

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

PRINTED: 03/23/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185242	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/09/2012
NAME OF PROVIDER OR SUPPLIER  WINDSOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 125 STERLING WAY MOUNT STERLING, KY 40353	
(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	INITIAL COMMENTS	F 000	The following constitutes the facility's response to the findings of the Department for Health Services and does not constitute an admission of the facts alleged or conclusions set forth on the summary statement of deficiencies.	
F 282 SS=D	<p>An Abbreviated Survey investigating KY#00017933 was initiated on 03/08/12 and concluded on 03/09/12. KY#00017933 was substantiated with deficiencies cited.</p> <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: Based on interview and record review, it was determined the facility failed to provide care for one (1) of three (3) sampled residents (Resident #1), in accordance with Resident #1's written plan of care. The Resident was assisted to the floor on 06/08/11 by the Beautician and a non-staff person while they were attempting a transfer from the wheelchair to the beauty shop chair.</p> <p>The findings include:</p> <p>Review of Resident #1's clinical record revealed the facility admitted the resident on 05/27/11 with diagnoses which included generalized weakness. Review of the Admission Minimum Data Set (MDS) Assessment, dated 06/03/11, revealed the the facility assessed Resident #1 as being a fall risk and having a fall prior to admission. Further review of the MDS revealed Resident #1 was an extensive, physical assist of 2+ persons for transfers. Review of Resident #1's initial Care Plan, dated 05/27/11, and the nursing assistant</p>	F 282	<p>This plan of correction is prepared as required by the provisions of the Health Safety code, 42 CFR and constitutes the facility's written credible allegation of compliance.</p> <p>F 282</p> <p>(1) Resident # 1 is no longer a resident of Windsor Care Center - she was discharged on 06-17-11, however following the incident on 6-08-11, the beauticians who are not employees of the facility were educated by nursing home staff to not to attempt to transfer any resident from a wheelchair to the beauty shop chair, but was to ask for assistance of certified nursing staff to complete the transfers. A sign was posted in the beauty shop following the incident with resident # 1 reminding the</p>	

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MAR 30 2012

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

TITLE

(X6) DATE

*Rubena Cooley*

Administrator

3-30-12

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 282	Continued From page 1 plan of care for May 2011, revealed Resident #1 was to be transferred with a mechanical lift.  Review of the facility's investigation summary, dated 06/08/11, revealed Resident #1 was assisted to the floor by a family member and the Beautician, while they attempted to transfer the resident from the wheelchair to the beauty shop chair. Further review of the facility's investigation revealed Resident #1 was assessed to require mechanical lift with transfers and had the lift pad under him/her at the time of the fall.  Interviews with seven (7) direct care staff, on 03/08/12 and 03/09/12, revealed staff were unable to remember Resident #1. Further, interview revealed staff used the nursing assistant plan of care to know the needs of the residents. The direct care staff revealed if a care plan stated mechanical lift, then that resident was a (2) person assist using the appropriate mechanical lift.  Interview with Registered Nurse #1, on 03/08/12 at 3:15 PM, revealed she was aware the resident was a mechanical lift transfer. She further stated the resident had been gotten up earlier in the day using the lift and the lift pad was in the wheelchair when she went to assess the resident at the beauty shop after the incident. Continued interview revealed the facility failed to follow Resident #1's Care Plan related to transfers, which caused the fall on 06/08/11.	F 282	beauticians to not transfer residents. (2) How will facility identify other residents having the potential to be affected by the same deficient practice? (a) In the nine months since the beauticians were educated following the 6-8-11 incident no other incidents have occurred. (b) All residents who go to the beauty shop are potential for being at risk. (c) The QA Nurse or the Activity Director will monitor the beauty shop attendance. (3) What measures will be put into place or systemic changes made to ensure the deficient practice will not recur. (a) Immediately following the 6-8-11 incident the beauticians were educated by the activity director to notify the activity staff (who are certified nursing assistants) when someone came into the beauty shop that needed to be assisted into the beauty shop chair. (b) A notice was hung in the beauty shop indicating beauticians are not to attempt transfer of any residents – to ask for assistance. (c) As an additional means to ensure resident safety the beauty	
F 323 SS=D	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	<p>Continued From page 2 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure residents received adequate supervision and assistive devices to prevent accidents for one (1) of three (3) sampled residents (Resident #1). On 06/08/11, Resident #1 fell while being assisted into the chair in the beauty shop by a family/non-family member and the beautician.</p> <p>The findings include:</p> <p>Review of Resident #1's clinical record revealed diagnoses which included generalized weakness. Review of the Admission Minimum Data Set (MDS) Assessment, dated 06/03/11, revealed the facility assessed Resident #1 as being a fall risk and having a fall prior to admission. Review of the resident's initial Care Plan, dated 05/27/11, and the nursing assistant plan of care for May 2011, revealed Resident #1 was to be transferred with a mechanical lift.</p> <p>Review of the facility's investigation summary, dated 06/08/11, revealed Resident #1 was assisted to the floor by a family member and the Beautician, while they attempted to transfer the resident from the wheelchair to the beauty shop chair. Further review of the facility's investigation</p>	F 323	<p>shop was provided with a two way radio to notify activity staff of need for assistance with transfer in the beauty shop on 3-29-12. (d) All new beauticians will be educated on transfer procedures for beauty shop clients and documentation of same will be maintained by the activity director. (e) Beautician education done on 6/8/11 and was re-educated on 3/29/12 by Activity Director. (f) In-service for all staff was initiated on 3/15/12 by ADON on following the care plan and only transferring residents if you are certified and will be completed by 4/10/12 by the ADON.</p> <p>(4) How the facility plans to monitor its performance to ensure that solutions are sustained. (a) A date book will be placed in the beauty shop for the beauticians to write the names of residents who have appointments scheduled in the shop. (b) Random audits will be completed weekly x 4 on Following plan of care then monthly x 4 then quarterly by QA Nurse or ADON utilizing the QA audit tool. (c) Activity director and or QA nurse will</p>	

