

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

PRINTED: 12/23/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/23/2015
NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 6415 CALM RIVER WAY LOUISVILLE, KY 40299		
(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 An onsite re-visit was concluded on 12/23/15 and found the facility in compliance on 12/10/15 as alleged in their PoC.	{F 000}		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

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.

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185461	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 12/23/2015
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Name of Facility GLEN RIDGE HEALTH CAMPUS	Street Address, City, State, Zip Code 6415 CALM RIVER WAY LOUISVILLE, KY 40299
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This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0157 Reg. # 483.10(b)(11) LSC _____	Correction Completed 12/10/2015	ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC _____	Correction Completed 12/10/2015	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC _____	Correction Completed 12/10/2015
ID Prefix F0309 Reg. # 483.25 LSC _____	Correction Completed 12/10/2015	ID Prefix F0323 Reg. # 483.25(h) LSC _____	Correction Completed 12/10/2015	ID Prefix F0371 Reg. # 483.35(i) LSC _____	Correction Completed 12/10/2015
ID Prefix F0372 Reg. # 483.35(i)(3) LSC _____	Correction Completed 12/10/2015	ID Prefix F0441 Reg. # 483.65 LSC _____	Correction Completed 12/10/2015	ID Prefix F0456 Reg. # 483.70(c)(2) LSC _____	Correction Completed 12/10/2015
ID Prefix F0490 Reg. # 483.75 LSC _____	Correction Completed 12/10/2015	ID Prefix F0514 Reg. # 483.75(l)(1) LSC _____	Correction Completed 12/10/2015	ID Prefix F0520 Reg. # 483.75(o)(1) LSC _____	Correction Completed 12/10/2015
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By State Agency	Reviewed By	Date: 12/23/15	Signature of Surveyor: Lynn Stewart / NCI #	Date: 12/23/15
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 10/29/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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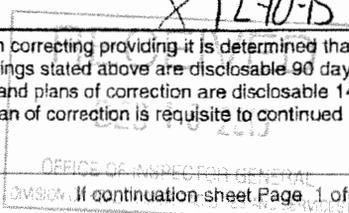
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NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 6415 CALM RIVER WAY LOUISVILLE, KY 40299
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F 000	INITIAL COMMENTS Amended 12/09/15 An Abbreviated Survey was initiated on 10/01/15 to investigate complaint KY23888. The complaint was substantiated. After supervisory review a Recertification/Extended/Abbreviated Survey was initiated on 10/12/15 and concluded on 10/29/15; another complaint KY23923 was investigated and substantiated. Immediate Jeopardy was identified on 10/16/15 and determined to exist on 09/07/15 at 42 CFR 483.20 Resident Assessment (F280 and F282) at a scope and severity of a "K"; 42 CFR 483.25 Quality of Care (F323) at a scope and severity of a "K"; and, 42 CFR 483.75 Administration (F514 and F520) at a scope and severity of a "K". Substandard Quality of Care was at 42 CFR 483.25 Quality of Care. The facility was notified of the Immediate Jeopardy on 10/16/15. After supervisory and CMS review, 42 CFR 483.75 Administration (F490) was cited at a scope and severity of a "K". The facility provided an acceptable Allegation of Compliance (AOC) on 12/03/15 with a compliance date of 10/23/15. The scope and severity was lowered to an "E". On 09/07/15 Resident #1 sustained an unwitnessed fall that resulted in injury and transfer to the hospital. Review of the Emergency Room record, dated 09/07/15, revealed the resident sustained a 2.5 centimeter laceration to the cheek/eye area, two (2) rib fractures and a Flailed Chest injury (a life threatening medical condition that occurs when a segment of the rib cage breaks under extreme stress and becomes	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *X Repuffard* TITLE: *X ED* (X6) DATE: *X 12-10-15*

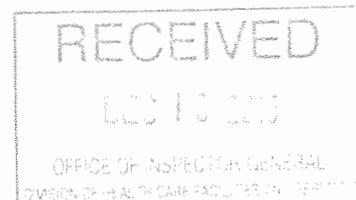
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F 000	Continued From page 1 detached from the rest of the chest wall. So a part of the chest wall moves independently). Review of the Death Summary, dated 09/07/15, revealed the resident passed, thirteen (13) hours after the fall, on 09/07/15, due to the injuries sustained from the fall which led to respiratory failure. The facility provided an acceptable Allegation of Compliance (AOC) on 10/22/15 which alleged removal of the Immediate Jeopardy on 10/23/15. The State Survey Agency verified Immediate Jeopardy was removed on 10/23/15 as alleged prior to exit on 10/29/15. The scope and severity was lowered to an "E" at F280, F282, F323, F514, and F520, while the facility implements and monitors the Plan of Correction for the effectiveness of systemic changes and quality assurance. Additional deficiencies were cited as a result of the abbreviated and recertification surveys at 42 CFR 483.10 Resident Rights (F157) at a scope and severity of a "D"; 42 CFR 483.25 Quality of Care (F309) at a scope and severity of a "D"; 42 CFR 483.35 Dietary Services (F371) at a scope and severity of an "F" and (F372) at a scope and severity of a "D", 42 CFR 483.65 Infection Control (F441) at a scope and severity of a "D"; and, 42 CFR 483.70 (F456) at a scope and severity of an "F".	F 000			
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an	F 157			



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F 157	<p>Continued From page 2</p> <p>accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure the resident's physician and responsible party was notified immediately of a medication error that required physician intervention for one (1) of twenty-five (25) sampled residents (Resident #16). RN #5 administered a medication to Resident #16 that</p>	F 157	<p>Notification of medication error was made to MD on 10/11/15. Orders were received for stat BMP lab. Lab results reflected Potassium was in normal range, creatinine slightly elevated at 1.39 and BUN normal. Orders were received to encourage fluids. Responsible party was notified on 10/12/15. Lab results and orders were communicated as well. Resident #16 was discharged from the facility on 10/13/15. Orders were obtained for home health to follow to include PT/OT/ST and nursing.</p> <p>All other residents have the potential to be affected by the deficient practice. Inservice, re-education of staff and audits will ensure physician/family notification is timely.</p>	

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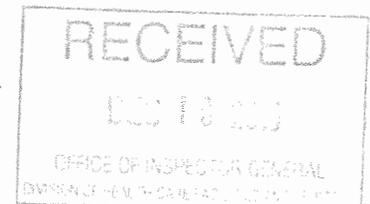
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F 157	<p>Continued From page 3 was ordered for another resident and failed to notify the physician, family and Director of Health Services (DHS).</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Medication Error and Adverse Drug Reaction, revised 09/17/12, revealed in the event a significant medication error, immediate action was to be taken as necessary to protect the resident's safety and welfare. The Physician was to be notified promptly, and the resident would be monitored closely for twenty-four (24) to seventy-two (72) hours as directed. The incident would be documented on the shift change report to alert staff to monitor the resident.</p> <p>Review of the facility's policy regarding Family Notification, effective 11/09/10, revealed the responsible party would be notified of a change in condition or diagnostic testing results in a timely manner.</p> <p>Review of the medical record for Resident #16, revealed the facility admitted the resident on 10/01/15 with diagnoses of Intestinal Obstruction, Chronic Kidney Disease Hypokalemia and Parkinson Disease. Review of the Minimum Data Set (MDS) assessment, dated 10/08/15, revealed the facility assessed the resident's cognition using the Brief Interview for Mental Status (BIMS) test and determined the resident was cognitively intact with a BIMS score of thirteen (13) out of possible fifteen (15) meaning the resident was interviewable.</p> <p>Review of the physician orders for Resident #16,</p>	F 157	<p>All nurses were inserviced concerning the campus procedure for physician/family notification guidelines 12/8/15 and 12/9/15 by Director of Clinical Compliance (who is serving as Interim DHS). Systemic change is that nurse leaders will review all new events in CCM daily to ensure timely family and MD notification. During weekend hours, the DHS or ADHS will review 3 resident events to ensure timely notification.</p> <p>DHS and/or ADHS will review 5 new events daily for timely</p>	

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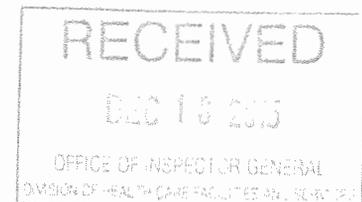
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F 157	<p>Continued From page 4</p> <p>revealed an order was entered on 10/09/15 for Lasix eighty (80) milligrams (mg) two (2) times a day and discontinued on 10/09/15. A second order was entered for Lasix eighty (80) mg two (2) times a day on 10/09/15 and was discontinued on 10/10/15.</p> <p>Review of the Medication Administration Record (MAR) for Resident #16, revealed Lasix eighty (80) mg was to be administered two (2) times a day starting on 10/09/15 and the medication was discontinued on 10/10/15. The resident received the morning dose on 10/10/15 and refused the evening dose.</p> <p>Review of the Event Report- Medication Error Circumstance for Resident #16, revealed Registered Nurse (RN) #5 recorded, on 10/12/15 at 12:28 AM, Resident #16 received one (1) dose of Lasix eighty (80) mg on 10/10/15 in the AM. The facility's investigation revealed the medication was not prescribed for this resident, but for another resident. The report revealed the resident's physician was not notified until 10/11/15 at 4:28 PM. The Nurse Practitioner gave orders to encourage fluids and draw labs on 10/14/15. The family was not notified until 10/11/15 after they questioned staff about the medications. The physician had was not notified of the medication error until Sunday afternoon, 10/11/15.</p> <p>Interview with the Responsible Party (RP) of Resident #16, on 10/13/15 at 12:45 PM, revealed the resident called the RP on Saturday, 10/10/15, and told them there was an extra pill with his/her morning medications. The RP stated the resident questioned staff as to why he/she was urinating so much and refused the dose scheduled for that evening. The RP stated they came in on Sunday</p>	F 157	<p>notification of family and physicians. Frequency of these audits will be 5 times per week for 1 month; then 3 times per week for one month, then weekly for 6 months. Results forwarded to QA committee and will continue quarterly thereafter.</p> <p>Completion 12/10/15</p>	



