

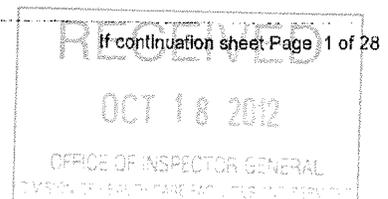
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185348	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/28/2012
NAME OF PROVIDER OR SUPPLIER BROWNSBORO HILLS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2141 SYCAMORE AVENUE LOUISVILLE, KY 40206		
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F 000	INITIAL COMMENTS An abbreviated survey investigating KY18965 was initiated 08/23/12 and concluded on 08/28/12. The Division of Health Care did not substantiated the allegation, however, unrelated deficiencies were cited.	F 000	Brownsboro Hills Health Care acknowledges receipt of the statement of deficiencies and the plan of correction does not constitute any admission that any deficiencies are accurate. The plan of correction is submitted as a written allegation of compliance.		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	Comprehensive care plans of residents identified with behaviors will be reviewed and revised by the Interdisciplinary Team by 10/4/12. 3. Social Services Director has been re-educated by the Regional Case Mix Consultant on the assessment of residents for mood and/or behaviors and the coding of the MDS 3.0 by 9/28/12.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X Jane Stahl / Bill Fanlow TITLE: Director of Clinical Services (X6) DATE: X 10/18/12

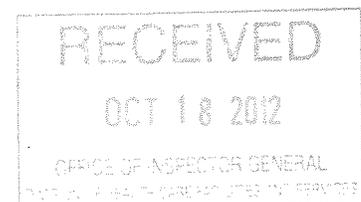
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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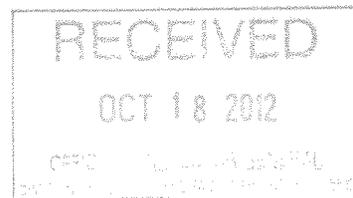
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F 278	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility policy, it was determined the facility failed to complete an accurate admission assessment for behaviors for one (1) of seven (7) sampled Residents, (#1). Resident #1 had no documented behaviors during the five day Assessment Reference date period or the fourteen day Assessment Reference date period. The findings include: The facility stated they use the Resident Assessment Instrument (RAI) as their guide to complete the Minimum Data Set (MDS) Assessment. Review of the RAI manual revealed the Comprehensive Assessments Section indicated the Assessment Reference Dates were the last day of the observation and count back to determine the beginning of the observation/look back period. A 7-day observation period would be day 8 of admission (ARD + 6 previous calendar days). Page 2-39 of the RAI manual stated nursing homes are required to conduct initial and periodic assessments for all their residents. The assessment information was used to develop, review and revise the residents plan of care that will be used to provide services to attain or maintain the residents highest practical physical, mental, and psychological well being. Review of the clinical record for Resident #1 revealed the facility admitted the resident on 07/28/12 with diagnoses including: Status Post Right Total Knee Replacement, Encephalopathy	F 278	Nursing staff have been re-educated by the Director of Clinical Services and/or the Assistant Director of clinical Services on the accurate assessment and documentation of behavior in the clinical record and care tracker (electronic medical record for the capturing of ADL-Behaviors as well as communication to staff). Nursing staff will complete pre and post testing to assess understanding of this education prior to taking assignment on next scheduled shift. Licensed nursing staff have been re-educated by the Director of Clinical Services and/or Assistant Director of Clinical Services on the management of resident behaviors and the use of non pharmacological interventions by 10/4/12. Nursing staff will complete pre and post testing to assess understanding of this education prior to taking assignment on next scheduled shift.		



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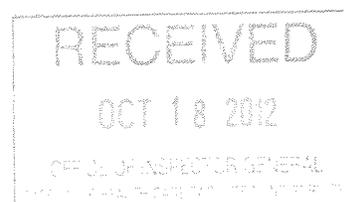
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F 278	<p>Continued From page 2</p> <p>secondary to Herpes Simplex Virus, Confusion, Seizures, Renal Insufficiencies, and Gastrostomy feeding tube.</p> <p>Review of the Nurses notes for Resident #1 revealed on 08/01/12 a change of condition was completed as the resident was found on the floor. The nurse documented confusion and restlessness in the post fall assessment dated 08/01/12. On 08/02/12 the Nurse documented the resident was confused and anxious, and had 1:1 supervision with a Certified Nursing Assistant. On 08/03/12 the Nurse documented in the nurses notes at 2:30 PM the Therapy Department had reported the resident, while in therapy at 10:20 AM, had behaviors including aggressive grabbing of staff, stripping off clothes, yelling and attempted to bite staff. Continued review of the nurses notes for 08/03/12 revealed Resident #1 refused to allow staff to connect the feeding tube from 4:00 PM - 9:00 PM. Nurses notes on 08/04/12 at 2:00 AM revealed the tube feeding was held because the resident was observed unhooking the pump from the tube.</p> <p>Review of the five (5) day Admission MDS Assessment with an Assessment Reference Date of 08/04/12 revealed the facility was unable to complete the cognitive Brief Interview for Mental Status (BIMS), and documented the resident had short term and long term memory problems. Documentation on the Mood and Behaviors portion of the MDS revealed the staff did not code for any mood or behavior symptoms.</p> <p>Review of the Nurses notes for Resident #1 revealed on 08/05/12 the resident pulled the G-tube apart, was restless most of the shift and</p>	F 278	<p>Staff have been re-educated by the Director of Clinical Services and/or Assistant Director of Clinical Services on the importance of notification to the nurse of resident behaviors. Staff will complete pre and post testing to assess understanding of this education prior to taking assignment on next scheduled shift.</p> <p>Competency of staff regarding the documentation of behaviors and completing an accurate assessment will be determined through the ongoing auditing of new 5 and 14 day assessments in comparison to the clinical record by the IDT (RN MDS Coordinator, MDS Nurse, Activities Director, Dietary Manager, and Social Services Director) prior to transmission of the assessment. Any variances will result in the correction of the MDS prior to transmission.</p> <p>4. The Director of clinical Services, Assistant Director of Clinical Services and/or RN MDS Coordinator will QI monitor all new admission 5 and 14 day assessments prior to transmission of the assessment, weekly x 4 weeks then monthly x 2 months then quarterly to ensure accurate assessment of behaviors.</p>



