

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

PRINTED: 07/30/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/16/2012
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NAME OF PROVIDER OR SUPPLIER PEMBROKE NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>An abbreviated survey (KY #18662 and KY #18675) was conducted on 07/10/12-07/16/12. KY #18662 and KY #18675 were unsubstantiated with unrelated deficiencies.</p> <p>The facility assessed Resident #3 as at high risk for falls. Resident #3 experienced 11 falls from the wheelchair from 01/25/12 through 06/02/12 (approximately four months). On 02/26/12, Resident #3 sustained a laceration to the right eyebrow from an unwitnessed fall that required sutures and had two more unwitnessed falls from the wheelchair (on 04/07/12 and 05/20/12) which resulted in the laceration being reopened. The facility failed to implement interventions for Resident #3 to be in visualized areas when up in wheelchair and to provide an activity box. The facility failed to identify Resident #3 had five unwitnessed falls even though there was an intervention for Resident #3 to be in visualized areas when in wheelchair. In addition, the facility failed to provide increased supervision for Resident #3 when the facility was knowledgeable the resident's self alarming seat belt was not working. These failures to ensure adequate supervision to prevent accidents resulted in Resident #3 having an unwitnessed fall on 06/02/12 which resulted in a fractured right hip. The facility's failures to prevent Resident #3 from experiencing multiple falls without effective intervention to result in a fractured right hip was identified as Substandard Quality of Care. Substandard Quality of Care was identified at 483.25 Quality of Care (F323) at a S/S of a "H". A partial extended survey was conducted on 07/16/12.</p>	F 000	<p>Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p>	
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 282		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rebecca Collins</i>	TITLE <i>Administrator</i>	(X6) DATE <i>08/08/12</i>
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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.

Per Edman Admin / RBT

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F 282 SS=H	<p>Continued From page 1 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 interviews, record review and review of the facility's policy and procedure it was determined the facility failed to implement the care plan for two residents (#3 and #4), in the selected sample of four. The facility failed to implement the care plan for activity box, failed to ensure the alarming seat belt was functioning, and failed to ensure Resident #3 was in a visualized area when up in wheelchair. A record review revealed Resident #3 had a total of seven unwitnessed falls and sustained a laceration to the right eyebrow from an unwitnessed fall that required sutures on 02/26/12 and had two more unwitnessed falls from the wheelchair (on 04/07/12 and 05/20/12) which resulted in the laceration being reopened. In addition, Resident #3 had an unwitnessed fall on 06/02/12 which resulted in a fractured right hip.</p> <p>In addition, the facility failed to implement non-skid socks and non-skid strips to the floor for Resident #4 per the resident's plan of care.</p> <p>Findings include: A review of the facility's policy and procedure related to Plans of Care, dated January 2012, revealed the plan of care provides information</p>	F 282	<p>F282</p> <ol style="list-style-type: none"> 1. The activity box for resident # 3 is in place, care planned and on the CNA worksheet as of 7-17-2012 as noted by the Administrator. The self alarming seat belt for resident # 3 was on and functioning as noted by the Administrator on 7-17-2012. Resident # 3 was noted to be in a visualized area by the Administrator on 7-17-2012. Resident # 4 was wearing non-skid socks and had non-skid strips on the floor as noted by the Administrator on 7-17-2012. 2. A complete review of all current residents' fall care plans was completed by the Director of Nursing and the Unit Manager on 7-18-2012 to assure that all fall interventions were in place and functioning and that any fall interventions that should be communicated to the nursing assistants was listed on the CNA worksheets. Any identified concerns were immediately corrected. 3. All Licensed staff and Nursing Assistants were re-educated on following the CNA worksheets and reporting to the nurse if they are not able to follow any fall interventions. This education was completed by the Education and Training Director or Director of Nursing by 7-30-2012 with no licensed staff or CNA working past 7-30-2012 without having received this education. The 	

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F 282	<p>Continued From page 2</p> <p>regarding how the causes and risks associated with issues and/or conditions can be addressed to provide for a resident's highest practicable level of well being. A review of the Fall/Injury Management policy and procedure, last revised April 2012, revealed interventions should be communicated to staff through the Care Delivery Guide/Nursing Assistant Assignment Sheet.</p> <p>1. A record review revealed Resident #3 was admitted to the facility on 01/24/12 with diagnosis to include Traumatic Brain Injury, Hypertension, Gastro Esophageal Reflux Disease, Dementia, Depression, Anemia and Dysphasia.</p> <p>A review of the Falls/Injury Assessment, dated 01/24/12, revealed the facility assessed Resident #3 at risk for falls/injury due to unsteadiness, Traumatic Brain Injury and on anti-anxiety medication.</p> <p>A review of the Fall/Injury, Prevention and Management Plan of Care, dated 01/24/12, revealed staff should keep frequently used items within reach of the resident and provide a bed alarm, low bed and mat to floor. Further review revealed an intervention was added on 01/25/12 for staff to conduct 15 minutes checks on Resident #3 due to a fall from his/her bed.