



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

PRINTED: 07/14/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185278	(X2) MULTIPLE CONSTRUCTION A. BUILDING CARE B. WING	(X3) DATE SURVEY COMPLETED C 07/01/2015
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NAME OF PROVIDER OR SUPPLIER LORETTO MOTHERHOUSE INFIRMARY	STREET ADDRESS, CITY, STATE, ZIP CODE 516 NERINX ROAD NERINX, KY 40049
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F 000	INITIAL COMMENTS	F 000		
F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the facility failed to ensure services were provided in accordance with each resident's written plan of care for one (1) of three (3) sampled residents (Resident #1). The facility developed a care plan with interventions to prevent falls for Resident #1; however, on 08/13/15, the staff caring for Resident #1 failed to ensure the interventions were provided and the resident sustained a non-injury fall from the wheelchair onto the floor.</p> <p>The findings include: Review of the facility policy titled "Resident Assessment and Care Plan Policy and Procedure," updated 11/11/14, revealed a resident's Comprehensive Care Plan would detail services that would be used to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The policy indicated the care plan would be reviewed and</p>	F 282	<p>F282 Corrective action for resident found to be affected by the deficient practice was the immediate investigation of the fall by the nurse supervisor, who notified the Administrator of the fall and failure to follow the Care Plan. The SRNA responsible for ensuring Care Plan interventions were in place was suspended immediately pending the investigation and the facility self-reported the incident to the appropriate agencies.</p> <p>The facility will identify other residents having the potential to be affected by the same deficient practice with SRNA compliance rounds and weekly nurse supervisor review of the SRNA care plan. DON or Administrator is notified anytime a resident fall occurs. If the Nurse determines that any Resident Care Plan interventions were not in place at the time of the fall, the Administrator is to be contacted immediately. The Administrator will assist the Nurse Supervisor in completing the investigation on why interventions were not in place, determine appropriate corrective</p>	7/21/15

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

TITLE

(X6) DATE

Nichelle Essex

Administrator

7/21/15

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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NAME OF PROVIDER OR SUPPLIER LORETTO MOTHERHOUSE INFIRMARY			STREET ADDRESS, CITY, STATE, ZIP CODE 615 NERINX ROAD NERINX, KY 40049		
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F 282	<p>Continued From page 1</p> <p>revised on an ongoing basis to reflect changes in the resident and the care that the resident was to receive. The policy also stated that a Nurse Aide Care Plan, containing interventions the nurse aide was responsible for, would be kept in the resident's room for daily review by direct care staff.</p> <p>Review of Resident #1's medical record revealed the facility admitted Resident #1 on 12/21/08. Review of Resident #1's Minimum Data Set Assessment (MDS) and Fall Risk Assessment both dated 03/25/15, revealed the facility assessed Resident #1 to be at high risk for falls.</p> <p>Review of Resident #1's Comprehensive Care Plan, undated, which was in effect on 03/13/15, revealed Resident #1 was to be transferred utilizing a mechanical lift with two staff members assisting, was to have a non-skid pad placed in any chair the resident sat in, and was to have foot pedals in place on the wheelchair utilized by Resident #1. Additionally, review of the Nurse Aide Care Plan, dated 05/27/15, revealed the care plan directed staff that Resident #1 required a mandatory lift for transfers with two staff members, to make sure foot pedals were on when the resident was in a wheelchair, and that a non- skid pad was required to be in "any chair" Resident #1 was sitting in.</p> <p>Review of a facility investigation dated 06/17/15, revealed on 06/13/15, Certified Nursing Assistant (CNA) #1 transferred Resident #1 from the wheelchair to the bedside toilet and then back from the bedside toilet to the wheelchair, both times without obtaining assistance of an additional staff member. Additionally, the investigation revealed CNA #1 failed to ensure</p>	F 282	<p>action and ensure that the staff involved has implemented appropriate Care Plan interventions on other residents.</p> <p>Measures put in place to ensure that the deficient practice will not recur are additional training for SRNA staff on fall prevention and the SRNA Care Plan document, which lists the resident's care plan interventions and preferences applicable to direct care staff and is kept in the resident room in a confidential manner. This document is reviewed each shift and signed by the responsible SRNA verifying that all applicable care plan interventions are in place. Nursing staff attended this mandatory training the week of 07/06/15 to ensure all understand their responsibility to implement Resident Care Plan interventions. Prior to the training, immediately following fall on 6/13/15 the Administrator sent Nursing Staff a memo reminding them of this responsibility and all nursing staff working that week were required to read and sign the memo.</p> <p>The facility will monitor its performance to ensure that solutions are sustained with compliance rounds conducted by the Nurse Supervisor to review the SRNA Care Plan to ensure care plan</p>		