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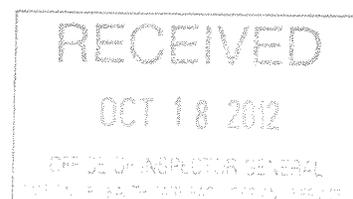
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F 278	<p>Continued From page 3</p> <p>was brought to the nurses station for 1:1 supervision. On 08/06/12 the resident was found up on the side of the bed stripping clothes off, removing the abdomen binder and attempting to disconnect the G-tube. Further documentation's revealed Resident #1 was brought to the nurses station for increased supervision. On 08/07/12 Resident #1 had a fall at 2:00 AM. The nurses notes revealed the resident was restless and confused. Nurses notes written at 8:45 PM revealed the residents monitored with 1:1 supervision at the nurses station, and the resident was anxious when left alone. On 08/09/12 the nurse documented at 4:00 AM the resident was found at the side of the bed with the feeding tube pulled apart and the machine was on the floor. The nurse wrote the resident was confused and brought to the nurses station for the remainder of the shift with 1:1 supervision. On 08/10/12 the nurses documented at 4:00 AM Resident #1 had increase anxiety and was given as needed ativan and Tramadol that was ineffective. The resident was brought to the nurses station for supervision because the resident was pulling apart the G-Tube feeding. At 4:45 AM the resident attempted an unsafe transfer and was yelling.</p> <p>Review of the Psychiatric Consult report, dated 08/10/12, revealed the MD had visited on 08/10/12 and stated Resident #1 had bitten the Assistant Director of Nursing on the arm unprovoked.</p> <p>Review of the fourteen (14) day MDS Assessment with an Assessment Reference date of 08/11/12 revealed the facility was unable to complete the BIMS assessment. Documentation for Mood and Behaviors again revealed no</p>	F 278	<p>The Administrator will over see the department heads' compliance with the audit tools and completion of pre/post testing. The Director of Clinical Services will bring the findings of the audits to the Risk Management/Quality Improvement meeting at least quarterly for review and development of an action plan to ensure accurate admission assessments for behaviors is completed. Need for more frequent monitoring will be determined during the QI meeting.</p> <p style="text-align: right;">F278 10/18/12</p>



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F 278	<p>Continued From page 4</p> <p>indication the resident exhibited any mood or behavior issues. An assessment completed on 08/11/12 revealed the functional status for Resident #1 required extensive assistance with 1-2 staff for ambulation, dressing and eating.</p> <p>Interview with the MDS Coordinator, on 08/27/12 at 9:10 AM, revealed she oversees the RAI process. She stated the Social Service Director entered the information for the behavior and mood section of the Assessment. She stated everyone was responsible to ensure care plans are developed and revised.</p> <p>Interview with the Social Services Director, on 08/27/12 at 9:55 AM, revealed she completed the mood and behaviors section on the MDS for Resident #1. She stated both the 5 day Assessment and 14 day assessment were not accurate and did not reflect the behaviors the resident was having. She stated that she just missed them.</p> <p>F 279 483.20(d), 483.20(k)(1) DEVELOP SS=D COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's</p>	F 278	<p>F 279</p> <ol style="list-style-type: none"> 1. Resident #1 was transferred to the hospital on 8/19/12. Resident #7 was a closed record review. 2. Current residents have been reviewed by the Interdisciplinary Team (MDS Coordinator, Social Services Director, Activities Director, Dietary Manager, MDS Nurse and Assistant Director of Clinical Services) by 9/21/12 to determine if the resident was accurately assessed for behaviors. No issues identified during this review.



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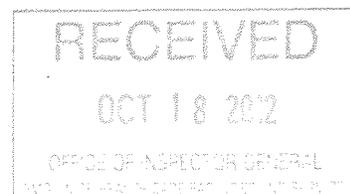
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F 279	<p>Continued From page 5</p> <p>highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review, and review of the facility's policy, it was determined the facility failed to develop a care plan for two (2) of seven (7) sampled residents (#1, and #7). The facility assessed Resident #1 upon admission at high risk for falls and failed to develop an initial care plan for falls. The resident had falls on 07/30/12, and 08/01/12; however, the facility failed to develop a care plan for falls until 08/06/12. The facility failed to develop a care plan for behaviors after Resident #1 exhibited multiple behaviors during the stay. In addition, the facility assessed Resident #7 upon admission as a high falls risk; however, failed to add any new interventions in place after the resident after a fall on 07/25/12 and 07/28/12.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Falling Stars Program, effective 03/12, revealed: 8) the performance improvement team will review each resident on the program, and assessments will be updated and new care plans will be developed as needed.</p> <p>The facility revealed they used the Resident</p>	F 279	<p>Comprehensive care plans of residents identified with behaviors have been reviewed and revised by the Interdisciplinary Team by 10/4/12.</p> <p>Current residents have had a falls assessment completed by MDS Coordinator, MDS Nurse, Unit Manager, Nurse Supervisor, and Assistant Director of Clinical Services by 9/28/12. These assessments have been reviewed by the Interdisciplinary Team for accuracy and reassessed as indicated. Appropriate safety measures and interventions have been updated/developed by the Interdisciplinary Team on the care plan by 10/4/12.</p> <p>Residents at high risk for falls have been identified with a star on the door plate, MAR/TAR and resident equipment.</p> <p>Current residents have been reviewed by the Interdisciplinary Team by 9/21/12 to determine if the resident was accurately assessed for behaviors. A new MDS will be completed as necessary.</p>
			<p>Comprehensive care plans of residents identified with behaviors have been reviewed and revised by the Interdisciplinary Team by 10/4/12.</p>

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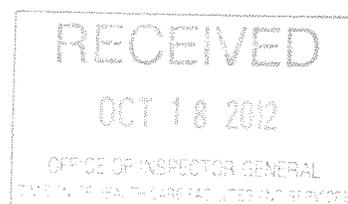
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F 279	<p>Continued From page 6</p> <p>Assessment Instrument (RAI) Guidelines in regards to completion of Care Plans. Review of the Centers for Medicare and Medicaid (CMS) RAI Version 3.0 Guidelines Chapter 2-39 Care Plan Completion revealed the Interdisciplinary Team (IDT) must evaluate the information gained to develop a care plan that addresses those findings in the context of the resident's strengths, problems, and needs.</p> <p>Review of the Centers for Medicare and Medicaid (CMS) RAI Version 3.0 Guidelines Section E, revealed Review of the Behaviors included those that are potentially harmful to the resident himself or herself. Identification of the frequency and the impact of the behavioral symptoms on the resident and on others was critical to distinguish which behaviors that constitute problems for the resident from those that are not problematic. Once the frequency and impact of the behavioral symptoms are accurately determined, follow-up evaluation and care plan interventions can be developed to improve the symptoms or reduce their impact.</p> <p>1. Review of the closed clinical record for Resident #1 revealed the facility admitted the resident on 07/28/12 with diagnoses including Encephalopathy secondary to Herpes Simplex Virus, Confusion, Seizures, and Right Total Knee Replacement. The facility assessed the resident on 07/28/12 to determine the risk for falls and found the resident as high risk with a score of 12. (A score of >10 indicated the resident was high risk for falls) and indicated the resident had 1-2 falls in the past 3 months.</p> <p>Review of the admission care plan, undated, for</p>	F 279	<p>3. Social Services Director have been re-educated by the Regional Case Mix Consultant on the assessment of residents for mood and/or behaviors and the coding of the MDS 3.0 by 9/28/12.</p> <p>Nursing staff have been re-educated by the Director of Clinical Services and/or the Assistant Director of clinical Services on the accurate assessment and documentation of behavior in the clinical record and care tracker (electronic medical record for the capturing of ADL-Behaviors as well as communication to staff by 10/4/12. Nursing staff will complete pre and post testing to assess understanding of this education prior to taking assignment on next scheduled shift.</p> <p>Licensed nursing staff have been re-educated by the Director of Clinical Services and/or Assistant Director of Clinical Services on the management of resident behaviors and the use of non pharmacological interventions by 10/4/12. Nursing staff will complete pre and post testing to assess understanding of this education prior to taking assignment on next scheduled shift.</p>