</p> <p>A review of the Accident/Injury Report, dated 02/06/12 at 10:00 AM, revealed Resident #3 sustained an unwitnessed fall at 8:20 AM in the lobby from the wheelchair with no apparent injury. The staff reattached the chair alarm and monitored the resident. A review of the 24 hour flow checks revealed the facility continued to monitor Resident #3 every 15 minutes as was</p>	F 282	<p>Director of Nursing was re-educated related to assuring the CNA assignment sheets are updated following clinical review. The re-education was provided by the Regional Nurse Consultant on 7-17-2012..</p> <p>4. A Department Head will review all CNA assignment sheets daily for two (2) weeks followed by five (5) times per week for ten (10) weeks to assure that all fall interventions are in place and functioning properly. The Department Heads consist of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Manager, Social Services Director, Activity Director, Dietary Services Manager, Maintenance Supervisor, Business Office Manager Medical Records Clerk, Education and Training Director, MDS Nurse and Business Office Assistant. The results of the audits will be reviewed with the Quality Assurance Committee monthly for three (3) months for further recommendations as needed. If at anytime concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Social Services Director, Activity Director and the Medical Director attending at least quarterly.</p> <p><i>Compliance Date</i></p>	7/31/12
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F 282	<p>Continued From page 3 initiated on 01/25/12.</p> <p>A review of an IDT note, dated 02/06/12 at 3:10 PM, revealed the IDT met to discuss Resident #3's fall at 8:20 AM. The IDT had therapy evaluate the resident and therapy placed a self releasing alarming seatbelt on the resident's wheelchair.</p> <p>A review of the nurse's note and review of the Accident/Injury Report, dated 02/26/12 at 8:25 PM, revealed Resident #3 was found in the hallway outside of his/her room lying on the floor on his/her right side. A review of the 24 hour flow checks revealed the facility continued to monitor Resident #3 every 15 minutes, the same intervention that was initiated on 01/25/12. The resident had a two centimeter (cm.) laceration noted to the right periorbital area across eyebrow. The facility transferred the resident to the emergency room and the resident received five sutures to the right eyebrow. In addition, neuro-checks were conducted when the resident returned to the facility.</p> <p>A review of the IDT Note, dated 02/27/12 at 4:00 PM, revealed the IDT team developed an intervention for staff to ensure when the resident was up in the wheelchair the resident should be in visualized areas.</p> <p>A review of the Nurses Notes and Accident/Injury Report, dated 03/13/12 at 5:10 PM and 5:20 PM respectively, revealed Resident #3 had a witnessed fall from the wheelchair in the dining room and sustained an abrasion to the jaw. The resident was assisted back in the wheel chair. A review of the 24 hour flow checks revealed the</p>	F 282			

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F 282	<p>Continued From page 4</p> <p>facility continued to monitor Resident #3 every 15 minutes, as initiated on 01/25/12.</p> <p>A review of the IDT note, dated 03/14/12 at 2:00 PM, the facility's timeline and an interview with the Activity Director, on 07/13/12 at 2:37 PM, revealed an activity box was put together and kept in the resident's room. However, review of the Comprehensive Care Plan, last updated 06/18/12 and Nurse Assistant Assignment Sheet, last updated 07/10/12, revealed the care plans were not updated to provide an activity box for the resident.</p> <p>Interviews with LPN #4, LPN #5, LPN #7, CNA #5, CNA #6 and CNA #8 on 07/13/12 at 3:42 PM and 4:10 PM, on 07/15/12 at 5:05 PM and on 07/16/12 at 8:05 AM, 9:10 AM and 1:50 PM respectively, revealed they were not aware of the resident having an activity box.</p> <p>Interview conducted with the Unit Manager after reviewing the CNA care plan, on 07/11/12 at 11:17 AM, revealed the Activity box was not placed on the CNA care plan. She revealed it was the Social Worker's responsibility to update the CNA Care Plans.</p> <p>An interview with the Social Services Director, on 07/11/12 at 1:10 PM, revealed that the social worker was responsible for updating the CNA Care Plans. He stated he should have updated the CNA care plan to include the activity box.</p> <p>A review of an electronic Incident Report, dated 04/07/12 at 1:28 PM, revealed Resident #3 had a fall from the wheelchair while not being visualized by staff and was found on the floor beside his/her</p>	F 282		
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F 282	<p>Continued From page 5</p> <p>wheelchair. The fall resulted in reopening the laceration to the right eyebrow.</p> <p>An interview on 07/16/12 at 8:05 AM with CNA #6 revealed she was at the nurse's station when Resident #3 fell on 04/07/12 in the hallway in front of the dining room. She stated she was working on the computer at the nurse's desk and when she looked up she saw Resident #3 had fallen.</p> <p>A review of the Nurse's Note and Accident/Injury Report, dated 04/26/12 at 6:10 PM, revealed Resident #3 had a fall in the wheelchair while not being visualized by staff.</p> <p>An interview on 07/13/12 at 4:10 PM with LPN #5 revealed she was working on 04/26/12 getting ready to clock out when she turned and saw Resident #3 with wheelchair tipped over in the lobby. She stated the resident was still in the wheelchair but sustained no injuries.</p> <p>A review of the electronic Incident Report, dated 05/06/12 at 1:30 PM, revealed Resident #3 had a fall from the wheelchair in the dining room while no being visualized by staff. There was no injury identified.</p> <p>A review of the electronic Incident Report, dated 05/20/12 at 4:00 PM, revealed Resident #3 was found on the floor under the wheelchair with a puddle of blood on the floor in the dining room while not being visualized by staff. The unwitnessed fall caused the laceration to the resident's right eyebrow to reopen. The resident was sent to the emergency room and returned with five sutures to the right eyebrow. Further review revealed the self-release alarming seat</p>	F 282		
