STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185265**	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED **11/05/2013**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRANT CENTER	**201 KIMBERLY LANE** **WILLIAMSTOWN, KY 41097**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0280 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Allow the resident the right to participate in the planning or revision of the resident's care plan.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure the Comprehensive Plan of Care was reviewed and revised after falls, for two (2) of three (3) sampled residents (Residents #2 and #3). Resident #2 sustained a fall on 10/24/13; however, the resident's care plan was not reviewed and/or revised. Resident #3 sustained a fall on 06/26/13. The resident's care plan was not reviewed and/or revised and the resident sustained [REDACTED]. The findings include: Review of the facility's policy titled Care Plan: Patient, with an effective date of 04/15/02 and revision date of 05/01/11, revealed care plans were to be reviewed and revised a minimum of quarterly and as needed to reflect response to care and changing needs and goals. Review of the facility's Falls Care Delivery Process dated 06/01/13, section Response to a Patient Fall revealed to implement immediate interventions after a fall and update the care plan with new interventions as appropriate. 1. Record review revealed the facility admitted Resident #2 on 03/09/10, and readmitted him/her on 01/30/13, with [DIAGNOSES REDACTED]. Continued review revealed the resident had fallen six (6) times in the past six (6) months as follows: on 07/07/13, he/she tripped over the walker going outside; on 07/22/13, the resident was in the dining room, raised up from the chair, his/her feet slid and he/she fell ; on 07/28/13, the resident was kneeling on bed to fix his/her fan and fell off the bed; on 09/04/13, the resident was taking his/her breakfast tray to the cart in the hallway and fell ; on 10/15/13, he/she slipped from the bed; and, on 10/24/13, he/she was self transferring trying to go to the bathroom and fell . Review of Resident #2 Comprehensive Care Plan with a print date of 04/15/13, revealed it was not revised to include additional interventions to prevent further falls after the 10/24/13 fall. Interview, on 10/31/13 at 11:35 AM, with Licensed Practical Nurse (LPN) #8 revealed she had cared for Resident #2. She stated as a nurse she should revise care plans, in addition, to the Unit Manager when a fall occurred. 2. Record review revealed the facility admitted Resident #3 on 12/28/11, with [DIAGNOSES REDACTED]. Record review revealed no documented evidence of fall risk assessments prior to 07/12/13. Further review revealed a Fall Risk Evaluation completed on 07/12/13 which had a score of nine (9) and a Fall Risk Evaluation completed on 09/27/13 with a score of eight (8). These scores indicated Resident #3 was not a high risk for falls. Continued record review revealed the resident had experienced three (3) falls on the following dates: on 05/23/13 while walking barefoot to the bathroom; on 06/26/13 after complaining of dizziness during a facility shopping trip where the resident was lowered to the floor; and, on 09/09/13 the resident was found sitting in his/her room on the floor and stated he/she had fallen; however, he/she didn't know why. Review of Resident #3's Comprehensive Care Plan with a print date of 07/23/13, revealed the following interventions: on 05/23/13, to re-educate the resident as needed on wearing proper footwear before ambulating. Continued review of the Comprehensive Care Plan revealed no documented evidence the care plan was revised with additional interventions to prevent further falls after the 06/26/13 fall. Additional review of the Comprehensive Care Plan revealed on 09/09/13 staff was to obtain a urinalysis to rule out a urinary tract infection [MEDICAL CONDITION]. Review of the record revealed a nurse's hand written note to the Physician requesting the urinalysis. Continued review of this hand written none revealed the Physician approved the order on 09/11/13; however, the nurse receiving the order on that date noted Resident #3 was no longer symptomatic and indicated the urinalysis would not be obtained at that time. However, continued review of the Comprehensive Care Plan revealed no documented evidence it was revised to include this information. Interview, on 11/04/13 at 11:30 AM, with LPN #7 revealed she had failed to revise the care plan for Resident #3, after the resident's fall on 06/26/13, for the resident to go on future outings in his/her wheelchair. She indicated care plans should be revised with each intervention after a resident's fall. Interview, on 10/31/13 at 1:25 PM, with the Minimum Data Set (MDS) Assistant revealed Comprehensive Care Plans were revised by MDS Nurses with the Quarterly, Annual or Significant Change MDS Assessments. She stated the Comprehensive Care Plan was then printed out and Nurse Aide Care Plans were updated with the revisions made as indicated. Interview, on 11/01/13 at approximately 12:10 PM, with Registered Nurse (RN) #2 revealed nurses were responsible for revising residents' Comprehensive Care Plans the day after a resident experienced a fall. She stated as the Unit Manager she checked the Comprehensive Care Plan the next day after a fall. RN #2 indicated the facility's process was to take the records of residents who had fallen to the morning clinical meeting to discuss the fall and any new interventions required. She stated Resident #2's Comprehensive Care Plan did not appear to have been revised for the 10/24/13 fall. Interview, on 11/05/13 at 1:44 PM, with the Interim Director of Nursing (DON) revealed nurses caring for residents and completing Incident Report paperwork were responsible to ensure care plans were revised to include any new interventions after a resident's fall. She indicated all records for residents with a fall or incident were reviewed within seventy-two (72) hours by the Interdisciplinary Team (IDT). She stated Unit Managers reviewed the Comprehensive Care Plan for revisions. The Interim DON stated for Resident #2 she did not know why care plan revisions were not completed after the 10/24/13 fall. Additionally, she stated for Resident #3's fall on 06/26/13 she did not know why the care plan was not revised to include additional interventions to prevent further falls. She indicated she did not know why the care plan was not revised on 09/11/13 when the decision was made to not obtain the urinalysis.