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F 279	<p>Continued From page 7</p> <p>Resident #1 revealed the facility determined the problem areas were Activities of Daily Living Functional/ rehab potential, infection alert, Dehydration, Tube feeding and Diabetes. There was no documentation on the care plan for high risk for falls, and the fall risk score was not included on the care plan.</p> <p>Continued review of the clinical record for Resident #1 revealed a change of condition was completed related to a fall on 07/30/12 from the bed with no injury. A Physician's order was written for a low bed with fall mats and a bed alarm. The resident sustained a second fall on 08/01/12 with no injuries. A change of condition was completed related to the fall. A Physicians order was again written for a low bed with floor mats and a bed alarm. The Comprehensive Care Plan for falls was not developed for Resident #1 until 08/06/12.</p> <p>Interview with Registered Nurse (RN) #2/Supervisor, on 08/27/12 at 7:45 AM, revealed when the facility admitted a resident all three shifts do a part of the admission. She stated based on the responsibility of the Admission/Readmission Data Collection, the third nurse would have completed the admission care plan for Resident #1. She stated the resident should have been checked for high falls risk based on the falls risk score of 12. She went on to say after the resident had a fall the IDT should have met and added interventions to the care plan. She could not explain the rationale for why a care plan had not been developed for Resident #1 after the falls on 07/30/12 and 08/01/12 and did not know why the same physicians order was written twice for the low bed with fall mats and</p>	F 279	<p>Staff have been re-educated by the Director of Clinical Services and/or Assistant Director of Clinical Services on the importance of notification to the nurse of resident behaviors by 10/4/12. Nursing staff will complete pre and post testing to assess understanding of this education prior to taking assignment on next scheduled shift.</p> <p>Staff have been re-educated on the falls program and the visual identification of residents at high risk for falls by the Director of clinical Services and/or Assistant Director of clinical Services by 10/4/12. Nursing staff will complete pre and post testing to assess understanding of this education prior to taking assignment on next scheduled shift.</p> <p>To evaluate the competency of staff in development of the comprehensive care plan, the Director of Clinical Services will be notified following the fall to assist the nursing staff in identifying appropriate interventions to reduce the risk of further falls.</p>	



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F 279	Continued From page 8 bed alarm. Review of the closed clinical record for Resident #1 revealed on 08/01/12 the nurse's documented the resident was confused, restless and a Certified Nursing Assistant (CNA) was sitting with the resident. On 08/03/12 the nurse documented while in therapy, the resident was aggressive, grabbing staff, stripping off clothes, yelling and attempting to bite staff. On 08/04/12 nursing documented the resident was having 1:1 supervision at the nurses' station due to high risk for falls. On 08/07/12 the nurse's notes revealed the resident was anxious on first and second shift. The nurses continued to monitor the resident at the nurses' station, as the resident gets very anxious when left alone at the nurses' station. On 08/09/12 the nurse's notes revealed the resident was very anxious, and the feeding tube machine was found on the floor. On 08/10/12 the nurses notes indicated the resident was very anxious, disconnected the feeding tube, and had the bed alarm tucked under the arm while up in the room. On 08/13/12 the nurses notes indicated the resident was moved to the B unit, a semi-private room, but had to be moved back to unit F as the resident was very agitated, had threatened the roommate with a fork, and threw a cup out in the hallway at a passing resident. The nurse's notes from 08/14/12-08/19/12 revealed the resident continued to attempt to get up without assist and required increased supervision.	F 279	The Administrator will be reviewing incidents 5 days a week in the morning meeting. Ongoing the residents falls care plan will be QI monitored by the IDT (RN MDS Coordinator, MDS Nurse, Activities Director, Dietary Manager, and Social Services Director) post incident during the daily operations meeting the next business day following a fall. Any variances will result in the correction of the care plan. Re-education will be provided as identified. 4. The Administrator will ensure that the audit tools are completed appropriately. The Director of Clinical Services, Assistant Director of Clinical Services and/or RN MDS Coordinator will QI monitor comprehensive care plans per the assessment calendar, weekly x 4 weeks then monthly x 2 months then quarterly to ensure the development of an appropriate comprehensive care plan.		
	Review of the Psychiatric initial consult, completed on 08/10/12, revealed Resident #1 had bitten the Assistant Director of Nursing's (ADON) arm unprovoked.				



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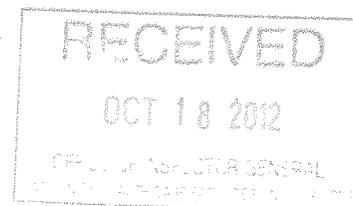
PRINTED: 09/12/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185348	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/28/2012
NAME OF PROVIDER OR SUPPLIER BROWNSBORO HILLS NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2141 SYCAMORE AVENUE LOUISVILLE, KY 40206		
(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)	(X6) COMPLETION DATE
F 279	Continued From page 9 Review of the comprehensive Care Plan for Resident #1 revealed no care plan for behaviors. (Refer to tag F278). 2. Review of the closed clinical record for Resident #7 revealed the facility admitted the resident on 07/25/12 with diagnoses including Diabetes, End Stage Renal Disease, Dialysis Dependent, and status post Right Below the Knee Amputation. Review of the admission assessment completed on 07/25/12 revealed the facility assessed the resident at a high falls risk with a score of 20. The facility assessed the resident's cognitive status as alert, short and long term memory okay and independent with decision making. Review of the admission care plan, dated 07/25/12, revealed the facility checked goals for ADL Functional, Rehab potential, Pain, Diabetes, and Visual function. The facility checked under falls to instruct the resident on appropriate safety measures. However, nothing else was written to instruct staff what appropriate safety measures were, and there was no indication of a falls risk, including the falls risk score or the falls that occurred on 07/25/12 and 07/28/12. No interventions were documented after the falls on 07/25/12 and 07/28/12. The comprehensive care plan was not developed until 08/02/12 and did not include the falls on 07/25/12 and 07/28/12.	F 279	The Director of Clinical Services will bring the findings to the Risk Management/Quality Improvement meeting at least quarterly for review and development of an action plan to ensure appropriate care plans are being developed. Need for more frequent monitoring will be determined during the QI meeting.	279 10/18/12
	Interview with the MDS Coordinator, on 08/27/12 at 9:10 AM, revealed all staff was responsible to update the care plan. She stated normally after a resident had a fall, the Interdisciplinary (IDT) team would meet the following business day and review the fall investigation and update the care			