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F 157	<p>Continued From page 5</p> <p>and questioned RN #5 about the medications and RN #5 told them the resident had received Lasix eighty (80) mg that was not prescribed by the physician. The RP stated they were not notified of the medication error until they questioned the staff that day.</p> <p>Interview with RN #4, on 10/13/15 at 3:38 PM, revealed the nurse who took off the orders also signed off the orders. She stated she wrote the order for the Lasix on 10/09/15 at 10:23 PM and realized it was the wrong resident and discontinued the medication on 10/09/15 at 10:31 PM. She stated somehow a second order was put into the system, but denied putting the order in. She stated the computer must have had a glitch. She stated RN #5 called her on Saturday night and to ask her about the Lasix and she told her it was not ordered for Resident #16.</p> <p>Interview with RN #5, on 10/14/15 at 11:19 AM, revealed she was passing medication on Saturday night, 10/10/15. When she took the medications in to Resident #16's room, she explained Lasix was not usually given at bedtime and then the resident refused to take the medication. She said she called RN #4 that evening and the nurse told her Resident #16 was not to receive that medication. She stated RN #4 told her not to report the medication error, so she didn't fill out the Event Occurrence. She stated she did not notify the DHS, the Physician, or family upon discovery of the medication error. She stated she knew the resident was clinically stable, but the risk could be dehydration.</p> <p>Interview with the DHS, on 10/15/15 at 10:05 AM, revealed she was not notified of the medication error for Resident #16 until Sunday 10/11/15,</p>	F 157		



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F 157	Continued From page 6 around 5:30 PM. She stated RN #5 told her she found the error on Saturday evening, but when she called RN #4, she had begged her not to report the error. The DHS stated she instructed RN #5 to complete an event occurrence, call the physician and notify the responsible party. She stated staff had been trained on what to do when a medication error had been discovered and should have checked for new orders to verify the medications in the next Clinical Care Meeting. She stated Resident #16's medications would not have had a second check until Monday, 10/12/15.	F 157			
F 280 SS=K	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280			

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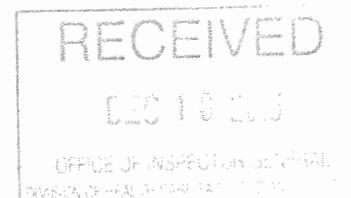
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F 280	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system in place to ensure resident care plan interventions were revised related to fall prevention interventions in order to prevent further falls for six (6) of twenty-five (25) sampled residents. (Resident's #5, #8, #9, #10, #11, and #13)	F 280	Resident #5 experienced falls on 7/1/15, 8/11/15, 8/19/15, and 8/20/15. New interventions were implemented after each fall. For the fall occurring on 7/1/15, a bed/chair alarm was implemented. For the fall on 8/11/15, intervention was to increase observation after the fall by asking the resident to transfer to a room closer to the nurses station. On 8/19/15, interventions were to review medications to determine if contributing factor and to obtain UA/C&S. For 8/20/15, the intervention initiated was not documented. Falls reassessment completed by DHS and Clinical Support Nurses was completed October 12, 13 and October 17, 2015. Care plan was revised by MDS nurses and interventions updated based on reassessment on 10/17/15. MDS nurses updated to include personal safety alarm (already in place) and wanderguard. No further	
	On 09/26/15 Resident #8 sustained an unwitnessed fall that resulted in a right non-displaced lateral 8th rib fracture. The staff heard the resident yelling for help, went to investigate and found the resident on the floor. The resident sustained bruising and a skin tear to the right elbow, abrasion to mid-lower spinal bony prominence and complained of right lower rib pain. The care plan was not revised to prevent further falls. On 09/09/15 Resident #9 was found on the floor by the resident's son. The resident's right foot was bleeding and the resident continued to be extremely confused. The resident's bed alarm was noted on the floor and non-functioning with a tear in the wiring. The family transported the resident to the hospital for evaluation. The resident received ten (10) sutures to the right foot, underneath and between the fourth and fifth toes and a closed non-displaced transverse fracture of the right fifth metatarsal. The facility failed to revise the care plan to prevent further falls or injury. On 09/30/15 Resident #10 was found on the floor by staff complaining of back pain. The resident			

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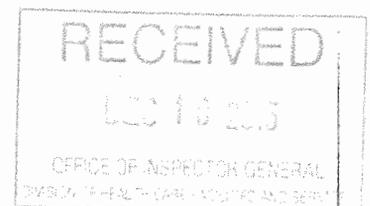
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/29/2015
NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 8415 CALM RIVER WAY LOUISVILLE, KY 40299	
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F 280	<p>Continued From page 8</p> <p>stated he/she had attempted to get to their walker and it tipped over with the resident going over with it. Emergency Medical Services were called and transferred the resident to the hospital. Hospital x-ray result, revealed a thoracic compression fracture at T9. The resident continued to have severe pain and muscle spasms and a back brace was ordered. The facility failed to revise the care plan to prevent further falls or injury.</p> <p>In addition, Resident #5, #11 and #13 sustained falls without revisions to the care plans to prevent further falls and/or injuries.</p> <p>The facility's failure to have an effective system in place, to ensure care plans were revised for residents with a history of falls has caused or is likely to cause serious injury, harm, impairment or death. Immediate Jeopardy was determined to exist on 09/07/15.</p> <p>The facility provided an acceptable Allegation of Compliance (AOC) on 10/22/15 which alleged removal of the Immediate Jeopardy on 10/23/15. The State Survey Agency verified Immediate Jeopardy was removed on 10/23/15 as alleged prior to exit on 10/29/15. The scope and severity was lowered to an "E" at F280, while the facility implements and monitors the Plan of Correction for the effectiveness of systemic changes and quality assurance.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Interdisciplinary Team Care Plan Guidelines, dated June 2015, revealed the purpose was to ensure appropriateness of services and</p>	F 280	<p>updates indicated based on reassessment.</p> <p>Resident #8 experienced a fall on 9/26/15. New interventions included encouraging resident to rest and provide personal safety alarm, to check placement and function every shift. Falls risk reassessment was completed by DHS and Clinical Support Nurses beginning on October 12 and 13, 2015. Care Plan was revised by MDS nurses and interventions updated based on reassessment on October 12, 13 and 17, 2015. Resident was discharged on October 17, 2015 to home with family with plan in place for 24 hour supervision.</p> <p>Resident #9 experienced falls on 9/9/15 and 10/2/15. Resident discharged from facility on 10/4/15.</p>	



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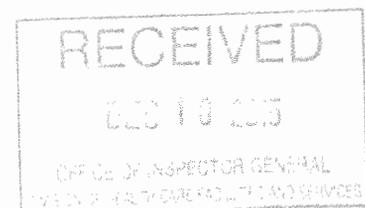
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F 280	<p>Continued From page 9 .</p> <p>communication that would meet the resident's needs, severity/stability of conditions, impairments, disability, or disease in accordance with state and federal guidelines. The care plan interventions would be reflective of the impact the risk area(s), disease process(es) have on the individual resident. Goals would be measurable and attainable. Interventions would be reflective of the individual's needs and risk influence as well as the resident's strengths.</p> <p>Review of the facility's policy regarding Clinical Documentation Systems, Circumstance, and Reassessment Forms, not dated, revealed the purpose was to provide a tool to document an investigation as to the root cause of an episodic event. Reassessment of the resident's risk factors that may have contributed to the event and evaluate the current care of plan interventions for effectiveness and select additional interventions if required. The care plan would be reviewed for effectiveness of the current interventions in place to minimize or eliminate the risk factors. New interventions would be implemented as appropriate.</p> <p>Review of the facility's policy for Falls Management, dated February 2015, revealed the facility would maintain a hazard free environment, mitigate fall risk factors and implement preventative measures. Should the resident experience a fall the attending nurse would complete the Fall Circumstance and Reassessment Form. The form included an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possible contributing factors, interventions to reduce risk of a repeat and a review by the Interdisciplinary Team to</p>	F 280	<p>Resident #10 experienced falls on 9/30/15 and 10/9/15. New interventions placed after the 9/30/15 fall included placement of personal safety alarm. The fall on October 10 resulted in transfer to hospital. Falls risk reassessment completed on October 12 and 13. Care plan was revised and updated by MDS nurses on October 12, 13 and 17, 2015 based on reassessment. MDS nurses updated to include remaining with resident while being toileted and hourly rounding.</p>	



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F 280	<p>Continued From page 10</p> <p>evaluate thoroughness of the investigation and appropriateness of the interventions. The resident care plan/profile would be updated to reflect any new or change in interventions.</p> <p>1. Review of the clinical record for Resident #8 revealed the facility admitted Resident #8 on 08/04/15 with diagnoses of Colon Cancer, Respiratory Failure and Atrial Fibrillation. The resident had a hospital admission on 09/15/15 and was re-admitted to the facility on 09/24/15. Review of Resident #8's Quarterly Minimum Data Set (MDS) assessment, completed on 09/29/15, revealed the facility assessed the resident using the Brief Interview for Mental Status with a score of fourteen (14) of fifteen (15) meaning the resident was interviewable. The facility also assessed the resident as needing the extensive assistance of one with transfers, walking, and toileting. The facility assessed the resident as not steady on their feet and only able to stabilize with staff assistance when moving from a seated to standing position, walking, moving on and off the toilet and from surface to surface.</p> <p>Review of the Comprehensive Care Plan for Resident #8 revealed the facility developed a plan of care related to skin integrity and falls on 09/15/15 with updated goals and target dates for 12/15/15. The goals stated the resident would have no falls with major injury and would maintain intact skin. The approaches directed staff to check placement and function of the bed/chair alarm, assist the resident with transfers, and keep the call light within reach.</p> <p>Resident #8 had an unwitnessed fall on 09/26/15 and sustained a skin tear, bruise to the right elbow, and a right rib fracture. However, review</p>	F 280	<p>Resident #11 discharged from facility on 8/27/15.</p> <p>Resident #13 experienced a fall on 7/7/15. New intervention implemented after the fall included placing bed in lowest position and toileting every 2 hours. Falls risk reassessment was completed by DHS and clinical support nurse.</p> <p>Resident #19 experienced a fall on 9/18/15. New interventions implemented after the fall included encouraging rest, continuing personal safety alarm and immobilizer to extremity. Falls risk reassessment was completed by DHS and clinical support nurses beginning October 12, 13 and 17, 2015 and care plan was revised and updated by MDS nurses beginning on October 12 and 13, 2015 based on reassessment.</p>	