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F 282	<p>Continued From page 6</p> <p>belt was not in good repair. The seat belt was not working properly as the alarm would not sound. Administration was aware and a new lap belt had been ordered but had not been received yet. Incident report noted the "lap belt is not working properly. Administration is aware, and a new lap belt has been ordered, but not yet received."</p> <p>An interview with CNA #10, on 07/16/12 at 12:05 PM, revealed Resident #3 was left unattended in the dining room on 05/20/12 by the assigned CNA and Activity Director. She revealed all aides were aware Resident #3 should not be left unattended because of his/her risk of falls. She stated she was charting at the nursing desk on at hall 2 when a dietary staff came out and told her that Resident #3 had fallen in the dining room. Resident #3 was laying on his/her right side with eye busted open and blood everywhere. She stated the resident's alarm was not sounding because it had not been working for a couple of days. She stated Administration was aware and a new self releasing alarming lap belt had been ordered. She was not aware of any interventions put in place to address the fact that the resident's alarming seat belt was not working.</p> <p>Interview with Registered Nurse (RN) #3, on 07/16/12 at 9:50 AM, revealed when Resident #3 fell on 05/20/12, the resident's self alarming lap belt was not working. She stated she called Administration and was told a new one had been ordered and had not come in yet. She was not aware of any interventions put in place to address the resident's risk for falls with the self releasing alarming seat belt not working.</p> <p>A review of e-mail of a proof of order form and</p>	F 282		

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F 282	<p>Continued From page 7</p> <p>interview with the Nurse Consultant on 07/16/12 at 11:20 AM, revealed a self alaming Velcro seat belt was ordered on 05/18/12 and was delivered on 05/26/12.</p> <p>A review of the nurse's note and electronic Incident Report, dated 06/02/12 at 4:30 PM and 6:00 PM respectively, revealed Resident #3 had an unwitnessed fall in the dining room. The resident was found under the table, bleeding from the left hand. The resident denied pain after the fall.</p> <p>An interview with the Unit Manager, LPN #2, LPN #3, CNA #3 and the Cook (staff #2), on 07/11/12 at 3:50 PM and 5:05 PM and on 07/12/12 at 12:40 PM, 2:35 PM, 3:20 PM and 3:55 PM respectively, revealed Resident #3 was in the dining room with no staff present and not visualized when the fall occurred. The staff revealed that staff were not assigned to the dining room area when meals were not being provided.</p> <p>Interviews with Licensed Practical Nurse (LPN) #2, LPN #5, LPN #7, Certified Nurse Assistant (CNA) #3, CNA #4, CNA #5, CNA #8 and a Physical Therapist Assistant, on 07/12/12 at 9:10 AM, 9:30 AM and 12:40 PM, on 07/13/12 at 2:25 PM and 4:10 PM, on 07/15/12 at 5:05 PM and on 07/16/12 at 9:10 AM and 1:50 PM respectively, revealed the staff interpreted the intervention for Resident #3 to be in visualized areas as the resident should have been in an area where the resident was in view of staff at all times. The staff revealed Resident #3 should not have been left in the dining room without staff present.</p> <p>An interview with the Director of Nursing (at the</p>	F 282		
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F 282	<p>Continued From page 8</p> <p>time of the falls), dated 07/12/12 at 4:00 PM, revealed staff should implement the interventions on the care plan.</p> <p>A review of a Nurse's Notes revealed Resident #3 was assessed every shift after the fall until 06/03/12 at 8:00 AM when staff identified Resident #3's toes were blue and the right ankle and toes were swollen. The physician was called with orders were received to x-ray under the right knee and ankle. A review of an x-ray report of the right knee, dated 06/06/12, revealed there was no evidence of a fracture or dislocation. Further review of the nurse's notes, dated 06/03/12-06/09/12 revealed the nursing staff continued to assess Resident #3 and identified the resident had right leg pain at times. A review of the nurse's notes, dated 06/09/12 revealed Resident #3 was identified as having edema to the right hip and thigh. The physician was notified and orders were received to x-ray the right hip. A review of the x-ray report, dated 06/09/12, revealed there was an acute verses subacute intertrochanteric fracture with mild angulation deformity to the right hip. A review of the hospital's history and physical, dated 06/10/12, revealed Resident #3 had surgery to perform an open reduction internal fixation of the right hip.</p> <p>2. A record review revealed Resident #4 was admitted to the facility on 05/30/12 with diagnoses to include Arthritis, Generalized Weakness, Peripheral Neuropathy, Cataract & Glaucoma.</p> <p>A review of the Comprehensive Care Plan for fall/injury assessment: prevention and management, dated 05/31/12, revealed Resident</p>	F 282		