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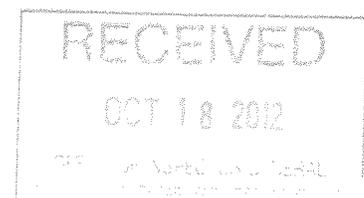
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F 279 F 280 SS=E	Continued From page 10 plan. She stated interventions should have been implemented to prevent further falls. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent 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. 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 revise the care plan for three (3) of seven (7) sampled residents. The facility failed to revise the care plan for Residents #1, #2, and #3, after the residents had falls.	F 279 F 280	F 280 1. Resident #1 transferred to the hospital on 8/19/12. Resident #2's comprehensive care plan was reviewed and revised by the IDT on 8/29/12. Resident #3's comprehensive care plan was reviewed and revised by the IDT on 8/29/12. 2. Current residents have had a falls assessment completed by nurse management by 9/28/12. These assessments will be reviewed by the Interdisciplinary Team for accuracy and reassessed as indicated. Appropriate safety measures and interventions will be updated/developed by the Interdisciplinary Team on the care plan by 10/4/12.



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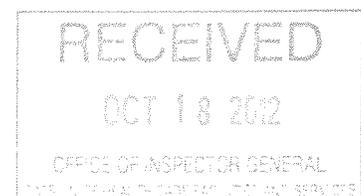
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F 280	Continued From page 11 The findings include: The facility revealed they used the Resident Assessment Instrument (RAI) Guidelines in regards to completion of Care Plans. Review of the Centers for Medicare and Medicaid (CMS) RAI Version 3.0 Guidelines for Section J Falls, revealed residents who are identified as a high falls risk is a top priority for care planning. A fall should stimulate evaluation of the residents need for rehabilitation, ambulation aids and the need for additional monitoring. 1. Review of the closed clinical record for Resident #1 revealed the facility admitted the resident on 07/28/12 with diagnoses including Encephalopathy secondary to Herpes Simplex Virus, Confusion, Seizures, and Right Total Knee Replacement. The admission assessment completed on 07/28/12 indicated the resident had 1-2 falls in the past 3 months. Review of the admission MDS (Minimum Data Set) Assessment completed 08/13/12 revealed the facility assessed the resident to have short and long term memory loss with moderately impaired decision making ability. In addition, the facility assessed the resident as requiring extensive assistance with one person physical assist for bed mobility and transfers with no ambulation during the assessment reference date. The resident sustained falls on 07/30/12, 08/01/12, 08/07/12, and 08/16/12 without injuries. The resident sustained a fall on 08/18/12 and the nurse assessed the resident as having swelling to the right side of the face and right thigh. X-rays	F 280	Residents identified as high risk for falls have been assessed for the need for ambulation aids and the need for additional monitoring by the Director of clinical Services by 10/4/12. 3. Licensed nursing staff have been re-educated by the Director of clinical Services and/or Assistant Director of Clinical Services on the importance of the development, implementation and documentation of new interventions on the resident's comprehensive care plan immediately following a fall by 10/4/12. Nursing staff will complete pre and post testing to assess understanding of this education prior to taking assignment on next scheduled shift. To evaluate the competency of staff in the revision of the care plans post falls, the Director of Clinical Services will be notified following the fall to assist the nursing staff in identifying appropriate interventions to reduce the risk of further falls.	



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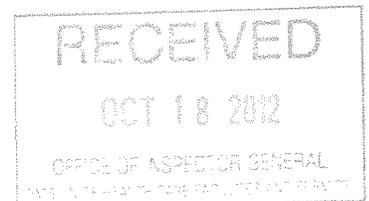
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F 280	Continued From page 12 were obtained and were negative for fracture. The resident sustained another fall on 08/19/12 and was sent to the hospital related to low blood pressure. Review of the comprehensive care plan for Resident #1 initiated on 08/06/12 revealed the resident was at risk for injury related to falls. The interventions were: provide needed devices for locomotion, transfer, etc; therapy as ordered; low bed with mat as ordered; bed alarm as ordered; assist with transfers as indicated; observe for sign and symptoms from medication such as dizziness, increased confusion, sedation or weakness; and Psychiatric referral. There were no new Interventions put into place after 08/06/12 to assist with the prevention of additional falls. 2. Review of the clinical record for Resident #3 revealed the facility admitted the resident on 12/30/04 with the most recent readmission on 03/21/11. The resident had diagnoses including Alzheimer Dementia, Decline in Condition, and Multiple Falls. Review of the MDS, dated 08/10/12, was completed as a significant change assessment due to a decline in condition and revealed the resident required extensive assistance of one person with bed mobility, transfers and mobility. Review of the change of condition, dated 07/26/12, revealed the resident was found on the floor on 07/26/12 at 9:30 PM. No injuries were noted at the time. Review of the care plan, potential for injury	F 280	Ongoing the residents falls care plan will be QI monitored by the IDT (RN MDS Coordinator, MDS Nurse, Activities Director, Dietary Manager, and Social Services Director) post incident during the daily operations meeting the next business day following a fall. Any variances will result in the correction of the care plan. Re-education will be provided as identified. 4. The Administrator will hold the department head accountable for the audit completion. The Director of Clinical Services, Assistant Director of Clinical Services and/or RN MDS Coordinator will QI monitor falls care plans post incident, weekly x 4 weeks then monthly x 2 months then ongoing quarterly to ensure the revision of the falls care following an incident. The Director of Clinical Services will bring the findings to Risk Management/Quality Improvement meeting which will meet at least quarterly for review and development of an action plan to ensure care plans are being revised as needed. Need for more frequent monitoring will be determined by the committee during the QI meeting.	280 10/18/12



