

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

PRINTED: 07/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185257	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/21/2013
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-GREEN HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 213 INDUSTRIAL ROAD GREENSBURG, KY 42743
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(X4) IO 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
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F 000 INITIAL COMMENTS

F 000

F 282
SS=G

An Abbreviated Survey investigating compliant KY00020345 was conducted 08/19/13 through 08/21/13. KY00020345 was substantiated with related deficiencies cited. The highest scope and severity was a "G" with an opportunity to correct.

483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:

Based on interview and record review, it was determined the facility failed to ensure services were provided by the facility in accordance with each resident's written Plan of Care for one (1) of three (3) sampled residents (Resident #1). Resident #1 was care planned as having a physical functioning deficit related to mobility impairment and had an intervention to utilize a padded foot rest with protective bolsters to the top the leg rest when the resident was up in a wheelchair. On 04/25/13, Resident #1 suffered a right leg distal tibia spiral fracture when Resident #1's right foot was outside of the foot positioning assistive device and got caught on the outside door facing when propelled, by the Certified Nursing Assistant (CNA) via wheelchair through the doorway of the resident's room.

The findings include:

F 282

Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of correction is prepared and executed as means to continually improve the quality of care and to comply with all applicable state and federal regulatory requirements.

F 282 G

Corrective Actions for Targeted Residents:

At the time of the accident, Resident #1 did have a care planned for use of a protective foot cradle as an intervention to keep his/her feet safely on wheelchair. The care plan intervention is dated as initiated on 09/07/2012. The device was in place on the wheelchair as the comprehensive plan of care and CNA care record indicated on 04-25-13, the date of accident. Resident #1 was sent to the hospital promptly after accident and returned to the facility the next day, 4/26/13 with a cast on her right leg. Due to a change in condition the Care Plan was updated to reflect the change. However, a foot cradle was still provided as the CNA care record indicated. The care plan has been updated to reflect the current changes on her plan of care.

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AUG - 8 2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Dawn Zipp* TITLE: *Executive Director* (X6) DATE: *8-8-2013*

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	<p>Continued From page 1</p> <p>Interview, on 06/21/13 at 8:10 AM, with the Executive Director revealed the facility did not have policies on care plans and as a practice did not use policies, but instead used the Centers for Medicare and Medicaid Services (CMS) Regulations and provided guides for their staff.</p> <p>Review of Resident #1's medical record revealed the facility admitted the resident on 08/31/11 with diagnoses which included Downs Syndrome, Osteoarthritis (a progressive degenerative joint disease), Seizure Disorder, Anxiety Disorder, and Non-Alzheimer's Dementia. Review of the Quarterly Minimum Data Set (MDS) Resident Assessment and Care Screening, dated 02/20/13, revealed the facility assessed Resident #1 as rarely/never able to make themselves understood or understood others and had severely impaired cognitive skills. Continued review of the MDS, under Functional Status, revealed Resident #1 was assessed as non-ambulatory and needing extensive assistance from staff for transfers and locomotion. Under mobility devices, the assessment indicated the resident used a wheel chair for mobility.</p> <p>Continued review of Resident #1's medical record revealed the resident was care planned as having a physical functioning deficit related to mobility impairment. Review of the Comprehensive Plan of Care, undated but according to interview was the care plan in effect for Resident #1 on 04/25/13, revealed an intervention to utilize a padded foot rest with protective bolsters to the top of the leg rests when the resident was up in a wheelchair.</p>	F 282	<p><u>Identification of Other Residents with Potential to Be Affected:</u></p> <p>All in house residents with a DX of Mental Retardation, Seizure Disorder, lower extremity paralysis, involuntary or uncontrolled movement and severely cognitively impaired were identified by DNS to be potentially affected by the alleged deficient practice. It was determined that only 13 other residents met the criteria. RNAC and ADNS reviewed those resident's current condition and care plans on 6-21-12 and found all plans of care to be appropriate. Additionally all in house residents care plans were reviewed for adequacy by the Resident Assessment Coordinator, this was completed on July 15, 2013. DNS interviewed CNA and Nurses regarding Care Plans and CNA Care Records to determine their understanding and knowledge of their responsibility for. Emphasis was given on following Plans of Care. Documented reeducation of nursing staff was completed on 08/01/13 by DNS and DCE.</p> <p>Education included Importance of following the Care Plans and Needed supervision required to assure this is done as well as the systemic change to hold them accountable. Resident Assessment Coordinators responsible for the comprehensive plan of care completed reeducation on July 15, 2013. Clinical Start, Up (CSU) meeting is held daily to review all new orders and update care plans</p>	

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F 282 Continued From page 2

Interview, on 06/21/13 at 11:00 AM, with the MDS Coordinator revealed the purpose of the care plan was to guide care. The MDS Coordinator stated Resident #1's feet were unable to reach the wheelchair foot pedals so the padded foot rest (padded contoured leg trough) was ordered to keep the resident's legs/feet in position while in the wheelchair. She said the intervention to utilize the padded foot rest with protective bolsters to the top of the leg rests when up in the wheelchair was listed under the resident's ambulation care plan.

Interview, on 06/21/13 at 10:35 AM, with Licensed Practical Nurse (LPN) #1 revealed the resident had involuntary jerky movements at times and thought Resident #1's foot cradle device (contoured leg trough) was for positioning and the safety of the resident. LPN #1 stated the use of the foot cradle was something normally put on the care plan so staff knew about it especially the nurse assistants. She further stated, after review of the aide care plan, the foot cradle was listed.

Further review of Resident #1's medical record revealed on 04/25/13 a Change of Condition Progress Note, timed 2:45 PM, which stated staff was taking Resident #1 to his/her room (via wheelchair) and the resident threw his/her right leg over the wheelchair pedal (contoured leg trough device) and staff was unaware (the right leg was outside). The Note indicated the resident's right lower extremity became caught between the wheelchair pedal and door frame. Further review of the Note revealed staff stated they heard a pop and the resident began to yell out.

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accordingly. IDT attends to discuss changes in conditions that occur between quarterly updates. All members have been reeducated on their role during this meeting. Education was completed on July 12, 2013. The IDT consists of the DNS, ADNS, Social Worker, Activities, Dietary, RNACs, and Therapy.

Systemic Changes:

Accountability Form which includes CNA signatures verifying they have read the CNA care record and noted any changes has been revised to include the supervising nurses initials, thus holding them accountable for making rounds to see that the care plans are followed. CNA care records are to be brought to the Clinical Start Up meeting daily to assure they are updated accordingly.

Monitoring:

Weekly care plans will be audited by DNS for 4 weeks, then monthly times 3 months to assure compliance is maintained. Accountability Form will be monitored daily for signatures and appropriate follow-up will be done if needed.

