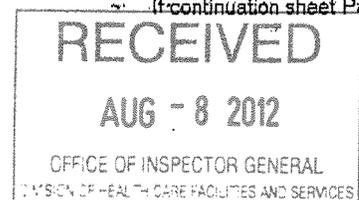


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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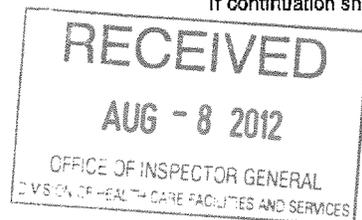
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185327 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 06/27/2012 |
| NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF SPENCER COUNTY | | | STREET ADDRESS, CITY, STATE, ZIP CODE 625 TAYLORSVILLE RD TAYLORSVILLE, KY 40071 | |
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| F 282 | Continued From page 1 Record review revealed the facility admitted Resident #1 on 06/16/10 with diagnoses of Chronic Kidney Disease, Osteoarthritis, Diabetes and Cerebral Vascular Accident, which resulted in the lack of use and contractures to the left hand, leg and foot. Record review of the Minimum Data Set (MDS), dated 04/05/12, revealed the facility assessed Resident #1 as requiring extensive assist with transfers and a two (2) plus person physical assist. Review of the Comprehensive Care Plan for Resident #1 revealed an identified problem with the resident's ability to perform the activities of daily living (ADL). It stated Resident #1 required assist with all care needs related to his/her diagnosis. The approach column of the care plan identified a two (2) person lift was required for transfers. The transfer of Resident #1, on 06/18/12, was attempted alone by Certified Nursing Assistant (CNA) #1 and resulted in Resident #1 and CNA #1 falling to the floor. Resident #1 sustained a fractured femur and required hospitalization and surgical intervention. Review of the Certified Nursing Assistant Care Plan, dated 04/30/11, revealed under the heading Transfers, Resident #1 was able to bear weight, was weight bearing as tolerated and was to be transferred with the assist of one person. The use of a gait belt was not marked. Interview, on 06/26/12 at 4:26 PM, with Registered Nurse (RN) Unit Manager #1 revealed the nurses monitor the CNA Care Plan to ensure | F 282 | F 282 483.20 (K)(3)(II) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The facility will provide services by qualified persons in accordance with each residents care plan. Residents affected: Resident #1 has been re-assessed, along with chart audit, assistance with transfers, based on the resident's clinical assessment, and care plans/CNA care plans were updated to reflect current care needs. Educational training has been provided to IDT team in regards to care plan/CNA care plan, transfer policy and procedure, and communication of care plans starting on 6/29/2012 and will be completed by 7/24/2012 by Regional Nurse Consultant. Education/Training was provided to staff in regards to following the care plan for resident # 1, to include but not limited to, gait belt utilization, use of 2 person assistance with transfers, lifts and abuse policy and procedure, by the SDC, nurse scheduler, and charge nurse starting on 6/29/12 and ending on 7/11/12. Residents potentially affected: Residents of the facility have the potential to be affected by the cited deficient practice. Residents noted with incidents/accidents over the past 30 days were reviewed by the ADONs and DON along with chart audit completed and care plans/CNAs care plans updated to reflect current care needs by 7/13/2012. Education/ training has been provided to the IDT team by 7/24/2012 by the Regional Nurse Consultant on care plan/CNA care plan policy and procedure along with process for compliance with accuracy. IDT team will complete remaining resident chart audits, to include, care plans/CNA care plans by 7/30/12. Education/Training was provided by the SDC, scheduler, and charge nurse to the nursing staff on care plan/CNA care plan, gait belt usage, transfers, lifts, and abuse policy and procedure starting on 6/29/12 and ending on 7/11/12. | 7/31/12 |