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F 280	<p>Continued From page 11</p> <p>of Resident #8's plan of care for falls revealed the facility did not revise the plan until eleven (11) days later on 10/07/15.</p> <p>Interview with Minimum Data Set (MDS) Nurse #1 on, 10/27/15 at 11:05 AM, revealed she had revised Resident #8's plan of care on 10/07/15. She stated the date at the bottom of the plan of care was the date the care plan had been revised. She stated normally she revised care plans the next business day after the event. She stated nursing staff would have to verbally tell each other if they developed additional care plan interventions for a resident until she was able to make revisions to the computerized plan of care.</p> <p>Interview with Licensed Practical Nurse (LPN) #8, on 10/14/15 at 8:10 PM, revealed Resident #8 did have a bed alarm on prior to the last admission to the hospital; however, it was not reinstated after the resident was readmitted to the facility. She stated a bed alarm should have been put in place after readmission to alert staff of the resident's attempts to transfer without assistance. She revealed she did not make revisions to care plans and that MDS nursing staff made them. She stated her part of care plan revision was completed when she filled out a facility Event Form. She stated the forms had areas for her to click for possible interventions to be added to the care plan; however, the care plan itself was not updated until sometime later when the management team met to review the event information. She stated if she implemented an intervention she would verbally tell staff, but if they did not tell others, the information would not be known by all. She stated revising care plans and communicating the information timely would ensure resident care needs were met.</p>	F 280	<p>All residents have the potential to be affected by the deficient practice. Inservice, re-education and audits will ensure effective system in place to ensure resident care plan interventions are revised to prevent further falls.</p> <p>All resident care plans reviewed began on October 12,2015. Care plans reviews continued on October 13 and 17-21, 2015, External Audit Support nurse, MDS Support Nurse and MDS nurse, to ensure alarms status of</p>		

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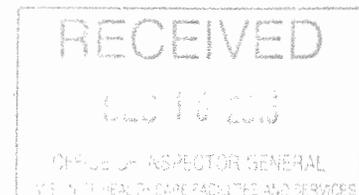
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F 280	Continued From page 12 Interview with the Director of Health Services (DHS), on 10/16/15 at 3:00 PM, revealed Resident #8's plan of care should have been revised to address the fall to ensure the resident needs were met. 2. Review of the clinical record for Resident #10 revealed the facility admitted the resident on 09/23/15 with a history of falls with hip fractures and kidney transplant. The resident had diagnoses of Spinal Stenosis, Colon Cancer, and Deep Vein Thrombosis. Review of Resident #10's five-day Minimum Data Set (MDS) assessment, completed on 09/30/15, revealed the facility assessed the resident using the BIMS with a score of fourteen (14) of fifteen (15) meaning the resident was interviewable. The facility also assessed the resident as needing the extensive assistance of one with transfers, bed mobility and toileting. The facility assessed the resident as not steady on their feet and only able to stabilize with staff assistance when: moving from a seated to standing position, walking, moving on and off the toilet and from surface to surface. Review of the Comprehensive Care Plan for Resident #10 revealed the facility developed a plan of care related to activities of daily living and falls on 08/28/15 with updated goals and target dates for 08/28/15. The approaches directed staff to provide assistance with mobility. The care plan stated the resident needed the assistance of one when transferring, used a rolling walker with staff assistance and needed a wheelchair for long distances. The care plan also stated the resident required assistance with; oral care, grooming,	F 280	resident and interventions current. Any identified residents whose care plans needed revisions or updates were updated at the time of review. Education was completed by Assessment Support Nurse and External Audit nurse on 10/19/15 for the Interdisciplinary Team which included Administrative Nurses, Social Services, Activities, Therapy Program Director and Facility MDS nurses. Comprehension was validated by verbal questions and answers. Emphasis was on the importance of timely and accurate revisions of care plans.		

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F 280	<p>Continued From page 13</p> <p>bathing and dressing. In addition, the fall care plan approaches directed staff not to leave the resident alone up in the wheelchair for extended periods of time, keep the call light within reach and remind the resident to use it. Further review revealed nursing staff did not revise the care plans after the resident sustained the unwitnessed injury fall on 09/30/15.</p> <p>Review of Resident #10's Nursing Notes, dated 09/30/15 at 1:52 PM, revealed staff found the resident on the floor complaining of back pain. Nursing noted the resident stated he/she had attempted to use their rolling walker and it tipped over causing the resident to go over with it. Emergency Medical Services was called and transferred the resident to the hospital for evaluation and treatment. The resident was diagnosed with a thoracic compression fracture at T9. The resident continued to have severe pain and muscle spasms and a back brace was ordered and the resident returned to the facility on 10/05/15.</p> <p>Interview with LPN #4, on 10/09/15 at 12:55 PM, revealed Resident #10 experienced an unwitnessed fall with injury on 09/30/15. She stated she did not revise the plan of care because the resident was sent to the hospital.</p> <p>Interview with the DHS, on 10/16/15 at 3:00 PM, revealed the care plan was not revised due to the resident not immediately returning to the facility. However, review of the plan of care for activities of daily living and falls revealed no revisions for fall interventions had been made since the resident's return. Per interview, an intervention that could have been put in place would be for staff to continually check on the resident to</p>	F 280	<p>Systemic change is front line were inserviced concerning reviewing plan of care on EMR and implementing immediate interventions to prevent a future fall on 12/8/15 and 12/9/15 by Director of Clinical Compliance (Interim DHS). Staff to update profile book with new fall interventions when implemented. During CCM, MDS or DHS will update care plans when change of conditions occur.</p> <p>DHS or ADHS will monitor 3 residents with changes to assure care plans are updated. Frequency of these audits will be 5 times per week for 1 month; then 3 times per week for one month, then weekly for 6 months. Results forwarded to</p>		



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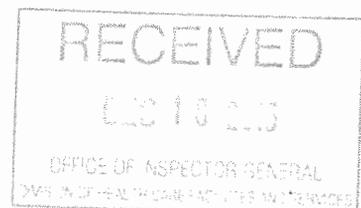
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F 280	<p>Continued From page 14</p> <p>anticipate their needs. She stated the plan of care directed staff on how to meet the needs of the resident.</p> <p>3. Review of the closed clinical record for Resident #9 revealed the facility admitted the resident on 09/09/15 with diagnoses of Gastro-intestinal Hemorrhage, Urinary Retention, Weakness and Difficulty Walking.</p> <p>Review of Resident #9's Admission Minimum Data Set (MDS) assessment, completed on 09/16/15, revealed the facility assessed the resident using the BIMS and scored the resident as a twelve (12) of fifteen (15) meaning the resident was interviewable. The facility also assessed the resident as needing the extensive assistance of two with transfers, bed mobility and toileting. The facility assessed the resident as not steady on their feet and only able to stabilize with staff assistance when: moving from a seated to standing position, walking, moving on and off the toilet and from surface to surface.</p> <p>Review of the Comprehensive Care Plan for Resident #9 revealed the facility developed a plan of care for fall prevention on 09/14/15 with updated goals and target dates for 11/14/15. On 09/09/15, the plan of care noted the resident was found on the floor (family at bedside) and sustained a cut to the foot requiring the resident to be sent to the emergency room for evaluation. The plan of care was edited on 10/01/15 and stated the bed/chair alarm was discontinued; however, no revisions were made after this edit. In addition, Resident #9 had a care plan related to short term memory loss and recall impairments. The goal stated the resident's cognitive impairment would not interfere with care routine</p>	F 280	<p>QA committee and will continue quarterly thereafter.</p> <p>Completion date 12/10/15</p>		

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F 280	<p>Continued From page 15 or quality of life. Review of the approaches revealed no revisions were made after the development of the plan of care.</p> <p>Review of the Nursing Notes, dated 09/09/15, revealed the facility admitted the resident on 09/09/15 at 1:51 PM and nursing noted seven (7) hours later, at 8:45 PM, that Resident #9 was found on the floor by the resident's son. The resident's right foot was bleeding and the resident continued to be extremely confused. The resident's bed alarm was on the floor and non-functioning with a tear in the wiring. The family transported the resident to the hospital for evaluation and the resident received ten (10) sutures to the right foot, underneath and between the fourth and fifth toes. The X-ray results at the hospital revealed a closed non-displaced transverse fracture of the right fifth metatarsal.</p> <p>Review of Resident #9's Fall Circumstance Event Form (FCEF), dated 09/09/15, revealed nursing did not implement any new interventions that would prevent/decrease the opportunity for another fall. The interventions listed were to apply direct pressure to the wound and elevate the extremity.</p> <p>Review of the Fall Circumstance Event Form, dated 10/02/15, revealed Resident #9 had an unwitnessed fall from the wheelchair, without injury. Continued review of the FCEF, revealed nursing did not revise the care plan or implement any additional interventions to prevent another fall.</p> <p>Interview with LPN #9, on 10/15/15 at 11:40 AM, revealed she believed the resident was still under the effects of anesthesia when he/she was</p>	F 280		



