

Second SOD

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

PRINTED: 02/10/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185414	(K2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(K3) DATE SURVEY COMPLETED 01/06/2012 FEB 14 2012
NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1626 EUCLID AVENUE PAINTSVILLE, KY 41240	
(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)	Division of Health Care Enforcement Branch
F 000	INITIAL COMMENTS A standard survey was conducted on 01/03-06/12. Deficient practice was identified with the highest scope and severity at "G" level, with no opportunity to correct. An abbreviated standard survey (KY17611) was also conducted at this time. The complaint was substantiated with deficient practice identified at "G" level.	F 000	Mountain Manor of Paintsville does not believe and does not admit that any deficiencies existed, either, before, during or after the survey. Mountain Manor of Paintsville reserves all rights to contest the survey findings through informal dispute resolution, formal legal appeal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds, nor is it meant to establish any standard of care, contract obligation or position, and Mountain Manor reserves the right to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance, or self-critical examination privileges which Mountain Manor of Paintsville does not waive, and reserves the right to assert in any administrative, civil, criminal claim, action or proceeding. Mountain Manor of Paintsville offers its responses, credible allegation of compliance, and plan of correction as part of its ongoing effort to provide quality care to its residents.	
F 281 SS=G	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review it was determined the facility failed to ensure admission care planning was sufficient to meet the needs of newly admitted residents prior to completion of the resident's first comprehensive assessment and care plan for one of twenty-four sampled residents (Resident #21). Resident #21 sustained a fall on 12/30/11 and 12/31/11, and two falls on 01/01/12; however, the facility failed to review/revise the resident's admission care plan to prevent recurrence of the resident's falls. After the resident sustained the second fall on 01/01/12, Resident #21 was transferred to the hospital and diagnosed with a fractured left hip that required surgical intervention. The findings include:	F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS It is the policy of Mountain Manor of Paintsville that services provided or arranged by the facility must meet professional standards of quality.	

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

TITLE

(X6) DATE

Heborah Finkbeiner

3/14/2012

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

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F 281	<p>Continued From page 1</p> <p>A review of the facility's fall prevention policy/procedure, dated 04/27/11, revealed any resident that experienced a pattern of falls (2 or more during a 30-day period) or an injury from a fall would be referred for a falls assessment to be completed by the nurse. Following completion of the falls risk assessment, the interdisciplinary team/nursing staff would inform the family and resident about the recommended fall prevention management approach and adjust the care plan.</p> <p>Review of the medical record of Resident #21 revealed the facility admitted the resident on 12/07/11, and readmitted the resident on 12/23/11, after a hospitalization for gastrointestinal bleeding. The facility had not completed a Minimum Data Set (MDS) assessment because the resident had not been in the facility long enough for the assessment to be completed.</p> <p>A review of Resident #21's admission care plan, dated 12/08/11 and updated on 12/27/11, revealed the resident was at risk for falls related to generalized weakness. The interventions in place for the prevention of falls included the following interventions:</p> <ol style="list-style-type: none"> 1) "Fall precautions as needed" 2) "Orient to room including call light and bathroom" 3) "Call light within reach at all times" 4) "Place on Level 3 restorative program for active range of motion to extremities and ambulation training." <p>A review of the nursing notes for Resident #21 dated 12/30/11, at 2:00 PM, revealed the resident</p>	F 281	<p>1. The falls committee met on 01/3/12 and discussed falls related to Resident #21. A plan of action was developed to implement on readmission to the facility.</p> <p>A copy of the minutes related to this resident is enclosed.</p> <p>Resident #21 was readmitted to the facility on 01/10/12 to room 220 -1 from 243 - 2. This is closer to the nurse's station.</p> <p>Bed and chair alarms, floor mats and floor alarms were added to the care plan and implemented on 01/10/12 by Jeri Wright RN.</p> <p>On 01/11/12 Resident #21 was placed in a low bed with 1/4 SR x 2 by Christie Moore, RN.</p> <p>The fall risk and side rail assessments were updated on readmission (01/10/12) by Jeri Wright RN.</p> <p>The initial care plan was reviewed and updated on readmission (01/10/12) to include safety precautions and it was again reviewed on 01/11/12 by Crystal Cantrell, LPN. A raised edge mattress was added to the bed on 01/13/12.</p> <p>The resident was referred to PT & OT on 01/13/12.</p> <p>A comprehensive care plan was completed for resident #21 on 01/30/12.</p>		

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F 281	<p>Continued From page 2</p> <p>was found on the floor after the resident had attempted to ambulate unassisted.</p> <p>Review of the resident's admission care plan revealed the care plan was updated again on 12/30/11, as a result of the resident's fall. The care plan revealed the resident had transferred and ambulated without calling for assistance and was unable to do so safely. At that time interventions were added for the resident to wear non-skid socks, to remind the resident to call for assistance, and noted the resident was at a high risk for a fall with injury.</p> <p>Further review of the nursing notes revealed on 12/31/11, at 5:40 PM, Resident #21 attempted to ambulate to the bathroom without assistance and fell onto the resident's roommate who lowered the resident to the floor.</p> <p>An interview with Registered Nurse (RN) #3 on 01/05/12, at 5:15 PM, revealed RN #3 was responsible for the care of Resident #21 on 12/31/11. According to RN #3, Resident #21 had attempted to ambulate to the bathroom, lost his/her balance and fell onto the roommate. The RN stated she reminded the resident to use the call light and to ask for assistance prior to ambulating. RN #3 stated she felt the resident needed a bed alarm to alert staff to the resident's attempts of unassisted transfers; however, she was unable to find a bed alarm. The RN informed the nurse on the next shift of the resident's falls and that there was no bed alarm available.</p> <p>Interview with CNA #6 on 01/05/12, at 5:35 PM, revealed she was assigned to Resident #21's</p>	F 281	<p>2. All residents with falls in the last 60 days prior to 01-03-2012, had their MDS, Comprehensive Care Plan/Initial Care Plan and Nurse Aide Care Plan reviewed and updated to ensure that falls or fall risk factors were identified and appropriate prevention measures were implemented. Roberta Thompson, MDS Coordinator completed these audits and updates from 01-03-2012 to 01-06-2012.</p> <p>The comprehensive/initial care plan for all residents was reviewed and updated as needed to ensure that falls or fall risk factors were identified and appropriate prevention measures were implemented. This was completed by Roberta Thompson RN, Donna Fannin LPN, Crystal Cantrell LPN, Mary Arms DON, Christy Moore RN and Emily Jones-Gray, Assistant Administrator.</p> <p>3. Inservices were started on 01-04-2012 and were completed on 01-07-2012 for all licensed nurses by Mary Arms, DON. The inservices included care planning and assessment with emphasis on fall prevention/interventions, supervision of residents, physician notification, location of alarms, alarm check sheets, updated Alarm Policy, Stock Control Policy, and updated Fall Risk Assessment Policy. A copy of the inservice is attached as well as the sign-in sheet.</p> <p>CNA's were inserviced beginning on 01-04-2012 and completed on 01-05-2012 regarding resident safety, supervision of residents, transfers, following the CNA care plan,</p>		