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| F 282 | Continued From page 2 accuracy. Updates and changes were addressed during morning meetings of the Interdisciplinary Team (IDT). Interview, on 06/26/12 at 4:45 PM, with RN Unit Manager #2 revealed the IDT reviews the CNA Care Plan and new orders were reviewed and updated on the CNA Care Plan. She revealed Resident #1 had always been a two (2) person assist and had never transferred alone. However, that was not what was on the CNA Care Plan but was on the Comprehensive Care Plan. Interview, on 06/27/12 by telephone at 2:00 PM, with CNA #1 revealed she was following the CNA Care Plan when transferring Resident #1 when the fall occurred. CNA #1 stated "I was just going by the care plan," referring to the CNA Care Plan. She stated to her knowledge, the resident had always been a one person transfer. Review of the interview statements obtained by the facility during their investigation, dated 06/18/12, revealed CNA #5, CNA #6 and CNA #8 had stated Resident #1 was a transfer with the assist of one according to the CNA Care Plan. Interview, on 06/27/12 at 3:30 PM, with the Director of Nursing revealed the Comprehensive Care Plan directed that the resident was to be a transfer with two (2) people and a gait belt. The Nursing Care Plan was not followed which resulted in a fractured femur to Resident #1. In addition, she revealed it was the IDT's responsibility to ensure the CNA care plan was accurate. | F 282 | Systemic measures: All incidents/accidents, any order changes and 24 hour report will be reviewed daily during morning clinical meeting for any changes to resident current care needs. DON and ADONs will utilize an incident tracking log and the white board process in order to verify completion of documentation and interventions during clinical meeting. Care plans/CNA care plans will be updated at this time by the DON and ADONs. The changes will be communicated via the CNA care plan written in red and on the 24 hour report. Education/Training has been provided to the IDT team on care plan/CNA care plan process, communication of updates and compliance by the Regional Nurse Consultant by 7/24/2012. Education/Training has been provided to the nursing staff on the care plan/CNA care plan process including communication of changes, along with following residents' care plans to ensure appropriate care delivery to meet residents' current care needs by the SDC, nurse scheduler, and charge nurse starting on 6/29/12 and ending on 7/11/12. The ADONs and/or charge nurse will directly supervise adherence to the care plans during daily rounds as evidenced by comparing actual care and assistance given to the care plan/CNA care plan needed assistance to monitor ongoing compliance. Results of the rounds will be discussed daily in clinical QA meeting. Monitoring measures: Incidents/Accidents, white board process and care plans/CNA care plans will be reviewed daily during the clinical QA meeting. The Administrator and/or Director of Nursing will audit 3 IDT care plans/CNA Care plans and compare to visual audits of delivery of care weekly for 4 weeks, then monthly ongoing. This monitoring will include adherence to care plans/CNA care plans in the provision of resident care. Findings of the audits and rounds will be discussed in monthly QA meetings. Completion date: | |
| F 323 | 483.25(h) FREE OF ACCIDENT | F 323 | | |