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F 282 Continued From page 3

F 282

Interview, on 06/20/13 at 2:10 PM and on 06/21/13 at 10:15 AM and 2:35 PM, with CNA #2 revealed she observed Resident #1 had his/her right leg outside of the wheelchair's leg positioning device, at times, when the resident was in the dining room. CNA #2 explained she had not told anyone, because she thought everyone knew about it. The CNA further stated she had never seen the resident move his/her feet out of the positioning device. When asked about the event on 04/25/13, she stated prior to transporting the resident back to his/her room, from the dining room she noticed the resident's right leg was out of the position device and she put the leg back into the positioning device. She further stated she was pushing the wheelchair, and CNA #5 was with her, and during the transport from the dining room and the doorway the resident's right leg had completely come out of the positioning device. She revealed she had not noticed the leg out because she had just put his/her right foot back into the positioning device, but as she went into the resident's room the front of the right tennis shoe caught the outer door facing and his/her right leg twisted. She further stated she thought the accident was avoidable, but she was not aware the resident's foot had flopped out of the device.

Interview, on 06/21/13 at 8:45 AM, with CNA #1 revealed they received training on the use of the foot cradle positioning device (contoured leg trough); it sat on the wheel chair foot rest and the purpose was to keep the resident's feet in place. The CNA stated she would watch to make sure Resident #1 would not move his/her feet out of the foot cradle when transporting the resident in

Summaries of Care Plan Audits will be submitted to the monthly QA Committee to ensure compliance and for follow-up, if needed. The Quality Assurance Committee Members include but is not limited to the following: Executive Director, Medical Director, Director of Nursing, Assistant Director of Nursing, Director of Education, Social Worker, Director of Housekeeping/Laundry, Director of Maintenance, Director of Activities, Rehab Manager, Director of Admissions, and Business Office Manager.

Correction Date: August 2, 2013

07-02-2013

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F 282	Continued From page 4 the wheelchair. The CNA further stated she had observed the resident's leg being outside of the positioning device when the resident was seated in his/her wheelchair at the dining room table, but had not observed the resident move his/her feet out of the positioning device when transporting the resident. Interview, on 06/21/13 at 1:10 PM, with the MDS Coordinator revealed the care plan at the time of the event (04/25/13) included the intervention to utilize the padded foot rest with protective bolsters when the resident was up in the wheelchair. She stated the resident's feet were supposed to be in the padded foot rest device and if Resident #1's (right) foot was outside of the foot rest device, staff was not following the care plan. Interview, on 06/21/13 at 11:40 AM, with the Director of Nursing Services (DNS) revealed Resident #1 had conditions which could impact his/her safety, a seizure disorder and severe mental retardation, and had involuntary startle reflex movements when sitting. She stated the positioning devices were to help keep the resident in a correct position and keep his/her feet safe. In addition, the DNS stated if she had known the resident was moving his/her foot out of the cradle device that would have been care planned for the resident's safety.	F 282			
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323			
	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				

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F 323	<p>Continued From page 5 prevent accidents.</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 an environment that is free from accident hazards over which the facility has control and failed to provide supervision and assistive devices to each resident to prevent accidents for one (1) of three (3) sampled residents (Resident #1). On 04/25/13, Resident #1 suffered a right leg distal tibia spiral fracture during wheelchair transport, by Certified Nursing Assistant (CNA) #2. Resident #1's right foot was outside of the foot positioning assistive device, provided by the facility, and got caught on the outside door facing when being propelled, by the CNA, at an angle through the doorway of the resident's room.</p> <p>The findings include:</p> <p>Interview, on 06/21/13 at 8:10 AM, with the Executive Director revealed the facility did not have policies on care plans or accidents and as a practice did not to use policies, but instead used the Centers for Medicare and Medicaid Services (CMS) Regulations and provided guides for their staff.</p> <p>Observation, on 06/20/13 at 9:50 AM and 11:00 AM, revealed Resident #1 had a below the knee cast to his/her right lower extremity and a</p>	F 323	<p>Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of correction is prepared and executed as a means to continually improve the quality of care and to comply with all applicable state and federal regulatory requirements.</p> <p>F 323 G <u>Corrective Actions for Targeted Residents</u> On 04/25/13, day of the accident, Resident #1 did have the protective foot bolster cradle on her wheelchair as written on her care plan that was initiated on 09-07-2012. Resident #1 was sent to the hospital promptly after accident and returned to the facility the next day, 04-26-13 with a cast on her right leg. Resident #1 was reassessed for changes specific to physical, mental and psychosocial changes. Cast care, transfer and positioning changes were given to direct care givers. Pain Assessment revealed no pain requiring narcotic analgesic ordered upon readmission. Foot cradle on wheelchair remains for proper positioning of lower extremities when up in wheelchair. Monitoring of foot placement while in wheelchair has been added.</p>	