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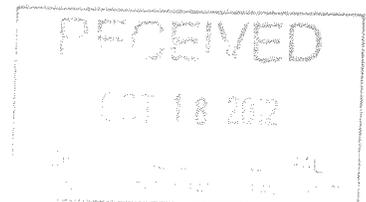
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F 280	<p>Continued From page 13</p> <p>related to falls for Resident #3 initiated on 01/09/12 revealed no documentation of the fall on 07/26/12 or any interventions put in place after the fall. The care plan included documentation of the resident climbing out of the bed and scooting across the floor on 07/29/12 with no interventions or documentation of injury.</p> <p>Review of the nurses notes for Resident #3 revealed on 08/01/12, 08/02/12, 08/03/12 the resident had a sitter at the bedside.</p> <p>Review of the care plan initiated on 01/09/12 and 08/10/12 revealed no documentation of an intervention for a sitter.</p> <p>Observation on 08/23/12 at 1:45 PM revealed Resident #3 had a 1:1 sitter. On 08/23/12 at 4:15 PM, Resident #3 was laying in bed with eyes closed. No sitter was present. Continued observations, on 08/25/12 at 8:10 PM, revealed Resident #3 had a sitter at the bedside. On 08/26/12 at 7:15 PM, Resident #3 had a sitter at the bedside</p> <p>Interview with RN #2/Supervisor, on 08/23/12 at 4:30 PM, revealed Resident #3 had a sitter on and off. She stated they assessed the resident to determine if the resident needed a sitter on a daily basis. She stated recently the resident had needed a sitter due to a decline in health, increase in agitation, and increase in falls.</p>	F 280	
	<p>Interview with Certified Nursing Assistant (CNA) #1, on 08/28/12 at 9:15 AM, revealed Resident #3 has had a sitter for about two months because the resident was a "continuous" falls risk. The CNA stated the CNA's were told verbally on a</p>		



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F 280	<p>Continued From page 14 daily basis about the sitter assignments.</p> <p>3. Review of the clinical record for Resident #2 revealed the facility admitted the resident on 04/28/07 with Diagnoses including Pneumonia, Congestive Heart Failure, and Diabetes. Review of the quarterly MDS assessment completed on 06/14/12 revealed the facility assessed the resident as requiring limited assistance with one person physical assist with bed mobility and transfers. The resident ambulated with supervision and one person physical assist. The facility assessed the resident's cognition as moderately impaired. Review of the change of conditions revealed the resident had a fall on 06/25/12 out of the bed without injury, on 07/20/12 the resident slid off the side of the bed to the floor, and on 07/27/12 the resident slid on to the floor from the bed and skinned the left knee.</p> <p>Review of the comprehensive care plan for Resident #2, initiated on 08/02/12, revealed no documentation of the falls on the care plan or any assessment of the interventions to determine if new interventions were needed to prevent additional falls.</p> <p>Interview with Registered Nurse (RN) #1, on 08/23/12 at 2:25 PM, revealed she was not trained to make changes to the care plan. She stated she never added any interventions to the care plan and that someone else did the care plan.</p> <p>Interviews with Licensed Practical Nurse (LPN)</p>	F 280	



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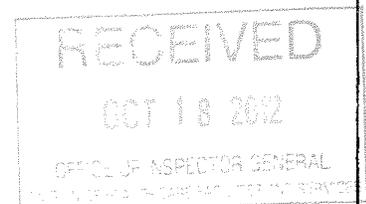
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F 280	<p>Continued From page 15</p> <p>#1, on 08/24/12 at 9:30 AM, revealed LPN #3 on 08/24/12 at 4:25 PM, LPN #6 on 08/25/12 at 5:40 PM, LPN #5 on 08/25/12 at 7:50 PM and LPN #2 on 08/26/12 at 7:20 PM, all stated they had not added interventions to the care plan for any reason including falls as that was the MDS nurse, Director of Nursing and Assistant Director of Nursing's responsibility.</p> <p>Interview with the MDS Coordinator, on 08/27/12 at 9:10 AM, revealed all staff was responsible to update the care plan. She stated normally after a resident had a fall, the Interdisciplinary (IDT) team will meet the following business day and review the fall investigation and update the care plan. She stated it was the facilities responsibility to prevent any injury from a fall for residents and interventions should have been implemented to prevent falls to the best of their ability.</p> <p>Interview with the ADON, DON and Administrator, on 08/27/12 at 10:30 AM, revealed the nurses on the unit and the management team was responsible to ensure interventions were put into place after a fall. They acknowledged there were no new interventions put into place for Resident #1 after the fall on 08/16/12 and 08/18/12 to prevent further falls or injury from falls.</p>	F 280	
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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</p>	F 323	<p>F 323</p> <p>1. Resident #1 was transferred to the hospital on 8/19/2012.</p>



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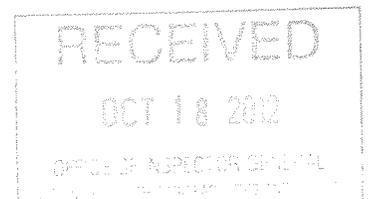
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F 323	Continued From page 16 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to provide adequate supervision or appropriate interventions to prevent falls for one (1) of seven (7) sampled residents (#1). The facility failed to provide increased supervision for Resident #1 after the resident had multiple falls and the staff had assessed and requested more staff to supervise the resident. (Refer to F353) The findings include: The facility did not provide a policy regarding the utilization of sitters, assessment of residents, or management of residents who may potentially require the use of a sitter. Observation, on 08/23/12 at 1:20 PM, revealed the F unit had one nurse to deliver care to four residents. Licensed Practical Nurse (LPN) #1 was in a resident's room from 1:20 PM until 1:30 PM. Additional observation, on 08/25/12 at 5:30 PM, of the F unit revealed one nurse to provide care to five residents who required assistance with ADLs (activities of daily living). Review of the closed clinical record for Resident #1 revealed the facility admitted the resident on	F 323	2. Current residents have had a falls assessment completed by MDS Coordinator, MDS Nurse, Unit Manager, House Supervisor and/or Assistant Director of Nursing by 9/28/12. These assessments have been reviewed by the Interdisciplinary Team for accuracy and reassessed as indicated. Appropriate safety measures and interventions will be updated/developed by the Interdisciplinary Team on the care plan by 10/4/12. Residents at high risk for falls have been identified with a star on the door plate, MAR/TAR and resident equipment. No residents were identified as requiring additional supervision to reduce the risk of falls.		