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F 280	<p>Continued From page 16</p> <p>admitted on 09/09/15. She stated the son found the resident on the floor and notified staff and staff could not determine exactly what the resident was trying to do at the time of the fall. She stated the second incident occurred when the resident was reaching for a hat and fell out of the wheelchair. She stated the resident told her he/she had forgotten to lock the wheelchair and slid out onto the floor. She stated she did not revise the resident's plan of care as it was not her responsibility. She stated she also forgot to completely fill out the Fall Circumstance Event Form. She stated updating the resident's plan of care ensured the resident's changing care needs were met.</p> <p>4. Review of the closed clinical record for Resident #11 revealed the facility admitted the resident on 06/01/15 with diagnoses of Coronary Artery Disease, Difficulty Walking with Abnormal Gait and Pain.</p> <p>Review of Resident #11's Admission Minimum Data Set (MDS) assessment, completed on 07/31/15, revealed the facility assessed the resident using the BIMS and scored the resident as an eleven (11) of fifteen (15) meaning the resident was interviewable. The facility also assessed the resident as needing the extensive assistance of two with transfers, bed mobility and toileting. The facility assessed the resident as not steady on their feet and only able to stabilize with staff assistance when moving from a seated to standing position, walking, moving on and off the toilet and from surface to surface.</p> <p>Review of the Comprehensive Care Plan for Resident #11 revealed the facility developed a plan of care for falls on 07/06/15 with updated</p>	F 280		

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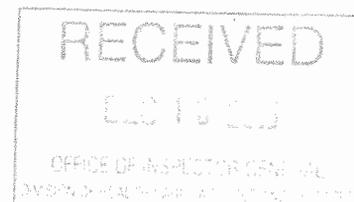
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F 280	<p>Continued From page 17</p> <p>goals and target dates for 10/06/15. The goal stated the resident would have no falls with major injury while a resident at the facility.</p> <p>Review of the clinical record revealed Resident #11 sustained a fall on 06/18/15, 07/06/15 and 08/14/15.</p> <p>Continued review of the care plan revealed the facility did not revise the plan of care after each fall event with interventions to prevent another fall. The information listed on the care plan after the fall on 06/18/15 stated the resident had a fall with no injuries and the intervention listed stated, place the bed in the low position; even though the fall occurred when the resident transferred themselves from the toilet. The care plan documentation for the 07/06/15 fall, stated the resident had a fall with a hematoma and the intervention to prevent another fall was to send the resident to the emergency department for evaluation. The 08/15/15 fall intervention information listed on the plan of care, stated education was provided to staff to transfer the resident the way the daughter transferred the resident. Even though the facility assessed the resident as needing the assistance of two with transfers; and determined the daughter had transferred the resident alone.</p> <p>Interview with LPN #4, on 10/08/15 at 2:25 PM, revealed Resident #11 had an unwitnessed fall on 07/06/15 but she must have forgotten to fill out the Fall Circumstance Event Form in the computer. She stated the form had areas for her to click on to add possible interventions to prevent another fall. She stated the MDS Nurses actually revised resident's plans of care after an event. She stated if a resident's care plan did not</p>	F 280		

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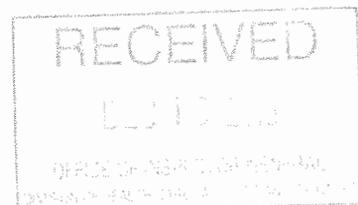
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F 280	<p>Continued From page 18</p> <p>get revised with interventions to prevent another fall the resident could experience another fall.</p> <p>Interview with LPN #7, on 10/16/15 at 12:00 PM, revealed she did not revise care plans because she was not the person to do so. She stated revising care plans ensured staff would meet the changing needs of the resident. She stated if a care plan did not get revised a bad outcome could occur to the resident.</p> <p>Interview with LPN #13, on 10/26/15 at 5:30 PM, revealed if an event occurred an electronic form was filled out that required staff to click on interventions which could be implemented to prevent another incident. However, she did not revise the residents' actual plans of care, and as far as she knew the interventions she clicked on did not automatically populate over to the resident's actual plan of care. She stated she had to verbally tell other staff if she implemented a new intervention, but if they did not continue to tell others the information might not be known to everyone.</p> <p>Interview with Minimum Data Set Nurse #1, on 10/08/15 at 10:40 AM and 10/27/15 at 11:05 AM, revealed resident care plans were usually revised the next business day after an event occurred. She stated the revision that stated, send Resident #11 to the emergency room after the fall, would not prevent another fall. She stated the plan of care should have been revised to include interventions that would actually prevent another fall. She stated without the revisions the resident could experience another fall.</p> <p>Interview with the Director of Health Services, on 10/16/15 at 3:00 PM, revealed Resident 11's care</p>	F 280		



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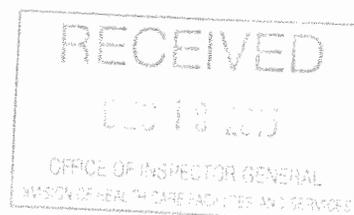
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F 280	Continued From page 19 plan should have been revised with interventions that would prevent another fall. She stated sending the resident to the emergency room would not prevent another fall. She stated she had not identified the information added to Resident #11's plan of care would not prevent another fall event until discussion with the surveyor. She stated revising the care plan with an intervention to provide increased supervision or a scheduled toileting program would have been interventions to prevent additional falls.	F 280		
	<p>5. Review of the clinical record for Resident #13 revealed the facility admitted the resident on 07/03/15 from an acute hospital with the following diagnoses: Dementia, Fracture of the Left Femur that required surgical interventions, After Care of the fractured leg, Abnormality Gait, and History of Falling.</p> <p>Review of the admission MDS assessment, dated 07/10/15, revealed the facility assessed the resident to have severe cognition impairment with a BIMS score of five (5) out of a possible fifteen (15). The facility assessed the resident to need extensive assistance from staff for bed mobility, transfers, locomotion, toilet use, and ambulation. The facility assessed the resident to have a balance deficit with unsteady gait and impaired with range of motion on one side. The resident was assessed to be high risk of falling.</p> <p>Review of the comprehensive care plan, created 07/15/15 revealed the facility had identified the resident at risk for falling due to weakness, incontinence, history of falls, medications, and needing assistance from staff with all ADLs. The goal was for the resident to remain free from major injuries during the resident's stay at the</p>			



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F 280	<p>Continued From page 20</p> <p>facility. The care plan approaches included to keep call light within reach, provide clutter free walkway; adequate footwear, appropriate lighting, and remind the resident to call for assistance prior to getting up. In addition, the resident was to remember to lock the wheelchair brakes before getting up.</p> <p>Review of the clinical record revealed Resident #13 had sustained falls on 08/12/15, on 09/06/15, and on 10/01/15. Review of the resident's care plan revealed no documented evidence the care plan was revised after the fall on 09/06/15 and on 10/01/15 the resident fell and sustained a skin tear to the left elbow, and the resident's right knee, left forehead, and left side of face was red with complaints of left shoulder/arm pain (6 out of 10 on the pain scale).</p> <p>Interview with MDS Coordinator #1, on 10/16/15 at 8:20 AM, revealed after the 09/06/15 fall (where the resident was found alone in the bathroom), the team did not revise the care plan but continued to implement the intervention to check the PSA for placement and function. She revealed the interventions for the resident to use the call light and request assistance prior to transfer was not effective. She stated the resident did not use the call light and request staff assistance prior to the three (3) previous falls and stated the resident didn't know to use the call light.</p> <p>Interview with the Director of Health Services (DHS), on 10/16/15 at 9:50 AM, revealed she reviewed Resident #13's care plan and stated the care plan was not appropriate for the resident because due to the resident's impaired cognition, the resident was not able to utilize the call light</p>	F 280			



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F 280	<p>Continued From page 21 and recall safety instructions.</p> <p>6. Review of the clinical record for Resident #5, revealed the facility admitted the resident on 03/05/14 with diagnoses of Dementia, Anxiety, Depression, Seizure Disorder, Hypertension, Transient Cerebral Ischemic Attack, Diabetes Type 2, and Anemia.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/05/15, revealed the facility assessed Resident #5 with a score of five (5) of fifteen (15) on the Brief Interview for Mental Status (BIMS) assessment, which meant the resident could not be interviewed. The facility also assessed the resident as needing the extensive assistance of one with transfers, bed mobility and toileting. The facility assessed the resident as not steady on their feet and only able to stabilize with staff assistance when: moving from a seated to standing position, moving on and off the toilet and from surface to surface.</p> <p>Review of the updated Comprehensive Care Plan, dated 08/19/15, revealed the resident was at risk for falls related to the need for extensive assistance with most Activities of Daily Living (ADL's), a history of falls, and the use of psychotropic medications. In addition, the resident had a care plan developed for safety and the need for assistance with transferring. The goal related to fall prevention, stated the resident would be free from falls during their stay at the facility. The goal related to activities of daily living stated the resident would be as independent as possible with ADL's. The goal related to safety stated the use of the chair/bed alarm would alert staff of the resident's need for assistance. The approaches directed staff to provide assistance</p>	F 280		