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F 282	<p>Continued From page 2</p> <p>the wheelchair that the resident was transferred into had the required non-skid pad in the seat or that the chair had attached foot pedals as required for Resident #1. As a result, Resident #1 sustained a non-injury fall from the wheelchair onto the floor on 06/13/15.</p> <p>Although attempted interviews with CNA #1 were unsuccessful, review of the Nurse Aide Care Plan dated 05/27/15, revealed CNA #1 had initialed the care plan to indicate she reviewed it prior to caring for Resident #1 on 06/13/15.</p> <p>Interview with the Administrator on 07/01/15 at 10:30 AM, revealed the facility's investigation determined that the fall sustained by Resident #1 on 06/13/15, could have likely been prevented if CNA #1 had followed the interventions listed on the resident's plan of care. The Administrator stated that CNA #1 was terminated from employment at the facility on 06/16/15.</p>	F 282	<p>interventions are implemented. If a Resident Care Plan intervention is not in place, the Nurse Supervisors will make an immediate correction, educate SRNA responsible, and will complete Employee Performance Report. This report is submitted to the DON for appropriate corrective action.</p> <p>The Quality Assurance Resident Focus Committee will audit monthly SRNA Care Plan documents to ensure SRNA staff are reviewing care plan interventions each shift as demonstrated by their initials signed off for each day/shift, will complete compliance rounds in addition to the compliance checks completed by the Nurse Supervisor, and will monitor performance.</p>	
F 323 SS=D	<p>Refer to F323.</p> <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 prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, facility policy</p>	F 323	<p>323</p> <p>Corrective action for resident found to be affected by the deficient practice was the immediate investigation of the fall by the nurse supervisor, who notified the Administrator of the fall and failure to follow the Care Plan. The SRNA responsible for ensuring Care Plan interventions were in place was suspended immediately pending the investigation and the facility self-reported the incident to the appropriate agencies.</p>	7/8/15

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F 323	<p>Continued From page 3</p> <p>review, and review of a facility investigation it was determined the facility failed to ensure staff utilized assistive devices when assisting one (1) of three (3) sampled residents (Resident #1) to transfer to and sit safely in a wheelchair. Resident #1 was assessed to require a mechanical lift for transfers with the assistance of two (2) staff members, placement of a non-skid pad in the chair the resident was to sit in, and have foot pedals on the wheelchair being utilized by Resident #1. However, on 06/13/15, Certified Nursing Assistant (CNA) #1 transferred Resident #1 from the bedside toilet to the wheelchair without assistance of another staff member and failed to ensure that a non-skid pad was in the chair or that the wheelchair's foot pedals were in place as required. Resident #1 sustained a non-injury fall from the wheelchair onto the floor on 06/13/15.</p> <p>The findings include:</p> <p>Review of the facility policy titled "Safe Lifting," undated, revealed any resident who could not sit up on the side of the bed would be transferred utilizing a mechanical lift. Review of the policy titled "Resident Safety Clinical protocol," undated, revealed if a resident had been identified to be at risk for falls, the resident's care plan would include appropriate approaches to prevent injury.</p> <p>Review of Resident #1's medical record revealed the facility admitted the resident on 12/21/08, with diagnoses including Alzheimer's Disease, Depression, and Diabetes Mellitus. Review of the quarterly Minimum Data Set (MDS) assessment completed on 03/25/15, revealed the facility assessed the resident to be severely cognitively impaired and dependent on staff to provide</p>	F 323	<p>The facility will identify other residents having the potential to be affected by the same deficient practice with SRNA compliance rounds and weekly nurse supervisor review of the SRNA care plan. DON or Administrator is notified anytime a resident fall occurs. If the Nurse determines that any Resident Care Plan interventions were not in place at the time of the fall, the Administrator is to be contacted immediately. The Administrator will assist the Nurse Supervisor in completing the investigation on the root cause of the fall, determine appropriate corrective action and ensure that the staff involved has implemented appropriate Care Plan interventions on other residents.</p> <p>Measures put in place to ensure that the deficient practice will not recur are additional training for SRNA staff on fall prevention and the SRNA Care Plan document, which lists the resident's care plan interventions and preferences applicable to direct care staff and is kept in the resident room in a confidential manner. This document is reviewed each shift and signed by the responsible SRNA verifying that all applicable care plan interventions are in place. Nursing staff attended this mandatory training the week of 07/06/15 to</p>		