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F 281	<p>Continued From page 3</p> <p>hallway on 12/30/11 and 12/31/11, and stated she found Resident #21 on the floor on both dates. The CNA stated that after the first fall she reinforced the need for the resident to call for assistance with transfers and ambulation. CNA #6 stated she informed the nursing staff that the resident was not using the call light and she thought the nursing staff would obtain a bed alarm for the resident. The CNA stated an alarm would have alerted staff the resident was attempting to get up. During the interview CNA #6 stated nursing staff had to issue the bed alarms and after the fall on 12/31/11, the nurse responsible for Resident #21 (RN #3) had stated she would obtain a bed alarm for the resident.</p> <p>Review of the nursing notes revealed on 01/01/12, at 2:40 AM, Resident #21 was found on the floor in the resident's room and at 6:25 AM, the resident was again found on the floor and had sustained injury to the left leg. The resident was transported to the hospital and found to have a fracture of the left hip that required surgical intervention.</p> <p>Further review of the resident's admission care plan revealed there was no evidence new interventions were put into place after the resident sustained a fall on 12/31/11, or after an additional fall at 2:40 AM on 01/01/12, to prevent further falls and/or injury.</p> <p>Interview with unsampled Resident B on 01/04/12, at 2:50 PM, revealed on 12/31/11, Resident #21 had attempted to ambulate to the bathroom and fell onto Resident B. Resident B stated the resident attempted unassisted transfers on three separate occasions on the</p>	F 281	<p>restraints, use of the lift, and call lights. The inservices were completed by Emily Jones-Gray, Assistant Administrator and Mary Arms, Director of Nursing. A copy of the inservice is attached as well as the sign-in sheets.</p> <p>All resident rooms with fall prevention measures were audited to ensure that all safety devices were in place as care-planned per physician order by 01-03-2012 by Kimberly Preston, RN and Christy Moore, RN.</p> <p>Fall Risk Assessment Policy was updated on 01-03-2012 by Deborah Fitzpatrick, Administrator, Mary Arms, Director of Nursing and Emily Jones-Gray, Assistant Administrator to reflect the following changes: #7 "If a resident has had any recent falls, the nurse should review the Fall Risk Assessment and update it at that time." This was added to the Fall Risk Assessment Policy. This policy was once again reviewed on 01-07-2012 by the Administrator, Assistant Administrator, and Director of Nursing with minor changes. A copy of the policy is attached.</p> <p>A new fall risk assessment was completed on all residents who had fallen within the last 60 days prior to 01-03-2012 by Anna Caldwell, ADON, Christy Moore, RN, Kimberly Preston, RN and Chanity Purcell, LPN. This was completed on 01-03-2012.</p> <p>Alarms Policy was updated on 01-03-2012 by Deborah Fitzpatrick, Administrator, Mary Arms, Director of Nursing and Emily Jones-</p>	

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F 281	<p>Continued From page 4</p> <p>evening of 12/31/11 and in the early morning on 01/01/12, and had not requested staff to assist him/her.</p> <p>Interview on 01/05/12, at 7:10 PM, with Licensed Practical Nurse (LPN) #2 revealed she was responsible for the care of Resident #21 on 01/01/12, during the 7:00 PM to 7:00 AM shift. LPN #2 stated she was informed by nursing staff on the previous shift that Resident #21 had sustained a fall. LPN #2 stated earlier in the shift Resident #21 had sustained a fall while she was on her lunch break. According to LPN #2, she felt the resident needed a bed alarm but there was no bed alarm in the medication room, and other available staff did not know where to find an alarm. LPN #2 stated that if a bed alarm had been placed on the bed of Resident #21, staff would have been alerted the resident was trying to get up unassisted and a fall might have been prevented.</p> <p>Interview on 01/06/12, at 10:10 AM, with LPN #3 revealed he/she was on duty on 01/01/12, during the 7:00 PM to 7:00 AM shift. According to LPN #3, one of the Certified Nursing Assistants (CNAs) came to the nursing station and stated she needed the LPN's assistance. LPN #3 found Resident #21 on the floor outside the bathroom door lying on his/her left side. According to LPN #3, the resident informed the nurse that he/she had used the bathroom, felt tired, and had lain down on the floor. LPN #3 was not aware if LPN #2 had obtained a bed alarm for Resident #21. According to LPN #3, if there were no bed alarms on the floor staff could obtain one from the first floor nursing unit or the facility stock room. LPN #3 stated staff could always telephone the</p>	F 281	<p>Gray, Assistant Administrator to reflect the following: #5 "If no alarm is located in the medication room, staff should go to the other floor to obtain an alarm. Staff should then notify Stock Control, the DON, Assistant Administrator or Administrator to replace the alarm" and #7 "The Stock Control Clerk will check the alarms at a minimum of three times per week to ensure they are in proper working condition. The alarm checks will be documented. Any problems should be reported immediately to the DON." This policy was once again reviewed and revised by the Administrator, Director of Nursing and Assistant Administrator on 01-07-2012. A copy of the policy is attached.</p> <p>A notation was added to the bottom of the alarm check sheet on 01-04-2012 by Mary Arms, Director of Nursing that states the following: "Alarms are available on each floor. If an alarm is missing, go to the other floor and obtain one. Then notify stock control, DON, ASST. ADM or ADM." A copy of this is attached.</p> <p>An Alarm Replacement Form is now attached to each alarm in stock in the med rooms to remind nursing staff to communicate with Stock Control to restock alarms. This was completed by Madge Arnett, Stock Control Clerk on 01-06-2012. A copy of this form is attached.</p> <p>A copy of the Stock Control Policy that was updated on 12-06-2010 was reviewed on 01-03-2012 with no changes by Deborah Fitzpatrick, Administrator, Mary Arms, Director of Nursing, and Emily Jones-Gray,</p>		

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F 281	<p>Continued From page 5</p> <p>Director of Nursing (DON) to assist with finding a bed alarm.</p> <p>Interview with CNA #7 on 01/01/12, at 5:40 AM, revealed the CNA was responsible for the care of Resident #21 on the 11:00 PM to 7:00 AM shift on 01/01/12. CNA #7 stated she found Resident #21 lying on the floor, in front of the bathroom, asleep. According to CNA #7, at that time the nurse discussed a bed alarm for Resident #21 but there was no alarm available on the floor. The CNA stated later that morning at approximately 6:00 AM, staff heard a "thud" and a nurse and two CNAs ran to the resident's room. The CNA stated the resident appeared to be hurt and complained of pain in the left leg. The CNA stated only nursing staff had access to the bed alarm storage area and acknowledged the resident did not have a bed alarm on the bed. CNA #7 stated in her opinion the resident's second fall could have been prevented if a bed alarm had been in place because staff would have been alerted when the resident attempted to get out of bed and could have intervened/assisted.</p> <p>Interview with RN #4 on 01/05/12, at 5:45 PM, revealed RN #4 had updated Resident #21's care plan after the fall on 12/30/11, to include the addition of non-skid socks. RN #4 stated all nursing staff was responsible for revising/updating the care plan for residents.</p> <p>An interview was conducted with the Director of Nursing (DON) on 01/05/12, at 11:25 AM. The DON stated Resident #21 sustained the first fall on 12/30/11. At that time staff determined the resident's socks were "regular" and the socks</p>	F 281	<p>Assistant Administrator. A copy of the policy is attached.</p> <p>The Falls Prevention Policy was revised on 01-07-2012 by Deborah Fitzpatrick, Administrator, Mary Arms, Director of Nursing and Emily Jones-Gray, Assistant Administrator. This was under revision at the time of the survey and was completed on 01-07-2012. A copy of this policy is attached.</p> <p>Licensed staff members caring for resident #21 when the alleged deficit practice occurred were terminated and/or disciplined by Mary Arms DON and Emily Jones-Gray, Assistant Administrator.</p> <p>4. Dr. Charles Hardin, Medical Director will provide oversight during the compliance process. The results of all audits will be reported to the Medical Director quarterly through CQI by Emily Jones-Gray, Assistant Administrator. This will be ongoing.</p> <p>Dr. Charles Hardin, the Medical Director at the facility was telephoned by Mary Arms, DON on 01-03-2012 at 12:05 PM. They discussed the falls related to resident #21 and the corrective actions taken by the facility.</p> <p>Dr. Charles Hardin was faxed by Mary Arms, DON a copy of the inservice provided to the licensed nurses that began on 01-04-2012 that was conducted by Mary Arms, DON and the CNA inservice that began on 01-04-2012 that was conducted by Mary Arms, DON and Emily Jones-Gray, Assistant Administrator.</p>		

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F 281	Continued From page 6 were the reason the resident had fallen on the tiled floor. Staff implemented non-skid socks and documented the intervention to the resident's care plan. The DON stated she had not been informed by staff of the resident's falls from 12/31/11 to 01/01/12, until the resident sustained the fall with injury on 01/01/12. The DON stated staff should have added interventions after the fall on 12/31/11.	F 281	Dr. Charles Hardin, the Medical Director telephoned Mary Arms, DON on 01-07-2011 concerning the survey ending on 01-06-2011. They discussed the alleged deficit practices regarding Resident #21 and the corrective actions taken by the facility.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and a review of the facility's "Post Fall Investigation", the facility failed to ensure services provided by the facility were provided by qualified persons in accordance with each resident's written plan of care for one of twenty-four sampled residents. Facility staff assessed Resident #16 to require the assistance of a minimum of two staff persons for transfers. On 10/02/11, one staff person attempted to transfer the resident from the bed to a shower chair and the resident sustained a fall. As a result of the fall, the resident's left knee, right side of the resident's underarm, and the left side of the resident's left breast area were bruised. The findings include: A review of the facility's policy "Care	F 282	An Interdisciplinary Falls Committee was formed in November 2011. This committee meets weekly and reviews all falls, and the Care Plans (Comprehensive/Initial) of the effected residents are reviewed for appropriateness of fall prevention interventions. The results of the Falls Committee Meeting will be reported quarterly through CQI by Emily Jones-Gray, Assistant Administrator. This will be ongoing. The care plans of all new residents or residents returning from a hospital stay will be audited during the morning CQI meeting to ensure that care plans accurately reflect the resident's needs. This will be monitored by Mary Arms, DON and Emily Jones-Gray, Assistant Administrator and the results will be reported quarterly through CQI. This will be ongoing. The Stock Control Clerk Madge Arnett will check the alarms at a minimum of three times per week to ensure they are available and are in proper working condition. The alarm checks will be documented by Madge. Any problems will be reported immediately to the DON and through quarterly CQI meetings by Emily Jones-Gray, Assistant Administrator. This will be ongoing.	