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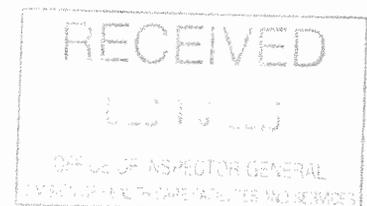
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F 280	<p>Continued From page 22 with transfers, and check the bed/chair alarm for placement and functionality every shift.</p> <p>Review of the Fall Circumstance Event Form, dated 07/11/15, revealed Resident #5 sustained an unwitnessed fall and was found on his/her back on the bathroom floor next to the wheel chair on 07/11/15. Resident #5's personal safety chair alarm had not sounded and the resident was unable to explain what he/she was doing due to cognition. Review of Resident #5's care plan revealed no new intervention was placed for the 07/11/15 fall event.</p> <p>Interview with the RN #2, on 10/15/15 at 3:15 PM, revealed she completed Resident #5's Fall Circumstance Event Form, on 07/11/15 and was not aware she had not implemented an immediate intervention. Per interview, she had not viewed Resident #5's care plan because she was not responsible for making changes to the care plan.</p> <p>Review of the Fall Circumstance Event Form, dated 08/11/15, revealed Resident #5 sustained an unwitnessed fall on 08/11/15 when he/she transferred unassisted to the bathroom. There were no contributing factors noted on the Fall Circumstance Event Form and no evidence the interventions were revised on the care plan to prevent further falls.</p> <p>Interview with LPN #14, on 10/15/15 at 2:35 PM, revealed she was not aware Resident #5 had prior falls in the bathroom. LPN #14 stated when documenting in the Fall Event Report, she could not review the care plan to determine what interventions were already in place because it was in the computer and she did not know how to</p>	F 280		

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F 280	Continued From page 23 retrieve it. Interview with the DHS, on 10/09/15 at 12:20 PM, revealed the MDS Coordinators were responsible for reviewing the Fall Care Plan interventions during the IDT meeting and she was unaware this was not consistently occurring. The DHS stated Resident #5's repeated falls might not have occurred if the IDT and MDS Coordinators had identified the discrepancies in the Fall Event Reports and lack of appropriate immediate interventions.	F 280			
	Continued interview with MDS Coordinator #1, on 10/16/15 at 8:20 AM, revealed all falls are discussed in the morning Clinical Care Meeting and the interdisciplinary team determine appropriate care plan interventions. She stated the team always reviews the Fall Circumstance Event Report during the meetings. Continued interview with the DHS, on 10/16/15 at 9:50 AM, revealed the staff nurses are supposed to complete the Fall Circumstance Event Report and find out what caused the fall. She reviewed all Fall Circumstance Event Reports during the meeting and the team would review the care plan to determine if the care plan inventions were appropriate and would prevent additional falls. She continued to state the team looked at existing care plan interventions to see if they are working and remove if not. The facility provided an acceptable credible Allegation of Compliance (AOC) on 10/22/15 and took the following actions to remove the Immediate Jeopardy on 10/23/15: 1. The facility conducted a review of the				



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F 280	<p>Continued From page 24</p> <p>sixty-three (63) current residents' care plans from October 12-20, 2015 by the Minimum Data Set (MDS) nurses to ensure care plan interventions were current. Eight (8) care plans required revision. Change in condition (including falls) will be reviewed with care plan revision as needed during the Clinical Care Meeting. The Director of Health Services will be responsible for overseeing the meetings with follow up on events that have occurred within the last twenty-four (24) hours. Education was provided for the Interdisciplinary Team (Administrative Nurses, Social Services, Activities, Therapy Director, and MDS Nurses on 10/19/15 by the Assessment Support Nurse and the External Audit Nurse.</p> <p>2. A Care Plan Audit tool was developed and will be used to ensure care plans are reviewed and revised during the Clinical Care Meeting (Monday-Friday) and weekend days by the Director of Health Services, Assistant Director of Health Services, or MDS Nurse.</p> <p>3. A Profile binder with current safety interventions (based on the care plan) for each resident was placed on each unit, on 10/21/15, for the nursing aides. The binders will be updated daily after the Clinical Care Meeting by the MDS or Medical Records. Audits will be completed daily.</p> <p>4. Charge Nurses will round daily during the Medication Pass to observe for compliance with safety interventions according to the plan of care. Audits will be conducted on the first and second shift and Night Shift Nurses will conduct routine rounds that included observing for safety interventions for five (5) random residents.</p>	F 280			



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F 280	<p>Continued From page 25</p> <p>5. Falls will be reviewed during the weekly Clinical at Risk meetings to ensure effective interventions are in place. Residents who sustained a fall will be followed in these meetings for four (4) weeks.</p> <p>6. Safety Device audits (five residents per day) will be conducted daily by department leaders, on random shifts, to ensure devices are in place and functioning.</p> <p>7. An audit was conducted on 10/18/15 of each resident's medical record to ensure proper information related to Advance Directives were in the Soft File at each unit. Advance Directives information will be obtained at admission with appropriate papers signed and placed into the Soft File at each unit. This would include each resident's code status.</p> <p>8. Education for the Executive Director, Medical Record Staff, Director of Health Services and her assistant, and Social Services were completed on 10/19/15, by the Clinical Director, of the importance of maintaining the integrity of medical record and Advance Directives information being available for Charge Nurses in the event of a resident was transferred to the hospital.</p> <p>9. Scanning guidelines will be followed based on protocols for the Electronic Health Record. Daily audits will be conducted by the DHS, ADHS, MDS, and Medical Records to ensure completion of all admission records and Advance Directive information placed into the Soft Files. These audits will be reviewed during the daily Clinical Care Meeting.</p> <p>10. A Quality Assurance (QA) Meeting was</p>	F 280			

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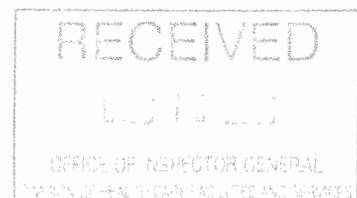
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F 280	<p>Continued From page 26</p> <p>conducted on 09/18/15 to review Falls Trending. Another QA meeting was held on 10/19/15 with the Medical Director in attendance to review the Guidelines and protocol for conducting Quality Assurance Meetings.</p> <p>11. Education was provided by the Clinical Director to the Executive Director, Director of Health Services and her assistant, and other department leaders that included issues of fall management, Advance Directives, and monitoring of care plans. Corrective plans were developed based on trends prevalent in a system not in compliance. Action plans developed with focus on goals and protocols for Clinical Care Meeting and its direct relationship to Quality Assurance activities.</p> <p>12. Audits implemented will be reviewed during the monthly QA meeting and during the Clinical Support Nurse's routine visits that occur once a week. Audits included Safety Device, Advance Directive, and Soft files, Clinical Care Meetings, Clinical at Risk Meetings, Care Plans, and QA.</p> <p>The State Survey Agency (SSA) validated the implementation of the facility's AOC as follows:</p> <p>1. Record review revealed Residents #5, #8, #10, #13, and #19 care plans were revised. Resident #20 was sampled during the extended survey due to being the only resident with a fall since the alleged Immediate Jeopardy abatement date of 10/23/15. The resident's care plan was reviewed during the Clinical Care Meeting and revised as needed.</p> <p>Interview with the Director of Health Services, on 10/28/15 at 1:50 PM, revealed the</p>	F 280			

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F 280	<p>Continued From page 27</p> <p>Interdisciplinary team received training on care plan revision and implementation. She stated she was responsible for overseeing the Clinical Care Meetings and ensured the care plan was revised and all events received follow-up monitoring to ensure the event reports were completed. In addition, she randomly reviewed one-two care plans daily to ensure completion.</p> <p>2. Sampled Resident #20's fall (10/25/15) was discussed in the Clinical Care Meeting and revision of the care plan was completed. Review of the care plan audits revealed revision of the care plans were occurring after an event or change in the resident. Review of the sampled residents for the extended survey revealed the care plan had been revised after a change in the resident's status to include falls.</p> <p>3. Observation of the 400, 500, and Health Care Units, on 10/27/15 at 11:30 AM and again at 4:00 PM, revealed Profile Binders at each unit that included specific information about each resident including code status. Observation on 10/27/15 at 4:35 PM, revealed staff updating the Profile Binder on the Healthcare Unit. Interview with the Medical Record Director, on 10/28/15 at 2:40 PM, validated the binders are updated after the Clinical Care Meetings with any new care plan interventions. The MDS Nurses were at a training offsite and unavailable for interview during the extended survey.</p> <p>4. Observation, on 10/28/15 at 10:00 AM, (on the 500 Unit) revealed the nurse was conducting rounds in the residents rooms during the medication pass for safety devices and call light placement.</p>	F 280			



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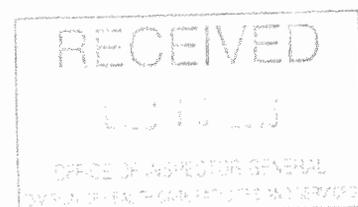
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F 282	Continued From page 56 Units, on 10/27/15 at 11:30 AM and again at 4:00 PM, revealed Profile Binders at each unit that included specific information about each resident including code status. Observation on 10/27/15 at 4:35 PM, revealed staff updating the Profile Binder on the Healthcare Unit. Interview with the Medical Record Director, on 10/28/15 at 2:40 PM, validated the binders are updated after the Clinical Care Meetings with any new care plan interventions. The MDS Nurses were at a training offsite and unavailable for interview during the extended survey.	F 282		
	4. Observation, on 10/28/15 at 10:00 AM, (on the 500 Unit) revealed the nurse was conducting rounds in the residents rooms during the medication pass for safety devices and call light placement. Interviews with LPN #5, on 10/26/15 at 4:00 PM, LPN #12 on 10/27/15 at 11:15 AM, and LPN #6 on 10/28/15 at 9:00 AM, revealed the nurses conducted walking rounds to check for safety devices and call lights at the beginning of the work shift and again when they administered medications. Interview with the Director of Health Services, on 10/28/15 at 1:50 PM, revealed she had randomly observed walking rounds between the nursing aides and nurses giving report. Review of the safety devices/call light audits revealed at least five (5) residents were observed daily for safety device and call light placement and proper functioning of the devices. 5. Review of the Fall Circumstance Event Report for Resident #20, revealed the fall was discussed in the Clinical Care Meeting. Audits revealed Resident #20 was included. Interview with LPN			