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F 323	<p>Continued From page 6 wheelchair with a padded foot board device.</p> <p>Review of Resident #1's medical record revealed the facility admitted the resident on 08/31/11 with diagnoses which included Downs Syndrome, Osteoarthritis (a progressive degenerative joint disease), Seizure Disorder, Anxiety Disorder, and Non-Alzheimer's Dementia.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment and Care Screening, dated 02/20/13, revealed the facility assessed Resident #1 as rarely/never able to make themselves understood or understood others and had severely impaired cognitive skills. Under the MDS Functional Status, the resident was assessed as non-ambulatory and needing extensive assistance from staff for transfers and locomotion. Under mobility devices the resident used a wheel chair.</p> <p>Continued review of Resident#1's medical record revealed the resident was care planned as having a physical functioning deficit related to mobility impairment. Review of the Comprehensive Plan of Care (undated but according to interview was the care plan in effect for Resident #1 on 04/25/13) revealed an intervention to utilize a padded foot rest with protective bolsters to the top of the leg rests when the resident was up in a wheelchair.</p> <p>Further review of Resident #1's medical record revealed on 04/25/13 a change of Condition Progress Note, timed 2:45 PM, which stated staff was taking the resident to his/her room (via wheelchair) and the resident threw his/her right leg over the wheelchair pedal (contoured leg</p>	F 323	<p><u>Identification of Other Residents with Potential to Be Affected:</u></p> <p>All residents have the potential to be affected by this alleged deficient practice related to assistive devices in order to prevent accidents.</p> <p><u>Systemic Changes:</u> The Director of Nursing immediately started education with the nursing staff on April 25, 2013 regarding safety while transporting residents throughout the facility. Reeducation on "Stop and Watch Policy" (A in house program directing any staff member to report important changes found while caring for residents) and Safety in transporting residents throughout the facility was completed by the Director of Education on 07-15-13. A weekly audit tool was developed specifically to observe staff transporting residents throughout the facility.</p> <p>Additionally, an Environmental Safety Inspection Checklist which includes-General Safety related to resident care areas, ie, call lights, bed locks, safety rails, W/C and geri chairs, O2 storage, Spills, Resident Lifting and Transfers ie Gait belt use, Mechanical Lift, Slings Electrical Safety, cords, outlets, etc. Chemical safety, Hazardous items out of reach, PPE use, Sharps safety, Fire safety, Smoking, Security Alarms, Elopement prevention, Water temperatures, Adaptive Equipment.</p>	
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F 323	<p>Continued From page 7</p> <p>trough device) and staff was unaware. The Note indicated the resident's right lower extremity became caught between the wheelchair pedal and door frame of his/her room. Further review of the Note revealed staff stated they heard a pop and the resident began to yell out. Another progress Note, on 04/25/13 at 2:50 PM, revealed Emergency Medical Services transported the resident to the Hospital Emergency Room.</p> <p>Review of the History and Physical (H&P), dated 04/25/13, from the hospital revealed imaging x-ray of the right lower extremity demonstrated a spiral fracture of the distal third of the tibia shaft. The H&P noted the resident got his/her legs stuck between a wheelchair and the wall. The H&P indicated Orthopedics was to see the patient and cast the right lower extremity.</p> <p>Review of one of the facility's medical equipment catalogs, revealed the foot rest device used by Resident #1 on 04/25/13 was a padded contoured leg trough which attached to the wheelchair foot rest with straps. Observation, on 06/21/13 at 2:35 PM, of the same type of foot rest, only with shorter sides, revealed the device had raised padded sides which extended up from the base at least eight (8) inches high and open front.</p> <p>Interview, on 06/20/13 at 2:10 PM and 06/21/13 at 10:15 AM and 2:35 PM, with CNA #2 revealed she observed Resident #1 had his/her right leg outside of the wheelchair's leg positioning device, at times, when the resident was in the dining room. CNA #2 explained she had not told anyone, because she thought everyone knew about it. The CNA further stated she had never</p>	F 323	<p><u>Monitoring:</u></p> <p>The Administrator and Assigned members of Nursing Management Team (DCE, ADNS, DNS, RNACs) will complete Environmental safety audits weekly x 4 weeks, then monthly x 3 or as Quality Assurance Committee assigns to ensure compliance. The Environmental safety list is also included with the nursing daily rounds. All nurses on all shifts are responsible to note any listed areas of concern and notify Management Team immediately. The list is available with their report sheets. The Transport Safety Audit Tool includes random observation of residents being transported in W/C, shower chairs, Geri chairs throughout the building. All members of the IDT are responsible for completing this audit as assigned. Members of IDT include DNS, ADNS, Social Worker, Activities, Therapy, Dietary and RNACs. Findings are turned into the Administrator after completion. The Transport Safety Audit will be completed weekly for 4 weeks, then monthly times 3 or as Quality Assurance Committee directs to ensure compliance. Timely correction of areas of concern will be completed by the appropriate discipline. Maintenance has a separate Safety Audit lists that complies with regulation including preventative maintenance and water temperatures etc.</p>	

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F 323	<p>Continued From page 8</p> <p>seen the resident move his/her feet out of the positioning device. When asked about the event on 04/25/13, she stated prior to transporting the resident back to his/her room, from the dining room, she put the resident's leg back in the positioning device. She further stated she was pushing the wheelchair, and CNA #5 was with her, and during the transport from the dining room and the doorway the resident's right leg had completely come out of the positioning device. She revealed she had not noticed the resident's leg out because she had just put his/her right foot back into the positioning device, but as she went into the room, the resident's front right tennis shoe caught the outer door facing and his/her leg twisted. When asked if it could have been avoided, the CNA stated she thought the accident was avoidable, but she was not aware the resident's foot had flopped out of the device.</p> <p>Interview, on 06/21/13 at 9:15 AM, with the Clinical Education Nurse revealed they trained staff on how to transport residents in a wheelchair and resident safety was first and foremost. The Educator stated staff was to make sure the resident's arms and legs were inside and was suppose to watch the resident when transporting. She further stated when going through the doorway with the wheelchair, they were trained to go straight through the door, because there was less chance of bumping into something.</p> <p>Interview, on 06/20/13 at 11:40 AM and on 06/21/13 at 8:35 AM, with Physical Therapy Assistant (PTA) #1 revealed Resident #1 had only reflexive type movements at the time, no voluntary leg movement. PTA #1 stated Resident #1 had a padded foot cradle position device</p>	F 323	<p>Summary of the Audit sheets with appropriate corrections as noted will be reviewed in the monthly Quality Assurance Committee. The Quality Assurance Committee includes but is not limited to: Executive Director, Medical Director, Director of Nursing Services, Assistant Director of Nursing Services, Director of Education, Social Worker, Director of Activities, Director of Maintenance, Director of Housekeeping/Laundry, Resident Assessment Coordinators and Rehab Manager</p> <p><u>Correction Date:</u> August 2, 2013 8-2-2013</p>

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-GREEN HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 213 INDUSTRIAL ROAD GREENSBURG, KY 42743		
(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)	
F 323	<p>Continued From page 9</p> <p>(contoured leg trough) for his/her wheel chair to keep the resident's legs/feet properly positioned and help prevent injuries when being transported. She stated aides were shown how to put the device on the wheelchair and how to place the resident's legs in the device. The PTA further stated aides were suppose to supervise the residents when transporting.</p> <p>During observation and interview, on 06/21/13 at 2:35 PM, CNA #2 demonstrated how she transported Resident #1 into room 104 to bed one (1) and the position of the resident's foot when the accident occurred. Observation revealed the bed used by Resident #1, at the time, was close to the wall by the door. CNA #2 approached the room doorway at an angle, which brought the right side of the wheelchair close to the room's outside door facing. The CNA stated she went through the doorway at an angle because it allowed them to better position the wheelchair next to the side of the bed nearest the door wall. She further stated if she took the wheelchair straight into the room, she would have to lift the back of the wheelchair in order to pivot the chair so it was turned in the position needed for the transfer; and, it was a safety issue for her to lift the wheelchair. When asked about moving the end of the bed over, CNA #2 stated if the end of the bed was moved over it allowed the wheelchair to go in straight without having to pivot the wheelchair. CNA #2 also verified when angling the wheelchair into the room, the right side of the footpedal was near the outer door frame and if pushing straight through the door frame it (right footpedal) was further from the door frame.</p> <p>Interview, on 06/21/13 at 10:35 AM, with Licensed</p>	F 323		