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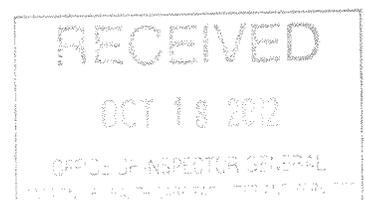
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F 323	Continued From page 17 07/28/12 to the F unit with diagnoses including Encephalopathy secondary to Herpes Simplex Virus, Confusion, Seizures, and Right Total Knee Replacement. The admission assessment completed on 07/28/12 indicated the resident had 1-2 falls in the past 3 months. Review of the admission MDS (Minimum Data Set) Assessment, dated 08/13/12, revealed the facility assessed the resident to have short and long term memory loss with moderately impaired decision making ability. In addition, the facility assessed the resident as requiring extensive assistance of one person for bed mobility and transfers with no ambulation occurring during the assessment reference period. Review of the admission assessment for Resident #1 revealed the facility had assessed the resident for high falls risk upon admission; however, failed to initiate a care plan or put interventions in place upon admission. Continued review of the clinical record for Resident #1 revealed a change of condition related to a fall, on 07/30/12, from the bed without injury. The facility wrote a Physician's order for a low bed with fall mats and a bed alarm. The resident had a second fall on 08/01/12 from the bed without injury. Registered Nurse (RN) #1 documented in the nurses note, the resident needed a bed alarm, and the nursing supervisor was notified.	F 323	3. Licensed nursing staff have been re-educated as of 10/4/2012 by the Director of clinical Services and/or Assistant Director of Clinical Services on the realignment of the staffing patterns and the importance of the development, implementation and documentation of new interventions on the resident's comprehensive care plan immediately following a fall. Nursing staff will complete pre and post testing and have verbal verification of understanding of the staffing realignment to assess understanding of this education prior to taking assignment on next scheduled shift. Staff have been re-educated on the falls program and the visual identification of residents at high risk for falls by the Director of clinical Services and/or Assistant Director of clinical Services by 10/4/12. Nursing staff will complete pre and post testing to assess understanding of this education prior to taking assignment on next scheduled shift.		
	Interview with the Administrator, on 08/27/12 at 10:30 AM, revealed on the facility investigation, nursing determined the bed alarm was not sounding and the batteries were replaced.				



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F 323	<p>Continued From page 18</p> <p>Review of the 08/07/12 clinical change of condition revealed Resident #1 had a fall, on 08/07/12 at 2:00 AM, without injury. Review of the care plan revealed the comprehensive care plan was developed on 08/06/12 with a Psychiatric consult written on 08/06/12. No other interventions were on the care plan.</p> <p>Interview with the Administrator, on 08/27/12 at 10:30 AM, revealed the falls investigation determined the resident was found in the room on the floor. She stated nursing brought the resident to the nurses' station and was waiting on the psychiatric consult.</p> <p>Review of the 08/16/12 clinical change of condition for Resident #1 revealed the resident had a fall in the resident's room, on 08/16/12 at 8:00 PM, and the bed alarm was sounding. No new interventions were on the care plan.</p> <p>Interview with the Administrator, on 08/27/12 at 10:30 AM, revealed the falls investigation determined the resident was brought to the nurses' station for 1:1 supervision related to behaviors as the intervention.</p> <p>Review of the 08/18/12 clinical change of condition for Resident #1, revealed the resident had a fall out of the Geri-Chair at the nurses' station on 08/18/12 at 9:45 PM. The resident had swelling of the right side of the face and right thigh. An X-ray was obtained and was found to be negative.</p> <p>Interview with the Administrator, on 08/27/12 at 10:30 AM, revealed the falls investigation had no documentation of new interventions added to the</p>	F 323	<p>To evaluate the competency of staff in the revision of the care plans post falls and the completion of the QI monitoring tool entitled Root Cause Analysis, the Director of Clinical Services will be notified following the fall to assist the nursing staff in identifying appropriate interventions to reduce the risk of further falls.</p> <p>Ongoing the residents falls care plan and the QI monitoring tool entitled Root Cause Analysis will be QI monitored by the members of the daily morning meeting, which is comprised of the Administrator, Director of Clinical Services, Assistant Director of Clinical Services, the RN MDS Coordinator, MDS Nurse, Activities Director, Dietary Manager, and Social Services Director, post incident during the daily operations meeting the next business day following incident.. Any variances will result in the correction of the care plan. Re-education will be provided as identified.</p>		



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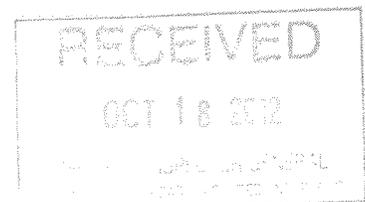
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F 323	<p>Continued From page 19</p> <p>care plan. The resident was put back on 1:1 supervision based on documentation in the nurse's notes.</p> <p>Review of the 08/19/12 clinical change of condition for Resident #1 revealed the resident had a fall out of the Geri-chair on 08/19/12 at the nurses' station. The nurse's notes indicated the Geri-chair was in the upright position. The resident was sent out to the hospital after the fall due to a low blood pressure of 88/60. The resident was unresponsive when the ambulance arrived.</p> <p>Interview with RN #1, on 08/23/12 at 3:25 PM, revealed on the F unit if there were 7 or fewer residents the Nurse provided primary care with no other staff on the unit. She stated Resident #1 had 1:1 supervision at times unless she had to go answer a call light. She stated she reported to the supervisors Resident #1 needed more supervision. Continued interview, on 08/24/12 at 5:15 PM, revealed she stated she had reported to the weekend supervisor on 08/18/12 of Resident #1 needing more supervision. She stated she was doing primary care on Saturday for six residents and there was no other staff working on the unit. She stated the weekend supervisor did provide a CNA on the F unit on 08/19/12 and the CNA sat with Resident #1 most of the time. She stated when the resident fell on 08/19/12 the CNA took a lunch break and then a resident on the unit started yelling so she went to check on that resident and that's when Resident #1 fell out of the chair.</p> <p>Interview with Registered Nurse (RN) #2/Supervisor, on 08/27/12 at 7:45 AM, revealed</p>	F 323	<p>4. The Director of Clinical Services will bring the findings to the Risk Management/Quality Improvement meeting held at least quarterly for effectiveness of the realignment of the staff for increased supervision by evaluating the QI tool entitled Root Cause Analysis to identify the causative factor of the incident. Need for more frequent monitoring will be determined during the QI meeting.</p> <p>The Director of Clinical Services will bring the findings to the monthly Risk Management/Quality Improvement meeting for review and development of an action plan to ensure care plans are being revised as needed. Need for more frequent monitoring will be determined during the QI meeting.</p>	323 10/18/12