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F 282	<p>Continued From page 57</p> <p>#5, on 10/26/15 at 4:00 PM, revealed the resident slid from the bed and experienced no injury.</p> <p>Interview with the Director of Health Services, on 10/28/15 at 1:50 PM, Executive Director, on 10/28/15 at 3:00 PM, and Clinical Director, on 10/29/15 at 12:00 PM, revealed all falls and any change in condition were discussed during the Clinical Care Meetings. Review of the audits revealed the meetings were held on October 21, 22, 23, 26, and 27. A meeting was held on 10/28/15 at 10:00 AM and validated by observation of the SSA.</p> <p>Review of the Changes in condition, including fall investigation and root cause analysis will be discussed during the Clinical Care Meetings. The Fall Circumstance Event Reports are reviewed for completion and ensure appropriate safety interventions had been implemented to reduce the risk of future falls.</p> <p>6. The facility reviewed all safety devices and conducted assessments with some safety devices discontinued. There were seven (7) residents with safety devices during the extended survey. Review of the audits revealed five (5) or more residents were audits to ensure safety devices were in place and functioning.</p> <p>7. Review of the Soft Files for the 500, 400, and Health Care Units revealed each resident had been offered Advance Directives and each resident had a code status. These forms were scanned into the electronic record and the original signed form was kept in the Soft File at each unit.</p> <p>Interview with the Medical Record Director, on</p>	F 282			



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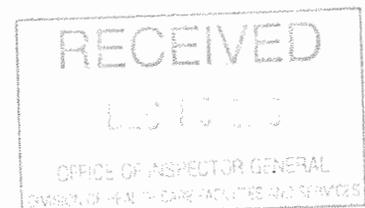
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F 282	<p>Continued From page 58</p> <p>10/28/15 at 2:40 PM, revealed she had received training on the Soft Files, scanning forms into the electronic record, and maintaining the medical record. She stated she was responsible for conducting audits of new admission paperwork to ensure the code status and Advance Directive forms are signed and placed into the Soft file on each unit.</p> <p>Observation of the new admission process revealed Advance Directive forms were signed and placed into the soft file. Resident #21, #22, and #23 were sampled during the extended survey to validate the admission paperwork was completed and Advance Directive forms signed and placed into the Soft file.</p> <p>8. Review of the training record revealed education was provided on 10/19/15 as stated in the AOC. Interview with the Medical Records, on 10/28/15 at 2:40 PM, Director of Health Services, on 10/28/15 at 1:50 PM, and Social Services on 10/28/15 at 2:48 PM, revealed they had received the training.</p> <p>9. Interview with the Medical Record Director, on 10/28/15 at 2:40 PM, revealed she received training on the scanning guidelines. She stated she now had additional staff to help with the scanning of the medical record into the electronic record. She stated audits were conducted daily to ensure scanning guidelines are followed.</p> <p>Review of the Daily Careplan audit forms, Falls Interventions audit forms, Call Light audit forms, Fall Investigation audit forms, the Safety/Assistive Device audit forms, and the Admission audit forms revealed they were all completed.</p>	F 282			

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F 282	<p>Continued From page 59</p> <p>10. Review of the QA signature sheets revealed QA meetings were held on 10/19/15 and 10/29/15. Interview with the Executive Director, on 10/28/15 at 3:00 PM, and the Clinical Director on 10/29/15 at 12:00 PM validated the QA meetings were held on those dates.</p> <p>Interview with the Clinical Director and the Clinical Support Nurse, on 10/29/15 at 12:00 PM, revealed the QA meeting on 10/19/15 was to develop the Plan of Action to correct the Immediate Jeopardy, develop audits, and capture any trends of non-compliance. The Clinical Director stated staffing was reviewed to determine if it contributed to the non-compliance and she was looking at staffing as part of the solution. She stated the facility had been given extra hours for staffing and was in the process of determining where the hours would be best spent. The Clinical Director stated the QA meeting of 10/29/15 was to review audits, and evaluate the plans of actions. She stated the audits revealed no problems and the AOC was implemented and monitored as stated. She stated the facility would continue to meet monthly and she would be at the facility almost daily to assist the new Executive Director and ensure compliance. The Clinical Support Nurse stated she would visit the facility at least twice a week and as needed to ensure the Clinical Care and Clinical at Risk meetings were conducted according to the AOC. The Clinical Director stated she would attend the monthly QA meetings for at least six (6) consecutive months.</p> <p>11. Interview with the Clinical Director, on 10/29/15 at 12:00 PM, revealed she provided the education to the Executive Director and Director of Health Services on 10/19/15. Review of the</p>	F 282			



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F 282	Continued From page 60 training records validated the training. Interview with the Executive Director and Director of Health Services on 10/29/15 at 12:15 PM, revealed they received training on Advanced Directives, revision of care plans, documentation, audits, monitoring, scanning guidelines, systems related to falls, and the protocols for Quality Assurance. 12. Review of the audits revealed the facility conducted the audits as stated in the AOC.	F 282			
F 309 SS=D	Interview with the Executive Director, on 10/28/15 at 3:00 PM, and the Clinical Director, on 10/29/15 at 12:00 PM, revealed the audits were conducted and forwarded to them for review of compliance. The audits were brought to the 10/29/15 QA meeting to review and discuss trending. 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure Physician	F 309	A Medication Error Circumstance form initiated on 7/14/15 for Resident #13. Physician and responsible party notified on 7/14/15. The Tramadol order was discontinued on 7/14/15. No negative outcomes documented		

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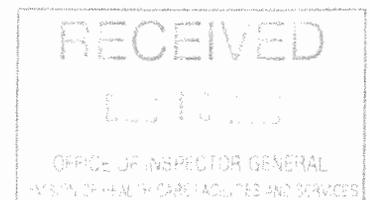
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F 309	Continued From page 61 Orders were followed for two (2) of twenty-five (25) sampled residents (Resident #13 and #16). The nursing staff administered fourteen (14) doses of pain medication to Resident #13 that was the wrong dose. Registered Nurse (RN) #5 administered one (1) dose of medication, Lasix 80 mg, to Resident #16 which was not prescribed by the physician. The findings include: Review of the facility's policy regarding Medication Orders, not dated, revealed each resident would be under the care of a licensed physician where care was provided and would be seen in accordance with regulations. Orders would be signed and dated in accordance with state regulations. Review of the facility's policy regarding Medication Error and Adverse Drug Reaction, revised 09/17/12, revealed in the event a significant medication error, immediate action would be taken as necessary to protect the resident's safety and welfare. The Physician would be notified promptly, and the resident would be monitored closely for twenty-four (24) to seventy-two (72) hours as directed. The incident would be documented on the shift change report to alert staff to monitor the resident. 1. Review of Resident #13's clinical record revealed the facility admitted the resident on 07/03/15 from an acute hospital with diagnoses of Dementia, Fracture of the Left Femur that required surgical interventions, After Care of the fractured leg, Abnormal Gait, and History of Falling. Review of the hospital's discharge medications orders, dated 07/03/15, revealed an	F 309	for resident after 72 hour follow up. Resident #16 Notification of medication error was made to MD on 10/11/15. Orders were received for stat BMP lab. Lab results reflected Potassium was in normal range, creatinine slightly elevated at 1.39 and BUN normal. Orders received to encourage fluids. Responsible party was notified on 10/12/15. Lab results and orders were communicated as well. Resident #16 was discharged from the facility on 10/13/15. Orders were obtained for home health to follow and include PT/OT/ST and nursing.		



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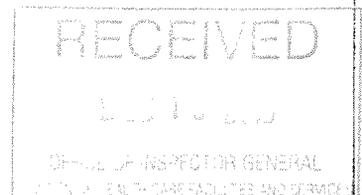
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F 309	<p>Continued From page 62</p> <p>order for Tramadol 25 mg (1) every six (6) hours, as needed. Review of the prescription slip signed by the physician for Scheduled Drugs, dated 07/03/15, revealed the physician had ordered thirty (30) tablets of Tramadol 25 mg (1) every six (6) hours, as needed for pain.</p> <p>Review of the pain medication care plan, dated 07/15/15, revealed the resident would receive pain medication per physician orders.</p> <p>Review of the Medication Error Circumstance Event Report, dated 07/14/15 at 5:53 PM, revealed Resident #13 had received the wrong dose of a Scheduled IV pain medication. Review of the Electronic Medication Administration Record (MAR) for July 2015 revealed the resident received fourteen (14) doses of the medication at the wrong dose. The MAR had instructions to administer Tramadol 25 mg every six (6) hours as needed for pain.</p> <p>Interview with License Practical Nurse (LPN) #5, on 10/15/15 at 4:31 PM, revealed she was the nurse who completed the admission paperwork for Resident #13 on 07/03/15. She stated she put the admission medication orders into the computer system. However, the computer software program did not list Tramadol 25 mg, only the 50 mg dose. She said she put in the Tramadol 50 mg and provided additional comments that stated to give 25 mg instead of the 50 mg. She stated she realized later (after the medication error was discovered) she should have used Ultram 25 mg that was listed in the computer's software library. She stated once she entered the medication orders, the orders were forwarded to the contract pharmacy to fill. She stated the pharmacy did not read her comments</p>	F 309	<p>All residents have the potential to be affected by the deficient practice. Inservice, re-education and monitoring through audits to ensure execution of physician orders related to medication administration.</p> <p>Medications for all residents were reviewed and checked against MD orders to assure accuracy by pharmacy staff (consultant pharmacist and nurse) on 12/3/15 and 12/4/15.</p> <p>All nurses were educated on medication pass guidelines and documentation required for a medication error by Director of Clinical Compliance (Interim DHS) on December 8-9, 2015. Systemic changes include all nurses will</p>	