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F 282	<p>Continued From page 7</p> <p>Plans-Comprehensive Statement" (not dated) revealed it was the policy of the facility to develop a comprehensive care plan for each resident that included measurable objectives and timetables to meet the resident's medical, nursing, and psychosocial needs. Further review of the policy revealed the comprehensive care plan had been designed to incorporate identified problem areas, and to prevent declines in the resident's functional status and/or functional level.</p> <p>The facility admitted Resident #16 on 06/01/11, with diagnoses of Coronary Artery Disease (CAD), Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), Dementia, Parkinson's Disease, and Arthritis.</p> <p>A review of the Admission Minimum Data Set (MDS) Assessment dated 06/08/11, revealed Resident #16 had an alteration in mobility and was at risk for falls with injury. The MDS Assessment revealed the facility had assessed the resident to require extensive physical assistance of a minimum of two staff persons with transfers. Continued review of the (MDS) Assessment revealed CNAs were to assist the resident with all transfers and were to apply non-skid footwear to the resident's feet for safety.</p> <p>A review of the Nursing Care Plan dated 06/21/11, also revealed Resident #16 was at risk for falls, had impaired mobility, and required assistance with transfers and mobility. Furthermore, a review of the Certified Nursing Assistant (CNA) Care Record dated October 2011 revealed Resident #16 required transfer assistance of two and the use of a gait belt.</p>	F 282	<p>A safety device audit is performed three times per week at a minimum by Administration/Nursing Administration. A calendar was developed to include all residents. Six residents are checked per audit to ensure that the proper safety device is in place and is operational. The results of the audits are reported quarterly through CQI by Emily Jones-Gray, Assistant Administrator. This will be ongoing.</p> <p>5. Date of correction is 02-03-2012.</p> <p>F282</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>It is the policy of Mountain Manor of Paintsville that 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>1. Resident #16's quarterly assessment, comprehensive care plan and CNA care plan/assignment sheet were updated on 12-07-2011 by Roberta Thompson, MDS Coordinator. The care plan and CNA care plan/assignment sheet was again reviewed on 01-06-2012 for accuracy by Mary Arms, Director of Nursing. No changes were made to the care plan at that time.</p> <p>Resident #16's Fall Risk Assessment was completed on 12-07-2011 by Crystal Cantrell, LPN. The Fall Risk Assessment was again reviewed and updated on 01-06-</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/06/2012
NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 41240		
(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 282	Continued From page 8 A review of a Post Fall Investigation dated 10/11/11 revealed on 10/02/11, at 12:30 AM, a CNA attempted to transfer Resident #16 from bed. The investigation stated the CNA did not use a gait belt or have another CNA assist with the transfer. The CNA grabbed the resident under the resident's arms and tried to pull the resident from bed, when the bed scooted and the resident fell on the floor on his/her left knee. The resident sustained bruising to the left knee, the right side of his/her underarm, and the left side of the left breast as a result of the fall. An interview with Resident #16 on 01/05/12, at 3:18 PM, confirmed facility staff had attempted to transfer the resident from the bed to a shower chair with the assistance of one. According to the resident, the bed was not locked and the resident was in bare feet. The resident stated he/she landed on his/her left knee causing a bruise, then sat on the floor on his/her buttocks. An interview conducted on 01/06/12, at 9:10 AM, with CNA #3 revealed she failed to review Resident #16's Care Record prior to her attempt to transfer Resident #16 from the bed to the shower chair. However, CNA #3 reported she had been trained to review resident Care Records to determine the resident's needs prior to providing assistance with care.	F 282	2012 by Mary Arms, DON. The fall risk score remained the same. CNA's were inserviced beginning on 01-04-2012 and completed on 01-05-2012 regarding resident safety, supervision of residents, transfers, following the CNA care plan, restraints, use of the lift, and call lights. The inservices were completed by Emily Jones-Gray, Assistant Administrator and Mary Arms, Director of Nursing. A copy of the inservice is attached as well as the sign-in sheets. 2. All residents with falls in the last 60 days prior to 01-03-2012 had their MDS, Comprehensive Care Plan/Initial Care Plan and Nurse Aide Care Plan reviewed and updated to ensure that falls or fall risk factors were identified and appropriate prevention measures were implemented. Roberta Thompson, MDS Coordinator completed these audits and updates from 01-03-2012 to 01-06-2012. The comprehensive/initial care plan for all residents was reviewed and updated as needed to ensure that falls or fall risk factors were identified and appropriate prevention measures were implemented. This was completed by Roberta Thompson RN, Donna Fannin LPN, Crystal Cantrell LPN, Mary Arms DON, Christy Moore RN and Emily Jones-Gray Assistant Administrator.		
F 323 SS=G	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.	F 323	3. Inservices were started on 01-04-2012 and were completed on 01-07-2012 for all licensed nurses by Mary Arms, DON. The		

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F 323	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy/procedures it was determined the facility failed to ensure two of twenty-four sampled residents (Residents #16 and #21) received adequate supervision and assistive devices to prevent accidents.</p> <p>Resident #21 was assessed by the facility to be at high risk for falls. On 12/30/11, staff implemented the use of non-skid socks for Resident #21 after the resident sustained a fall. On 12/31/11, Resident #21 sustained another fall and staff failed to develop and implement interventions to prevent further falls. On 01/01/12, Resident #21 sustained a fall at 2:25 AM, and again staff failed to implement new interventions. At 6:25 AM on 01/01/12, Resident #21 sustained a second fall. The resident was transferred to the hospital and was diagnosed with a fracture to the left hip. The resident underwent surgery on 01/01/12, and the fracture was surgically repaired.</p> <p>The facility assessed Resident #16 to require the assistance of a minimum of two staff persons for transfers. However, on 10/02/11, one staff person attempted to transfer the resident from the bed to a shower chair, and the resident sustained a fall. As a result of the fall, the resident's left knee, right side of the resident's underarm, and the left side of the resident's left breast area were</p>	F 323	<p>inservices included care planning and assessment with emphasis on fall prevention/interventions, supervision of residents, physician notification, location of alarms, alarm check sheets, updated Alarm Policy, Stock Control Policy, and updated Fall Risk Assessment Policy. A copy of the inservice is attached as well as the sign-in sheet.</p> <p>CNA's were inserviced beginning on 01-04-2012 and completed on 01-05-2012 regarding resident safety, supervision of residents, transfers, following the CNA care plan, restraints, use of the lift, and call lights. The inservices were completed by Emily Jones-Gray, Assistant Administrator and Mary Arms, Director of Nursing. A copy of the inservice is attached as well as the sign-in sheets.</p> <p>4. Random audits will be done weekly to ensure resident care records are being followed as per care plan. A minimum of four observed transfers per week will be completed by Chanity Purcell, Staff Development Coordinator, and a minimum of four cognitive resident interviews will be completed by Chanity or other staff as assigned by Emily Jones-Gray, Assistant Administrator to ensure resident care records are being followed with special attention to transfer of residents. The audits will be completed for a minimum of three months. The results of these audits will be reported through CQI by Emily Jones-Gray, Assistant Administrator. A copy of this audit form is attached.</p>	