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F 323	<p>Continued From page 10</p> <p>Practical Nurse (LPN) #1 revealed the resident had involuntary jerky movements at times and thought the resident's foot cradle device (contoured leg trough) was for positioning and the safety of the resident. The LPN stated the use of the foot cradle device was on the aide care plan. She further stated when aides were transferring residents in wheelchairs they were to supervise the resident's safety.</p> <p>Interview, on 06/20/13 at 12:15 PM, with Restorative Aide #1 revealed Resident #1 would not respond to verbal commands to move his/her legs, but was able to kick his/her legs out of the positioning device at times when in his/her wheelchair. She stated she saw the resident's legs outside of the positioning device at times.</p> <p>Interview, on 06/19/13 at 11:40 AM and on 06/20/13 at 1:00 PM, with Resident #1's mother revealed the resident could not move his/her legs a lot but would move them outside of the wheelchair footrest cushion (foot trough) on occasion. She stated the resident moved his/her right leg out of the positioning device.</p> <p>Interview, on 06/20/13 at 5:15 PM, with CNA #3 revealed he had taken care of Resident #1 routinely. He stated the resident had a padded footboard device for his/her wheelchair. CNA #3 stated Resident #1 occasionally had movements of his/her legs, kind of seizure like movements. CNA #3 further stated sometimes the resident's legs came out of the padded footboard device (contoured leg trough) and his/her foot was outside of the device. He stated when they noticed the foot was outside the positioning device they placed the foot back into the device</p>	F 323		

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F 323 Continued From page 11
prior to transport and when he transported the resident in his/her wheelchair he would watch to make sure the resident did not jerk his/her leg out of the device. He stated when transporting Resident #1, he could not recall the resident's leg coming out of the device. In addition, CNA #3 stated when he took the resident through a doorway in his/her room he went straight through the doorway with the wheelchair. He further stated prior to going into the resident's room with the wheelchair, they would move the foot of the bed away from the door so they were able to position the wheelchair next to the bed after entering.

Interview, on 06/21/13 at 8:45 AM, with CNA #1 revealed they received training on the use of the foot cradle positioning device; it sat on the wheelchair foot rest and the purpose was to keep the resident's feet in place. CNA #1 stated they would make sure Resident #1's feet were in the foot cradle prior to transporting the resident in the wheelchair and the resident had never moved his/her leg out of the device when she transported the resident. CNA #1 further stated she had observed the resident's leg being outside of the positioning device when the resident was seated in his/her wheelchair at the dining room table. She stated she was working on 04/25/13 when the accident happened and heard the resident crying out. She further stated the aides (CNA #2 and CNA #5) reported when they were transporting the resident through the door (to his/her room) the resident threw his/her leg outside of the foot cradle and the resident's foot hit the door facing.

Interview, on 06/21/13 at 9:25 AM, with CNA #5

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Continued From page 12

revealed when they transported a resident in his/her wheelchair they were suppose to make sure the residents were back in the chair, their feet were on the foot pedals (if on), and their arms were inside. She stated they did not want the residents to get hurt, the number one priority when transporting a resident was their safety. She further stated Resident #1 had a contoured leg trough on his/her wheelchair and they had been trained how and why it was used. CNA #5 reported she felt the device helped, but at times the resident's legs were outside the device and they had to make sure his/her legs were inside the device when transporting. She stated she was not sure if the resident's leg movement was voluntary or involuntary. She further revealed they (CNA #2 and herself) were transporting Resident #1 to his/her room on 04/25/13 and had put the resident's foot back inside the contoured leg trough on his/her wheelchair prior to transport and somewhere between the dinning room table and the door frame to his/her room the resident's right foot came out of the device. CNA #5 stated she was walking behind CNA #2 so she did not see the foot out of the cradle, but heard it (the foot) hit the door facing and told the other CNA what happened. Continued interview with CNA #5 revealed when they took Resident #1 through the doorway to his/her they entered at an angle and not straight through the door. She stated because the resident's bed was near the door, they went at an angle to get the wheelchair between the bed and wall in order to transfer the resident from the wheelchair to the bed.

Further interview, on 06/21/13 at 1:15 PM, with PTA #1 revealed if staff was aware the resident's feet were coming out of the "foot cradle" device

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F 323 Continued From page 13
she would have expected them to have let therapy know so they could have assessed the situation to determine if another device may have kept the resident's feet positioned properly in the wheelchair.

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Interview, on 06/21/13 at 2:50 PM, with Physical Therapist (PT) #1 revealed he had not worked much with Resident #1, but was aware the resident had a padded foot cradle position device (contoured leg trough) for the wheel chair which was used to keep his/her feet in place. PT #1 stated if the resident's leg was moving out of the positioning device it put the resident's leg in an unsafe position, Physical Therapy should have been notified to assess the situation to see what could be more effective for Resident #1.

Interview, on 06/21/13 at 11:40 AM, with the Director of Nursing Services (DNS) revealed Resident #1 had conditions which could impact his/her safety, a seizure disorder and severe mental retardation, and had involuntary startle reflex movements when sitting. She stated the positioning devices were to help keep the resident in correct position and keep his/her feet safe. The DNS also stated during transport of a resident, in his/her wheelchair, staff was suppose to supervise the resident to make sure the resident's arms and legs were in the wheelchair and look for obstacles in the way. She further stated if staff was aware Resident #1's feet were coming out of the foot cradle device she would have expected staff to let someone like the Charge Nurse know, who then could have discussed the issue with Therapy. In addition, the DNS stated if she had known the resident was moving his/her foot out of the cradle device it

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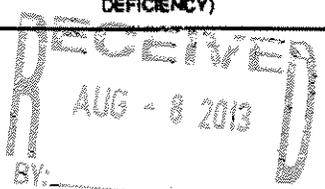
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F 323 Continued From page 14
would have been care planned for the resident's safety. Continued interview with the DNS revealed she felt the event was an accident. She stated the CNAs called her over after the event and told her the resident had kicked his/her foot out of the positioning device as they were going through the door. She stated the CNA had backed the wheelchair away from the door prior to her coming over. She further stated she assessed the leg and stayed with the resident until they got her positioned correctly in bed, while other nurses called the ambulance. The DNS stated she was informed, by the CNAs, they had angled the wheelchair in order to get the chair to the side of the bed, she would not expect them to go through the door at an angle.

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N 000	INITIAL COMMENTS A Complaint Survey investigating KY00020345 was conducted 06/19/13 through 08/21/13. KY00020345 was substantiated with related deficiencies cited.	N 000		
N 194	902 KAR 20:300-7(4)(c)2. Section 7. Resident Assessment (4) Comprehensive care plans. (c) The services provided or arranged by the facility shall: 2. Be provided by qualified persons in accordance with each resident's written plan of care. This requirement is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure services were provided by the facility in accordance with each resident's written Plan of Care for one (1) of three (3) sampled residents (Resident #1). Resident #1 was care planned as having a physical functioning deficit related to mobility impairment and had an intervention to utilize a padded foot rest with protective bolsters to the top the leg rest when the resident was up in a wheelchair. On 04/26/13, Resident #1 suffered a right leg distal tibia spiral fracture when Resident #1's right foot was outside of the foot positioning assistive device and got caught on the outside door facing when propelled, by the Certified Nursing Assistant (CNA) via wheelchair through the doorway of the resident's room. The findings include: Interview, on 06/21/13 at 8:10 AM, with the Executive Director revealed the facility did not have policies on care plans and as a practice did	N 194	 <p>Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of correction is prepared and executed as means to continually improve the quality of care and to comply with all applicable state and federal regulatory requirements.</p> <p>N 194</p> <p><u>Corrective Actions for Targeted Residents:</u> At the time of the accident, Resident #1 did have a care planned for use of a protective foot cradle as an intervention to keep his/her feet safely on wheelchair. The care plan intervention is dated as initiated on 09/07/2012. The device was in place on the wheelchair as the comprehensive plan of care and CNA care record indicated on 04-25-13, the date of accident. Resident #1 was sent to the hospital promptly after accident and returned to the facility the next day, 4/26/13 with a cast on her right leg. Due to a change in condition the Care Plan was updated to reflect the change. However, a foot cradle was still provided as the CNA care record indicated. The care plan has been updated to reflect the current changes on her plan of care.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Vicki Trump* TITLE: *Executive Director* (X6) DATE: *8/18/2013*