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F 309	Continued From page 63 and sent Tramadol 50 mg with orders to give one (1) tablet every six (6) hours as needed. She stated the pharmacy should have sent a half tablet of the 50 mg pill because the nursing facility nurses were not allowed to score and break tablets. Pharmacy must send the medication already broken into 1/2 tablet in a sealed packet. Review of the pharmacy manifest revealed thirty (30) tablets of Tramadol 50 mg were delivered on 07/08/15. A telephone interview with the Contract Pharmacist, on 10/27/15 at 2:50 PM, revealed he had investigated the medication error and found the pharmacy had sent 50 mg tablets of Tramadol instead of breaking the medication in half to equal 25 mg. He stated he discovered that not all of the safety checks at the pharmacy were followed by the Pharmacy Technician during the Pharmacist's last check of the medication. He said the Pharmacist should have scored and broke the 50 mg tablet into half tablets and packaged them separately as one dose. He stated the investigation revealed two (2) mistakes from the pharmacy. Once, when the Pharmacist Technician filled the wrong dose and then when the pharmacist failed to conduct the final check. Although the pharmacist took responsibility for the medication error, he stated the facility's nurses had been trained in the Five Rights of medication administration and should have discovered the medication error prior to administering to the resident. Interview with LPN #3, on 10/28/15 at 9:00 AM, revealed she discovered the medication error during the medication pass. She stated she called the resident's physician and was told to monitor the resident. LPN #3 stated the higher dose of	F 309	complete a medication pass competency by Director of Clinical Compliance (Interim DHS) and clinical support nurses December 8-10, 2015, and annually thereafter. DHS or ADHS will complete an audit of 3 residents medication pass daily to ensure MD orders are followed 5 times a week for one month then 3 times a week for a month then weekly with results forwarded to the QA committee monthly for 6 months and quarterly thereafter for review and further suggestions/comments. Completion date 12/10/15		



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F 309	<p>Continued From page 64</p> <p>pain medication actually helped the resident so the physician ordered Tramadol 50 mg (1) every six (6) hours as needed for pain. The nurse stated she entered the medication error into the Event Report and the medication error should have been discussed during the morning Clinical Care Meeting. She stated she informed the DHS of the medication error. LPN #3 stated she could not recall any training provided after the medication error was discovered.</p> <p>Interview with the (Director of Health Services) DHS, on 10/16/15 at 9:50 AM, revealed the medication error was reported, but she could not recall if the Event Report was discussed in the Clinical Care Meeting the next day. She reviewed the Medication Error Circumstance Event Report and stated it must have been discussed because the Interdisciplinary Team documented they had reviewed and she had closed out the event. She said she had spoken with the Pharmacist and discovered the pharmacy had sent Tramadol 50 mg tablet instead of a half tablet to equal 25 mg. She stated nurses are taught to conduct the Five Rights of administering medication and the right dose was included. She stated the nurse who administered the first dose of the medication should have picked up that the medication was the wrong dose. She stated there had been no additional training provided to the nurses except talking with the nurses about the medication error.</p> <p>2. Review of the clinical record for Resident #16 revealed the facility admitted the resident on 10/01/15 with diagnoses of Intestinal Obstruction, Chronic Kidney Disease Hypokalemia and Parkinson Disease. Review of the Comprehensive Minimum Data Set (MDS)</p>	F 309			

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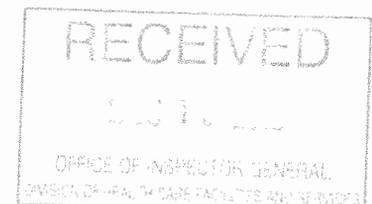
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F 309	<p>Continued From page 65</p> <p>Assessment, dated 10/08/15, revealed the facility assessed the resident's cognition using the Brief Interview for Mental Status, (BIMS) test and determined the resident was cognitively intact with a BIMS score of thirteen (13) out of possible fifteen (15) meaning the resident was interviewable.</p> <p>Review of the Physician's orders for Resident #16, revealed an order was entered on 10/09/15 for Lasix (a diuretic) eighty (80) milligrams (mg) two (2) times a day and discontinued on 10/09/15. A second order was entered for Lasix eighty (80) mg two (2) times a day on 10/09/15 and was discontinued on 10/10/15.</p> <p>Review of the Medication Administration Record (MAR) for Resident #16, revealed Lasix eighty (80) mg was to be administered two (2) times a day starting on 10/09/15 and the medication was discontinued on 10/10/15. The resident received the morning dose on 10/10/15 and refused the evening dose.</p> <p>Review of the Event Report- Medication Error Circumstance for Resident #16, revealed Registered Nurse (RN) #5 recorded, on 10/12/15 at 12:28 AM, that Resident #16 received one (1) dose of Lasix eighty (80) mg on 10/10/15 in the AM. A second dose was written for bedtime that was not given due to the time and the resident refused the medication. The medication was discontinued for further investigation and was found that it was not indicated for this resident, but for another resident. That resident did receive the medication. The report stated the resident's physician was not notified until 10/11/15 at 4:28 PM. Stat labs were ordered and the results were called to the Nurse Practitioner. The</p>	F 309		

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F 309	<p>Continued From page 66</p> <p>resident's Potassium was within normal limits with the Creatinine slightly elevated at 1.39 from the previous level. The Nurse Practitioner gave orders to encourage fluids and draw labs on 10/14/15. The family was not notified until 10/11/15, after they questioned staff about the medications.</p> <p>Observation, on 10/13/15 at 11:45 AM, revealed Resident #16 in his/her room. The resident was able to communicate but was difficult to understand. The resident's granddaughter was in the room and repeated what the resident was trying to say. Resident #16's family transferred the resident to another facility.</p> <p>Interview with the responsible party of Resident #16, on 10/13/15 at 12:45 PM, revealed the resident called the responsible party on Saturday, 10/10/15, and told them there was an extra pill with his/her morning medications. The responsible party stated the resident questioned staff as to why he/she was urinating so much and refused the dose scheduled for that Saturday evening. The responsible party stated they came in on Sunday and questioned RN #5 about the medications, and RN #5 told them the resident had received Lasix eighty (80) mg that was not prescribed for him/her by the physician. The nurse stated she had discovered the medication error on Saturday evening. The responsible party stated they were not notified about the medication error until they questioned staff that day. In addition, the physician was not notified until Sunday afternoon, 10/11/15, with labs ordered stat.</p> <p>Interview with RN #4, on 10/13/15 at 3:38 PM, revealed she had worked at the facility for two (2)</p>	F 309			



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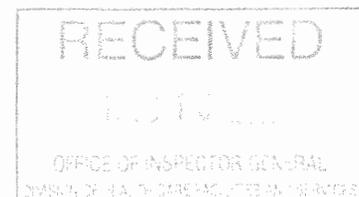
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F 309	<p>Continued From page 67</p> <p>months. She stated she was trained on the electronic medical record and how to enter physician orders. She stated the nurse who took off the orders also signed off the orders. RN#4 stated she created the order for the Lasix on 10/09/15 at 10:23 PM and realized it was the wrong resident and discontinued the medication on 10/09/15 at 10:31 PM. She stated somehow a second order was put in, but she denied putting the order in the system. She stated the computer must have had a glitch. RN #4 stated RN #5 called her on Saturday night and asked her about the Lasix and she told her it was not ordered for Resident #16.</p> <p>Interview with RN #5, on 10/14/15 at 11:19 AM, revealed she was passing medication on Saturday night, 10/10/15. When she took the medications in to Resident #16's room, she explained Lasix was not usually given at bedtime and then the resident refused to take the medication. She said she called RN #4 that evening and the nurse told her Resident #16 was not to receive that medication. She stated RN #4 told her not to report the medication error, so she didn't fill out the Event Occurrence. She stated she failed to notify the Director of Health Services (DHS), the Physician, or family upon discovery of the medication error. She stated she knew the resident was clinically stable, but the risk could be dehydration.</p> <p>Interview with the DHS, on 10/15/15 at 10:05 AM, revealed she was not notified of the medication error for Resident #16 until Sunday 10/11/15, around 5:30 PM. She stated RN #5 told her she found the error on Saturday evening, but when she called RN #4, she had begged her not to report the error. The DHS stated she instructed</p>	F 309		

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FORM APPROVED
OMB NO. 0938-0391

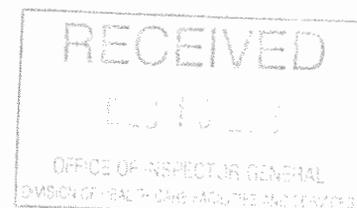
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/29/2015
NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 6415 CALM RIVER WAY LOUISVILLE, KY 40299		
(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 309	Continued From page 68 RN #5 to complete an event occurrence, call the physician and notify the responsible party. She stated staff had been trained on what to do when a medication error had been discovered. She stated the process for checking new orders was to verify the medications in the next Clinical Care Meeting. The DHS stated Resident #16's medications would not have had a second check until Monday, 10/12/15.	F 309			
F 323 SS=K	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the manufacturer's guidelines and the facility's policy, it was determined the facility failed to have an effective system in place to ensure staff provided adequate supervision to prevent accidents. In addition, the facility failed to ensure the facility's bed/chair alarms were used in accordance with the manufacturer's recommendations, and failed to complete the Fall Circumstance forms and/or determine the root cause for the falls. The facility's failure affected ten (10) of twenty-five (25) sampled residents. (Residents #1, #2, #5, #6, #8,#9, #10, #11, #12 and #13).	F 323	Resident #1 was discharged to hospital on 9/7/15. Resident #2 sustained a skin tear of unknown origin. MD and responsible party were notified on 9/7/15 by charge nurse. Treatment orders obtained and implemented to cleanse with normal saline and apply triple antibiotic ointment. Other interventions included geri sleeves to prevent further injuries. Resident had fall on 7/1/15. Upon investigation by IDT, it was determined that the fall was witnessed while resident was attempting to close blinds. Staff could not get to the resident		