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F 323	Continued From page 10 bruised. The findings include: Review of the stock control policy/procedure (dated 12/06/10) revealed a personal alarm, bed pad alarm, and a chair pad alarm would be stored in the medication room for use after hours or on weekends. In the event staff should run out of supplies after hours a key to the main stock control room was located at each nurses' station in the drawer. Review of the facility's Fall Prevention Policy (dated 04/27/11) revealed any resident experiencing a pattern of falls (2 or more during a 30-day period) or an injury from a fall would be referred for a falls assessment to be completed by the nurse. 1. A review of the medical record of Resident #21 revealed the resident was initially admitted to the facility on 12/07/11, and readmitted on 12/23/11, with diagnoses that included End Stage Cirrhosis of the Liver, Ascites, End Stage Chronic Obstructive Pulmonary Disease, and Gastrointestinal Bleeding. Review of Resident #21's admission care plan dated 12/08/11, revealed interventions in place to prevent falls were as follows: 1) "Fall precautions as needed" 2) "Orient to room including call light and bathroom" 3) "Call light within reach at all times" and 4) "Place on Level 3 restorative program for active range of motion to extremities and	F 323	Dr. Charles Hardin, Medical Director will provide oversight during the compliance process. The results of all audits will be reported to the Medical Director quarterly through CQI by Emily Jones-Gray, Assistant Administrator. This will be ongoing. Dr. Charles Hardin, the Medical Director telephoned Mary Arms, DON on 01-07-2011 concerning the survey ending on 01-06-2011. They discussed the alleged deficit practices regarding Resident #16 and the corrective actions taken by the facility. Dr. Charles Hardin was faxed by Mary Arms, DON a copy of the inservice provided to the licensed nurses that began on 01-04-2012 that was conducted by Mary Arms, DON and the CNA inservice that began on 01-04-2012 that was conducted by Mary Arms, DON and Emily Jones-Gray, Assistant Administrator. 5. Date of Correction is 02-03-2012. F323 483.25(h) FREE OF ACCIDENT HAZARD/SUPERVISION/DEVICES It is the policy of Mountain Manor of Paintsville that the facility must ensure that the resident environment remains as free of accident hazards as is possible; and that each resident receives adequate supervision and assistance devices to prevent accidents.	

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F 323	<p>Continued From page 11 ambulation training."</p> <p>A review of the re-admission nursing notes dated 12/23/11, revealed Resident #21 was alert and oriented to person, place, and time. The facility assessed the resident to require assistance with activities of daily living and to be at risk for falls due to generalized weakness. The admission Minimum Data Set (MDS) assessment had not been completed at the time of the survey.</p> <p>Review of the nursing notes dated 12/30/11, at 2:00 PM, revealed staff found Resident #21 lying on the floor of the bedroom on his/her back, between both beds. According to the nursing notes, the resident had regular socks on and had been sitting in a geri-chair. The resident had attempted to get out of the chair without assistance and fell. A review of the updated admission care plan, dated 12/30/11, revealed the resident had sustained a fall in the facility due to ambulating without calling for assistance and an intervention had been implemented for the resident to wear non-skid socks. Additionally, the care plan update documented the resident was a high risk for a fall with injury.</p> <p>Further review of the nursing notes dated 12/31/11, at 5:40 PM, revealed Resident #21 got out of bed without calling for assistance and fell onto his/her roommate on the way to the bathroom. The resident's roommate reportedly eased the resident to the floor and called staff for assistance.</p> <p>Interview on 01/04/12, at 2:50 PM, with the roommate (Resident B) of Resident #21 confirmed the resident had fallen onto the</p>	F 323	<p>1. The falls committee met on 01/3/12 and discussed falls related to Resident #21. A plan of action was developed to implement on readmission to the facility. A copy of the minutes related to this resident is enclosed.</p> <p>Resident #21 was readmitted to the facility on 01/10/12 to room 220 -1 from 243 -2. This is closer to the nurse's station.</p> <p>Bed and chair alarms, floor mats and floor alarms were added to the care plan and implemented on 01/10/12 by Jeri Wright RN.</p> <p>On 01/11/12 Resident #21 was placed in a low bed with 1/4 SR x 2 by Christie Moore, RN.</p> <p>The fall risk and side rail assessments were updated on readmission (01/10/12) by Jeri Wright RN.</p> <p>The initial care plan was reviewed and updated on readmission (01/10/12) to include safety precautions and it was again reviewed on 01/11/12 by Crystal Cantrell, LPN. A raised edge mattress was added to the bed on 01/13/12.</p> <p>The resident was referred to PT & OT on 01/13/12.</p> <p>A comprehensive care plan was completed for resident #21 on 01/30/12.</p> <p>Resident #16's quarterly assessment, comprehensive care plan and CNA care plan/assignment sheet were updated on 12-07-2011 by Roberta Thompson, MDS</p>	

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F 323	<p>Continued From page 12</p> <p>roommate's lap while ambulating to the bathroom. According to Resident B, Resident #21 had not used the call light to inform staff the resident needed assistance. Resident B stated that on 12/31/11, Resident #21 had attempted to ambulate to the bathroom and fell onto Resident B. Resident B stated the resident attempted to transfer unassisted on three separate occasions on the evening of 12/31/11 and the early morning of 01/01/12.</p> <p>Interview with CNA #6 on 01/05/12, at 5:35 PM, revealed she was assigned to Resident #21's hallway on 12/30/11 and 12/31/11. According to CNA #6, she found Resident #21 on the floor on 12/30/11 and 12/31/11, and informed the resident's assigned nurse on both occasions. The CNA stated that after the first fall she reinforced the need for the resident to call for assistance with transfers and ambulation. CNA #6 stated she informed the nursing staff that the resident was not using the call light and she assumed the nursing staff would obtain a bed alarm for the resident. The CNA stated an alarm would have alerted staff the resident was attempting to transfer without assistance. During the interview CNA #6 stated nursing staff had to issue the bed alarms and after the fall on 12/31/11, the nurse responsible for Resident #21 (RN #3) had stated she would obtain a bed alarm for the resident. CNA #6 was unaware whether the nurse had obtained a bed alarm for Resident #21.</p> <p>Registered Nurse (RN) #3 stated in an interview on 01/05/12, at 5:15 PM, that she provided care to Resident #21 on 12/31/11, and on that date the resident attempted to ambulate to the bathroom</p>	F 323	<p>Coordinator. The care plan and CNA care plan/assignment sheet were again reviewed on 01-06-2012 for accuracy by Mary Arms, Director of Nursing. No changes were made to the care plan at that time.</p> <p>Resident #16's Fall Risk Assessment was completed on 12-07-2011 by Crystal Cantrell, LPN. The Fall Risk Assessment was again reviewed and updated on 01-06-2012 by Mary Arms, DON. The fall risk score remained the same.</p> <p>CNA's were inserviced beginning on 01-04-2012 and completed on 01-05-2012 regarding resident safety, supervision of residents, transfers, following the CNA care plan, restraints, use of the lift, and call lights. The inservices were completed by Emily Jones-Gray, Assistant Administrator and Mary Arms, Director of Nursing. A copy of the inservice is attached as well as the sign-in sheets.</p> <p>2. All residents with falls in the last 60 days prior to 01-03-2012, had their MDS, Comprehensive Care Plan/Initial Care Plan and Nurse Aide Care Plan reviewed and updated to ensure that falls or fall risk factors were identified and appropriate prevention measures were implemented. Roberta Thompson, MDS Coordinator completed these audits and updates from 01-03-2012 to 01-06-2012.</p> <p>The comprehensive/initial care plan for all residents was reviewed and updated as needed to ensure that falls or fall risk factors were identified and appropriate prevention</p>	