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F 323	<p>Continued From page 3</p> <p>revealed Resident #1 was assessed to require mechanical lift with transfers and had the lift pad under him/her at the time of the fall.</p> <p>Interview with Beautician #1, on 03/08/12 at 1:05 PM, via telephone revealed the non-staff person with the resident stated it would be okay for them (beautician and non-staff member) to transfer Resident #1 from the wheelchair to the beauty shop chair. Further interview revealed "it seemed like his/her legs just gave out", and the resident was helped to the floor.</p> <p>Interviews with seven (7) direct care staff, on 03/03/12 and 03/09/12, revealed staff used the nursing assistant plan of care to know the needs of the residents. The direct care staff revealed if a care plan stated mechanical lift, then that resident was a two (2) person assist using the appropriate mechanical lift.</p> <p>Interview with Registered Nurse (RN) #1, on 03/08/12 at 3:15 PM, revealed she was aware Resident #1 required a mechanical lift transfer. She further stated the resident had been gotten up earlier in the day using the lift and the lift pad was in the wheelchair when she went to assess the resident at the beauty shop.</p> <p>Interview with the Director of Nursing (DON), on 03/09/12 at 3:30 PM, revealed if staff had known that the non-staff member with the resident was going to stop at the beauty shop, they would have assisted with the transfer. Further interview revealed the Activities Department was beside the beauty shop and the staff there was trained to assist with transfers.</p>	F 323	<p>monitor the beauty shop 2 days per week x 4 weeks and then 1 day per week times four weeks; then monthly x 4; to ensure residents are getting the proper assistance to transfer to and from beauty shop chairs utilizing the QA audit tool.</p> <p>F 323</p> <p>(1) Resident # 1 is no longer a resident of Windsor Care Center – she was discharged on 06-17-11, however following the incident on 6-08-11, the beauticians who are not employees of the facility were educated by nursing home staff to not to attempt to transfer any resident from a wheelchair to the beauty shop chair, but was to ask for assistance of certified nursing staff to complete the transfers per resident's plan of care. A sign was posted in the beauty shop following the incident with resident # 1 reminding the beauticians to not attempt to transfer any resident while in the beauty shop. - (continued) Sec Attachment</p>	4-11-12	

Attachment # 1 - F 323 - Continued

(2) How will facility identify other residents having the potential to be affected by the same deficient practice? (a) In the nine months since the beauticians were educated following the 6-8-11 incident no other incidents have occurred. (b) All residents who go to the beauty shop are potential for being at risk for falls during transfers from w/c to beauty shop chair. (c) Incident reports were reviewed for the past 9 months by the QA Nurse and DNS, on 3/28/12. No other incidents related to beauty shop noted. (d) The QA Nurse or the Activity Director will monitor the beauty shop attendance to ensure proper transfer procedures are being followed.

(3) What measures will be put into place or systemic changes made to ensure the deficient practice will not recur. (a) Immediately following the 6-8-11 incident the beauticians were educated by the activity director to notify the activity staff (who are certified

Attachment # 2 - F 323 - Continued

nursing assistants) when someone came into the beauty shop that needed to be assisted into the beauty shop chair. (b) A notice was hung in the beauty shop indicating beauticians are not to transfer residents - to ask for assistance. (c) The facility has an adequate number of lifts and that are available to be used during the transfer if resident is care planned to be transferred by a lift. (d) As an additional means to ensure resident safety in the beauty shop, a reminder has been included to family members in the April 2012 facility newsletter to not transfer residents. (e) Beautician education done on 6/8/11 and was re-educated on 3/29/12 by Activity Director. (f) In-service for all staff was initiated on 3/15/12 by ADON on following the care plan and only transferring residents if you are certified and will be completed by 4/10/12, by the ADON. (g) Admission information provided to all responsible family members was updated to include

Attachment 2 of 3

Attachment # 3 - F 323 -- Continued

information on transferring residents  
on 3/28/12.

- (4) How the facility plans to monitor its performance to ensure that solutions are sustained. (a) Random Audits will be completed weekly x 4 on: Following plan of care then monthly x4 then quarterly by QA nurse or ADON utilizing the QA audit tool.

4-11-12