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F 282	<p>Continued From page 9</p> <p>#4 was at risk for falls related to pain, Diabetic Neuropathy, Arthritis, Weakness, High Blood Sugar, Exhaustion, Hypertension, Bowel/Bladder Incontinence, Sensory Impairment and Pharmacologic factors. Further review revealed Interventions for one staff to assist with ambulation and transfer, provide increased supervision and a high/low bed.</p> <p>A review of Minimum Data Set (MDS), dated 06/12/12, revealed the facility assessed Resident #4 as cognitively intact and the resident required extensive assistance of one staff for transfers, walking and toilet use.</p> <p>A record review of Accident/Incident report, dated 06/17/12 at 8:05 PM, reveals that Resident #4 had an un-witnessed fall in her room.</p> <p>A record review of the Fall/Injury Assessment, dated 06/18/12, revealed the addition of interventions for non-skid adhesive to floor and non-skid socks.</p> <p>An observation on 07/10/12 at 8:50 AM and 1:56 PM respectively, revealed Resident #4 was ambulating in room with walker, there were no non-skid strips noted on the floor beside resident's bed or bathroom and the resident did not have non-skid socks on his/her feet.</p> <p>Interviews with CNA #1 and CNA #8, on 07/10/12 at 2:47 PM and 4:00 PM and on 07/11/12 at 8:22 AM and 9:40 AM respectively, revealed that they were unaware of any special fall precautions in place for this resident.</p> <p>An interview with Unit Manager, LPN #1, on</p>	F 282		
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NAME OF PROVIDER OR SUPPLIER PEMBROKE NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 282	Continued From page 10 07/11/12 at 10:20 AM, revealed Resident #4 should have non-skid strips on the floor and should have non-skid socks on his/her feet. After reviewing the Comprehensive Care Plan and CNA assignment sheet the Unit Manager noted the interventions for the non-skid socks and strip was not transferred to the CNA Assignment Sheet. An interview with Social Services Director, staff #1, on 07-11-12 at 1:10 PM revealed that he/she was aware that he failed to get the non-skid strips and non-skid socks listed on the Comprehensive Care Plan for Resident #4 transferred to the CNA Assignment Sheet. This resulted in the CNAs not knowing about the interventions so they could ensure the interventions were implemented.	F 282		
F 323 SS=H	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy and procedure review, it was determined the facility failed to provide adequate supervision to prevent accidents for one resident (#3), in the selected sample of four. The facility failed to ensure their policies and procedures	F 323	F323 1. The resident identified as resident #3 was reviewed by the Interdisciplinary Team on 7-16-2012 to include all falls for the past ninety (90) days to assure that the fall interventions and fall care plan meets the needs of the resident as well as resident's supervision level to include any trends and patterns. Resident #3's care plan was updated to reflect any changes. 2. All current resident falls for the past forty five (45) days were reviewed as well as all current residents fall care plans were reviewed including all current resident level of supervision. This review by the Interdisciplinary Team occurred on 7-16-2012. Any necessary changes were completed immediately. The Interdisciplinary Team consisted of Director of Nursing, Unit Manager, Social Services Director, Dietary Services Manager, Administrator, Activity Director and the Facility Rehabilitation Coordinator. 3. All licensed Staff were re-educated on fall investigation, root cause analysis and appropriate intervention by the Director of Nursing by 7-30-2012 with no staff working after 7-30-12 without	

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F 323	<p>Continued From page 11</p> <p>related to falls investigations and interventions were followed. The facility assessed Resident #3 as at high risk for falls. Resident #3 experienced 11 falls from the wheelchair from 01/25/12 through 06/02/12 (approximately four months). On 02/26/12, Resident #3 sustained a laceration to the right eyebrow from an unwitnessed fall that required sutures and had two more unwitnessed falls from the wheelchair (on 04/07/12 and 05/20/12) which resulted in the laceration being reopened. The facility failed to implement interventions for Resident #3 to be in visualized areas when up in wheelchair and to provide an activity box.</p> <p>The facility failed to conduct interdisciplinary Team (IDT) meetings after each fall to identify if the fall interventions were implemented and if the interventions provided adequate supervision for Resident #3.</p> <p>The facility failed to identify Resident #3 had five unwitnessed falls even though there was an intervention for Resident #3 to be in visualized areas when in wheelchair. In addition, the facility failed to provide increased supervision for Resident #3 when the facility was knowledgeable the resident's self alarming seat belt was not working. These failures to ensure adequate supervision to prevent accidents resulted in Resident #3 having an unwitnessed fall on 06/02/12 which resulted in a fractured right hip.</p> <p>The facility's failures to prevent Resident #3 from experiencing multiple falls without effective intervention to result in a fractured right hip was identified as Substandard Quality of Care.</p>	F 323	<p>having had this re-education. The Interdisciplinary Team was re-educated on fall prevention, root cause analysis and investigation as well as the system change to include trends and patterns analysis. This education was provided by the Regional Nurse Consultant on 7-19-2012. The facility system change is as follows. All falls will be reviewed by the clinical manager and will be reviewed with the Quality Assurance Committee during morning stand up meetings. The Quality Assurance Committee will meet weekly for fall committee review for any further recommendations.</p> <p>4. The Quality Assurance Committee will meet weekly and review all falls to assure that there is a thorough investigation, root cause analysis and appropriate interventions to include appropriate supervision and analysis of trends and patterns. If at any time concerns are identified, the Quality Assurance Committee will review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Social Services Director, Activity Director and the Medical Director attending at least quarterly.</p>	7/31/12
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Compliance Date