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F 323	<p>Continued From page 13</p> <p>unassisted but lost his/her balance and fell onto the roommate, and was on the floor when she entered the room. The RN stated she assessed Resident #21, found no injuries, and reminded the resident to use the call light and call for assistance prior to getting out of bed and walking in the room. In addition, RN #3 stated due to the resident's prior attempts to get out of bed and walk unassisted she planned to place a bed alarm on the resident's bed to alert staff when the resident attempted to get out of bed unassisted. However, according to the RN, there were no bed alarms available on the nursing unit and she had informed the nurse on the next shift of the resident's falls and that there were no bed alarms available.</p> <p>Further review of Resident #21's admission care plan revealed no additional interventions were added after the resident sustained a fall on 12/31/11.</p> <p>Further review of the nursing notes revealed on 01/01/12, at 2:25 AM, Resident #21 was found on the floor. The resident was assessed and no injuries were found. At 6:25 AM on 01/01/12, Resident #21 again sustained a fall in the room, and at that time, the resident complained of pain to the left leg. The resident was transported to the hospital for evaluation and was found to have a fracture of the left hip that required surgical intervention.</p> <p>Interview on 01/05/12, at 7:10 PM, with Licensed Practical Nurse (LPN) #2 revealed she was responsible for the care of Resident #21 on 01/01/12, during the 7:00 PM to 7:00 AM shift. LPN #2 stated she was informed by nursing staff</p>	F 323	<p>measures were implemented. This was completed by Roberta Thompson RN, Donna Fannin LPN, Crystal Cantrell LPN, Mary Arms DON, Christy Moore, RN and Emily Jones-Gray Assistant Administrator.</p> <p>3. Inservices were started on 01-04-2012 and were completed on 01-07-2012 for all licensed nurses by Mary Arms, DON. The inservices included care planning and assessment with emphasis on fall prevention/interventions, supervision of residents, physician notification, location of alarms, alarm check sheets, updated Alarm Policy, Stock Control Policy, updated Fall Risk Assessment Policy. A copy of the inservice is attached as well as the sign-in sheet.</p> <p>CNA's were inserviced beginning on 01-04-2012 and completed on 01-05-2012 regarding resident safety, supervision of residents, transfers, following the CNA care plan, restraints, use of the lift, and call lights. The inservices were completed by Emily Jones-Gray, Assistant Administrator and Mary Arms, Director of Nursing. A copy of the inservice is attached as well as the sign-in sheets.</p> <p>All resident rooms with fall prevention measures were audited to ensure that all safety devices were in place as care-planned per physician order by 01-03-2012 by Kimberly Preston, RN and Christy Moore, RN.</p> <p>Fall Risk Assessment Policy was updated on 01-03-2012 by Deborah Fitzpatrick,</p>	

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F 323	<p>Continued From page 14</p> <p>on the previous shift that Resident #21 had sustained another fall. According to LPN #2, when she returned to the unit from break she was informed Resident #21 had sustained a fall. LPN #2 felt the resident needed a bed alarm but a bed alarm was not available in the medication room. LPN #2 stated she asked other staff on duty where she could obtain a bed alarm and no one knew. The LPN stated she was unaware she could obtain a bed alarm from the stock room or the first floor nursing unit. LPN #2 stated that if Resident #21 had received a bed alarm staff would have been alerted to the resident's attempt at unassisted transfers and the fall could have been prevented.</p> <p>During an interview on 01/06/12, at 10:10 AM, with LPN #3, it was revealed she was on duty on 01/01/12, during the 7:00 PM to 7:00 AM shift. LPN #3 stated she provided nursing coverage to patients while LPN #2 was on lunch break. According to LPN #3, one of the Certified Nursing Assistants (CNAs) came to the nursing station and stated she needed the LPN's assistance. LPN #3 found Resident #21 on the floor outside the bathroom door lying on his/her left side. According to LPN #3, the resident informed the nurse that he/she had used the bathroom, felt tired, and had lain down on the floor. LPN #3 stated she assessed the resident's vital signs and assessed for injuries. At that time, according to LPN #3, LPN #2 returned to the nursing unit and was informed the resident had been found on the floor and that she had completed the required incident report. LPN #3 was not aware if LPN #2 had obtained a bed alarm for Resident #21. According to LPN #3, if there were no bed alarms on the floor staff could have obtained one from</p>	F 323	<p>Administrator, Mary Arms, Director of Nursing and Emily Jones-Gray, Assistant Administrator to reflect the following changes: #7 "If a resident has had any recent falls, the nurse should review the Fall Risk Assessment and update it at that time." This was added to the Fall Risk Assessment Policy. This policy was once again reviewed on 01-07-2012 by the Administrator, Assistant Administrator, and Director of Nursing with minor changes. A copy of the policy is attached.</p> <p>A new fall risk assessment was completed on all residents who had fallen within the last 60 days prior to 01-03-2012 by Anna Caldwell, ADON, Christy Moore, RN, Kimberly Preston RN and Chanity Purcell, LPN. This was completed on 01-03-2012.</p> <p>Alarms Policy was updated on 01-03-2012 by Deborah Fitzpatrick, Administrator, Mary Arms, Director of Nursing and Emily Jones-Gray, Assistant Administrator to reflect the following: #5 "If no alarm is located in the medication room, staff should go to the other floor to obtain an alarm. Staff should then notify Stock Control, the DON, Assistant Administrator or Administrator to replace the alarm" and #7 "The Stock Control Clerk will check the alarms at a minimum of three times per week to ensure they are in proper working condition. The alarm checks will be documented. Any problems should be reported immediately to the DON." This policy was once again reviewed and revised by the Administrator, Director of Nursing and Assistant Administrator on 01-07-2012. A copy of the policy is attached.</p>	

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F 323	<p>Continued From page 15</p> <p>the first floor nursing unit or the facility stock room. LPN #3 stated staff could always telephone the Director of Nursing (DON) to assist with finding a bed alarm.</p> <p>An interview was conducted with CNA #7 on 01/01/12, at 5:40 AM. The CNA stated she was responsible for the care of Resident #21 on the 11:00 PM to 7:00 AM shift on 01/01/12. CNA #7 had started to enter a room adjacent to Resident #21's when she observed the bathroom door in Resident #21's room was open. CNA #7 stated she found Resident #21 lying on the floor in front of the bathroom, asleep. According to CNA #7, at that time LPN #2 discussed a bed alarm for Resident #21 but LPN #2 informed the CNA a bed alarm was not available. The CNA stated the same morning at approximately 6:00 AM, staff heard a "thud" and LPN #2 and two CNAs ran to the resident's room. The CNA stated the resident appeared to be hurt and complained of pain in the left leg. The CNA stated only nursing staff had access to the bed alarm storage area and was to obtain the alarms and the CNAs would apply the alarms to the bed. CNA #7 acknowledged the resident did not have a bed alarm on the bed. CNA #7 stated, in her opinion the resident's second fall could have been prevented if a bed alarm had been in place because staff would have been alerted when the resident attempted to get out of bed and could have intervened/assisted.</p> <p>Further review of Resident #21's admission care plan revealed no additional interventions were added after the resident sustained falls on 01/01/12.</p>	F 323	<p>A notation was added to the bottom of the alarm check sheet on 01-04-2012 by Mary Arms, Director of Nursing that states the following: "Alarms are available on each floor. If an alarm is missing, go to the other floor and obtain one. Then notify stock control, DON, ASST. ADM or ADM." A copy of this is attached.</p> <p>An Alarm Replacement Form is now attached to each alarm in stock in the med rooms to remind nursing staff to communicate with Stock Control to restock alarms. This was completed by Madge Arnett, Stock Control Clerk on 01-06-2012. A copy of this form is attached.</p> <p>A copy of the Stock Control Policy that was updated on 12-06-2010 was reviewed on 01-03-2012 with no changes by Deborah Fitzpatrick, Administrator, Mary Arms, Director of Nursing, and Emily Jones-Gray, Assistant Administrator. A copy of the policy is attached.</p> <p>The Falls Prevention Policy was revised on 01-07-2012 by Deborah Fitzpatrick, Administrator, Mary Arms, Director of Nursing and Emily Jones-Gray, Assistant Administrator. This was under revision at the time of the survey and was completed on 01-07-2012. A copy of this policy is attached.</p> <p>Licensed staff members caring for resident #21 when the alleged deficit practice occurred were terminated and/or disciplined by Mary Arms DON and Emily Jones-Gray, Assistant Administrator.</p>	

