STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185052	A. BUILDING _____ B. WING _____	**01/19/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE AT SUMMIT MANOR REHAB & WELLN	**400 BOMAR HEIGHTS COLUMBIA, KY 42728**

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 0157 **Level of harm -** Actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to immediately consult with the resident's physician for a change of condition for one (1) of six (6) sampled residents (Resident #6). Review of Resident #6's clinical record revealed the resident sustained [REDACTED]. However, there was no documented evidence Resident #6's physician was immediately contacted or consulted when the resident sustained [REDACTED].#6 had complaints of pain; x-rays were ordered which revealed the resident had a right humerus fracture. Refer to F323. The findings include: Review of the facility's policy titled Change of Condition, undated, revealed the facility would assess and document changes in a resident's health, mental, or psychosocial status in an efficient and effective manner. The policy further stated the physician would be notified of a significant change in the resident's physical, mental, or psychosocial status or a need to alter treatment. Review of the policy guidelines revealed licensed staff was to assess any change in condition through direct observation, physical examination, and vital signs at the onset of the change. Further review of the policy revealed the Situation, Background Assessment Response (SBAR) form was to be completed and the physician and responsible party notified of the resident's change of condition. Review of the closed medical record for Resident #6 revealed the facility admitted the resident on 02/14/14 with [DIAGNOSES REDACTED]. Additional review of the record revealed the resident sustained [REDACTED]. According to the facility's SBAR and fall investigation documentation, the resident slid from the toilet and had an abrasion to the right eyebrow and bruising and a raised area to the forehead. Further review of the SBAR revealed the resident complained of right shoulder pain. However, there was no documented evidence in the record that the resident's physician was contacted related to this fall with injury until 10:00 AM on 12/05/15 (eleven hours after the fall occurred). Record review revealed the physician was again contacted at 1:30 PM on 12/05/15 due to the resident's complaints of pain; x-rays were ordered which revealed the resident had a right humerus (bone in the upper arm) fracture. The resident was ordered a sling/immobilizer for the right arm and scheduled to see an orthopedic physician. Review of the clinical record revealed there was no documented evidence the resident's physician was contacted related to the resident's decline and of the increased pain with movement until 12/07/15, when a request was made to change the resident's pain medication from as needed to scheduled. Further record review revealed the resident continued to decline, not eating and drinking as usual on 12/08/15 and 12/09/15. The resident's family requested the resident be transferred to the emergency roiagnom on [DATE] for evaluation and treatment of [REDACTED]. There was no documented evidence the resident received treatment for [REDACTED]. Interview with Registered Nurse (RN) #1 on 01/13/16 at 12:52 PM revealed she had been notified by staff that the resident was on the floor of his/her bathroom on 12/04/15. According to RN #1, the resident was sitting on his/her buttocks on the floor of the bathroom with his/her legs stretched out and was upset. RN #1 stated she assessed the resident and the resident had no visible injuries at that time or any complaints of pain at that time. Further interview with RN #1 revealed the resident was assisted up to a chair by RN #1 and a State Registered Nurse Aide (SRNA) with the use of a gait belt. The resident was further assessed and it was discovered the resident had an abrasion to the right eye and a red area to the forehead. During interview with RN #1 she stated she had contacted the resident's family and the family member came to the facility and stayed with the resident. According to RN #1, she thought she contacted the resident's physician, but she could not remember. RN #1 stated she administered Tylenol (pain medication) to the resident for complaints of pain to the right arm and general pain at approximately 12:30 AM and 4:30 AM on 12/05/15. RN #1 stated she was not aware the resident had a fractured right humerus until returning to work on the evening of 12/05/15, and she became aware the resident had a [MEDICAL CONDITION] after the resident was sent to the hospital on [DATE]. Interview with RN #2 on 01/13/16 at 2:50 PM revealed she contacted the resident's physician via fax on 12/05/15 at 10:00 AM to inform the physician that Resident #1 had fallen, as there was no documented evidence that RN #1 had notified the physician. Further interview revealed after the resident's family had informed the nurse the resident was having arm, leg, and knee pain, the physician was contacted at 1:30 PM by phone and orders were received for x-rays to be completed. Further interview revealed the x-rays revealed the resident had a fractured humerus. Interview with Resident #1's physician on 01/13/16 at 2:20 PM revealed the physician could not remember being notified of the resident's fall. According to the physician, if he had been notified of a suspected injury he would have ordered the resident to be transferred to the hospital for evaluation and treatment. Interview with the Director of Nursing (DON) revealed the facility was under new management that started on 12/01/15. The DON stated that some of the facility's documentation forms had changed, but standard procedures for notifying the resident's physician for falls and change of condition were the same as before 12/01/15. According to the DON, it was facility policy to notify the resident's physician of a fall or a change of condition. Further interview revealed the DON had reviewed the fall investigation on 12/07/15 and discussed the facility's failure to notify the physician with RN #1.