F 0282 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined the facility failed to ensure care was provided by qualified persons in accordance with each residents' written Plan of Care for two (2) of three (3) sampled residents (Residents #1, and #2). Resident #1 had an interventions to be assisted to the recliner after meals. Observation on 10/29/2013 at 10:30 AM, after the breakfast meal, revealed Resident #1 was up in the wheel chair. Resident #2 had an intervention to be walked to meals with staff assistance. Observation on 10/30/13 at 11:30 AM, revealed the resident propelling self in his/her wheelchair to the dining room. The findings include: 1. Review of Resident #1's medical record revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. Record review revealed Resident #1 had two (2) falls in a five (5) month period. Review of the Annual Minimum Data Set (MDS) Assessment, dated 05/04/13 revealed the facility assessed Resident #1 as being severely cognitively impaired. Additional review of the MDS Assessment revealed the facility assessed Resident #1 to require extensive assist of one (1) staff person for all Activities of Daily Living (ADLs). Review of the Resident Fall Evaluation form completed on 05/16/13, 05/22/13 and 08/01/13 revealed Resident #1 had fall risk factors on all these Fall Evaluations. Record review revealed Resident #1 fell on [DATE] while trying to self transfer. Review of Resident #1's Comprehensive Care Plan, dated 05/14/13 revealed after the fall on 05/22/13, an intervention for a personal pull tab alarm was to be on the resident when he/she was in the recliner; additionally, the resident was to have a pressure alarm. Record review revealed Resident #1 experienced another fall on 09/04/13; attempting to transfer self

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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 0282

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 1)
without assistance. Review of the record revealed no alarm was in place at the time of the fall. Interview, on 11/04/13 at 11:40 AM, with Licensed Practical Nurse (LPN) #3 revealed he had been the nurse assigned to Resident #1's care when he/she fell on [DATE]. He stated Resident #1 was lying in front of the recliner like he/she had tried to self transfer to the recliner from the wheel chair. According to LPN #3, Resident #1 did not have an alarm in place as per the Comprehensive Care Plan interventions. He further stated the resident should have had the alarm in place. Comprehensive Care Plan revealed an intervention was added after the 09/04/13 fall to assist the resident to the recliner after meals for rest periods and as requested. Observations on 10/29/13 at 10:30 AM, 10/31/13 at 9:30 AM and 11/01/13 at 10:30 AM of Resident #1, revealed the resident to be sitting up in the wheel chair and not assisted to the recliner after the breakfast meals for rest periods as per the Comprehensive Care Plan. Interview, on 11/4/13 at 3:54 PM, with State Registered Nursing Assistant (SRNA) #12, who was assigned to Resident #1, revealed the resident would not let staff assist him/her to the recliner sometimes. She stated sometimes it was just too busy. She indicated she reported it to the nurse when they couldn't get Resident #1 to assist him/her to the recliner after meals. Interview, on 11/04/13 at 10:20 AM, with LPN #7 revealed she had been informed at times by the SRNAs Resident #1 refused to be transferred to the recliner. 2. Medical record review for Resident #2 revealed the resident was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED]. Review of the Quarterly MDS dated [DATE] revealed the facility assessed Resident #2 to have Brief Interview for Mental Status (BIMS) score of fifteen (15) which indicated the resident had no cognitive deficits. Review of the Resident Fall Evaluation form dated 03/09/13 revealed the facility assessed Resident #2 to have fall risk factors. Review of the Fall Risk Evaluation dated 10/24/13, which was a different from the previous form, revealed a score of seventeen (17) which indicated Resident #2 was a high risk for falls. Continued review revealed the resident had fallen six (6) times in the past six (6) months. Review revealed on 07/07/13 the resident tripped over the walker going outside and sustained two (2) skin tears on the left arm; on 07/22/13, the resident's feet slid when he/she was raising up from the chair, and he/she fell which resulted in two (2) skin tears to the left forearm; on 07/28/13, the resident fell off the bed which resulted in a skin tear to the right elbow and left shin; on 09/04/13, the resident was taking his/her breakfast tray to the cart in the hallway and fell with no injuries noted; on 10/15/13, the resident slipped off the bed with no injuries noted; and, on 10/24/13, he/she was self transferring trying to go to the bathroom and fell which resulted in a skin tear to the right wrist. Review of Resident #2's Comprehensive Care Plan, dated 08/15/13 revealed fall interventions which included non-skid strips to the floor at bedside, for the resident to be walked to dining room with staff assistance, and for large print signs to remind the resident to ask for assistance. Review of Resident #2's State Registered Nursing Assistant (SRNA) Care Plan for 07/13 through 10/13 revealed no documented evidence of directions for SRNAs to walk the resident to the dining room, for the resident to have non-skid strips to the floor beside the bed, or large print signs to remind the resident to ask for assistance. Observation of Resident #2 on 10/30/13 at 11:30 AM revealed the resident in a wheelchair self propelling to the dining room. Observation revealed no staff assistance was offered to walk the resident to the dining room. Observation of the resident on 10/30/13 at 5:30 PM revealed the resident again rolling self to the dining room in the