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NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 41240	
(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 323	<p>Continued From page 16</p> <p>A visit was conducted to the hospital on 01/06/12, and revealed Resident #21 was in the Intensive Care Unit of the local hospital. The resident was in bed with an oxygen mask in place. The resident responded to questions with a shake of the head. An interview with the resident could not be obtained due to the resident's use of an oxygen mask and pain.</p> <p>Review of the facility's safety alarm checklist revealed staff was to check to ensure a pad alarm, a personal alarm, and a chair alarm were available on each floor during the change of shift medication count. The form stated that if an alarm was missing staff was to contact Stock Control or the Director of Nursing (DON). A review of the safety alarm checklist for the second floor alarms revealed staff had documented on 12/31/11, that no pad alarm was available. However, there was no evidence the DON was notified of the need for a pad alarm. Review of the safety alarm checklist for the pad alarm for the first floor revealed an alarm was available.</p> <p>Interview on 01/06/12, at 10:00 AM, with the Social Services Director (SSD) revealed RN #3 had called her on 12/31/11, and informed the SSD that staff was having trouble with Resident #21 attempting unassisted transfers and ambulation. The SSD stated RN #3 asked her why the resident did not have a bed alarm and asked what she should do. According to the SSD, she informed RN #3 to notify the Charge Nurse. The SSD stated she was informed on 01/02/12, that RN #3 had not notified the Charge Nurse. The SSD stated staff was aware that alarms were stored in the medication rooms on</p>	F 323	<p>4. Dr. Charles Hardin, Medical Director will provide oversight during the compliance process. The results of all audits will be reported to the Medical Director quarterly through CQI by Emily Jones-Gray, Assistant Administrator. This will be ongoing.</p> <p>Dr. Charles Hardin, the Medical Director at the facility was telephoned by Mary Arms, DON on 01-03-2012 at 12:05 PM. They discussed the falls related to resident #21 and the corrective actions taken by the facility.</p> <p>Dr. Charles Hardin was faxed by Mary Arms, DON a copy of the inservice provided to the licensed nurses that began on 01-04-2012 that was conducted by Mary Arms, DON and the CNA inservice that began on 01-04-2012 that was conducted by Mary Arms, DON and Emily Jones-Gray, Assistant Administrator.</p> <p>Dr. Charles Hardin, the Medical Director telephoned Mary Arms, DON on 01-07-2011 concerning the survey ending on 01-06-2011. They discussed the alleged deficit practices regarding Resident #16 and Resident #21 and the corrective actions taken by the facility.</p> <p>An Interdisciplinary Falls Committee was formed in November 2011. This committee meets weekly and reviews all falls, and the Care Plans (Comprehensive/Initial) of the effected residents are reviewed for appropriateness of fall prevention interventions. The results of the Falls Committee Meeting will be reported quarterly through CQI by Emily Jones-Gray,</p>	

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

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FORM APPROVED
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F 323	<p>Continued From page 17</p> <p>each floor and also in the stock room and that all nursing staff had access to the stock room.</p> <p>Interview with the Director of Nursing (DON) on 01/05/12, at 11:25 AM, revealed Resident #21 sustained the first fall on 12/30/11. At that time staff determined the resident's socks were "regular" and the socks were the reason the resident had fallen on the tiled floor. Staff implemented non-skid socks and documented the intervention to the resident's care plan. The DON stated she had not been informed by staff of the resident's falls from 12/31/11 to 01/01/12, until the resident had sustained the fall with injury on 01/01/12. The DON stated the facility had a system in place to aid in the prevention of falls and staff had received education related to falls during the past year. The DON stated all staff had been trained related to accessing bed alarms when needed and, according to the DON, a bed alarm was always available to staff, if not on the unit then in the stock room.</p> <p>2. On 06/01/11, the facility admitted Resident #16 with diagnoses of Coronary Artery Disease (CAD), Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Disease (CHF), Dementia, Parkinson's Disease, and Arthritis. A review of the Admission Minimum Data Set (MDS) Assessment dated 06/08/11, and the Quarterly Minimum Data Set (MDS) Assessment dated 09/08/11, revealed the facility assessed the resident to require extensive assistance of a minimum of two staff persons to assist with transfers.</p> <p>A review of the Nursing Care Plan dated 06/21/11, revealed Resident #16 was at risk for</p>	F 323	<p>Assistant Administrator. This will be ongoing.</p> <p>The care plans of all new residents or residents returning from a hospital stay will be audited during the morning CQI meeting to ensure that care plans accurately reflect the resident's needs. This will be monitored by Mary Arms, DON and Emily Jones-Gray, Assistant Administrator and the results will be reported quarterly through CQI. This will be ongoing.</p> <p>The Stock Control Clerk Madge Arnett will check the alarms at a minimum of three times per week to ensure they are available and are in proper working condition. The alarm checks will be documented by Madge. Any problems will be reported immediately to the DON and through quarterly CQI meetings by Emily Jones-Gray, Assistant Administrator. This will be ongoing.</p> <p>A safety device audit is performed three times per week at a minimum by Administration/Nursing Administration. A calendar was developed to include all residents. Six residents are checked per audit to ensure that the proper safety device is in place and is operational. The results of the audits are reported quarterly through CQI by Emily Jones-Gray, Assistant Administrator. This will be ongoing.</p> <p>Random audits will be done weekly to ensure resident care records are being followed as per care plan. A minimum of four observed transfers per week will be</p>	

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F 323	<p>Continued From page 18</p> <p>falls, had impaired mobility, and required assistance with transfers and mobility. Furthermore, a review of the Nursing Care Plan revealed Resident #16 was to wear non-skid footwear if available.</p> <p>A review of the Certified Nursing Assistant (CNA) Care Record dated October 2011 revealed Resident #16 required the assistance of two staff persons along with the use of a gait belt during transfers.</p> <p>A review of documentation on the "Fall Chronological" (no date) revealed on 10/02/11, at 12:00 AM, Certified Nursing Assistant (CNA) #3 attempted to transfer Resident #16 from the bed to a shower chair unassisted. Documentation in the report revealed as the CNA assisted Resident #16 from bed the bed began to "scoot" back and, as a result, the resident sustained a fall. The documentation revealed the resident sustained no injuries other than a bruise to the left knee. In addition, documentation revealed the resident did not have socks on and was barefooted. A review of the Post Fall Investigation dated 10/11/11, revealed Resident #16 also sustained bruises to the right side of the underarm and to the left side of the left breast as a result of the fall.</p> <p>An interview conducted on 01/06/12, at 9:10 AM, with CNA #3 revealed she was assigned to provide Resident #16's care for the night shift on 10/02/11. CNA #3 reported it was the responsibility of the CNAs to obtain a new CNA Care Record at the start of each shift. The CNA stated she was trained to review the Care Record at the beginning of the shift and prior to the provision of care to the residents. Further</p>	F 323	<p>completed by Chanity Purcell, Staff Development Coordinator, and a minimum of four cognitive resident interviews will be completed by Chanity or other staff as assigned by Emily Jones-Gray, Assistant Administrator to ensure resident care records are being followed with special attention to transfer of residents. The audits will be completed for a minimum of three months. The results of these audits will be reported through CQI by Emily Jones-Gray, Assistant Administrator. A copy of this audit form is attached.</p> <p>5. Date of Correction is 02-03-2012.</p>	

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F 323	<p>Continued From page 19</p> <p>interview revealed CNA #3 was trained that a resident should not be transferred by the assistance of one person if the resident's CNA Care Record indicated the resident required the assistance of two to transfer the resident. CNA #3 reported she had not reviewed Resident #16's Care Record before she attempted to assist the resident from the bed to the shower chair, had not used a gait belt, checked the resident's bed to ensure it was locked, and had not applied non-skid socks to the resident's feet prior to attempting the transfer. According to CNA #3 Resident #16 had previously been assigned to a room on the second floor, and had been moved to a room on the first floor. CNA #3 stated when she had provided care to the resident on the second floor, the resident only required the assistance of one staff person and the CNA assumed the resident's plan of care had not changed.</p> <p>An interview conducted on 01/06/12, at 9:25 AM, with the Director of Nursing (DON) revealed staff was trained upon hire to obtain a new CNA Care Record at the beginning of a new shift, and to review the Care Record before providing care to the resident. Further interview with the DON revealed staff was trained if the Care Record indicated a resident required the assistance of two people to transfer, they should not attempt to transfer the resident alone. The DON reported staff was also trained to check beds and wheelchairs to ensure they were locked prior to transferring a resident.</p>	F 323			

EMPLOYEE'S INSERVICE

DEPARTMENT Nursing

DATE 1-4-12 (Various Times)

MEETING HELD ON: (DAY) 1/4/12 - 1/11/12 FROM _____ TO _____

MEETING AREA _____ SUBJECT(S) COVERED Falls,

Contact Adm = each Fall

Fall Interventions TOTAL NO. EMPLOYEES PRESENT _____

EMPLOYEE SIGNATURES: _____

CONFERENCE CONDUCTED BY: _____

Notification of Changes

F157 A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is

- A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;**
- B) A significant change in the resident's physical, mental, psychosocial status (ie: , a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);**
- C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or**
- D) A decision to transfer or discharge the resident from the facility.**

(ii) The facility must also promptly notify the resident and if known, the resident's legal representative or interested family member when there is;

A) A change in room or roommate assignment

B) A change in residents rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

(iii) The facility must record and periodically update the address and phone # of the resident's legal representative or interested family member.

