

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

PRINTED: 12/20/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185242	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/07/2012
NAME OF PROVIDER OR SUPPLIER  WINDSOR CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 125 STERLING WAY MOUNT STERLING, KY 40353	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 000 INITIAL COMMENTS

An Abbreviated Survey investigating KY#00019457 was initiated on 12/05/12 and concluded on 12/07/12. KY#00019457 was substantiated and deficient practice was identified at 42 CFR 483.20 (F-282) and 42 CFR 483.25 (F-323) at a scope and severity (S/S) of a "D".  
F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS; PER CARE PLAN  
SS=D

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

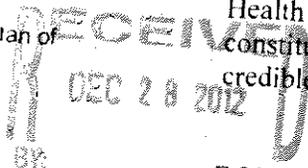
This REQUIREMENT is not met as evidenced by:  
Based on observation, interview and record review it was determined the facility failed to ensure resident care was provided in accordance with each residents written plan of care for one (1) of three (3) sampled residents (Resident #1). Resident #1 had a known history of grabbing things while staff was providing care and had a plan of care in place with interventions which included Resident #1 was to be bathed and have incontinence care provided with the assistance of two (2) staff. However, on 11/26/12 the plan of care was not followed when State Registered Nursing Assistant (SRNA) #8 gave Resident #1 a bath by herself and SRNA #7 provided incontinence care to Resident #1 by herself. In addition, SRNA #2 provided incontinence care to Resident #1 during the 11 PM to 7 AM shift on 11/26/12. On the morning of 11/27/12, Resident

F 000 The following constitutes the facility's response to the findings of the Department for Health Services and does not constitute an admission of the facts alleged or conclusions set forth on the summary statement of deficiencies.

F 282 This plan of correction is prepared as required by the provisions of the Health Safety code, 42 CFR and constitutes the facility's written credible allegation of compliance.

F 282 The facilities internal investigation was inconclusive as to how the fracture occurred; residents care plan was updated with new interventions to minimize risk for further injuries and for pain management.

Twenty five nursing employees were interviewed about random residents care plans to ensure they are being followed, 12/10/12 through 12/14/12 by DON and The QA Nurse. No other reports of not following the care plan came out of interviews.



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

*Rebecca Cooley*

TITLE

*Administrator*

(X6) DATE

*12/27/12*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other Safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 282 Continued From page 1

#1 was noted to have dark purple bruise between his/her right shoulder and elbow and a swollen shoulder. Resident #1 was sent to the hospital for evaluation and treatment.

The findings include:

Interview with the Director of Nursing (DON), on 12/07/12 at 7:00 PM, revealed although the facility did not have a written policy related to following care plans the expectation was that staff should always follow the written plan of care. Additional interview with the DON revealed staff was instructed during orientation and during inservices that they were to follow the written plan of care.

Review of the clinical record revealed the facility admitted Resident #1, on 09/21/10, with diagnoses which included a Closed Distocation of Hip, Alzheimer's Disease and Senile Dementia. Review of a Quarterly Minimum Data Set (MDS) assessment, dated 08/29/12, revealed the facility assessed Resident #1 to require extensive assistance of two (2) staff for bed mobility, transfers, dressing, toileting and bathing. Review of Resident #1's Comprehensive Plan of Care related to Activities of Daily Living (ADLs), dated 08/12, revealed Resident #1 was dependent with all ADLs and was at risk for developing complications associated with decreased ADL self-performance related to Alzheimer's Dementia and mood and behaviors problems of pulling or grabbing objects during care. Further review of the Comprehensive Plan of Care and the Nursing Assistant Plan of Care revealed interventions which included Resident #1 was to be given a bath and provided incontinence care with the

F 282

Nursing staff education regarding following the care plan initiated 11/27/12 and will be completed by 1/1/13 by Staff Development Coordinator and / or nursing supervisors

Utilizing the nursing assistant care plans 10 employee interviews will be completed weekly x 4 then monthly x 3 and then quarterly by QA nurse, DON or nursing supervisors to ensure re-education is sustained.

1/2/13

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F 282 Continued From page 2

F 282

assistance of two (2) staff. Additional review of the plan of care revealed staff was to watch the resident's hands during transport.