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N 194	Continued From page 1 not use policies, but instead used the Centers for Medicare and Medicaid Services (CMS) Regulations and provided guides for their staff. Review of Resident #1's medical record revealed the facility admitted the resident on 08/31/11 with diagnoses which included Downs Syndrome, Osteoarthritis (a progressive degenerative joint disease), Seizure Disorder, Anxiety Disorder, and Non-Alzheimer's Dementia. Review of the Quarterly Minimum Data Set (MDS) Resident Assessment and Care Screening, dated 02/20/13, revealed the facility assessed Resident #1 as rarely/never able to make themselves understood or understood others and had severely impaired cognitive skills. Continued review of the MDS, under Functional Status, revealed Resident #1 was assessed as non-ambulatory and needing extensive assistance from staff for transfers and locomotion. Under mobility devices, the assessment indicated the resident used a wheel chair for mobility. Continued review of Resident #1's medical record revealed the resident was care planned as having a physical functioning deficit related to mobility impairment. Review of the Comprehensive Plan of Care, undated but according to interview was the care plan in effect for Resident #1 on 04/25/13, revealed an intervention to utilize a padded foot rest with protective bolsters to the top of the leg rests when the resident was up in a wheelchair. Interview, on 06/21/13 at 11:00 AM, with the MDS Coordinator revealed the purpose of the care plan was to guide care. The MDS Coordinator stated Resident #1's feet were unable to reach the wheelchair foot pedals so the padded foot rest	N 194	<u>Identification of Other Residents with Potential to Be Affected:</u> All in house residents with a DX of Mental Retardation, Seizure Disorder, lower extremity paralysis, involuntary or uncontrolled movement and severely cognitively impaired were identified by DNS to be potentially affected by the alleged deficient practice. It was determined that only 13 other residents met the criteria. RNAC and ADNS reviewed those resident's current condition and care plans on 6-21-12 and found all plans of care to be appropriate. Additionally all in house residents care plans were reviewed for adequacy by the Resident Assessment Coordinator, this was completed on July 15, 2013. DNS interviewed CNA and Nurses regarding Care Plans and CNA Care Records to determine their understanding and knowledge of their responsibility for. Emphasis was given on following Plans of Care. Documented reeducation of nursing staff was completed on 08/01/13 by DNS and DCE. Education included Importance of following the Care Plans and Needed supervision required to assure this is done as well as the systemic change to hold them accountable. Resident Assessment Coordinators responsible for the comprehensive plan of care completed reeducation on July 15, 2013. Clinical Start, Up (CSU) meeting is held daily to review all new orders and update care plans	

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N 194	<p>Continued From page 2</p> <p>(padded contoured leg trough) was ordered to keep the resident's legs/feet in position while in the wheelchair. She said the intervention to utilize the padded foot rest with protective bolsters to the top of the leg rests when up in the wheelchair was listed under the resident's ambulation care plan.</p> <p>Interview, on 06/21/13 at 10:35 AM, with Licensed Practical Nurse (LPN) #1 revealed the resident had involuntary jerky movements at times and thought Resident #1's foot cradle device (contoured leg trough) was for positioning and the safety of the resident. LPN #1 stated the use of the foot cradle was something normally put on the care plan so staff knew about it especially the nurse assistants. She further stated, after review of the aide care plan, the foot cradle was listed.</p> <p>Further review of Resident #1's medical record revealed on 04/25/13 a Change of Condition Progress Note, timed 2:45 PM, which stated staff was taking Resident #1 to his/her room (via wheelchair) and the resident threw his/her right leg over the wheelchair pedal (contoured leg trough device) and staff was unaware (the right leg was outside). The Note indicated the resident's right lower extremity became caught between the wheelchair pedal and door frame. Further review of the Note revealed staff stated they heard a pop and the resident began to yell out.</p> <p>Interview, on 06/20/13 at 2:10 PM and on 06/21/13 at 10:15 AM and 2:35 PM, with CNA #2 revealed she observed Resident #1 had his/her right leg outside of the wheelchair's leg positioning device, at times, when the resident was in the dining room. CNA #2 explained she had not told anyone, because she thought</p>	N 194	<p>accordingly. IDT attends to discuss changes in conditions that occur between quarterly updates. All members have been reeducated on their role during this meeting. Education was completed on July 12, 2013. The IDT consists of the DNS, ADNS, Social Worker, Activities, Dietary, RNACs, and Therapy.</p> <p>Systemic Changes:</p> <p>Accountability Form which includes CNA signatures verifying they have read the CNA care record and noted any changes has been revised to include the supervising nurses initials, thus holding them accountable for making rounds to see that the care plans are followed. CNA care records are to be brought to the Clinical Start Up meeting daily to assure they are updated accordingly.</p> <p>Monitoring:</p> <p>Weekly care plans will be audited by DNS for 4 weeks, then monthly times 3 months to assure compliance is maintained. Accountability Form will be monitored daily for signatures and appropriate follow-up will be done if needed.</p>	
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N 194	<p>Continued From page 3</p> <p>everyone knew about it. The CNA further stated she had never seen the resident move his/her feet out of the positioning device. When asked about the event on 04/25/13, she stated prior to transporting the resident back to his/her room, from the dinning room she noticed the resident's right leg was out of the position device and she put the leg back into the positioning device. She further stated she was pushing the wheelchair, and CNA #5 was with her, and during the transport from the dining room and the doorway the resident's right leg had completely come out of the positioning device. She revealed she had not noticed the leg out because she had just put his/her right foot back into the positioning device, but as she went into the resident's room the front of the right tennis shoe caught the outer door facing and his/her right leg twisted. She further stated she thought the accident was avoidable, but she was not aware the resident's foot had flopped out of the device.</p> <p>Interview, on 06/21/13 at 8:45 AM, with CNA #1 revealed they received training on the use of the foot cradle positioning device (contoured leg trough); it sat on the wheel chair foot rest and the purpose was to keep the resident's feet in place. The CNA stated she would watch to make sure Resident #1 would not move his/her feet out of the foot cradle when transporting the resident in the wheelchair. The CNA further stated she had observed the resident's leg being outside of the positioning device when the resident was seated in his/her wheelchair at the dining room table, but had not observed the resident move his/her feet out of the positioning device when transporting the resident.</p> <p>Interview, on 06/21/13 at 1:10 PM, with the MDS Coordinator revealed the care plan at the time of</p>	N 194	<p>Summaries of Care Plan Audits will be submitted to the monthly QA Committee to ensure compliance and for follow-up, if needed. The Quality Assurance Committee Members include but is not limited to the following: Executive Director, Medical Director, Director of Nursing, Assistant Director of Nursing, Director of Education, Social Worker, Director of Housekeeping/Laundry, Director of Maintenance, Director of Activities, Rehab Manager, Director of Admissions, and Business Office Manager.</p> <p><u>Correction Date:</u> August 2, 2013</p>	8-2-13