wheelchair. Interview with Resident #2, at the time of this observation, revealed he/she never walked to the dining room anymore. Observation of Resident #2's room on 10/31/13 at 11:30 AM, revealed no evidence of large reminder signs in the room to remind the resident to ask for assistance. Observation did revealed a hand written sign on the resident's refrigerator door approximately five (5) inches by four (4) which stated ask for assistance. Continued observation revealed no evidence of non-skid strips on the floor beside the bed. Further observation revealed Resident #2 self propelling his/her wheelchair towards the dining room; and, an Activity staff person asked the resident if he/she wanted some help to the dining room. Observation revealed the Activity staff person then pushed Resident #2 to the dining room in the wheel chair. Interview, on 11/04/13 at 2:38 PM, with SRNA # 14 revealed she was assigned to provide care for Resident #2 sometimes. She stated she was not aware the resident was to have non-skid strips on the floor at bedside or that the resident was to be walked to the dining room. She indicated this information would be very helpful to have on the SRNA Care Plan as she moved around to other units in the facility and things changed. Interview, on 11/04/13 at 3:54 PM, with SRNA #12, who also cared for Resident #2, revealed she was not aware the resident was to be walked to the dining room or to have non-skid strips to the bedside floor. She reviewed the SRNA Care Plan and stated this information was not on it. Interview with Unit Manager/Licensed Practical Nurse (LPN) #7, on 11/04/13 at 10:20 AM, revealed it was the nurses' responsibility to update the care plans and the Unit Manager responsibility to ensure the SRNA care plans were update to reflect current interventions. Interview, on 11/01/13 at 12:10 PM, with Registered Nurse (RN) #2 and the Interim Director of Nursing (DON) revealed nurses were to review and monitor resident care to ensure interventions were being followed. They stated it was the nurses' responsibility to revise the care plans and monitor the residents' care to ensure interventions were being implemented as per the care plan. The Interim DON stated Resident #2's care plan had not been followed to reduce the risk for further falls. The Interim DON indicated care plan interventions should be in place and followed to ensure resident safety.

F 0323

Level of harm - Immediate jeopardy

Residents Affected - Few

Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on interview, record review, and review of the facility's policy and Incident Report it was determined the facility failed to have an effective system to ensure the residents' environment remained as free of accident hazards as possible. The facility failed to have procedures in place to ensure all lab specimens were stored in a safe secure area to prevent resident access for one (1) of three (3) sampled residents (Resident #1). (Refer to F281) On 10/19/13 at approximately 9:00 AM, Resident #1, who was sitting in a wheelchair in front of the Heritage Unit nursing station, was observed by a nurse to have a lab specimen tube of blood with the stopper removed, holding the tube to his/her mouth. Resident #1 had a red substance in his/her mouth; on his/her face and hands; on the blanket covering Resident #1's upper leg area; and, on the floor beside his/her wheelchair. A second lab specimen tube of blood was lying on the floor near Resident #1's wheelchair, and the biohazard specimen bag was lying on the blanket covering the resident's upper leg area. Resident #1 was assessed and laboratory tests were obtained for both Resident #1 and the resident from whom the specimen was drawn. Based on the results of the assessment and tests no negative impact on Resident #1 had been identified. The facility's failure to ensure the residents' environment remained as free of accident hazards as possible was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy (IJ) was identified on 10/30/13, and was determined to exist on 10/19/13. The facility was notified of the Immediate Jeopardy on 10/30/13. An acceptable credible Allegation of Compliance (AOC) was received on 11/01/13, which alleged removal of the Immediate Jeopardy on 10/22/13, prior to the initiation of the abbreviated survey. The State Survey Agency determined the deficient practice was corrected related to environmental hazards on 10/22/13 as alleged in the AOC, therefore, it was determined to be Past Immediate Jeopardy. In addition, based on interview, record review, and review of the facility's policy it was determined the facility failed to ensure residents received adequate supervision to prevent accidents for three (3) of three (3) sampled residents (Residents #1, #2, and #3). Resident #1 experienced a fall on 09/04/13 which resulted in complaints of pain and the resident being transported to the hospital for evaluation. The facility failed to ensure the personal tab alarm and chair alarm were in place at the time of the fall. Resident #2 experienced a fall on 10/24/13 and the facility failed to ensure revisions to the care plan. Resident #3 experienced falls on 06/26/13 and 09/09/13; however, the care plan was not revised to include additional interventions to prevent further falls. (Refer to F280 and F282) Therefore, it was determined the facility had continued non-compliance at 42 CFR 483.25 in regards to falls at a Scope and Severity (S/S) of a E while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic change. The findings include: Review of the facility's policy titled Collection and Transportation of Specimens dated 02/15/01, with a revision date of 10/01/13, revealed the policy contained a process for obtaining blood specimens and ensuring placement in a biohazard specimen bag. However, the policy failed to address where specimens should be stored for lab pick-up. Review of an Incident Report dated 10/19/13, timed 9:30 AM, revealed Resident #1 was found sitting in a wheelchair in front of the nursing station. Resident #1 was noted to have a lab vial in his/her hand with the cap to the lab vial laying on the resident's lap. Continued review of the Incident Report revealed Resident #1 had a red colored residue noted to his/her face around mouth and on blanket and floor. A lab bag was on the floor in front of Resident #1. Further review of the Incident Report revealed a head to toe assessment was completed by staff with no open areas noted. Resident #1 was