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F 323	<p>Continued From page 12</p> <p>Findings include:</p> <p>A review of the facility's Falls and Injuries policy and procedure, last revised 04/2012, revealed the facility strives to reduce the risk of falls and injuries by promoting the implementation of the Risk Reduction: Falls and Injuries Program, and strives to provide supervision and assistance devices to each resident to prevent avoidable accidents. Adequate supervision is defined as the type and frequency of supervision, based on the individual residents assessed needs. Supervision may vary from time to time and resident to resident. The use of tools or items such as personal alarms can help monitor resident's activities but does not eliminate the need for staff vigilance and are not to be utilized in lieu of supervision.</p> <p>A review of the facility's Fall/Injury Management-Post Fall or Injury policy and procedure, last revised 04/2012, revealed actions that need to be taken following a fall includes: determining what may have caused the fall, addressing the contributing factors of the fall and revising the plan of care to reduce the likelihood of another fall. The fall/injury should be reviewed at the next scheduled appropriate daily clinical meeting. The review should include a review of current assessments, a review and discussion of the residents previous fall/injury history and identifying trends or potential new risk factors. The care plan should be revised to include new interventions and the interventions should be communicated to staff through the 24 hour status report, Nursing Assistant Assignment Sheet and Plan of Care.</p>	F 323		
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F 323	<p>Continued From page 13</p> <p>A record review revealed Resident #3 was admitted to the facility on 01/24/12 with diagnosis to include Traumatic Brain Injury, Hypertension, Gastro Esophageal Reflux Disease, Dementia, Depression, Anemia and Dysphasia. A review of the Falls/Injury Assessment, dated 01/24/12, revealed the facility assessed Resident #3 at risk for falls/injury due to unsteadiness, Traumatic Brain Injury and anti-anxiety medication.</p> <p>A review of the Fall/Injury, Prevention and Management Plan of Care, dated 01/24/12, revealed staff should keep frequently used items within reach of the resident and provide a bed alarm, low bed and mat to floor. Further review revealed an intervention was added on 01/25/12 for staff to conduct 15 minutes checks on Resident #3 due to a fall from his/her bed.</p> <p>A review of the Accident/Injury report, dated 01/28/12 at 11:45 AM, revealed Resident #3 had a witnessed fall from the wheelchair in the common area. The resident sustained an abrasion to the right eyebrow area. A review of the 24 hour flow checks revealed the facility continued monitoring Resident #3 every 15 minute checks, an intervention which the facility had initiated on 01/25/12. The facility shortened the chair alarm cord.</p> <p>An interview with Licensed Practical Nurse (LPN) #4, on 07/13/12 at 3:42 PM, revealed she witnessed the fall on 01/28/12. She stated she was at the medication cart and the resident was leaning forward and fell before she could get to him/her. She stated the chair alarm sounded. She revealed the resident often leaned to the right side as was in this instance. She stated the</p>	F 323		

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F 323	<p>Continued From page 14</p> <p>chair alarm was shortened so it would sound if the resident leaned forward.</p> <p>A review of the IDT Notes, dated 01/28/12-02/01/12, revealed there was no evidence the IDT met to discuss this fall. In addition, there was no evidence the facility evaluated the effectiveness of the 15 minute checks to prevent falls.</p> <p>A review of an Accident/Injury report, dated 02/01/12 at 1:40 PM, revealed Resident #3 had an un-witnessed fall in the hall from the wheelchair with no obvious injury reported. A review of the 24 hour flow checks revealed the facility continued to monitor Resident #3 every 15 minutes as was initiated on 01/25/12. The facility implemented laboratory studies to include urinalysis and anti-anxiety medications.</p> <p>A review of the IDT Notes, dated 02/01/12-02/04/12, revealed there was no evidence the IDT met to discuss this fall. In addition, there was no evidence the facility evaluated the effectiveness of the 15 minute checks to prevent falls.</p> <p>A review of a Nurses Note and an Accident/Injury Report, dated 02/04/12 at 2:20 PM, revealed Resident #3 had a witnessed fall from the wheelchair resulting in an abrasion. The staff determined the resident was incontinent and he/she was taken to his/her room for incontinent care. The resident was placed on a toileting program. A review of the 24 hour flow checks revealed Resident #3 continued on 15 minute checks that were initiated on 01/25/12.</p>	F 323		
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F 323	<p>Continued From page 15</p> <p>A review of the Interdisciplinary Team (IDT) Notes, dated 02/04/12-02/06/12 revealed there was no evidence the IDT met to discuss this fall. In addition, there was no evidence the facility identified the 15 minute checks did not provide adequate supervision to prevent a fall.</p> <p>An interview with LPN #4, on 07/13/12 at 3:42 PM, revealed she witnessed the fall on 02/04/12 when the resident fell in the lobby but she was unable to get to the resident before he/she fell. She stated the resident had been incontinent so staff provided incontinent care and placed the resident on a toileting program.</p> <p>A review of the Accident/Injury Report, dated 02/06/12 at 10:00 AM, revealed Resident #3 sustained an unwitnessed fall at 8:20 AM in the lobby from the wheelchair with no apparent injury. The staff reattached the chair alarm and monitored the resident. A review of the 24 hour flow checks revealed the facility continued to monitor Resident #3 every 15 minutes as was initiated on 01/25/12.</p> <p>A review of an IDT note, dated 02/08/12 at 3:10 PM, revealed the IDT met to discuss Resident #3's fall at 8:20 AM. The IDT had therapy evaluate the resident and therapy placed a self releasing alarming seatbelt on the resident's wheelchair. However, there was no evidence the facility identified the 15 minute checks did not provide adequate supervision to prevent a fall.</p> <p>A review of the Minimum Data Set (MDS) assessment, dated 02/06/12, revealed the facility assessed Resident #3 as severely cognitively impaired requiring extensive assistance for</p>	F 323		