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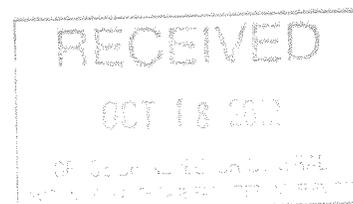
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F 323	<p>Continued From page 20</p> <p>she did not have authorization to approve extra staffing for a sitter and she would have to call the DON or Administrator for approval. She went on to say that about a week prior to the falls on 08/18/12 and 08/19/12, she had attended morning meeting, and it was brought up that Resident #1 possibly needed a sitter but there was no follow up. She stated she believed Resident #1 needed a sitter.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 08/23/12 at 2:25 PM, revealed on the F unit if there were seven or fewer residents the nurses did primary care and had no other staff on the unit.</p> <p>Interview with LPN #1, on 08/24/12 at 9:30 AM, revealed Resident #1 needed 1:1 care and that she had documented that information on the 24 hour report. She stated she did as much as she could for Resident #1 but the resident did not have a specific order for 1:1 supervision.</p> <p>Interview with the Director of Nursing (DON), on 08/23/12 at 9:44 AM, revealed the facility did not keep the 24 hour reports and they were shredded after they were reviewed. Continued interview with the DON on 08/23/12 at 11:05 AM revealed on the F unit if there are 7 residents or less they look at the acuity and determine if there needed to be 1 nurse or 1 nurse and a Certified Nursing Assistant (CNA). She stated if it was on the weekends the weekend supervisor can make the</p>	F 323		
	<p>determination on staffing and if they have questions they can call the on call Manager which was rotated between the DON, Assistant Director of Nursing (ADON) and the RN Unit Manager.</p>			



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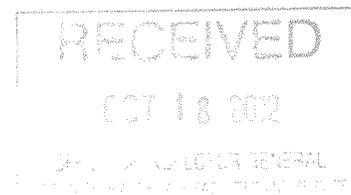
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F 323	Continued From page 21 Interview with LPN #3, on 08/24/12 at 4:30 PM, revealed she was aware the staff had reported to management that Resident #1 needed a sitter. She stated if a resident needs a sitter, each shift will cover the staffing difference. Some shifts would assign a sitter and some shifts rotate the CNA with the resident every 30 minutes or so. Interview with LPN #6, on 08/25/12 at 5:40 PM, revealed Resident #1 did not have a sitter and if a resident had a sitter there was an extra staff person on the schedule assigned to sit. She stated management was aware of the needs of Resident #1 and the increase in the resident's acuity level. Interview with the DON, ADON, and Administrator, on 08/27/12 at 10:30 AM, revealed they all voiced they were not aware of the needs of Resident #1 or that staff had requested more staffing for the F unit due to the acuity level and falls for Resident #1. Interview with the Psychiatrist's Nurse Practitioner (NP), on 08/28/12 at 9:20 AM, revealed she had spoken to the ADON on 08/16/12 about Resident #1 and the changes in the medication. She stated the ADON told her the resident was still having problems with restlessness, and described it as "really restless". The NP told the ADON it could take a while for the medications to take effect.	F 323			
F 353 SS=D	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental,	F 353	F 353 1. Resident #1 was transferred to the hospital on 8/19/12. Resident #7 was a closed record review		



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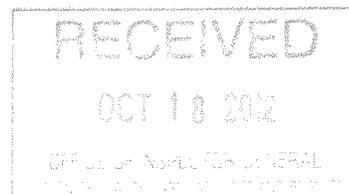
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F 353	<p>Continued From page 22</p> <p>and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, review of the facility's staffing and review of the facility's policy, it was determined the facility failed to provide sufficient staff to meet the residents needs for supervision to prevent falls for one (1) of seven (7) sampled residents (#1). The facility failed to acknowledge the increase in acuity level for Resident #1 resulting in the resident having multiple falls related to lack of sufficient staffing to provide adequate supervision. (Refer to F323)</p>	F 353	<p>Staffing assignments were reviewed by the Executive Director and the Director of Clinical Services on 9/18/12 and staff responsibilities realigned to ensure there is sufficient personnel to provide nursing care to residents in accordance with the resident care plans.</p> <p>2. Current residents have had a falls assessment completed by nurse management by 9/28/12. These assessments will be reviewed by the Interdisciplinary Team for accuracy and reassessed as indicated. Appropriate safety measures and interventions will be updated/developed by the Interdisciplinary Team on the care plan by 10/4/12.</p> <p>Residents identified as high risk for falls will be assessed for the need for ambulation aids and the need for additional monitoring by the Director of clinical Services by 10/4/12.</p> <p>3. Licensed staff have been re-educated by the Director of Clinical Services on the clinical staffing pattern re alignment to provide adequate supervision to meet the resident's assessed needs by 10/4/12.</p>
	<p>The findings include:</p> <p>Review of the facility's policy regarding Scheduling, effective 03/12, revealed scheduling</p>		



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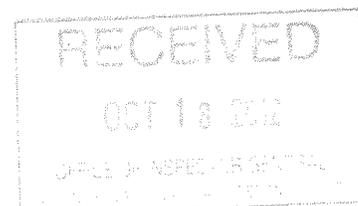
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F 353	<p>Continued From page 23</p> <p>shall be based on the occupancy and the acuity needs of the residents to provide safe and effective resident care.</p> <p>The facility provided a staffing ratio model that indicated the number of staff scheduled was based on the census. The lowest number provided was a census of 87. Review of the staffing ratios revealed for 87 residents first and second shift would have five nurses, and 6 nursing assistants. There was a Unit Manager scheduled on first and second shift as well and on the weekends.</p> <p>Review of the daily staffing for 08/18/12 revealed a census of 84. The daily staffing and Certified Nursing Assistants (CNA) assignments revealed five CNA's on first and second shift. Daily staffing for 08/18/12 revealed a census of 82. Staffing on first and second shift was five nurses and five CNA's. One additional CNA was assigned to sit with one resident on the E unit on all three shifts. Review of the daily staffing for 08/19/12 revealed a census of 82 with five CNA's scheduled to work the floor, one CNA as a sitter on the E unit and two CNA's given budget days (a day off) even though the nursing staff assessed Resident #1 as requiring a 1:1 sitter. On 08/19/12 second shift, five CNA's were assigned on the floor and one sitter for the resident on the E unit.</p> <p>Interview with the Administrator, on 08/27/12 at 11:00 AM, revealed when asked about the staffing ratio when the census dropped below 87, she stated they did not staff any less than six CNA's on first and second shift. At that time, the DON and ADON intervened and stated, no remember we discussed the census and acuity to</p>	F 353	<p>Licensed staff have been re-educated by the Director of Clinical Services on the protocol for the need for 1:1 supervision. Licensed staff has been re-educated to contact a designated member of the nursing management team, which is comprised of Director of Clinical Services, the Assistant Director of Clinical Services, and the Unit Manager, prior to the initiation of 1:1 supervision by 10/4/12.</p> <p>Validation of understanding of licensed staff by verbal interview by the nursing management team, which is comprised of Director of Clinical Services, the Assistant Director of Clinical Services, and the Unit Manager, will be completed before the beginning of their next scheduled shift.</p> <p>To evaluate the competency of staff in the development of a comprehensive care plan, the revision of the care plans post falls, and the completion of an accurate assessment the Director of Clinical Services will be notified following a fall to assist the nursing staff in identifying appropriate interventions to reduce the risk of further falls.</p>
	<p>Interview with the Administrator, on 08/27/12 at 11:00 AM, revealed when asked about the staffing ratio when the census dropped below 87, she stated they did not staff any less than six CNA's on first and second shift. At that time, the DON and ADON intervened and stated, no remember we discussed the census and acuity to</p>		