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) transported to his/her room and mouth care was completed by staff. Record review revealed the facility admitted Resident #1 on 06/11/11, and readmitted the resident on 09/08/13, with [DIAGNOSES REDACTED]. Review of the Annual Minimum Data Set (MDS) Assessment, dated 05/14/13, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of two (2) which indicated severe cognitive impairment. Review of a Nurse's Note dated 10/19/13 and timed 5:30 PM, revealed at around 9:30 AM that morning Resident #1 was noted to be sitting in front of the nurse's station. The Nurse's Note stated red-colored residue was observed on Resident #1's face around the mouth area, on the blanket in his/her lap, and on the floor. Continued review of the Note revealed oral and denture care was provided and a head to toe skin assessment was performed. Further review of the Note revealed Resident #1's responsible party was notified of this information. Interview, on 10/29/13 at 1:15 PM, with Resident #1's daughter, who was the resident's Power of Attorney (POA), revealed on 10/19/13, at approximately 10:00 AM she received a call from a facility staff person to tell her Resident #1 had been sitting in front of the nurse's station and had gotten a vial of blood off the desk. Resident #1's daughter indicated she was told Resident #1 opened the vial of blood and had the blood all over him/her; including in his/her mouth. Interview, on 10/30/13 at 10:40 AM, with Licensed Practical Nurse (LPN) #1 revealed she was the first employee to see Resident #1 with the tube of blood on 10/19/13. She stated Resident #1 had obtained the tube of blood from the nurse's desk at the nurse's station. LPN #1 indicated she did not recall seeing the tube of blood on the desk when she received report that morning. Further interview with LPN #1, on 10/31/13 at 10:10 AM, revealed lab specimens had always been placed on the nurse's station for lab to pick up. Interview, on 10/30/13 at approximately 1:55 PM, with State Registered Nursing Assistant (SRNA) #3 revealed she had followed a nurse from another unit to the nurse's station on Resident #1's unit on 10/19/13. She stated she observed Resident #1 sitting in his/her wheelchair by the nurse's station. SRNA #3 stated Resident #1 had blood on his/her clothes and blood was coming out of his/her mouth. According to SRNA #3, a nurse had a vial in her hand and asked SRNA #3 to get some mouthwash. SRNA #3 stated she thought Resident #1 had been coughing up blood, then realized what had happened. Interview, on 10/30/13 at 2:05 PM, with LPN #4, who was the facility supervisor on 10/19/13, revealed Resident #1 had a vial of blood in his/her hand and had blood on his/her face and mouth, on a blanket, and on the floor. LPN #4 indicated the facility process had always been to place lab specimens that did not require refrigeration on the nurse's desk, at the nurse's station, for lab to pick up. Interview, on 10/30/13 at 5:20 PM, with Registered Nurse (RN) #3 revealed she was the night shift nurse who had obtained the two (2) tubes of blood from another resident on another unit on 10/19/13. She stated that she had taken the two (2) tubes of blood to Resident #1's unit because the resident she had drawn the blood from also had a urine specimen to be picked up which was located in a refrigerator on the unit where Resident #1 resided. She indicated that way all the specimens would be in the same area for the lab pick up. According to RN #3, she handed the specimen bag with the two (2) tubes of blood in it to LPN #5 on Resident #1's unit. She stated there was never a specific place for staff to put lab specimens waiting for lab pick up. Interview, on 10/31/13 at 10:05 AM, with LPN #5 revealed RN #3 had brought blood specimen tubes to her on 10/19/13. LPN #5 stated she put the blood specimen tubes, RN #3 had brought to her, on the desk at the nurse's station. She stated staff had always placed lab specimens on the desk at the nurse's station for lab pickup. Interview, on 10/30/13 at 2:48 PM, with the Interim Director of Nursing (DON) revealed she received a call from facility staff at approximately 9:30 AM on 10/19/13. She stated staff notified her of the incident at that time. The Interim DON stated that she directed staff on what to do, and notified the Administrator of the incident on her way in to the facility. She further stated there was no system in place as to where to store lab specimens that did not require refrigeration until lab picked the specimens up. Interview, on 10/30/13 at 4:15 PM, with the Administrator revealed he was notified of the incident involving Resident #1 at approximately 9:00 AM on 10/19/13. He indicated he was informed by staff it had always been the process to store lab specimens on the desk at the nurse's station to await lab pickup. According to the Administrator, he had not been aware staff was using this process for lab specimens until the incident involving Resident #1. He reported the process had been changed since the incident. The Administrator stated he thought processes, for lab specimens awaiting pickup, had been developed by the former DON who left the facility in September 2013. The facility provided an acceptable credible Allegation of Compliance (AOC) on 11/01/13, that alleged removal of the IJ effective 10/22/13. Review of the AOC revealed the facility implemented the following: 1) On 10/19/13, Resident #1 was assessed head to toe with vital signs for any injuries. No injuries were noted. 