F 0280 **Level of harm -** Actual harm **Residents Affected -** Few	**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 care plan policy/procedure it was determined the facility failed to revise the care plan for one (1) of six (6) sampled residents (Resident #6). Resident #6 went to the hospital on [DATE] for an amputation of the right great toe. The resident was previously assessed by the facility to be at risk for falls and was noncompliant with asking for assistance to ambulate. The facility failed to revise the resident's care plan to reflect an increased risk for falls after the amputation of his/her great toe. Resident #6 ambulated to the bathroom without assistance on 12/04/15 and sustained a fall with injury (a fractured right humerus and fractured right hip). Refer to F323. The findings include: Review of the facility's policy titled Care Plans-Comprehensive, dated 06/01/15, revealed an individualized comprehensive care plan including measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychological

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185052	A. BUILDING _____ B. WING _____	01/19/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE AT SUMMIT MANOR REHAB & WELLN	400 BOMAR HEIGHTS COLUMBIA, KY 42728

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** - Actual harm **Residents Affected** - Few	(continued... from page 1) needs was developed for each resident. Review of the policy's guidelines revealed care plans were revised as information about the resident and the resident's condition changed. Further review of the guidelines revealed the nurse/interdisciplinary team was responsible for reviewing and updating care plans with changes in the resident's status when there was a significant change of condition, when a desired outcome was not met, and when the resident had been readmitted to the facility from a hospital stay. Review of Resident #6's medical record revealed the facility admitted the resident on 02/14/14 with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed the resident to be severely impaired for cognition with a Brief Interview for Mental Status (BIMS) score of 6. The facility assessed the resident to require the extensive assistance of one person for ambulation. Review of the resident's Comprehensive Care Plan dated 11/06/15 revealed the facility care planned the resident for potential for falls related to weakness, unsteady gait, balance problems, history of [MEDICAL CONDITION], and noncompliance with calling for assistance. Review of the interventions developed to prevent falls revealed staff was to encourage the resident to use the call light for assistance, remind the resident to ask for assistance, and to provide routine care according to the nurse aide care plan which indicated the resident was to be assisted with ambulation. Further review of the care plan revealed the facility did not review or revise the interventions related to falls after the resident had the amputation of the right great toe on 12/04/15 related to the resident requiring more assistance with ambulation and supervision related to a history of not calling for assistance. Review of nurse's notes dated 12/04/15 revealed Resident #6 was transported to the hospital at 7:20 AM for surgery to have the right great toe amputated and returned to the facility at 11:45 AM the same day after the procedure. Further review of the nurse's notes revealed the resident sustained [REDACTED]. Review of the fall investigation revealed it was determined the resident slid from the toilet. According to the nurse's notes, the resident was found to have a right humerus fracture the next day on 12/05/15. Further review of the notes revealed the resident was transferred to the hospital at the request of the family on 12/09/15 and was diagnosed with [REDACTED]. Interview with Family Member (FM) #1 on 01/12/16 at 2:05 PM revealed the family member was at the facility on 12/04/15 when Resident #6 returned from surgery. The family member stayed with the resident and had assisted the resident to ambulate to the bathroom. According to FM #1, the resident was unsteady and required more assistance than usual when ambulating due to the toe ambulation and the surgical dressing on his/her right foot. Interview with Registered Nurse (RN) #2 on 01/13/16 at 2:50 PM revealed she assessed Resident #6 after the resident returned from surgery on 12/04/15. According to the RN, the resident's right foot was bandaged, the dressing was clean, dry, and intact, and the resident had no complaints of pain. RN #2 stated she did not assess the resident's gait when the resident returned to the facility, nor had she considered the resident to be at increased risk for falls due to the toe amputation. RN #2 stated she discussed with the State Registered Nurse Aides (SRNAs) to watch the resident more closely, but she did not revise the resident's plan of care to include any interventions for increased supervision related to the resident's potential change in his/her gait. Interview with the MDS Nurse on 01/15/16 at 2:20 PM revealed the MDS Nurse revised Resident #6's pressure ulcer plan of care to include interventions to leave the resident's surgical dressing in place and to wear a surgical shoe when ambulating when the resident had surgery on 12/04/15. However, she did not revise the resident's fall care plan because the resident was already care planned to be at risk for falls. According to the MDS Nurse, she was not aware the amputation of the right great toe would affect the resident's balance and she had not considered any increased supervision even though the resident was not compliant with asking for assistance with ambulation. Interview with the Director of Nursing (DON) on 01/12/16 at 4:00 PM revealed when a resident returned from the hospital after a procedure, the resident was to be assessed by the nurse and the resident's care plan updated with interventions the resident would require to meet his/her needs related to the assessment. According to the DON, she was not aware the resident's falls care plan had not been updated or any interventions considered related to the resident ambulating unassisted after the amputation of his/her right great toe.
