurse aide care plan as required. Further interview with the</p>	F 323		
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F 323	Continued From page 8 DON on 07/14/11, at 4:15 PM, and the House Supervisor on 07/14/11, at 6:00 PM, revealed even though the facility did not have a falls/accident policy, if a resident sustained a fall the nurse would develop an intervention related to the fall and add the intervention to the comprehensive care plan and the nurse aide care plan. However, according to interviews, the facility did not monitor interventions related to falls and assumed the interventions were effective if the resident sustained no further falls.	F 323			