Observation, on 12/07/12 at 2:40 PM, revealed two (2) State Registered Nursing Assistant's (SRNAs) gave Resident #1 a bed bath. Further observation revealed Resident #1 had dark purple bruising on the resident's upper right arm and a dark purple bruise with yellow/green edges on the resident's right inner elbow area. Additional observation revealed when Resident #1 was turned on his/her right side and again on the left side he/she grabbed the side rail and also the SRNA's shirt.

Review of Nurse's Notes (NN) and a skin assessment, dated 11/27/12, revealed Resident #1 was noted to have swelling and discoloration to the resident's right shoulder.

Interview with SRNA #8, on 12/07/12 at 3:50 PM, revealed on 11/26/12 that although she and another SRNA had transferred Resident #1 to the shower bed she had given Resident #1 his/her shower by herself. She stated Resident #1 was a two (2) person assist for bathing and staff needed to watch his/her arms because Resident #1 "grabs". She stated she should not have given Resident #1 his/her shower by herself. She indicated Resident #1 did not grab onto anything "that she saw" while giving the resident a shower and did not notice any swelling or bruising.

Interview with SRNA #7, on 12/07/12 at 1:15 PM, revealed on 11/26/12 she changed Resident #1's brief by herself. She stated Resident #1 was Care Planned to be a two (2) person assist for

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F 282 . Continued From page 3

F 282

incontinence care and she should have had a second staff with her to change Resident #1. Further interview revealed Resident #1 had a history of grabbing anything he/she could get his/her hands on including a side rail; however, she could not remember if Resident #1 grabbed anything on 11/26/12 while she was changing Resident #1 by herself.

Interview with SRNA #2, on 12/7/12 at 11:15 AM, revealed on 11/26/12 during the 11 PM to 7 AM shift she changed Resident #1's brief by herself because Resident #1 was calm and the other SRNA had gone on break. SRNA #2 indicated if Resident #1 had a bad night where he/she grabbed the side rails or other things then she wouldn't have changed Resident #1 by herself. She further stated Resident #1 was an assist of two (2) for incontinence care and she should not have changed Resident #1 alone.

Interview with SRNA #10, on 12/07/12 at 6:40 PM, revealed she was in the process of changing Resident #1's shirt after breakfast on 11/27/12 and noted Resident #1's left shoulder was swollen and a dark purple bruise was noted above the resident's left elbow. Further interview revealed she informed Licensed Practical Nurse (LPN) #2.

Interview with LPN #2, on 12/07/12 at 4:15 PM, revealed Resident #1 was noted to have a dark purple bruise between his/her shoulder and elbow and a swollen shoulder on the morning of 11/27/12. Further interview revealed when he assessed Resident #1 he/she did not show any signs of pain. LPN #2 stated Resident #1 was a two (2) person assist, which included

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F 282 Continued From page 4  
incontinence care. Additional interview revealed he had never seen staff transfer Resident #1 by themselves.

F 282

Review of a portable x-ray, obtained 11/27/12, revealed Resident #1 sustained a comminuted fracture in the proximal humerus with dislocation at the shoulder.

Interview with Resident #1's Power of Attorney (POA), on 12/06/12 at 5:00 PM, revealed he had observed staff change Resident #1 by themselves. He further stated he would help the staff if they attempted to change Resident #1 by themselves because due to the resident's contracted left leg and because he/she would grab onto the side rail or would attempt to grab onto the staffs clothing during care, he felt it was extremely difficult for one (1) person to provide care for Resident #1. He further stated he did not feel it was safe for one (1) person to provide care to Resident #1. During the interview the POA stated he knew they didn't mean to hurt Resident #1 but they did wrong or he/she wouldn't have had a broken or dislocated arm.

Interview with the Director of Nursing (DON), on 12/07/12 at 7:00 PM, revealed that during her investigation of the injury she even got on the shower bed herself to see how the fracture could have occurred. She stated staff had told her Resident #1 grabbed "stuff" during care and Resident #1 could have reached out and grabbed hold of something and when staff moved Resident #1 he/she could have hit a bar on the shower bed causing the fracture. She stated Resident #1 had been a two (2) person assist since he/she was admitted to the facility for bed

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F 282 Continued From page 5

mobility, incontinence care, and personal hygiene, and at no time should staff have provided those care needs by themselves per the plan of care. Additional interview revealed that during the investigation the facility determined SRNAs #8, #7 and #2 had provided care to Resident #1 by themselves and had not followed the written plan of care. She stated staff involved received a "write up" and all staff were re-educated between 11/27/12 through 11/30/12 related to Resident Safety and following the plan of care.