F 0323 **Level of harm** - Actual harm **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, hospital emergency room record, and review of the facility's falls policy it was determined the facility failed to ensure one (1) of six (6) sampled residents (Resident #6) received adequate supervision and assistance to prevent accidents. Resident #6 had an amputation of the right great toe on 12/04/15 and returned to the facility the same day. The facility failed to assess the resident's need for assistance with ambulation and develop a care plan to address the risks related to the amputation of the toe. As a result, Resident #6 ambulated to the bathroom without assistance and sustained a fall with injury fracturing the right humerus and the right hip on 12/04/15. The findings include: Review of the facility's policy for falls with a revision date of 06/01/15 revealed all residents would have a comprehensive fall risk assessment completed with a significant change of condition, and appropriate care plan interventions would be implemented and evaluated as indicated by the assessment. Further review of the policy revealed if a resident sustained [REDACTED]. Further review of the policy revealed the resident would be assessed every shift for 72 hours after the fall and pain would be evaluated for 72 hours for all residents who experienced a fall. Review of the closed medical record for Resident #6 revealed the facility admitted the resident on 02/14/14 with [DIAGNOSES REDACTED]. Further review of the record revealed the resident had [DIAGNOSES REDACTED]. Review of the resident's most recent Minimum Data Set (MDS) assessment dated [DATE] revealed the facility assessed the resident to be severely impaired for cognition with a Brief Interview for Mental Status (BIMS) score of 6. The facility assessed the resident to require the extensive assistance of one person for ambulation. Review of the resident's Comprehensive Care Plan dated 11/06/15, revealed the resident was care planned for potential for falls related to weakness, unsteady gait, balance problems, history of vertigo, and noncompliance with calling for assistance. Further record review revealed the resident had surgery for [REDACTED]. There was no documented evidence the resident was assessed upon his/her return to the facility for increased fall risks. There was no documented evidence of any additional interventions added to the resident's fall care plan. Record review revealed Resident #6 was found on the floor of his/her bathroom at 11:20 PM on 12/04/15. The resident was assessed to have an abrasion to the right eyebrow and a raised area to the forehead and no other injuries. There was no documented evidence the physician was immediately notified of the fall. Further review revealed staff assisted the resident back to bed. The resident had complaints of right arm pain and was given Tylenol (pain medication) on 12/05/15 at 12:20 AM, and again at 4:45 AM. Record review revealed the physician was not notified of the fall until 12/05/15 at 10:00 AM. According to the record, the resident continued to complain of pain and the physician was contacted again at 1:30 PM on 12/05/15 and ordered x-rays that revealed a fracture to the right humerus. Orders were received for the resident to have a sling/immobilizer and follow up with an orthopedic physician. According to nurse's notes, pain flow sheets, dietary intake record, and the resident's care flow record, Resident #6 continued to have pain and declined in eating and drinking and activities of daily living. On 12/09/15 at 5:30 PM, the resident's family requested the resident be sent to the hospital for evaluation and treatment. Review of the emergency room hospital record revealed the resident was admitted and diagnosed with [REDACTED]. Interview with State Registered Nurse Aide (SRNA) #1 on 01/13/16 at 12:10 PM revealed she was passing ice on night shift (10:00 PM to 6:00 AM) on 12/04/15, when she heard Resident #6 call for help. According to the SRNA, she found Resident #6 on the bathroom floor and immediately notified Registered Nurse (RN) #1. Further interview with the SRNA revealed RN #1 checked the resident and the resident did not complain of pain; staff assisted the resident back to bed. SRNA #1 stated prior to Resident #6's surgery on 12/04/15, the resident could ambulate independently and did not ask for assistance in going to the bathroom. The SRNA stated the resident was modest and she would check on him/her every two hours. SRNA #1 stated she was not aware of the resident having any complaints of pain. Interview with SRNA #2, who was assigned to Resident #6 on 12/05/15 and who routinely was assigned to care for the resident,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185052	A. BUILDING _____ B. WING _____	**01/19/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE AT SUMMIT MANOR REHAB & WELLN	**400 BOMAR HEIGHTS COLUMBIA, KY 42728**