2) On 10/19/13, incident report entered into the facility electronic system. 3) On 10/19/13 an entry was made to the Treatment Administration Record (TAR) of the exposed resident, Resident #1, to monitor for signs and symptoms (S/S) of infection each shift to include vital signs every shift time forty-eight (48) hours. 4) On 10/19/13 the Physician and family of each resident was notified. 5) On 10/19/13 lab work for the source resident was to be re-drawn to comply with the original lab orders for this resident. Lab work was obtained as ordered for both the source resident and Resident #1 after the incident to screen for Human Immunodeficiency Virus (HIV) and Hepatitis B & C. No abnormalities were noted on the initial lab work for each resident. The lab work was to be repeated in three (3) months as recommended by the Physician for further monitoring. 6) On 10/19/13 a complete audit of the facility areas that were accessible to residents (nursing station, medication carts, hallways, day rooms, resident rooms, dining rooms, shower rooms, and lobby) was performed to determine that no potentially hazardous items were present and if any other resident obtained any lab specimen or other potentially hazardous item. Any items identified were to be secured. No other concerns were identified after the audit. 7) On 10/19/13 the facility developed a protocol for the storage of lab specimens while waiting for lab pick up. The protocol was for placement of a bin in each medication room labeled Lab Specimens for all pending lab specimens to be stored in until lab pick up. 8) On 10/19/13 all nurses were educated by the Director of Nursing (DON) and Unit Managers on the new Lab Specimen storage location. Nurses were educated on supervision of residents and to monitor for potentially hazardous items in areas accessible to residents. All nurses were educated either in person or via telephone. All new hires will be educated on this protocol during orientation. The facility did not use agency staff. 9) On 10/21/13 education was provided by the DON, Unit Manager, and Administrator for all nursing assistants, therapy, activity, dietary, housekeeping, social services, and maintenance staff in regards to supervision of residents and, to monitor for potentially hazardous items in areas accessible to residents. 10) On 10/19/13 and ongoing, the nursing supervisor was to complete a round of the facility daily for five (5) days to include a weekend day. The nursing supervisor would then complete rounds weekly for three (3) weeks including a weekend day to determine that no potentially hazardous items were accessible to residents, such as lab specimens. 11) On 10/19/13 and ongoing, the nursing supervisor was to audit utilization of the lab specimen storage bin each morning for two (2) weeks including a weekend. Then the nursing supervisor was to audit utilization of the lab specimen storage bin weekly for four (4) weeks to include a weekend to determine that pending lab specimens were secure. 12) On 10/19/13 a message was left by the Administrator for the Medical Director to notify him of the incident. On 10/21/13 the Administrator discussed the incident in more detail with the Medical Director. 13) On 10/21/13 an ad hoc (which means for a particular purpose only) Performance Improvement (PI) meeting was held to review the AOC plan for further review and recommendation. 14) On 10/19/13, the Administrator was educated by the Manager of Clinical Operations, on the protocol for storage of lab specimens and the expectations of the Administrator as indicated by the regulations. 15) On 10/20/13, the lab was notified of the incident and of the new facility protocol for lab specimen storage. 16) On 10/19/13, the DON checked lab vials in the facility to determine that no defective lab vials were present. 17) On 10/21/13, the Administrator performed a check of lab vials to determine that no defective lab vials were present. The State Survey Agency validated the implementation of the facility's AOC as follows: 1) Review of the resident record revealed that on 10/19/13, Resident #1 did have a head to toe assessment completed with vital signs. 2) Review of the facility's electronic system for Incident Reports revealed the Incident Report related to Resident #1 was entered on 10/19/13. 3) Review of Resident #1 Treatment Administration Record (TAR) revealed the resident was monitored every shift for forty-eight (48) hours for S/S of infection which included vital signs. 4) Record review for both the source resident and the exposed resident revealed that the Physician and family were notified of the incident on 10/19/13. 5) Record review of the source resident revealed that the labs were re-drawn to comply with the original lab order and for the new lab order on 10/19/13. Review of Resident #1's record revealed labs were drawn as ordered on [DATE]. Further record review for Resident #1 and the source resident revealed lab results were filed in both of the medical records for the labs drawn on 10/19/13 with negative results for both residents. 6) Review of the facility's investigation binder revealed that audits of the facility areas accessible to residents was completed on 10/19/13. 7) Review of the facility's investigation binder revealed it contained the protocol dated 10/19/13, that was developed for safe secure storage of lab specimens that did not require refrigeration. 8) Review of the facility's investigation binder revealed all nurses were educated to the new lab specimen storage protocol and expectations either in person or by telephone by 10/21/13 as evidenced by the sign-in sheets.