F 323 483.25(h) FREE OF ACCIDENT  
SS=D 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 facility policy review it was determined the facility failed to ensure one (1) of three (3) sampled residents (Resident #1) received adequate supervision and assistive devices to prevent accidents.

Resident #1 had a known history of grabbing things while staff were providing care and had a plan of care in place with interventions which included Resident #1 was to be bathed and have

F 282 F 323

The facilities internal investigation was inconclusive as to how the fracture occurred residents care plan was updated with new interventions to reduce the risk for further injuries and for pain management.

F 323 The known employees that were identified for not following the care plan received disciplinary action.

Twenty five nursing employees were interviewed about 20 random residents care plans to ensure they are being followed, 12/10/12 through 12/14/12 by the DON and the QA Nurse, no other reports of not following the care plan came out of interviews.

Resident and environmental rounds conducted 12/10/12 through 12/14/12 by the QA Nurse. No hazards identified.

continued on  
page 7 of 11

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F 323 Continued From page 6  
incontinence care provided with the assistance of two (2) staff. However, on 11/26/12 State Registered Nursing Assistant (SRNA) #8 gave Resident #1 a bath by herself and SRNA #7 provided incontinence care to Resident #1 by herself. In addition, SRNA #2 provided incontinence care to Resident #1 during the 11 PM to 7 AM shift on 11/27/12. On the morning of 11/27/12, Resident #1 was noted to have dark purple bruise between his/her right shoulder and elbow and a swollen shoulder and was sent to the emergency room for evaluation and treatment.

The findings include:

Review of the facility's policy titled "Abuse Prevention", dated 05/2011, revealed the facility was committed to maintaining a safe environment for all residents. Further review of the policy revealed resident and environmental rounds were conducted to ensure that resident needs were being met in accordance with the plan of care, that residents were being supervised and that the environment was free of hazards. Additional review of the policy revealed the facility would conduct analysis for trends and patterns related to incidents, such as injuries of unknown origin.

Review of the clinical record revealed the facility admitted Resident #1 on 09/21/10, with diagnoses which included a Closed Dislocation of Hip, Alzheimer's Disease and Senile Dementia. Review of a Quarterly Minimum Data Set (MDS) Assessment, dated 08/29/12, revealed the facility assessed Resident #1 to require extensive assistance of two (2) staff for bed mobility, transfers, dressing, toileting and bathing. Review of Resident #1's Comprehensive Plan of Care

F 323 Residents care equipment/devices (wheel chairs, walkers, shower beds, bedside commodes, hoier lifts, century tubs and scales were checked 12/10/12 through 12/14/12 by the QA nurse, DON and unit managers and devices were in good working order.

Safety rounds and environmental rounds are conducted monthly by the QA nurse or Supervisors.

Nursing staff education regarding following the care plan initiated 11/27/12 and will be completed by 1/1/13 by staff development and / or nursing supervisors

Utilizing the nursing assistant care plans 10 employee interviews will be conducted weekly x 4, then monthly x 3 and then quarterly by the QA Nurse, DON or weekend supervisor to ensure education is sustained.

Environmental and safety rounds will be completed monthly by the QA Nurse or supervisors

1/2/13

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F 323 Continued From page 7

F 323

related to Activities of Daily Living (ADLs), dated 08/12, revealed Resident #1 was dependent with all ADLs and was at risk for developing complications associated with decreased ADL self-performance related to Alzheimer's Dementia and mood and behaviors problems of pulling or grabbing objects during care. Further review of the Comprehensive Plan of Care and the Nursing Assistant Plan of Care revealed interventions which included Resident #1 was to be given a bath and provided incontinence care with the assistance of two (2) staff. Additional review of the plan of care revealed staff were to watch the residents hands during transport.

Observation, on 12/07/12 at 2:40 PM, revealed two (2) State Registered Nursing Assistants (SRNAs) gave Resident #1 a bed bath. Further observation revealed Resident #1 had dark purple bruising on the resident's upper right arm and a dark purple bruise with yellow/green edges on the resident's right inner elbow area. Additional observation revealed when Resident #1 was turned on his/her right side and again on the left side he/she grabbed the side rail and also the SRNA's shirt.