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N 194	Continued From page 4 the event (04/25/13) included the intervention to utilize the padded foot rest with protective bolsters when the resident was up in the wheelchair. She stated the resident's feet were supposed to be in the padded foot rest device and if Resident #1's (right) foot was outside of the foot rest device, staff was not following the care plan. Interview, on 06/21/13 at 11:40 AM, with the Director of Nursing Services (DNS) revealed Resident #1 had conditions which could impact his/her safety, a seizure disorder and severe mental retardation, and had involuntary startle reflex movements when sitting. She stated the positioning devices were to help keep the resident in a correct position and keep his/her feet safe. In addition, the DNS stated if she had known the resident was moving his/her foot out of the cradle device that would have been care planned for the resident's safety.	N 194	Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of correction is prepared and executed as a means to continually improve the quality of care and to comply with all applicable state and federal regulatory requirements.	
N 220	902 KAR 20:300-8(7)(b) Section 8. Quality of Care (7) Accidents. The facility shall ensure that: (b) Each resident receives adequate supervision and assistive devices to prevent accidents. This requirement is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure an environment that is free from accident hazards over which the facility has control and failed to provide supervision and assistive devices to each resident to prevent accidents for	N 220	<u>N 220</u> <u>Corrective Actions for Targeted Residents</u> On 04/25/13, day of the accident, Resident #1 did have the protective foot bolster cradle on her wheelchair as written on her care plan that was initiated on 09-07-2012. Resident #1 was sent to the hospital promptly after accident and returned to the facility the next day, 04-26-13 with a cast on her right leg. Resident #1 was reassessed for changes specific to physical, mental and psychosocial changes. Cast care, transfer and positioning changes were given to direct care givers. Pain Assessment revealed no pain requiring narcotic analgesic ordered upon readmission. Foot cradle on wheelchair remains for proper positioning of lower extremities when up in wheelchair. Monitoring of foot placement while in wheelchair has been added.	

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-GREEN HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 213 INDUSTRIAL ROAD GREENSBURG, KY 42743		
(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) COMPLETE DATE
N 220	Continued From page 5 one (1) of three (3) sampled residents (Resident #1). On 04/25/13, Resident #1 suffered a right leg distal tibia spiral fracture during wheelchair transport, by Certified Nursing Assistant (CNA) #2. Resident #1's right foot was outside of the foot positioning assistive device, provided by the facility, and got caught on the outside door facing when being propelled, by the CNA, at an angle through the doorway of the resident's room. The findings include: Interview, on 06/21/13 at 8:10 AM, with the Executive Director revealed the facility did not have policies on care plans or accidents and as a practice did not to use policies, but instead used the Centers for Medicare and Medicaid Services (CMS) Regulations and provided guides for their staff. Observation, on 06/20/13 at 9:50 AM and 11:00 AM, revealed Resident #1 had a below the knee cast to his/her right lower extremity and a wheelchair with a padded foot board device. Review of Resident #1's medical record revealed the facility admitted the resident on 08/31/11 with diagnoses which included Downs Syndrome, Osteoarthritis (a progressive degenerative joint disease), Seizure Disorder, Anxiety Disorder, and Non-Alzheimer's Dementia. Review of the Quarterly Minimum Data Set (MDS) Assessment and Care Screening, dated 02/20/13, revealed the facility assessed Resident #1 as rarely/never able to make themselves understood or understood others and had severely impaired cognitive skills. Under the MDS Functional Status, the resident was assessed as non-ambulatory and needing	N 220	<u>Identification of Other Residents with Potential to Be Affected:</u> All residents have the potential to be affected by this alleged deficient practice related to assistive devices in order to prevent accidents. <u>Systemic Changes:</u> The Director of Nursing immediately started education with the nursing staff on April 25, 2013 regarding safety while transporting residents throughout the facility. Reeducation on "Stop and Watch Policy" (A in house program directing any staff member to report important changes found while caring for residents) and Safety in transporting residents throughout the facility was completed by the Director of Education on 07-15-13. A weekly audit tool was developed specifically to observe staff transporting residents throughout the facility. Additionally, an Environmental Safety Inspection Checklist which includes-General Safety related to resident care areas, ie, call lights, bed locks, safety rails, W/C and geri chairs, O2 storage, Spills, Resident Lifting and Transfers ie Gait belt use, Mechanical Lift, Slings Electrical Safety, cords, outlets, etc. Chemical safety, Hazardous items out of reach, PPE use, Sharps safety, Fire safety, Smoking, Security Alarms, Elopement prevention, Water temperatures, Adaptive Equipment .	

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N 220	<p>Continued From page 6</p> <p>extensive assistance from staff for transfers and locomotion. Under mobility devices the resident used a wheel chair.</p> <p>Continued review of Resident #1's medical record revealed the resident was care planned as having a physical functioning deficit related to mobility impairment. Review of the Comprehensive Plan of Care (undated but according to interview was the care plan in effect for Resident #1 on 04/25/13) revealed an intervention to utilize a padded foot rest with protective bolsters to the top of the leg rests when the resident was up in a wheelchair.</p> <p>Further review of Resident #1's medical record revealed on 04/25/13 a change of Condition Progress Note, timed 2:45 PM, which stated staff was taking the resident to his/her room (via wheelchair) and the resident threw his/her right leg over the wheelchair pedal (contoured leg trough device) and staff was unaware. The Note indicated the resident's right lower extremity became caught between the wheelchair pedal and door frame of his/her room. Further review of the Note revealed staff stated they heard a pop and the resident began to yell out. Another progress Note, on 04/25/13 at 2:50 PM, revealed Emergency Medical Services transported the resident to the Hospital Emergency Room.</p> <p>Review of the History and Physical (H&P), dated 04/25/13, from the hospital revealed imaging x-ray of the right lower extremity demonstrated a spiral fracture of the distal third of the tibia shaft. The H&P noted the resident got his/her legs stuck between a wheelchair and the wall. The H&P indicated Orthopedics was to see the patient and cast the right lower extremity.</p>	N 220	<p>Monitoring:</p> <p>The Administrator and Assigned members of Nursing Management Team (DCE, ADNS, DNS, RNACs) will complete Environmental safety audits weekly x 4 weeks, then monthly x 3 or as Quality Assurance Committee assigns to ensure compliance. The Environmental safety list is also included with the nursing daily rounds. All nurses on all shifts are responsible to note any listed areas of concern and notify Management Team immediately. The list is available with their report sheets. The Transport Safety Audit Tool includes random observation of residents being transported in W/C, shower chairs, Geri chairs throughout the building. All members of the IDT are responsible for completing this audit as assigned. Members of IDT include DNS, ADNS, Social Worker, Activities, Therapy, Dietary and RNACS. Findings are turned into the Administrator after completion. The Transport Safety Audit will be completed weekly for 4 weeks, then monthly times 3 or as Quality Assurance Committee directs to ensure compliance. Timely correction of areas of concern will be completed by the appropriate discipline. Maintenance has a separate Safety Audit lists that complies with regulation including preventative maintenance and water temperatures etc.</p>	