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) Interviews on 11/01/13 at 2:25 PM, with Licensed Practical Nurse (LPN) #6; at 2:27 PM with LPN #7; at 2:30 PM with Registered Nurse (RN) #4; and at 3:10 PM with RN #2, revealed they had been educated and were aware of the new lab protocol. These interviews revealed the nurses had also been educated on supervision of residents and monitoring areas accessible to residents for hazardous items. 9) Review of the facility's investigation binder revealed that education on supervision of residents and to monitor the environment for potentially hazardous items was completed with all nursing assistants, therapy, activity, dietary, housekeeping, social services, and maintenance staff on 10/21/13 as evidenced by the sign-in sheets. Interviews on 11/01/13, at 2:35 PM with State Registered Nursing Assistant (SRNA) #6; at 2:45 PM with SRNA #1; at 3:10 PM with SRNA #3; and at 4:00 PM with SRNA #2 revealed they had all received the education on supervision of residents and monitoring areas accessible to residents for hazardous items. Interviews with other facility staff on 11/01/13, at 1:00 PM with an Activities personnel; at 3:30 PM with Housekeeper (HK) #2; at 3:35 AM with HK #1; at 3:00 PM with Cook #1; and at 3:15 PM with a Maintenance personnel, revealed they had all been inserviced on the supervision of residents and monitoring areas accessible to residents for hazardous items. 10) Review of the facility's investigation binder revealed the nursing supervisor performed rounds of the facility to determine that no potentially hazardous items were accessible to residents. Review of the forms revealed the rounds were initiated on 10/19/13 and they completed them daily for seven (7) days versus five (5) days; and, were being performed weekly for three (3) weeks. 11) Review of the facility's investigation binder revealed the nursing supervisor was auditing the utilization of the lab specimen storage bin each morning for two (2) weeks which was initiated on 10/20/13. 12) Review of the facility's investigation binder revealed the facility's Medical Director was notified of the incident involving Resident #1 and the AOC plan, by the Administrator via a phone message on 10/19/13. Further review revealed on 10/21/13, the Administrator covered the AOC plan in more detail with the Medical Director. 13) Review of the facility's investigation binder revealed the Administrator did hold an ad hoc PI meeting on 10/21/13, to discuss the incident and AOC plan. Review of the documentation revealed the DON, Social Services personnel, Minimum Data Set (MDS) personnel, and Unit Managers, were present in the meeting. Additionally review revealed two (2) Physicians and the Medical Director participated in the PI meeting via phone. Interview with the DON confirmed a PI meeting was held on 10/21/13 with discussion of the incident and AOC plan. 14) Review of the facility's investigation binder and interview revealed on 10/19/13, the Administrator was educated by the Manager of Clinical Operations, on the protocol for storage of lab specimens and the expectations of the regulations in regards to the Administrator. 15) Review of the facility's investigation binder revealed Med Lab, the lab utilized by the facility, was notified on 10/20/13, of the facility's new protocol for lab specimen storage of specimens that did not require refrigeration. 16) Review of the facility's investigation binder and interview revealed on 10/19/13, the DON checked all lab vials and no defective vials were found. 17) Review of the facility's investigation binder and interview revealed that on 10/21/13, the Administrator checked all lab vials and no defective vials were found. Additionally, based on observation, interview, and record review it was determined the facility failed to implement interventions to prevent accidents and to monitor and modify interventions as necessary. Review of the facility's policy titled, Accidents/Incidents with an effective date of 01/08, revealed the intent of the policy was for the facility to identify each resident at risk for accidents and/or falls, adequately care plan these residents and implement procedures to prevent accidents. Interview with the Interim DON, on 10/31/13 at 5:40 PM, revealed the facility's process for reviewing and investigating falls was for the IDT team to review the Incident Reports to determine what was going on at the time of the falls, see if there were any medical issues that contributed to the falls, and look at environmental issues as indicated. Then interventions were developed and added to the care plan by the Unit Managers. She further stated Unit Managers were also responsible for adding the interventions to the SRNA care plans. She continued by saying the Fall Risk Assessments were reviewed by the Unit managers to ensure accuracy. 