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NAME OF PROVIDER OR SUPPLIER PEMBROKE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 24 WEST NASHVILLE ST PEMBROKE, KY 42266	
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F 323	<p>Continued From page 16</p> <p>transfers, toileting and walking did not occur. In addition, Resident #3 had two falls with one injury since admission. A review of the Comprehensive Care Plan, last updated 01/25/12, revealed there were no new interventions added to address prevention of falls.</p> <p>A review of the nurse's note and review of the Accident/Injury Report, dated 02/26/12 at 8:25 PM, revealed Resident #3 was found in the hallway outside of his/her room lying on the floor on his/her right side. A review of the 24 hour flow checks revealed the facility continued to monitor Resident #3 every 15 minutes, the same intervention that was initiated on 01/25/12. The resident had a two centimeter (cm.) laceration noted to the right periorbital area across eyebrow. The facility transferred the resident to the emergency room and the resident received five sutures to the right eyebrow. In addition, neuro-checks were conducted when the resident returned to the facility.</p> <p>A review of the IDT Note, dated 02/27/12 at 4:00 PM, revealed the IDT team developed an intervention for staff to ensure when the resident was up in the wheelchair the resident should be in visualized areas. In addition, the resident's Ativan was decreased from Ativan 0.5 mg. three times a day to two times a day related to lethargy.</p> <p>A review of the Nurses Notes and Accident/Injury Report, dated 03/13/12 at 5:10 PM and 5:20 PM respectively, revealed Resident #3 had a witnessed fall from the wheelchair in the dining room and sustained an abrasion to the jaw. The resident was assisted back in the wheel chair. A review of the 24 hour flow checks revealed the</p>	F 323		

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F 323	<p>Continued From page 17</p> <p>facility continued to monitor Resident #3 every 15 minutes, as initiated on 01/25/12.</p> <p>An interview, on 07/14/12 at 5:10 PM with a dietary employee, revealed that he saw Resident #3 in the dining room during meal time on 03/13/12. He stated Resident #3 released his/her seat belt and fell, hitting his/her head on the table. He revealed he did not recall hearing an alarm sound. The dietary window was open during meal times and dietary staff was able to view the residents from the kitchen.</p> <p>Interviews with LPN #2, LPN #5, LPN #7, Certified Nurse Aide (CNA) #3, CNA #4, CNA #5, CNA #8 and a Physical Therapist Assistant, on 07/12/12 at 9:10 AM, 9:30 AM, and 12:40 PM, on 07/13/12 at 2:25 PM and 4:10 PM, on 07/15/12 at 5:05 PM and on 07/16/12 at 9:10 AM and 1:50 PM respectively, revealed the staff interpreted the intervention for Resident #3 to be in visualized areas as the resident should have been in an area where the resident was in view of staff at all times. The staff revealed Resident #3 should not have been left in the dining room without staff present.</p> <p>A review of the IDT note, dated 03/14/12 at 2:00 PM, revealed the IDT team developed an intervention for staff to offer Resident #3 a nap after lunch. In addition, a review of the facility's timeline and an interview with the Activity Director, on 07/13/12 at 2:37 PM, revealed an activity box was put together and kept in the resident's room. However, review of the Comprehensive Care Plan, last updated 03/14/12, and CNA Assignment Sheet, dated 07/10/12, revealed the care plan did not include an intervention to</p>	F 323		
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F 323	<p>Continued From page 18 provide an activity box for the resident.</p> <p>Interviews with LPN #4, LPN #5, LPN #7, CNA #5, CNA #6 and CNA #8 on 07/13/12 at 3:42 PM and 4:10 PM, on 07/15/12 at 5:05 PM and on 07/16/12 at 8:05 AM, 9:10 AM and 1:50 PM respectively, revealed they were not aware of the resident having an activity box.</p> <p>Interview conducted with the Unit Manager after reviewing the CNA care plan, on 07/11/12 at 11:17 AM, revealed the Activity box was not placed on the CNA care plan. She revealed it was the Social Worker's responsibility to update the CNA Care Plans.</p> <p>An interview with the Social Services Director, on 07/11/12 at 1:10 PM, revealed that the social worker is responsible for updating the CNA Care Plans. He stated he should have updated the CNA care plan to include the activity box.</p> <p>A review of an electronic Incident Report, dated 04/07/12 at 1:28 PM, revealed Resident #3 had an unwitnessed fall from the wheelchair and he/she was found on the floor beside his/her wheelchair. The fall resulted in reopening the laceration to the right eyebrow. The resident stated he/she was trying to go smoke. A review of the 24 hour flow checks revealed the facility had discontinued the 15 minute checks on 03/19/12.</p> <p>An interview, on 07/16/12 at 8:05 AM with CNA #6, revealed she was at the nurse's station when Resident #3 fell on 04/07/12 in the hallway in front of the dining room. She stated she was working on the computer at the nurse's desk and when</p>	F 323		