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N 220	<p>Continued From page 7</p> <p>Review of one of the facility's medical equipment catalogs, revealed the foot rest device used by Resident #1 on 04/25/13 was a padded contoured leg trough which attached to the wheelchair foot rest with straps. Observation, on 06/21/13 at 2:35 PM, of the same type of foot rest, only with shorter sides, revealed the device had raised padded sides which extended up from the base at least eight (8) inches high and open front.</p> <p>Interview, on 06/20/13 at 2:10 PM and 06/21/13 at 10:15 AM and 2:35 PM, with CNA #2 revealed she observed Resident #1 had his/her right leg outside of the wheelchair's leg positioning device, at times, when the resident was in the dining room. CNA #2 explained she had not told anyone, because she thought everyone knew about it. The CNA further stated she had never seen the resident move his/her feet out of the positioning device. When asked about the event on 04/25/13, she stated prior to transporting the resident back to his/her room, from the dining room, she put the resident's leg back in the positioning device. She further stated she was pushing the wheelchair, and CNA #5 was with her, and during the transport from the dining room and the doorway the resident's right leg had completely come out of the positioning device. She revealed she had not noticed the resident's leg out because she had just put his/her right foot back into the positioning device, but as she went into the room, the resident's front right tennis shoe caught the outer door facing and his/her leg twisted. When asked if it could have been avoided, the CNA stated she thought the accident was avoidable, but she was not aware the resident's foot had flopped out of the device.</p> <p>Interview, on 06/21/13 at 9:15 AM, with the</p>	N 220	<p>Summary of the Audit sheets with appropriate corrections as noted will be reviewed in the monthly Quality Assurance Committee. The Quality Assurance Committee includes but is not limited to: Executive Director, Medical Director, Director of Nursing Services, Assistant Director of Nursing Services, Director of Education, Social Worker, Director of Activities, Director of Maintenance, Director of Housekeeping/Laundry, Resident Assessment Coordinators and Rehab Manager</p> <p>Correction Date: August 2, 2013</p>	
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N 220	Continued From page 8 Clinical Education Nurse revealed they trained staff on how to transport residents in a wheelchair and resident safety was first and foremost. The Educator stated staff was to make sure the resident's arms and legs were inside and was suppose to watch the resident when transporting. She further stated when going through the doorway with the wheelchair, they were trained to go straight through the door, because there was less chance of bumping into something. Interview, on 06/20/13 at 11:40 AM and on 06/21/13 at 8:35 AM, with Physical Therapy Assistant (PTA) #1 revealed Resident #1 had only reflexive type movements at the time, no voluntary leg movement. PTA #1 stated Resident #1 had a padded foot cradle position device (contoured leg trough) for his/her wheel chair to keep the resident's legs/feet properly positioned and help prevent injuries when being transported. She stated aides were shown how to put the device on the wheelchair and how to place the resident's legs in the device. The PTA further stated aides were suppose to supervise the residents when transporting. During observation and interview, on 06/21/13 at 2:35 PM, CNA #2 demonstrated how she transported Resident #1 into room 104 to bed one (1) and the position of the resident's foot when the accident occurred. Observation revealed the bed used by Resident #1, at the time, was close to the wall by the door. CNA #2 approached the room doorway at an angle, which brought the right side of the wheelchair close to the room's outside door facing. The CNA stated she went through the doorway at an angle because it allowed them to better position the wheelchair next to the side of the bed nearest the door wall. She further stated if she took the wheelchair	N 220		

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N 220	Continued From page 9 straight into the room, she would have to lift the back of the wheelchair in order to pivot the chair so it was turned in the position needed for the transfer; and, it was a safety issue for her to lift the wheelchair. When asked about moving the end of the bed over, CNA #2 stated if the end of the bed was moved over it allowed the wheelchair to go in straight without having to pivot the wheelchair. CNA #2 also verified when angling the wheelchair into the room, the right side of the footpedal was near the outer door frame and if pushing straight through the door frame it (right footpedal) was further from the door frame. Interview, on 06/21/13 at 10:35 AM, with Licensed Practical Nurse (LPN) #1 revealed the resident had involuntary jerky movements at times and thought the resident's foot cradle device (contoured leg trough) was for positioning and the safety of the resident. The LPN stated the use of the foot cradle device was on the aide care plan. She further stated when aides were transferring residents in wheelchairs they were to supervise the resident's safety. Interview, on 06/20/13 at 12:15 PM, with Restorative Aide #1 revealed Resident #1 would not respond to verbal commands to move his/her legs, but was able to kick his/her legs out of the positioning device at times when in his/her wheelchair. She stated she saw the resident's legs outside of the positioning device at times. Interview, on 06/19/13 at 11:40 AM and on 06/20/13 at 1:00 PM, with Resident #1's mother revealed the resident could not move his/her legs a lot but would move them outside of the wheelchair footrest cushion (foot trough) on occasion. She stated the resident moved his/her right leg out of the positioning device.	N 220		

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N 220	<p>Continued From page 10</p> <p>Interview, on 06/20/13 at 5:15 PM, with CNA #3 revealed he had taken care of Resident #1 routinely. He stated the resident had a padded footboard device for his/her wheelchair. CNA #3 stated Resident #1 occasionally had movements of his/her legs, kind of seizure like movements. CNA #3 further stated sometimes the resident's legs came out of the padded footboard device (contoured leg trough) and his/her foot was outside of the device. He stated when they noticed the foot was outside the positioning device they placed the foot back into the device prior to transport and when he transported the resident in his/her wheelchair he would watch to make sure the resident did not jerk his/her leg out of the device. He stated when transporting Resident #1, he could not recall the resident's leg coming out of the device. In addition, CNA #3 stated when he took the resident through a doorway in his/her room he went straight through the doorway with the wheelchair. He further stated prior to going into the resident's room with the wheelchair, they would move the foot of the bed away from the door so they were able to position the wheelchair next to the bed after entering.</p> <p>Interview, on 06/21/13 at 8:45 AM, with CNA #1 revealed they received training on the use of the foot cradle positioning device; it sat on the wheel chair foot rest and the purpose was to keep the resident's feet in place. CNA #1 stated they would make sure Resident #1's feet were in the foot cradle prior to transporting the resident in the wheelchair and the resident had never moved his/her leg out of the device when she transported the resident. CNA #1 further stated she had observed the resident's leg being outside of the positioning device when the resident was</p>	N 220	