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F 323	<p>Continued From page 69</p> <p>On 09/07/15, Resident #1 sustained an unwitnessed fall that resulted in injury and transfer to the hospital. Review of the Emergency Room record, dated 09/07/15, revealed the resident sustained a 2.5 centimeter laceration to the cheek/eye area, two rib fractures and a Flailed Chest injury (a life threatening medical condition that occurs when a segment of the rib cage breaks under extreme stress and becomes detached from the rest of the chest wall, so a part of the chest wall moves independently). Review of the Death Summary, dated 09/07/15, revealed the resident passed, thirteen (13) hours after the fall on 09/07/15, due to the injuries sustained from the fall which led to respiratory failure. Staff stated they were busy off the unit or tending to other residents on another hall when Resident #1 fell. Additional interview with staff revealed the bed alarm unit was not turned on and the resident's call light was not within reach at the time of Resident #1's fall.</p> <p>On 09/30/15 Resident #10 sustained an unwitnessed fall. The staff found the resident on the floor complaining of back pain. The resident told the staff he/she had attempted to get to their walker; however, the walker tipped over and the resident fell. Emergency Medical Services was called and transferred the resident to the hospital. Hospital x-ray results revealed a thoracic compression fracture at T9. The resident continued to have severe pain and muscle spasms and a back brace was ordered.</p> <p>On 09/09/15 Resident #9 sustained an unwitnessed fall. The resident was found on the floor by the resident's son. The resident's right foot was bleeding and the resident continued to be extremely confused. The resident's bed alarm</p>	F 323	<p>to prevent the fall. Therapy screened and resident condition did not indicate skilled therapy services necessary. Care plan and profile updated to reflect current. Resident has had no additional falls with current interventions.</p> <p>Resident #5 experienced fall on 7/1/15, 8/11/15, 8/19/15, 8/20/15. Physician and responsible party notification made at the time of the events. New intervention for the 7/1 fall included replacement of alarm. 8/11 intervention included toileting every 2 hours. 8/19 intervention included increased observation and monitoring. Interventions for 8/20 included</p>		



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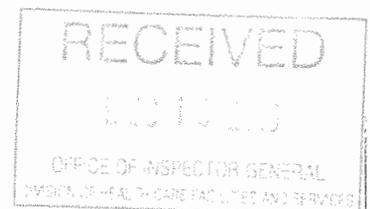
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F 323	<p>Continued From page 70</p> <p>was noted on the floor and non-functioning with a tear in the wiring. The family transported the resident to the hospital for evaluation and the resident required ten (10) sutures to the right foot, underneath and between the fourth and fifth toes. The hospital X-ray results revealed a closed non-displaced transverse fracture of the right fifth metatarsal.</p> <p>On 08/04/15 Resident #12 sustained an unwitnessed fall with injury. The resident reported he/she tried to get up from the potty chair and fell. The resident had swelling and an abrasion with bleeding to the nose. The Event Report revealed there were no possible contributing factors present at the time of the fall. The resident returned from the hospital with a diagnosis of a nasal fracture.</p> <p>In addition, the facility failed to ensure staff provided assistance to residents for toileting to prevent falls for Residents #11 and #13 and failed to monitor and follow the manufacture's recommendations for use of sensor pads for Residents #2, #5, and #6.</p> <p>The facility's failure to have an effective system in place to ensure adequate supervision to prevent accidents has caused or is likely to cause serious injury, harm, impairment or death. Immediate Jeopardy was determined to exist on 09/07/15.</p> <p>The facility provided an acceptable Allegation of Compliance (AOC) on 10/22/15 which alleged removal of the Immediate Jeopardy on 10/23/15. The State Survey Agency verified Immediate Jeopardy was removed on 10/23/15 as alleged prior to exit on 10/29/15. The scope and severity was lowered to an "E" at F323, while the facility</p>	F 323	<p>continuing observation. Therapy screened after each fall. For 8/11, fall IDT determined root cause to be resident being left unattended while toileting. For 8/19, IDT determined resident had been toileted 30 minutes prior and took self to bathroom by transferring herself. She needs assist. For 8/20 fall, resident was attempting to toilet self. As a result of repeat falls, supervision will involve toileting every 2 hours, personal alarm and bringing resident to common areas when not in room to increase observation. Resident condition did not indicate skilled therapy services at this time. Care plan and profile updated as</p>	

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F 323	Continued From page 71 implements and monitors the Plan of Correction for the effectiveness of systemic changes and quality assurance. The findings include: Review of the facility's policy for Falls Management, dated February 2015, revealed the facility would maintain a hazard free environment, mitigate fall risk factors and implement preventative measures. The fall risk assessment was included as part of the Admission and Monthly Nursing Assessment and Review and Circumstance forms. Identified risk factors should be evaluated for the contribution they may have to the resident's likelihood of falling. In addition, care plan interventions developed from the fall risk assessment which address the resident's risk factors, should be implemented. Should the resident experience a fall the attending nurse shall complete the "Fall Circumstance and Reassessment Form". The form includes an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possible contributing factors, interventions to reduce risk of repeat and a review by the Interdisciplinary Team to evaluate thoroughness of the investigation and appropriateness of the interventions. The resident "I care plan/profile" should be updated to reflect any new or change in interventions. Nursing staff will monitor and document continued resident response and effectiveness of interventions for seventy-two (72) hours; discuss risks and interventions with resident and/or responsible party; and, communicate interventions during shift report and update the twenty-four hour report and the nursing assistant assignment worksheet.	F 323	necessary to reflect current condition. Resident #6 was discharged on 11/6/15. Care plan interventions were reviewed on 10/18/15. Resident experienced no falls during this time. Resident discharged 11/6/15. Resident #8 was discharged to home on 10/17/15 with home health. Resident #10 experienced a fall on 9/30/15 while attempting to get walk and it tipped resulting in her fall. Resident was transferred to hospital. Upon return to facility, prevention care plan in place which included proper footwear, resident was re-educated on use of walker. Care plan and profile updated at the time and reviewed again on October 17 and 18, 2015 by MDS	



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F 323	<p>Continued From page 72</p> <p>Review of the facility's policy regarding Clinical Documentation Systems, Circumstance, and Reassessment Forms, not dated, revealed the purpose was to provide a tool to document an investigation as to the root cause of an episodic event. Reassessment of the resident's risk factors that may have contributed to the event and evaluate the current care of plan interventions for effectiveness and select additional interventions if required.</p> <p>The facility did not provide a policy related to the bed/chair alarms that would direct staff in how to check the alarms for functionality. However, observation on 10/02/15 at 2:10 PM, and review of the manufacturer's guidelines revealed the facility had three (3) different bed/chair alarm systems the facility used Medline, Posey and Universal Medical Products (UMP).</p> <p>Interview with the Director of Health Services (DHS), on 10/05/15 at 2:00 PM; and, on 10/09/15 at 12:20 PM, revealed the facility had not provided training to the staff for quite sometime. She stated she began her role in February of 2015 and she had not provided training and had not instructed anyone else to train staff on the bed/chair alarms. She stated she had not read the manufacturer's recommendations and was not aware there were three (3) different brands in use. She stated malfunctions could occur if staff did not know how to test the alarms appropriately and resident harm could occur.</p> <p>Review of the Medline bed/chair alarm brand revealed it was the responsibility of the facility to implement structured training procedures for all employees using the system. Only users who</p>	F 323	<p>nurses. No additional interventions indicated based on reassessment. Resident was on therapy caseload at the time and therapists were made of the fall. IDT review of all indicated to insure supervision to prevent accidents, residents will need proper footwear, walker in reach, encourage use of call light and offer rest periods during the day.</p> <p>Resident #11 was discharged from facility on August 27, 2015.</p> <p>Resident #12 was discharged from facility on August 6, 2015.</p>		

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F 323	<p>Continued From page 73</p> <p>have received adequate training on the use of the system should use the system. Failure to adequately train employees may cause system failure due to user error. In addition, incorrect use of the equipment may also result in system failure. The company recommended all expired, soiled or contaminated pads be disposed of in accordance with the law and facility policy. The sensor pads had a limited expected useful life. The facility must record the warranty date in the area provided on the label. The facility must not use the sensor pad after the in-service warranty expiration date. To set-up the system first visually inspect the pad and wires for damage. Power the unit by inserting a 9-volt battery, use adhesive strips on the bottom of the pad before putting in place to prevent shifting. When securing the system, take up extra slack in the cord that could become tangled with the resident, bed or chair. Failure to do so may result in resident injury. Insert the pad plug into the sensor pad, and the control unit should flash a green light and beep. In addition, the unit could be silenced for 30 seconds, by pressing the silence button. If the resident does not return to the pad within 30 seconds the unit turns itself off requiring the staff to reset it again.</p> <p>Interview on 10/02/15 at 2:30 PM, with LPN #4, revealed she did not know if the facility had a policy regarding the bed/chair alarms. She stated she had not received training on the alarms from the facility or the manufacturer.</p> <p>Review of the Posey manufacturer recommendations, revealed before leaving a resident unattended staff should always follow these steps each time: check to make sure that</p>	F 323	<p>Resident #13 experienced a fall on 10/1/15. Resident sustained a skin tear. MD and responsibility party notified on 10/1/15 by charge nurse at 11:00pm. Treatment order obtained and implemented. Resident was on therapy caseload for PT and receiving treatment to improve ambulation. Care plan and profile updated to reflect current status. Care plan reviewed again on 10/17 and 10/18/15 by MDS nurses. IDT review indicates necessity of long call light in reach, wheelchair and walker for mobility, wear eye glasses to insure alarm in place and functioning.</p> <p>Resident #19 was discharged from facility on 10/31/15.</p>		