This means:

- You must notify the physician of changes (mental, physical, wounds, falls, new onset of confusion.
- Nurse's *Do not write orders without obtaining orders from a physician!* Nurses do not practice medicine.
- Nurse Aides: Report to the nurse any change in condition.
- Nurses, if an aide tells you something, you should go and evaluate.
- Assess the resident.
 - Notify the physician.
 - Notify the family.

- **Document thoroughly in the clinical record. (Use s/s, what changes do you see?)**
- **What did you say to the MD; and what did he said to you? Document in detail the new orders; “You should paint a picture of what is going on.”**

If you contact a MD by fax, remember, it must be Monday through Friday during office hours. Do not fax on the weekends! Dr. Caruso and Dr. Hardin usually doesn't respond to a fax. Do not fax unless office staff tells you to do so. *Remember; just because; you fax something, you are still responsible. You are the residents advocate and caregiver; it is your responsibility to follow through with obtaining Physician Orders.*

All nurses are responsible to act in a professional manner. This means you are expected to provide an acceptable standard of care for your residents as required by law.

All nurses given a copy of “SCOPE OF PRACTICE DETERMINATION GUIDELINES”.

Care plan process. This is the basis of nursing education and practice. You must follow it. Each resident care plan is available.

Nurses must assess all residents using assessment skills taught in school. You should assess first and then contact the MD and the family.

Added

When you have a fall, you should ask yourself

- **Why did the resident fall?**
- **Why were they trying to get up?**
- **Did they need to go to the bathroom?**
- **Are they experiencing discomfort?**
- **Are they bored?**
- **Are they trying to reach something?**
- **Have they recently received a medication that could alter their mobility or thought processes?**

With each fall you must make changes to your interventions to prevent a fall from reoccurring.

You must notify the physician and put an intervention

into place immediately.

Added

Examples of interventions for falls:

- **Slip-** Place non-skid socks on resident or strips
- **Weakness-** Alarm pad
- **Arising from chair-** Chair pad alarm
- **Pain Medication-** Agitation due to pain
- **Notify Family-** Ask the family to come in and sit with resident.
- **Climbing out of bed-** Get the resident up in a chair and bring them out to the lobby
- **Need for 1:1-** Ask the hospitality aide to sit with resident, read to them, play a game with them. Involve activities for intervention.
- **Confusion-** Contact MD concerning obtaining a U.A. to rule out a UTI.
- **Going to Bathroom-** Provide with a urinal or bed side commode.

These are immediate interventions.

We can refer to therapy to screen for strength and endurance to see if the resident is appropriate.

Added

When a resident falls

The nurse should assess the resident. Check for

injuries before trying to move the resident. If the complains of pain or significant injury is noted, a staff member should remain with the resident to prevent the resident from moving while the nurse calls the physician, notifies EMS and prepares paper work for transport.

Added

Changes with falls

With each fall, not only do you notify the physician and the family. Now you have to notify the D.O.N, the Asst. Administrator or the Administrator.

Their phone numbers are posted in the med room and in the front of the incident book.

Document thoroughly the signs and symptoms the resident is having. Document any behaviors.

Document any orders received. BE SURE TO DATE AND TIME ALL ORDERS AND DATE AND TIME WHEN THE ORDER IS NOTED.

*NOTED MEANS THAT YOU HAVE TRANSCRIBED THE ORDER AND CARRIED THE ORDER OUT.

The person that receives the order should carry out the order. This means faxing pharmacy, notifying families of changes, notifying aides if their care has changed, complete and file the care plan and procuring and applying any type of device or equipment available.

If the order is for equipment you should check the clean utility room. If you are unable to find supplies or equipment you should notify the stock control person (Madge), the DON, Assistant Administrator or Administrator.

It is your responsibility to insure the order is carried out before you leave or for some **valid** reason you can't, you should pass this on to the oncoming nurse and put it in the shift report.

One person only should write and sign the order. If you are unsure about an order you must clarify the order with the physician.

A bed pad alarm and a personal alarm will be available in each of the medication rooms. You will sign a count sheet at each shift change to make sure the alarms are available. When you use one you should notify stock control concerning who it was used for and that it needs to be replaced. A form is provided.

Added

Now, the Alarm Check Sheet Says: Alarms are available on each floor. If an alarm is missing, go to the other floor and obtain one. Then notify stock control, director of nursing, assistant administrator or administrator.

Each resident has a fall risk assessment and a side rail assessment in their record. Nurses should review these assessments on all readmissions from the hospital and update as necessary. You should also review their plan of care for fall prevention and make any necessary changes to prevent injury.

Added

NEW: With each fall, the fall risk assessment must be updated to reflect the new fall risk score.

If you see a resident or are notified by nurse aides that a resident is exhibiting unsafe behavior you are

to evaluate the resident, notify the MD and family. Implement orders from the physician. A staff member should remain with them until precautions can be put in place.

If residents are up during the night one staff member should bring the resident/s to the day area and observe them. They can offer drinks or snacks or provide some other type of activity for them until they are ready to go to bed.

Nurses are to make walking rounds between shifts. During this time you should check all exit doors to make sure alarms are working properly. You should visualize all residents and the nurse leaving should give a report concerning the resident to the nurse coming on. Nurses coming on should make walking rounds on all residents even though another nurse might be their shift nurse. You are responsible for all residents and may be asked to assist in their care. If you are working with a CMA you should make a walking round on the group of residents the CMA is giving medications to initially and between med passes at a minimum.

Incident reports are to be completed at the time of an incident. They must be fully completed.

All corrections to documents must be according to practice. You are never to correct someone else's documentation.

All residents are to be supervised to prevent injury. If you have a resident that is exhibiting unsafe behavior a staff member should remain with them until the MD has been notified.

Break times are not to be abused. You are allowed a 15 minute paid break for every 4 hours worked and a 30 minute unpaid lunch. Your breaks and lunches are scheduled to ensure coverage on the nursing units.

CNA's

You are to stay out on the floor circulating to monitor residents, listen for alarms. Not all aides are to stay on the same hall or huddle in the hallway or rooms. You need to split up when not doing turn and change. This will allow for the entire floor to be

covered and will improve your response time to alarms and call lights.

Nurse's

If an aid reports something to you. You should go immediately and check the resident. The only exception would be if you are on a med pass and if what the aide is reporting is not an emergency.

Updated: 1-3-12

If a resident **FALL'S**

You must notify one of the
following:

D.O.N

Asst. Adm.

Adm.

Self Administers

Check the medication room for a pad alarm.

Back-up stock

HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
7a-7p																																
7p-7a																																

Check the medication room for a personal alarm

Back-up stock

HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
7a-7p																															
7p-7a																															

Check the medication room for a chair pad alarm.

HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
7a-7p																															
7p-7a																															

MONTH _____

HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Nurse's: You should check the medication room at the beginning of you shift and initial that you have an alarm pad and personal alarm available

****NOTE:** Alarms are available on each floor. If an alarm is missing, go to the other floor and obtain one. Then notify stock control, DON, ASST. ADM. or ADM

Key for Omission Recording:
 S - Self Medication L - LOA N - NPO
 R - Refused O - Other H - Held
 (*Refer to Facility Policy)

Check all restraints every 30 minutes; release every 2 hours; exercise 10 minutes; reposition

Indicate Injection Site by Number:
 1. Thigh Left 3. Deltoid Left 5. Abdomen Left
 2. Thigh Right 4. Deltoid Right 6. Abdomen Right
 7. Ventriloquial Left 8. Ventriloquial Right

Indicate Patch Site by Number:
 9. Chest Left 11. Back Left 13. Ear, Behind Left
 10. Chest Right 12. Back Right 14. Ear, Behind Right

MEDICAL REC. #

DATE

RIGHT

STATION

ROOM

BED

PHYSICIAN'S NAME

Call Lights: Call lights should be answered promptly. You should assist the resident before resetting the call light. If you need the assistance of another CNA then you should leave the light on until you get back to the resident's room. Emergency call lights are just that AN EMERGENCY. These have priority!!!

Resident alarms are also to be responded to promptly. These alarms are in place for a reason such as reducing falls and alerting you that a resident is trying to get out of bed without assistance. You have to pay attention to the alarms when they go off down other hallways. NEVER assume someone else is going to that resident's room to assist them.