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 0323 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) revealed on 12/05/15 the resident was not able to perform activities of daily living, ambulate, and transfer the same as before the surgery on 12/04/15. According to the SRNA, the resident was provided a bedside commode and would complain of pain with movement and transfers. The SRNA further stated that the resident was care planned to have assistance with ambulation to the bathroom, but the resident would normally ambulate without assistance to the bathroom prior to 12/04/15. The SRNA stated Resident #6 continued to decline to the point of not getting out of bed and was complaining of more pain. SRNA #2 stated on 12/09/15, the resident was sent to the hospital and it was discovered the resident had a fractured hip. Interview with RN #2 on 01/13/16 at 2:50 PM revealed RN #2 assessed Resident #6 when the resident returned from surgery on 12/04/15. According to RN #2, the resident was sitting in the recliner in the room with his/her feet elevated. The resident's right foot was bandaged and the dressing was clean, dry, and intact and the resident had no complaints of pain. RN #2 stated she did not assess the resident's gait, but she did discuss with the SRNAs to watch the resident more. RN #2 stated she did not revise the resident's plan of care to include any interventions for increased supervision related to the resident's amputation. Interview with RN #1 on 01/13/16 at 12:52 PM revealed the nurse had been notified by staff that Resident #6 was on the floor of the bathroom on 12/04/15. According to RN #1, the resident was sitting on his/her buttocks on the floor of the bathroom with his/her legs stretched out and was upset. RN #1 stated she assessed the resident and the resident had no visible injuries and no complaints of pain at that time. According to RN #1, she had the resident move his/her upper and lower extremities, but did not do range of motion or palpate the resident's joints for any deformities during the assessment. Further interview revealed RN #1 and SRNA #1 with the use of a gait belt assisted the resident up to a chair. The resident was further assessed and it was discovered the resident had an abrasion to the right eye and a red area to the forehead. RN #1 stated she contacted the resident's family and the family member came to the facility and stayed with the resident. According to RN #1, she thought she contacted the resident's physician, but could not remember. RN #1 stated that she would have documented the notification if she had notified the physician. She stated she was not aware the resident had a fractured right humerus until returning to work on the evening of 12/05/15, and she became aware the resident had a fractured hip after the resident was sent to the hospital on [DATE]. According to RN #2, she notified the resident's physician of the fall via fax on 12/05/15 at 10:00 AM because the physician had not been notified. Further interview with RN #2 revealed the family notified her that the resident was having arm, leg, and knee pain and the resident's physician was contacted again on 12/05/15 at 1:30 PM by phone. RN #2 stated the physician ordered x-rays to be completed and it was discovered the resident had a fractured humerus. RN #2 stated on 12/09/15 the resident was scheduled for an orthopedic appointment due to the fractured humerus, but the family declined and the physician was contacted because the resident was having pelvic/hip pain and additional portable x-rays were ordered. RN #2 stated the family did not want to wait on the x-rays and requested the resident be transferred to the hospital. The resident was sent to the hospital and was diagnosed with [REDACTED]. Interview conducted with Family Member (FM) #1 on 01/12/16 at 2:05 PM revealed the facility contacted him/her when the resident sustained [REDACTED]. FM #1 stated she came to the facility and stayed with the resident the rest of the night. According to FM #1, the resident complained of pain and was administered medication that did not relieve his/her pain; the resident cried and moaned the rest of the night. Further interview with FM #1 revealed she noticed the resident's pain was getting worse on 12/05/15 and reported this to RN #2; the resident was later found to have a fractured humerus. Additional interview with FM #1 revealed the resident continued to have pain and was not improving and she noticed the resident's right leg was turned in on 12/09/15. FM #1 stated this concern was reported to RN #2 on 12/09/15. According to the family member, portable x-rays were ordered but the x-rays could not be completed timely so the family requested the resident be sent to the hospital on [DATE] where the resident was diagnosed with [REDACTED]. Interview with the Director of Nursing (DON) on 01/12/16 at 4:00 PM revealed if the resident had a fall, the resident should have been assessed at the time of the fall, the physician and family contacted, and if the resident had injuries requiring treatment the resident should have been transferred to the hospital. The DON further stated if the resident had no injuries at the time of the fall, the resident was to be monitored for 72 hours for any further complications, and the physician notified of any changes of condition. According to the DON, when a resident returned from the hospital after a procedure, the resident was to be assessed and the resident's care plan updated with any interventions the resident would require related to the assessment.