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F 323	<p>Continued From page 4</p> <p>extensive assistance with all activities of daily living, including requiring extensive assistance of two or more staff members for transferring. Review of a Fall Risk Assessment dated 03/25/15, for Resident #1 revealed the resident was at "high risk" for falls. Review of Resident #1's Care Plan (undated) which was in effect on 06/13/15, revealed Resident #1 required a mechanical lift for transfers utilizing two staff members, required a non-skid pad to the chair the resident was sitting in, and staff was to "make sure" foot pedals were in place on Resident #1's wheelchair.</p> <p>Review of the facility investigation dated 06/17/15, revealed on 06/13/15, at approximately 1:15 PM, CNA #1 transferred Resident #1 utilizing a mechanical lift from the bedside toilet to a wheelchair without the assistance of another staff member. The investigation further revealed that the wheelchair Resident #1 was positioned in did not have a non-skid pad in place, and the CNA did not ensure that foot pedals were in place on the wheelchair. The investigation stated CNA #1 "then went to clean the (bedside toilet)" and Resident #1 kicked off a shoe, leaned over the side of the wheelchair, and "fell out." The investigation stated CNA #1 explained that Resident #1 "slipped" out of the chair onto his/her right side. The investigation determined that if CNA #1 had been utilizing two staff members as required to facilitate transferring Resident #1, the second staff member could have monitored Resident #1, while CNA #1 cleaned the bedside toilet and possibly prevented Resident #1 from sustaining the fall. Additionally, the investigation concluded that if the non-skid pad was appropriately placed in the wheelchair as directed, Resident #1 would have been "less</p>	F 323	<p>ensure all understand their responsibility to implement Resident Care Plan interventions. Prior to the training, immediately following fall on 6/13/15 the Administrator sent Nursing Staff a memo reminding them of this responsibility and all nursing staff working that week were required to read and sign the memo.</p> <p>The facility will monitor its performance to ensure that solutions are sustained with compliance rounds conducted by the Nurse Supervisor to review the SRNA Care Plan to ensure care plan interventions and safety measures are implemented. The Quality Assurance Resident Incident Committee reviews all Resident Fall Investigation reports, monitors interventions, and tracks trends. This committee audits the investigation conducted by the Nurse Supervisor, utilizes root cause analysis, and reviews Resident Care Plan interventions to ensure the resident environment is as free of hazards as is possible and to ensure adequate supervision and assistive devices are provided.</p>		

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F 323	<p>Continued From page 5</p> <p>likely" to slide out of the chair. The investigation revealed Resident #1 sustained no injury as a result of the fall.</p> <p>Observations of Resident #1 on 07/01/15, at 10:45 AM, revealed the resident was sitting up in a rocking chair with a non-skid mat positioned under the resident. Resident #1 would make eye contact when his/her name was spoken, but made no attempt to communicate verbally.</p> <p>Attempted interviews with CNA #1 were unsuccessful. However, review of the facility investigation dated 06/17/15, revealed when the Administrator interviewed CNA #1, the CNA stated she was aware that two staff members were required to utilize a mechanical lift when transferring Resident #1, and that the resident required a non-skid pad and foot pedals to be utilized when transferred into the wheelchair. However, according to the investigative interview with CNA #1, she "didn't consider what would happen the one time she did not follow it (the resident's plan of care)."</p> <p>Interview with the Administrator on 07/01/15, at 10:30 AM, revealed CNA #1 had received disciplinary action in December 2013 for failing to utilize a gait belt during a resident transfer and was again counseled during her December 2014 annual evaluation "to be sure and follow" each resident's plan of care. Therefore, the Administrator stated CNA #1 was terminated from employment at the facility on 06/16/15 for failure to follow instructions.</p> <p>Refer to F282.</p>	F 323		