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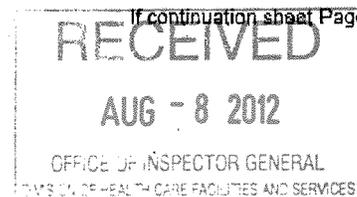
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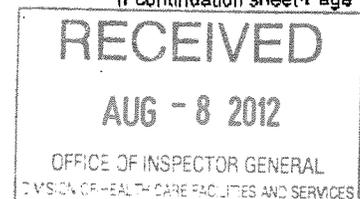
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| F 323 SS=G | <p>Continued From page 3 HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to provide an environment free of accidents by not implementing interventions for the safety of one (1) of six (6) sampled residents, Resident #1. A Certified Nursing Assistant (CNA) failed to transfer the resident with the assistance of two people. This failure resulted in Resident #1 falling and sustaining a fractured femur which required hospitalization and surgery.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Transfer Activities, effective 12/2010, revealed the procedural steps under the title Bed to Wheelchair Transfer addressed obtaining the assistance of another individual if necessary for safer transfer.</p> <p>Record review revealed the facility admitted Resident #1 on 06/16/10 with diagnoses of Chronic Kidney Disease, Cerebral Vascular Accident, which resulted in the lack of use and</p> | F 323 | <p>compliance on or by</p> <p>F 323 483.25 (h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICE</p> <p>The facility will provide services by qualified persons in accordance with each residents care plan.</p> <p>Residents affected: Resident #1 has been re-assessed, along with chart audit, assistance with transfers, based on the resident's clinical assessment, and care plans/CNA care plans were updated to reflect current care needs. Educational training has been provided to IDT team in regards to care plan/CNA care plan, transfer policy and procedure, and communication of care plans starting on 6/29/2012 and will be completed by 7/24/2012 by Regional Nurse Consultant. Education/Training was provided to staff in regards to following the care plan for resident # 1, to include but not limited to, gait belt utilization, use of 2 person assistance with transfers, lifts and abuse policy and procedure, by the SDC, nurse scheduler, and charge nurse starting on 6/29/12 and ending on 7/11/12.</p> <p>Residents potentially affected: Residents of the facility have the potential to be affected by the cited deficient practice. Residents noted with incidents/accidents over the past 30 days were reviewed by the ADONs and DON along with chart audit completed and care plans/CNAs care plans updated to reflect current care needs by 7/13/2012. Education/ training has been provided to the IDT team by 7/24/2012 by the Regional Nurse Consultant on care plan/CNA care plan policy and procedure along with process for compliance with accuracy. IDT team will complete remaining resident chart audits, to include, care plans/CNA care plans by 7/30/12. Education/Training was provided by the SDC, scheduler, and charge nurse to the nursing staff on</p> | 7/31/12 |
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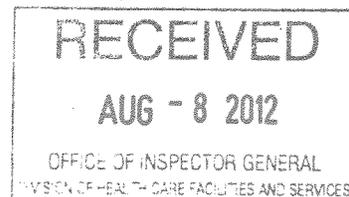
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| F 323 | <p>Continued From page 4</p> <p>contractures to the left hand, leg and foot, Osteoarthritis and Diabetes.</p> <p>Review of the Minimum Data Set (MDS), dated 04/05/12, revealed the facility assessed Resident #1 as needing extensive assistance with transfers and a two (2) plus person physical assist.</p> <p>Review of the Comprehensive Care Plan for Resident #1 revealed the facility identified a problem with the resident's ability to perform activities of daily living (ADL). The facility assessed Resident #1 as requiring assist with all care needs related to his/her diagnosis. A two person lift was required during transfers as noted under the Approach (intervention) column on the Care Plan. However, per record review it was revealed CNA #1 attempted to transfer Resident #1 alone and resulted in Resident #1 and CNA #1 falling to the floor. Resident #1 sustained a fractured femur and required hospitalization and surgical intervention.</p> <p>Review of the facility's investigation, dated 06/22/12, revealed on 06/18/12 at approximately 6:15 AM, CNA #1 was assisting Resident #1 to the chair when the CNA and resident lost their balance and fell towards the resident's dresser. The CNA put her hand between the resident's head and the dresser to prevent head injury as they fell. The CNA believed her leg fell on top of the resident during the fall. There was conflicting information as to whether a gait belt was used. The RN answered the call for help and assessed the resident who denied any injury at that time and was transferred to the chair per the resident's request. The MD was called and pain medication was ordered. An X-ray of the left leg was obtained</p> | F 323 | <p>care plan/CNA care plan, gait belt usage, transfers, lifts, and abuse policy and procedure starting on 6/29/12 and ending on 7/11/12.</p> <p>Systemic measures: All incidents/accidents, any order changes and 24 hour report will be reviewed daily during morning clinical meeting for any changes to resident current care needs. DON and ADONs will utilize an incident tracking log and the white board process in order to verify completion of documentation and interventions during clinical meeting. Care plans/CNA care plans will be updated at this time by the DON and ADONs. The changes will be communicated via the CNA care plan written in red and on the 24 hour report. Education/Training has been provided to the IDT team on care plan/CNA care plan process, communication of updates and compliance by the Regional Nurse Consultant by 7/24/2012. Education/Training has been provided to the nursing staff on the care plan/CNA care plan process including communication of changes, along with following residents' care plans to ensure appropriate care delivery to meet residents' current care needs by the SDC, nurse scheduler, and charge nurse starting on 6/29/12 and ending on 7/11/12. The ADONs and/or charge nurse will directly supervise adherence to the care plans during daily rounds as evidenced by comparing actual care and assistance given to the care plan/CNA care plan needed assistance to monitor ongoing compliance. Results of the rounds will be discussed daily in clinical QA meeting.</p> <p>Monitoring measures: Incidents/Accidents, white board process and care plans/CNA care plans will be reviewed daily during the clinical QA meeting. The Administrator and/or Director of Nursing will audit 3 IDT care plans/CNA Care plans and compare to visual audits of delivery of care weekly for 4 weeks, then monthly ongoing. This monitoring will include adherence to care plans/CNA care plans in the provision of resident</p> | |



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| F 323 | <p>Continued From page 5</p> <p>with results indicating an oblique fracture to the femur. The resident had surgery on 06/19/12 to repair the fracture and was re-admitted on 06/21/12.</p> <p>Interview with Resident #1 on 06/26/12 at 2:45 PM, revealed he/she fell when getting into the wheelchair. The resident stated he/she was a two (2) person assist most of the time; however, only one person was helping him/her when the fall occurred.</p> <p>Interview, on 06/27/12 at 2:00 PM by telephone, with CNA #1 revealed she attempted to transfer Resident #1 from his/her bed to the wheelchair by herself, even though it was documented on the comprehensive care plan to transfer the resident with assist of two (2). Both she and the resident fell.</p> <p>Review of the hand written statement by RN #1, dated 06/18/12, revealed she heard the CNA yell for help and upon entering the room found the CNA and the resident sitting in the floor next to the bed with the resident's back against the night stand. The resident complained of pain in his/her left outer knee with pain radiating to his/her hip. After assisting the resident to the wheelchair, the RN examined the resident and found no visible signs of injury. The resident stated a gait belt was not used during the transfer.</p> <p>Interview, on 06/27/12 at 3:30 PM, with the Director of Nursing revealed the Comprehensive Care Plan for Resident #1 stated the resident was to be a transfer with two (2) people and a gait belt. The Comprehensive Care Plan was not</p> | F 323 | <p>care. Findings of the audits and rounds will be discussed in monthly QA meetings.</p> <p>Completion date: The facility will be in compliance on or by 7/31/2012.</p> | |



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| F 323 | Continued From page 6 followed by CNA #1, which resulted in the fractured femur to Resident #1. | F 323 | | |
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