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F 323	<p>Continued From page 19</p> <p>she looked up she saw Resident #3 had fallen.</p> <p>A review of the IDT note, dated 04/09/12 at 2:45 PM, revealed the resident was sent to the hospital and received sutures to the laceration that was reopened. The IDT requested a therapy evaluation to drop the resident's wheelchair seat; however, there was no evidence the IDT team identified Resident #3 was not in a visualized area according to care plan.</p> <p>A review of the Nurse's Note and Accident/Injury Report, dated 04/26/12 at 6:10 PM, revealed Resident #3 was observed lying on the floor with the wheelchair tipped over and no injury. The resident was assisted back to the wheelchair, vital signs were taken and the resident was placed on 15 minute checks. The resident stated he/she was trying to get his/her keys.</p> <p>An interview, on 07/13/12 at 4:10 PM with LPN #5, revealed she was working on 04/26/12 getting ready to clock out when she turned and saw Resident #3 with wheelchair tipped over in the lobby. She stated the resident was still in the wheelchair.</p> <p>A review of the IDT Note, dated 04/27/12 (no time), revealed anti-tippers and a basket were applied to the resident's wheelchair, however, there was no evidence the IDT identified the resident was not visualized at the time of the fall.</p> <p>A review of the electronic Incident Report, dated 05/06/12 at 1:30 PM, revealed Resident #3 had an unwitnessed fall from the wheelchair in the dining room after the resident released the self release seatbelt and tried to walk. There was no</p>	F 323		
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NAME OF PROVIDER OR SUPPLIER PEMBROKE NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42268
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F 323	<p>Continued From page 20</p> <p>injury identified. The staff was educated on making sure the alarm was always on and to make sure to get to resident as soon as the alarm goes off, because the resident can move quick.</p> <p>A review of the IDT Notes, dated 05/04/12 -05/15/12, revealed there was no evidence the IDT met to discuss the 05/08/12 fall. In addition, there was no evidence the facility identified the resident was not visualized at the time of the fall.</p> <p>A review of the electronic Incident Report, dated 05/20/12 at 4:00 PM, revealed Resident #3 was found on the floor, in the dining room, under the wheelchair with a puddle of blood on the floor. The resident reported he/she was trying to walk to the window. The fall caused the laceration to the resident's right eyebrow to reopen. The resident was sent to the emergency room and returned with five sutures to the right eyebrow. Further review revealed the self-release alarming seat belt was not in good repair. The seat belt was not working properly as the alarm would not sound. Administration was aware and a new lap belt had been ordered but had not been received yet. The incident report noted the "lap belt is not working properly. Administration is aware, and a new lap belt has been ordered, but not received."</p> <p>An interview with CNA #10, on 07/16/12 at 12:05 PM, revealed Resident #3 was left unattended in the dining room on 05/20/12 by the assigned CNA and Activity Director. She revealed all aides were aware Resident #3 should not be left unattended because of his/her risk of falls. She stated she was charting at the nursing desk on hall 2 when a dietary staff told her that Resident #3 had fallen in the dining room. Resident #3 was laying on</p>	F 323		
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F 323	<p>Continued From page 21</p> <p>his/her right side with his/her eye busted open and blood everywhere. She stated the resident's alarm was not sounding because it had not been working for a couple of days. She stated Administration was aware and a new self releasing alarming lap belt had been ordered. She was not aware of any interventions put in place to address the fact that the resident's alarming seat belt was not working.</p> <p>Interview with Registered Nurse (RN)#3, on 07/16/12 at 9:50 AM, revealed when Resident #3 fell on 05/20/12, the resident's self alarming lap belt was not working. She stated she called Administration and was told a new one had been ordered and had not come in yet. She was not aware of any interventions put in place to address the resident's risk for falls with the self releasing alarming seat belt not working.</p> <p>A review of an e-mail (proof of order form) and interview with the Nurse Consultant, on 07/16/12 at 11:20 AM, revealed a self alarming Velcro seat belt was ordered on 05/18/12 and was delivered on 05/26/12.</p> <p>A review of the IDT Note, dated 05/22/12 at 5:00 PM, revealed the resident was referred to therapy and the seat belt was replaced; however, there was no evidence the IDT identified the resident was not visualized by staff at the time of the fall and there was no evidence the facility identified no intervention was put in place to address the resident's lack of supervision related to the self releasing alarming seat belt not working.</p> <p>A review of the nurse's note and electronic Incident Report, dated 06/02/12 at 4:30 PM and</p>	F 323		
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F 323	<p>Continued From page 22</p> <p>6:00 PM respectively, revealed Resident #3 had an unwitnessed fall in the dining room. The resident was found under the table, bleeding from the left hand. The resident denied pain after the fall.</p> <p>An interview with LPN #2, on 07/11/12 at 3:50 PM, revealed she was made aware of the fall by CNA #3 & LPN #3. They reported to her that the resident was found in the dining room floor by a kitchen staff worker. She revealed LPN #3 assessed the resident after the fall. She stated staff was not assigned to the dining room area when there are no meal times.</p> <p>An interview, on 07/12/12 at 3:20 PM with a cook, revealed that she was working on the day of the 06/02/12 fall. She revealed the kitchen window was open to the dining room and the next thing she knew Resident #3 was on the floor under the table. She notified a nurse but didn't remember which one. She did not recall if the alarm was sounding or not. She stated all staff was supposed to watch out for the residents but kitchen staff was not specifically assigned to watch residents while working in the kitchen.</p> <p>An interview with CNA #3, on 07/12/12 at 12:40 PM, revealed she was at the nurse's station when Resident #3 had the fall on 06/02/12. She stated she and a kitchen staff had just left the dining room approximately three (3) minutes prior to the resident fall. She revealed the kitchen staff and she went to the dining room when they heard the fall. The alarm was not sounding. The resident was found on the floor under the table and was bleeding. She notified the nurse and the nurse told staff to get the resident back into the</p>	F 323		