1. Review of Resident #1's record revealed an admission date of [DATE], and readmission date of [DATE], with [DIAGNOSES REDACTED]. Review of the Annual Minimum Data Set (MDS) Assessment, dated 05/04/13 revealed the facility assessed Resident #1 as being severely cognitively impaired. Further review of the MDS Assessment revealed the facility assessed Resident #1 to require extensive assist of one (1) staff person for all Activities of Daily Living (ADLs). Review of the Resident Fall Evaluation form revealed an assessment was completed on 05/16/13 and 05/22/13. Further review of the form revealed if a yes was answered this indicated a fall risk factor. Review of the assessments completed on 05/16/13 and 05/22/13 revealed a yes was answered seven (7) times on 05/16/13 and a yes was answered eight (8) times on the 05/22/13 evaluation, indicating Resident #1 was at risk for falls. Review of Resident #1's Comprehensive Care Plan dated 05/14/13, revealed a risk for falls care plan with interventions which included a chair alarm in chair, do not leave unattended while in wheelchair, Dycem (a product which prevents slippage) under the Chux (a protective pad) and wheelchair alarm. Review of the Nurse's Note dated 05/22/13 and timed 1:15 PM, revealed Resident #1 was found sitting on the floor in front of the chair with no injury noted. Review of the Incident Report, dated 05/22/13, revealed the resident was found in front of the chair on the floor. It further stated the resident appeared to have slipped from the chair and the chair alarm was in place. Further review of the care plan revealed it was revised on 05/22/13, following the fall, to include the use of a personal tab alarm when the resident was up in the recliner. Review of the Resident Fall Evaluation form with an assessment date of 08/01/13 revealed yes was answered six (6) times indicating Resident #1 had fall risk factors. Review of the Comprehensive Care Plan with a review date of 08/12/13, revealed the intervention of not to leave the resident unattended while in the wheelchair was discontinued. Additional review of a Nurse's Note dated 09/04/13 timed 10:40 AM, revealed Resident #1 was found on the floor, yelling out with complaints of pain in the lower back area; however, there was no documented evidence of an alarm being in place. Further review of the Note revealed Emergency personnel were contacted and transported Resident #1 to the hospital. Review of the Incident Report, dated 09/04/13 timed 10:40 AM, revealed Resident #1 had been found on the floor in front of chair with complaints of lower back pain. Continued review of the Incident Report revealed Resident #1 was transported to the hospital. Review of the hospital Radiology Report dated 09/04/13 timed 11:28 AM revealed no compression fracture was noted; however, degenerative changes were noted in Resident #1's lumbar region of the spine. Review of the Risk Management System (RMS) investigation form for the 09/04/13 fall revealed the resident self-propelled the wheelchair into his/her room and attempted to self-transfer to the recliner. It further indicated an alarm was to be used for Resident #1; however, further review of the form revealed no alarm was in place on the resident's wheel chair at the time of the resident's fall. Interview, on 11/04/13 at 11:40 AM, with Licensed Practical Nurse (LPN) #3 revealed he was the nurse assigned to Resident #1's care on 09/04/13 when the resident fell . LPN #3 stated Resident #1 was found lying in front of the recliner like he/she had tried to self-transfer to the recliner from the wheel chair. He further stated Resident #1 did not have an alarm on his/her wheel chair as care planned to alert staff of attempts of self-transfer. In addition, he stated it was the nurse's responsibility to ensure the alarms were in place and working. Review of the resident's Treatment Administration Record (TAR) revealed LPN #3 had signed off Resident #1's alarm was in place on 09/04/13. However, review of the facility's investigation revealed the alarm was not in place. Interview, on 11/04/13 at 2:30 PM, with the Interim DON revealed State Registered Nursing Assistants (SRNAs) were to assure the alarms were in place each time Resident #1 was transferred. Additional interview with the Interim DON revealed nurses were to check alarms for placement and function every shift and nurses were responsible to ensure the care plan interventions were implemented and document this on the residents' TAR. 2. Review of Resident #2's record revealed an admission date of [DATE], and readmission date of [DATE], with [DIAGNOSES REDACTED]. Further record review revealed a Fall Risk Evaluation form with assessment dates of 02/28/13 and 03/09/13, with yes checked indicating the resident was at risk for falls. Review of the Comprehensive Care Plan with a print date of 04/15/13 revealed a plan of care for risk for falls with interventions which included: large reminder signs in the room to ask for help; non skid strips beside the bed on the floor; discourage use of shoes without backs; encourage resident to ask for assistance when getting out of bed; provide reacher to assist with picking things up; and have commonly used articles within easy reach. Review of Resident #2's Annual MDS Assessment, dated 05/07/13, revealed the facility assessed the resident as having a potential for falls. Further review revealed Brief Interview for Mental Status (BIMS) score of fifteen (15) out fifteen (15) indicating the resident was assessed as being cognitively intact. Review of the Care Area Assessment (CAA) Summary of the MDS for falls revealed Resident #2 was at risk due to balance problems; receiving antidepressant medication; and, the resident utilized a walker. Further review of the CAA Summary revealed Resident #2 required assist from staff for ambulation. Continued record review revealed Resident #2 had fallen six (6) times since 07/07/13 with the last fall occurring on 10/24/13. Record review revealed the falls occurred on 07/07/13, 07/22/13, 07/28/13, 09/04/13, 10/15/13 and on 10/24/13. Further review of the resident ' s record revealed no documented evidence the facility assessed the resident any further after three (3) documented falls in July of 2013, a documented fall on 09/04/13 and a documented fall on 10/15/13. Review of the Incident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185265**	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED **11/05/2013**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRANT CENTER	**201 KIMBERLY LANE** **WILLIAMSTOWN, KY 41097**