If you find a resident in the floor, NEVER move them on your own. Get the nurse. All residents who experience a fall must be examined by the nurse. Also, when you walking to a resident's room, look in the door as you go down the hallway. You can see a lot when you are walking by. You may even see someone up by themselves who should have assistance. You should be checking on the residents more than turn and change.

Restraints are to be checked at a minimum of every 30 minutes and released every 2 hours. When the restraint is released, residents are to be walked, taken to the bathroom, repositioned, offered to lay down, etc. They have to be repositioned in some way. The restraints should be released for at least 10 minutes.

Lifts are to be used with 2 people. When transferring a resident, make sure the chairs are locked and you are guiding the resident from bed to chair, chair to bed, etc. Every effort should be made to avoid resident/staff injury during transfers. Resident safety is a must!!!!!! Pay attention to what you are doing.

If there are any changes in the resident, you should report this to the nurse as soon as possible. If it is an emergency, you should report it immediately.

Make sure to have and review your CNA care plans/assignment sheets on you at all times. This tells you how to care for the resident. This can include transfers, feedings, assistance, fall risks, and fluid needs just to name a few. Do not assume the resident is the same when they move floors. For example, if you worked with a resident on the Unit and he or she moves to the first/second floor, their care may have changed. (For example from one assist to two assist.) Failure to follow the CNA assignment sheet can result in resident and employee injury and staff are subject to termination and write ups for not following the assignment sheet. Information on a CNA assignment sheet is protected information.

Falls Risk Assessment Policy

Policy: It is the policy of this facility that all new admissions be assessed for fall risk.

1. The interdisciplinary care plan team will meet with residents and families on the day of admission to determine the history of falls/injury and identify other potential risk factors for injury.
2. The physician will be notified after the initial care plan meeting of any risk factors.
3. An initial individualized care plan will be created to better meet the resident's needs.
4. A referral to therapy services will be made following the initial care plan meeting if deemed necessary by the physician.
5. For new admissions, the admitting nurse will complete a Fall Risk Assessment and a Side Rail Assessment within 24 hours.
6. When a resident returns from the hospital, the admitting nurse will review the Fall Risk Assessment and the Side Rail Assessment and update them at that time.
7. If a resident has had any recent falls, the nurse should review the Fall Risk Assessment and update it at that time.

Updated: 01-03-2012
Revised: 01-07-2012

Alarms Policy

Policy: It is the policy of Mountain Manor of Paintsville to use safety alarms as part of a comprehensive falls management program.

1. Residents will be assessed for fall risk according to facility policy.
2. Alarms and other safety devices will be chosen based on resident fall risk, resident cognitive status and other individual factors on a case by case basis.
3. Alarms and other safety devices will be obtained from Stock Control according to facility policy.
4. Alarms are available in the medication room on each floor and are accessible to nursing staff.
5. If no alarm is located in the medication room, staff should go to the other floor to obtain an alarm. Staff should then notify Stock Control, the DON, Assistant Administrator or Administrator to replace the alarm.
6. Alarms will be changed on an annual basis according to manufacturer's recommendations by the Stock Control Clerk.
7. The Stock Control Clerk will check the alarms at a minimum of three times per week to ensure they are in proper working condition. The alarm checks will be documented when checked. Any problems should be reported immediately to the DON and through quarterly CQI meetings.

Updated: 01-03-2012

Revised: 01-07-2012

Alarm Replacement Form

Resident _____ Date _____

Type of alarm personal _____
 pad _____
 chair _____

Signature of nurse _____

Alarm Replacement Form

Resident _____ Date _____

Type of alarm personal _____
 pad _____
 chair _____

Signature of nurse _____

Updated 12/06/10

Stock Control Policy

Policy: Supplies used in the usual routine are readily available in the utility room.

Supplies not normally stocked or special items which include but are not limited to mattresses, raised edge mattresses, additional personal alarms and bed/chair alarm pads, bi-pap machines, and floor pads are available upon request.

A personal alarm and a bed pad alarm is in the medication room for use after hours or on week-ends.

However, staff may also notify the stock control clerk, the Administrator or the Director of Nursing after hours and from Friday 4:30pm to Monday 7:30am. Their telephone numbers are listed on each nursing unit.

In the event that you should run out of supplies after hours, a key to the main stock control room is located at each nurse's station in the drawer. The stock control room is located on the first floor of the facility near the time clock. You are to sign out supplies on a clip board that is lying on the desk. If you need further assistance in locating a supply, please notify stock control, Director of Nursing or the Administrator.

Before applying any safety/fall risk equipment, the physician must be notified.

See reverse side for verifying signatures

Stock Control Alarm Pad Check Sheets

1-11-12

Med Room 1st Floor

FREQUENCY 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

8am-

4:30 pm

Personal Alarm, Bed pad alarm, chair pad alarm

Med Room 2nd Floor

FREQUENCY 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

8am-

4:30pm

Personal Alarm, Bed pad alarm, chair pad alarm

Unit Med Room

FREQUENCY 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

8am-

4:30 pm

Personal Alarm, Bed pad alarm, chair pad alarm

FREQUENCY 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

FREQUENCY 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

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Note: Each alarm should have a form attached for nurse's to sign when a pad is used.

Month/Year _____

Fall Prevention Policy

It is the policy of Mountain Manor of Painesville to identify residents at risk for falls and to implement a fall prevention approach to prevent the resident from falling and to try to minimize complications from falling. The Fall Prevention Approach is incorporated with the facility's Quality Improvement Committee.

Procedure:

1. Every resident will be evaluated for falls upon admission and subsequently thereafter upon readmission (i.e. return from hospital), after each fall, at least quarterly and following any change in condition. A new Falls Risk Assessment should be filled out at these times.
2. Within 24 hours of admission, a resident will be assessed for risk of falls. Nursing staff will complete the Falls Risk Assessment.
3. Following the Falls Risk Assessment, the interdisciplinary team/nursing staff should notify the physician if the resident is a fall risk. Based on the results of the Fall Risk Assessment and the physician's recommendation(s), the interdisciplinary team/nursing staff should inform the family and resident about the recommended fall prevention management approach and adjust the care plan as needed.
4. A preliminary care plan will be initiated upon a resident's admission and will state the goals, interventions and approaches for every resident who is identified as being at risk for falls. A comprehensive care plan is developed within 7 days after the completion of the comprehensive assessment, at least quarterly and following any significant change in condition. At that time, individual resident fall prevention goals, interventions and approaches will be evaluated by the Interdisciplinary Care Plan Team for effectiveness and changes will be made as necessary to reduce the fall risk for the resident.
5. Staff will be instructed regarding approaches and goals for the management of the resident's fall risk. Staff will be trained to be alert to risks and hazards for falls in the environment. If a residents is identified as being a fall risk, this will be identified on the CNA Care Plan/Assignment sheet.
6. The falls prevention approaches will be evaluated by the Interdisciplinary Falls Committee/nursing staff to determine the effectiveness of the approaches. With the recommendations of the committee, changes will be implemented to reduce falls risk in the facility if needed.
7. If a resident continues to fall, the Falls Committee/nursing staff will re-evaluate the situation and will determine whether it is appropriate to continue or change current interventions. The physician will help staff reconsider possible causes and new interventions.
8. If a resident experiences a fall, nurses will complete an incident report and document the fall in the resident's record. Daily entries regarding the status of the resident's condition should occur each shift for 72 hours following the incident.
9. Staff will notify the Administrator, Assistant Administrator, or Director of Nursing of any falls on the same day the fall occurs. Phone numbers for the Administrator, Assistant Administrator and Director Nursing are posted in the medication rooms.

Revised 01-07-2012

FALL MEETING

Attendee's

Date 1-3-12

Minutes

⑤

- 12/30/11 - Resident lay on floor on back between both
nursing beds. Was wearing regular socks (Added
Non-Skid socks. Care resident 4 prior.)

①

12/31/11 - 5⁴⁰ pm (Saturday) Resident self ambulating, became
unsteady & lost balance. Room mate was in WC & resident
fell into roommate's Pan. Room mate assumed to be

⑦ 1-1-12

2:25 Am. Lying on L) side outside BR door. Resident stated he got tired & sat down.
No injuries noted at this time. (Skid or non-skid socks)

⑧ 1-1-12 6:25 Am - Lying on floor next to door.

Plan of action: Upon return from the hospital, will move resident closer to nurses station. Due to weakness & resident wanting independence, will add bed alarm. Refer to therapy for evaluation & rehabilitation of hip fracture.