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F 323	<p>Continued From page 23</p> <p>wheelchair without assessing the resident. She stated she did not recall the name of the nurse. The resident denied pain after fall. The CNA revealed she only worked at the facility for 1 ½ months and had never received a copy of the CNA Care Plan and wasn't aware of where to locate a copy in the facility.</p> <p>An interview, on 07/12/12 at 3:55 PM with LPN #3, revealed she recalled the fall on 06/02/12 with Resident #3 in the dining room. She stated she was called to the dining room by kitchen staff. She revealed she and a CNA responded. The resident was under the table. She did not recall if the alarm was sounding or not. She reported the fall to Resident #3's nurse, then went back to her assigned hall.</p> <p>An interview, on 07/11/12 at 5:05 PM and 07/12/12 at 2:35 PM, with the Unit Manager revealed she was the weekend manager on 06/02/12. She stated she was doing rounds when she heard an alarm sounding. She revealed she went into the dining room and saw the resident on the floor under the table. She stated she "checked over" the resident and did range of motion. The resident denied pain and the resident was assisted back into the wheelchair.</p> <p>A review of the IDT Note, dated 06/03/12 at 4:45 PM, revealed an intervention for therapy to evaluate Resident #3 for an activity tray; however, there was no evidence the IDT identified the resident was not visualized by staff at the time of the fall.</p> <p>An interview, on 07/13/12 at 2:25 PM with the</p>	F 323		
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F 323	<p>Continued From page 24</p> <p>Physical Therapist Assistant, revealed Resident #3 was impulsive and tried to get up on his/her own. He stated as far as he knew there was always someone watching him in the lobby. He revealed Resident #3 was always under constant supervision while in their department.</p> <p>An interview, on 07/13/12 at 2:37 PM with the Activity Director, revealed she attended the IDT meetings and meetings after the falls. She stated she set up the activity box and placed it in the resident's room so any one could assist the resident with the box. She revealed she would do the activity box with the resident once a week for about 15 minutes.</p> <p>A review of a Nurse's Notes revealed Resident #3 was assessed every shift after the fall until 06/03/12 at 8:00 AM when staff identified Resident #3's toes were blue and the right ankle and toes were swollen. The physician was called with orders were received to x-ray under the right knee and ankle. A review of an x-ray report of the right knee, dated 06/06/12, revealed there was no evidence of a fracture or dislocation.</p> <p>A review of a nurse's note, dated 06/08/12 at 6:00 PM revealed Resident #3 complained of right leg pain at times. The resident was complaining of pain less frequently and reported the pain is better. A review of a Nurse's Note, dated 06/08/12 at 10:00 PM, revealed Resident #3 complained of pain to the right knee. Pain medication was administered. Further review of the nurse's notes, dated 06/09/12, revealed Resident #3 was identified as having edema to the right hip and thigh. The physician was notified and orders were received to x-ray the</p>	F 323		
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F 323	<p>Continued From page 25</p> <p>right hip. A review of the x-ray report, dated 06/09/12, revealed there was an acute versus subacute intertrochanteric fracture with mild angulation deformity to the right hip. A review of the hospital's history and physical, dated 06/10/12, revealed Resident #3 had surgery to perform an open reduction internal fixation of the right hip.</p> <p>An interview, on 07/13/12 at 3:02 PM with the Social Services Director, revealed he attended the IDT meetings and had discussed the resident's falls. He revealed the staff discussed whether interventions had been effective or not. He stated IDT meetings were done daily.</p> <p>An interview with the Unit Manager, dated 07/16/12 at 10:35 AM, revealed she attended most of IDT meetings as well as meetings after falls. She stated the incident reports were brought to the meetings and the IDT discussed whether past interventions had been effective or not. She revealed when Resident #3 was in visualized areas of staff, it was determined that the resident interacted more with staff and other residents which kept him/her occupied. She stated they had not identified that the resident was continuing to have unwitnessed falls even when in a visualized area and had not identified eight out of eleven (8 of 11) falls from the wheelchair occurred on weekends.</p> <p>An interview with the Director of Nursing (at the time of the falls), dated 07/12/12 at 4:00 PM, revealed she would investigate the falls by interviewing staff present, look at medical history, medications, and environment. She stated falls were tracked and trended by times, residents,</p>	F 323		
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F 323	Continued From page 26 shifts, where in the building and days. She was unable to give an explanation as to why there were no interventions put in place to address the seat belt alarm not working, the resident continuing to have falls even when in visualized areas and having unwitnessed falls when the resident was supposed to be visualized.	F 323		