Interviews conducted with SRNA #6, on 12/06/12 at 7:00 PM, SRNA #3 on 12/07/12 at 4:00 PM and SRNA #4 at 3:40 PM revealed Resident #1 was a two person assist because it was difficult to provide incontinence care by yourself due to Resident #1 grabbing anything he/she could get his/her hands onto because Resident #1 had a strong grip.

Review of Nurse's Notes (NN) and a skin assessment, dated 11/27/12, revealed Resident

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F 323 Continued From page 8

F 323

#1 was noted to have swelling and discoloration to the resident's right shoulder.

Interview with SRNA # 8, on 12/07/12 at 3:50 PM, revealed on 11/26/12 that although she and another SRNA had transferred Resident #1 to the shower bed she had given Resident #1 his/her shower by herself. She stated Resident #1 was a two (2) person assist for bathing and staff needed to watch his/her arms because Resident #1 "grabs". She stated she should not have given Resident #1 his/her shower by herself. She indicated Resident #1 did not grab onto anything "that she saw" while giving the resident a shower and did not notice any swelling or bruising.

Interview with SRNA #7, on 12/07/12 at 1:15 PM, revealed on 11/26/12 she changed Resident #1's brief by herself. She stated Resident #1 was Care Planned to be a two (2) person assist for incontinence care and she should have had a second staff with her to change Resident #1. Further interview revealed Resident #1 had a history of grabbing anything he/she could get his/her hands on including a side rail, however she could not remember if Resident #1 grabbed anything on 11/26/12 while she was changing Resident #1 by herself.

Interview with SRNA #2, on 12/7/12 at 11:15 AM, revealed on 11/26/12 during the 11 PM to 7 AM shift she changed Resident #1's brief by herself because Resident #1 was calm and the other SRNA had gone on break. SRNA #2 indicated if Resident #1 had a bad night where he/she grabbed the side rails or other things then she wouldn't have changed Resident #1 by herself. She further stated Resident #1 was an assist of

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F 323 Continued From page 9  
two (2) for incontinence care and she should not have changed Resident #1 alone. F 323

Interview with SRNA #10, on 12/07/12 at 6:40 PM, revealed she was in the process of changing Resident #1's shirt after breakfast on 11/27/12 and noted Resident #1's left shoulder was swollen and a dark purple bruise was noted above the resident's left elbow. Further interview revealed she informed Licensed Practical Nurse (LPN) #2.

interview with LPN #2, on 12/07/12 at 4:15 PM, revealed Resident #1 was noted to have a dark purple bruise between his/her shoulder and elbow and a swollen shoulder on the morning of 11/27/12. Further interview revealed when he assessed Resident #1 he/she did not show any signs of pain. LPN #2 stated Resident #1 was a two (2) person assist, which included incontinence care. Additional interview revealed he had never seen staff transfer Resident #1 by themselves while conducting rounds.

Review of a portable x-ray, obtained 11/27/12, revealed Resident #1 sustained a comminuted fracture in the proximal humerus with dislocation at the shoulder.

Interview with Resident #1's Power of Attorney (POA), on 12/06/12 at 5:00 PM, revealed he had observed staff change Resident #1 by themselves. He further stated he would help the staff if they attempted to change Resident #1 by themselves because due to the resident's contracted left leg and because he/she would grab onto the side rail or would attempt to grab onto the staffs clothing during care, he felt it was

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F 323 Continued From page 10  
extremely difficult for one (1) person to provide care for Resident #1. He further stated he did not feel it was safe for one (1) person to provide care to Resident #1. During the interview the POA stated he knew they didn't mean to hurt Resident #1 but they did wrong or he/she wouldn't have had a broken or dislocated arm.

F 323

interview with the Director of Nursing (DON), on 12/07/12 at 7:00 PM, revealed that during her investigation of the injury she even got on the shower bed herself to see how the fracture could have occurred. She stated staff had told her Resident #1 grabbed "stuff" during care and Resident #1 could have reached out and grabbed hold of something and when staff moved Resident #1 he/she could have hit a bar on the shower bed causing the fracture. She stated Resident #1 had been a two (2) person assist since he/she was admitted to the facility for bed mobility incontinence care and personal hygiene, and at no time should staff have provided those care needs by themselves per the plan of care. Additional interview revealed that during the investigation the facility determined SRNAs #8, #7 and #2 had provided care to Resident #1 by themselves and had not followed the written plan of care. She stated staff involved received a "write up" and all staff were re-educated between 11/27/12 through 11/30/12 related to Resident Safety and following the plan of care.