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) Report, date 07/07/13, revealed Resident #2 was found outside the facility on his/her knees. The resident stated he/she tripped over the walker. The resident had two (2) skin tears to the left arm. Review of the care plan revealed the facility added the interventions to monitor the resident's gait and encourage the use of a wheel chair as needed. In addition the intervention was added to encourage the resident to ask for help if needed. Review of the Incident Report, dated 07/22/13 revealed Resident #2 fell in the dining room while trying to get up from the chair resulting in skin tears to his/her arms. Further review of the Incident Report revealed no documented evidence of the type of shoes the resident was wearing; however, review of the care plan revealed an intervention was added which stated encourage resident to use proper footwear, shoes or gripper socks and not to wear slip on shoes. Review of the Incident Report dated 07/28/13 revealed staff heard the resident yell and heard a thump. The resident was found next to the bed with skin tears to the right elbow and left shin and a small bump on the back of the resident's head. Further review revealed the resident stated he/she was kneeling on the bed and fell backwards. Review of the care plan revealed an intervention was added to encourage the resident not to kneel on bed and to ask for assistance. Review of the Incident Report dated 09/04/13 revealed the resident was found sitting in the center of his/her room at 9:00 AM and stated she fell while taking her breakfast tray to the hallway. Review of the care plan revealed an added intervention which stated educate resident not to carry lunch tray down the hall. Review of the Incident Report dated 10/15/13 revealed the resident was found sitting in the floor of his/her room and the resident stated he/she slid off the bed and the resident was not wearing gripper socks. Further review of the Incident Report revealed no indication that non skid strips were in place on the floor beside the bed. Review of the Incident Report dated 10/24/13 timed 8:15 PM, revealed Resident #2 was in his/her room yelling help. Review of the Incident Report revealed the nurse responded and found Resident #2 on the floor next to the bed. Continued review of the Incident Report revealed Resident #2 stated he/she was trying to get up and go to the bathroom and fell down. Further review revealed Resident #2 was observed to have a skin tear to the right wrist area. Review of the care plan revealed no documented evidence the care plan was revised following this fall. Observation on 10/31/13 at 11:30 AM, of Resident #2's room revealed no evidence of large reminder signs in the room to remind the resident to ask for assistance for transfers. Observation did reveal a hand written sign on the resident's refrigerator door approximately five (5) inches by four (4) inches which stated ask for assistance. Continued observation of Resident #2's room revealed no evidence of non-skid strips on the floor beside the bed. Review of the State Registered Nursing Assistant (SRNA) Care Plan from July 2013 to October 2013, revealed no documented evidence it had been updated to include for Resident #2 to have non-skid strips to the floor beside his/her bed. Additionally, there was no documented evidence that Resident #2 was to have large reminder signs in his/her room to request assistance for transfers. Interview, on 11/04/13 at 2:38 PM, with SRNA #14 revealed she was assigned to provide care for Resident #2 sometimes. She stated she was not aware the resident was to have non-skid strips on the floor by the his/her bed. She further stated it would be very helpful if this information was on the SRNA care plan. According to SRNA #14, she moved around the facility's units a lot and things did change with residents' care. Interview, on 11/04/13 at 3:54 PM, with SRNA #12, who provided care for Resident #2, revealed to have non-skid strips to the floor by his/her bed. She reviewed the SRNA care plan and stated the information for Resident #2 to have non-skid strips by his/her bed was not on it. Interview with the Unit Manager/Registered Nurse (RN) #2, on 11/01/13 at 12:10 PM, revealed it was the nurses' responsibility to ensure the SRNA care plans were revised with current interventions and the nurses' responsibility to ensure all care plan interventions were in place and implement for each resident. She further stated Resident #2's care plan was not revised after the 10/24/13 fall and was not followed for fall interventions. 3. Review of Resident #3's record revealed the facility admitted the resident on 12/28/11, with [DIAGNOSES REDACTED]. Review of the Comprehensive Care Plan dated 12/28/11 revealed a falls risk care plan with interventions which included re-educate resident as need on proper foot wear as needed, non-slip footwear, remind resident to use call light prior to ambulating or transferring, and have commonly used articles within easy reach. Review of the Nurse's Notes revealed Resident #3 experienced falls on 05/23/13, 06/26/13 and 09/09/13. Continued review of Resident #3's record revealed no documented evidence of the completion of Fall Risk Assessments after the resident had documented falls on 05/23/13 and 06/26/13. Review of the Incident Reported dated 05/23/13 at 7:00 AM revealed Resident #3 fell when walking to the bathroom. Review of this Incident Report revealed Resident #3 was noted to have no shoes on at the time of the fall, even though the care plan intervention was to ensure the resident had non-slip