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N 220	Continued From page 11	N 220		
	<p>seated in his/her wheelchair at the dining room table. She stated she was working on 04/25/13 when the accident happened and heard the resident crying out. She further stated the aides (CNA #2 and CNA #5) reported when they were transporting the resident through the door (to his/her room) the resident threw his/her leg outside of the foot cradle and the resident's foot hit the door facing.</p>			
	<p>Interview, on 06/21/13 at 9:25 AM, with CNA #5 revealed when they transported a resident in his/her wheelchair they were suppose to make sure the residents were back in the chair, their feet were on the foot pedals (if on), and their arms were inside. She stated they did not want the residents to get hurt, the number one priority when transporting a resident was their safety. She further stated Resident #1 had a contoured leg trough on his/her wheelchair and they had been trained how and why it was used. CNA #5 reported she felt the device helped, but at times the resident's legs were outside the device and they had to make sure his/her legs were inside the device when transporting. She stated she was not sure if the resident's leg movement was voluntary or involuntary. She further revealed they (CNA #2 and herself) were transporting Resident #1 to his/her room on 04/25/13 and had put the resident's foot back inside the contoured leg trough on his/her wheelchair prior to transport and somewhere between the dinning room table and the door frame to his/her room the resident's right foot came out of the device. CNA #5 stated she was walking behind CNA #2 so she did not see the foot out of the cradle, but heard it (the foot) hit the door facing and told the other CNA what happened. Continued interview with CNA #5 revealed when they took Resident #1 through the doorway to his/her they entered at an angle</p>			

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N 220	Continued From page 12 and not straight through the door. She stated because the resident's bed was near the door, they went at an angle to get the wheelchair between the bed and wall in order to transfer the resident from the wheelchair to the bed. Further interview, on 06/21/13 at 1:15 PM, with PTA #1 revealed if staff was aware the resident's feet were coming out of the "foot cradle" device she would have expected them to have let therapy know so they could have assessed the situation to determine if another device may have kept the resident's feet positioned properly in the wheelchair. Interview, on 06/21/13 at 2:50 PM, with Physical Therapist (PT) #1 revealed he had not worked much with Resident #1, but was aware the resident had a padded foot cradle position device (contoured leg trough) for the wheel chair which was used to keep his/her feet in place. PT #1 stated if the resident's leg was moving out of the positioning device it put the resident's leg in an unsafe position, Physical Therapy should have been notified to assess the situation to see what could be more effective for Resident #1. Interview, on 06/21/13 at 11:40 AM, with the Director of Nursing Services (DNS) revealed Resident #1 had conditions which could impact his/her safety, a seizure disorder and severe mental retardation, and had involuntary startle reflex movements when sitting. She stated the positioning devices were to help keep the resident in correct position and keep his/her feet safe. The DNS also stated during transport of a resident, in his/her wheelchair, staff was suppose to supervise the resident to make sure the resident's arms and legs were in the wheelchair and look for obstacles in the way. She further	N 220		

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N 220 Continued From page 13

stated if staff was aware Resident #1's feet were coming out of the foot cradle device she would have expected staff to let someone like the Charge Nurse know, who then could have discussed the issue with Therapy. In addition, the DNS stated if she had known the resident was moving his/her foot out of the cradle device it would have been care planned for the resident's safety. Continued interview with the DNS revealed she felt the event was an accident. She stated the CNAs called her over after the event and told her the resident had kicked his/her foot out of the positioning device as they were going through the door. She stated the CNA had backed the wheelchair away from the door prior to her coming over. She further stated she assessed the leg and stayed with the resident until they got her positioned correctly in bed, while other nurses called the ambulance. The DNS stated she was informed, by the CNAs, they had angled the wheelchair in order to get the chair to the side of the bed, she would not expect them to go through the door at an angle.

N 220

		Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
	DURING ROUNDING _ KEEP YOUR EYES FOCUSED ON ALL AREAS AS NOTED BELOW- IF ANY CONCERNS - REPORT TO MANAGEMENT TEAM IMMEDIATELY!							
	NURSING /RESIDENT CARE AREA---General Safety							
	Are Hallways free of equipment not in use?							
4G	Are wet-mopped areas identified by signs and only 1/2 of the area mopped at one time?							
5G	Do all associates clean up all foreign materials/puddles from the floor immediately?							
6G	Is defective or inoperative equipment reported and tagged?							
7G	Are resident room furnishings safely arranged and not cluttered?							
12G	Are all beds checked after being moved/pushed/pulled to make sure that electric outlets have not been struck and cords are not pinched under bed legs and possibly tearing protective covering of wires?							
17G	Is proper footwear always worn (by residents)?							
18G	Are medicine cabinets kept locked?							
20G	Are call buttons easily accessible to all residents and properly secured without frayed cords?							
22G	Are bed wheel locks, wheelchair locks used and in good working condition?							
23G	Are safety rails used on beds? Are bed side rails functioning (lock up, slide easily, no rough spots) ?							
24G	Are wheelchair and geri-chair foot rests used and in good working condition?							
25G	Are wheelchairs and geri-chair back rests, seat cushions, and arm rests in excellent condition (not loose, worn, or having any sharp areas)?							

62G	Are hopper rooms equipped with personal protective equipment necessary to minimize exposure to bloodborne pathogens (gloves, impervious gown, face shield)								
63G	Do nurses know and understand procedures to limit splashing or spilling blood and body fluids from use of spray nozzle?								
	Fire Safety								
64G	Are proper instructions given and applied when handling or using oxygen and other flammable gases?								
70G	Has special precautions been taken if these devices are going to be operated in close proximity of an oxygen rich environment such as nasal cannulas?								
77G	Is there adequate control where smoking is allowed? (residents always supervised in designated areas, sufficient ashtrays, smoking aprons in use)								
82G	Are associates instructed and trained in fire prevention and the fire emergency program? Ask 2 staff members what they would do?								

QAPI AUDIT : Transport Safety

DATE _____

Purpose of Audit: To Ensure Safety of Residents Being Transported Throughout Facility

Directions: Auditor will observe residents being transported in and out of doorways and common areas paying close attention to limb placement.

A Minimum of 3 residents per wing and 6 different associates to be observed

	Resident	W/C	Geri chair	Shower Ch	Other	Specify Area of buidling
N O R T H W I N G						
S O U T H W I N G						

DATE _____ OBSERVER'S NAME/ SIGNATURE _____

ASSOCIATES OBSERVED _____

COMMENTS:

developed 7-11-13