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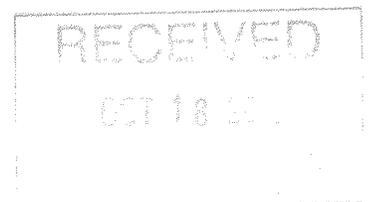
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F 353	Continued From page 24 determine staffing needs. Then the Administrator stated yes that's right. The Administrator went on to say she was never in a conversation regarding a need for a sitter for Resident #1. Interview with the Director of Nursing (DON), on 08/24/12 at 9:45 AM, revealed when the census drops below 87 the facility does not drop staffing any lower than the numbers for 87, which was six CNA's for first and second shift. Continued interview with the DON, on 08/24/12 at 11:05 AM, revealed on the F unit, where Resident #1 was located, if the census was seven or less the facility would look at the acuity of the residents on that unit and make a determination if they needed one or two staff. She went on to say, on the weekends, the weekend supervisor made the determination if the F unit needed one or two staff. She stated if the weekend supervisor had any questions they were to call the on call supervisor that was rotated between the DON, Assistant Director of Nursing and the Day shift supervisor. Interview with Registered Nurse #1, on 08/23/12 at 3:25 PM, revealed on the F unit if the census was 8 or more the facility would assign a CNA with the Nurse. She stated Resident #1 had 1:1 supervision at times unless she had to answer a call light. She stated the Administrator made the decision of whether a resident had a sitter. She stated she had reported to the supervisors of the resident's increased need for supervision when the resident had falls. Review of the nurses notes for Resident #1 revealed documentation on 08/01/12, 08/02/12, 08/04/12, 08/05/12, 08/07/12, 08/08/12, 08/09/12,	F 353	Ongoing the resident falls care plan and the 5 and 14 day assessment's will be QI monitored per the assessment schedule by the IDT (RN MDS Coordinator, MDS Nurse, Activities Director, Dietary Manager, and Social Services Director) during the daily operations meeting. Any variances will result in the correction of the assessment and/or care plan. Re-education will be provided as identified. 4. The Director of Clinical Services and/or the Assistant Director of Clinical Services will review staffing each business day in the daily operations meeting to ensure sufficient staffing is available 7 days per week to meet residents assessed needs. The Administrator will receive notification once the decision is made from the nursing management team, which is comprised of Director of Clinical Services, the Assistant Director of Clinical Services, and the Unit Manager, concerning any change in staffing patterns due to the need for 1:1 supervision for any resident.		



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F 353	Continued From page 26 weekend of 08/18/12-08/19/12. She stated the F unit was assigned one nurse and stated administration was aware of the needs for Resident #1. She stated she had called RN #2/Supervisor, on 08/19/12, after Resident #1 had fallen and RN #2/Supervisor told her she could not authorize a sitter for Resident #1 and to send the resident out to the hospital. Interview with LPN #5, on 08/25/12 at 7:50 PM, revealed she did not know how administration determined when a resident needed a sitter. She stated the staffing on the units were determined by the census only and not on acuity of the residents. She went on to say the supervisors were well aware of Resident #1's behaviors, falls, and need for 1:1 supervision. Interview with LPN #2, on 08/26/12 at 7:30 PM, revealed she believed administration based the staffing strictly on numbers and not on acuity. She stated she had talked with RN #2/Supervisor, on 08/19/12, about getting a sitter for Resident #1 and she told her it was not in the budget. She stated she asked if they could pull the sitter from Resident #3 to sit with Resident #1 and she stated no. Interview with RN #2/Supervisor, on 08/27/12 at 7:45 AM, who rotates weekend call with the DON, and ADON, revealed she did not have the authority to approve 1:1 sitters for residents and would have to call the DON and ADON, or the Administrator for approval. She went on to say the staffing of the facility was based on the census only and not on acuity of the residents. She stated she had sat in a morning meeting about one week before 08/18/12 and the	F 353	The Director of Clinical Services, Assistant Director of Clinical Services and/or RN MDS Coordinator will QI monitor effectiveness of the realignment of the staff for increased supervision by evaluating the QI tool entitled Root Cause Analysis to identify the causative factor of the incident. The Director of Clinical Services will bring the findings to the Risk Management/Quality Improvement meeting which will be held at least quarterly for review and development of an action plan to ensure accurate admission assessments for behaviors, the development of appropriate comprehensive care plans and the revision of care plans is completed. Need for more frequent monitoring will be determined during the QI meeting.	353 10/18/12	



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F 353	Continued From page 25 08/10/12, 08/14/12, 08/16/12, 08/17/12, 08/18/12, and 08/19/12 of the need for increased supervision with 1:1 or brought to the nurses' station for 1:1 supervision by the nurse. Interview with LPN #1, on 08/24/12 at 9:30 AM, revealed she had provided care for Resident #1 and the resident required 1:1 care and she provided care the best she could. She stated she had written on the 24 hour report the resident's need for 1:1 care/supervision. Interview with the DON, on 08/24/12 at 9:45 AM, revealed the facility did not keep 24 hour reports and they were shredded when reviewed. Interview with CNA #5, on 08/24/12 at 11:30 AM, revealed she was responsible for all of E unit and had to rotate the sitter responsibility for Resident #3. She stated Resident #3 had a sitter related to multiple falls. She stated it was difficult to provide care to the residents on the hall and watch Resident #3 because she couldn't take the resident into the rooms with her. When asked if she felt they had adequate staff, she stated she didn't think they needed to be giving budget days. Interview with LPN #3, on 08/24/12 at 4:30 PM, revealed she was aware the nurses on the F unit had reported to administration Resident #1 needed a sitter. She stated if she felt like the facility needed additional staff she would call the DON and they would evaluate the need for more staff. Interview with LPN #6, on 08/25/12 at 5:40 PM, revealed the staffing was already made out by administration when she came to work the	F 353			

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NAME OF PROVIDER OR SUPPLIER BROWNSBORO HILLS NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2141 SYCAMORE AVENUE LOUISVILLE, KY 40206		
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F 353	Continued From page 27 assessed need for a sitter for Resident #1 was brought up; however, there was no follow up by anyone in the meeting. Interview with the ADON, on 08/27/12 at 10:10 AM, revealed not just one person can make the decision for a resident to be assigned a sitter. It would have to be discussed with the Administrator and or the DON. She stated Resident #1 was sometimes ok, but changed. She acknowledged the facility did not provide adequate supervision to prevent falls for Resident #1.	F 353		

