STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185277	A. BUILDING _____ B. WING _____	08/25/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE AT HERITAGE HALL REHAB & WELL	331 SOUTH MAIN STREET LAWRENCEBURG, KY 40342

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 0282 **Level of harm -** Actual harm **Residents Affected -** Few	**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 interview, record review and review of the facility's policy, it was determined the facility failed to ensure the care plan related to staff assistance required during transfers was followed for one (1) of four (4) sampled residents (Resident #1). Resident #1's had a Comprehensive Care Plan which directed the resident be transferred by hoyer lift (mechanical lift) with two (2) person assist. However, on 08/19/16, at approximately 5:00 AM, State Registered Nurse Aide (SRNA) #10 attempted to transfer the resident from the bed to the wheelchair without use of the hoyer lift and without requesting assistance from other staff. During the transfer procedure, Resident #1 fell from the side of the bed onto the floor. SRNA #10 failed to inform the nurse of the fall and with the assistance of SRNA #7, transferred the resident from the floor to the wheelchair with a gait belt. Resident #1 sustained a Intertrochanteric Left Femoral Neck Fracture (hip). (Refer to F323) The facility's failure to ensure staff followed the Care Plan resulted in actual harm to Resident #1. The facility's written Quality Assurance (QA) Plan was received on 08/24/16. Based on validation of the QA Plan, the State Survey Agency determined the deficient practice represented past non-compliance, as it was identified and corrected regarding implementation of the Care Plan related to required staff assistance for transfers, prior to initiation of the investigation by the State Survey Agency. The findings include: Review of the policy titled Care Plans - Comprehensive, dated 06/01/15, revealed each resident was to have a plan of care based on a thorough assessment to incorporate risk factors associated with identified problems, reflect currently recognized standards of practice for problem areas and conditions, aide in preventing declines in the resident's functional status, and identify the professional services that are responsible for each element of care. Review of Resident #1's clinical record revealed the facility admitted the resident on 12/01/15 with [DIAGNOSES REDACTED]. Review of Resident #1's most recent Quarterly Minimum Data Set (MDS) Assessment, dated 06/24/16, related to transfer needs, revealed the facility assessed Resident #1 as requiring extensive assistance and two person physical assist. Review of the Comprehensive Care Plan initiated April 2015, and updated March 2016, revealed a problem of At Risk for Falls, related to decreased mobility, impaired balance during transitions, incontinence, visual impairment, and a [DIAGNOSES REDACTED]. There were several interventions including transfers per hoyer lift with assist of two (2) staff. Review of the Final Incident Report Form dated 08/23/16, revealed SRNA #10 attempted to transfer Resident #1 from the bed to the wheelchair without use of the hoyer lift and without the assist of another staff member. Per the Report, the resident slid from the side of the bed onto the floor during the transfer. Further review of the Incident Report revealed interventions in place at the time of the fall included Assist x 2 with hoyer lift for transfers. Continued review revealed SRNA #10 did not report the fall to the Administrator or DON, and transferred Resident #1 from the floor to the wheelchair without being appropriately assessed first. Per the Incident Report, Resident #1 complained of pain during breakfast on the following shift and was given Tylenol (pain reliever and fever reducer) with relief Further review revealed Resident #1 again complained of pain after lunch, was assessed, and an X-Ray was ordered. Additionally the Incident Report revealed following X-Ray results, Resident #1 was sent to the local hospital emergency room for evaluation. Review of Nurse's Notes dated 08/19/16, recorded at 9:24 PM, revealed Resident #1 was up in the wheelchair at 8:00 AM, complained of pain in the right hand and left leg and was administered Tylenol six hundred fifty (650) milligrams (mg). Per the Notes, a reassessment at 10:00 AM revealed the resident was in the wheelchair smiling and nodded when asked if he/she felt better. Continued review revealed Resident #1 was returned to bed at 1:30 PM and was yelling out in pain and holding his/her left hip. According to the Notes, the nurse conducted an assessment at that time, noted swelling to the left hip area, administered Tylenol 500 mg, and notified the ARNP of the resident's pain and swelling. Further review revealed at 2:00 PM orders were received for X-Rays and at 4:30 PM the ARNP was in to see the resident and orders were received for stat [MEDICATION NAME] (narcotic pain medication) which was taken from the E-box (emergency box) and administered. Per the Note, the Mobile X-Ray arrived at 8:00 PM. Review of physician's orders [REDACTED]. [REDACTED]. Review of the Radiology Report dated 08/19/16 and read by the Radiologist at 10:01 PM, revealed Resident #1 had a Left Intertrochanteric Femur Fracture. Review of Nurse's Notes dated 08/20/16, recorded at 4:49 AM, revealed at 10:45 PM EMS was contacted for transport, and at 1:00 PM the hospital called to state the resident was being admitted . Review of the Diagnostic Imaging Report from the hospital Emergency Department dated 08/20/16, revealed a Intertrochanteric Left Femoral Neck [MEDICAL CONDITION] Hip. According to the Witness Statement by SRNA #10, dated 08/19/16, she attempted to transfer Resident #1 from the bed to the wheelchair without assistance and without use of the hoyer lift, and after Resident #1 fell , she failed to report the fall to the nurse. Review of the written interview conducted by the Administrator with SRNA #10 on 08/20/16, revealed SRNA #10 knew Resident #1 required two (2) person assist with the hoyer lift, and didn't know why she didn't follow the care plan. The State Survey Agency Representative attempted to contact SRNA #10 by telephone for an interview on 08/24/16 at 3:45 PM and 08/25/16 at 3:00 PM; however, the attempts were unsuccessful. Interview with SRNA #7, on 08/25/16 at 9:08 AM, revealed on 08/19/16 just after 5:00 AM, SRNA #10 asked for her help, stating Resident #1 was on the floor. SRNA #7 revealed she arrived at Resident #1's room and observed the resident was on the floor beside the bed on his/her left side. She stated, she assisted SRNA #10 in transferring Resident #1 to the wheelchair, with use of a gait belt, and no mechanical lift and the resident complained of leg pain. She stated she then asked SRNA #10 if she needed any further help, and went back to assisting the unsampled resident she had been with previously. Further interview revealed she assumed SRNA #10 had reported the fall and Resident #1 had been assessed by a nurse prior to SRNA #10 asking her for help. She stated she had not worked with Resident #1 and did not know Resident #1 required the assist of two (2) staff and the use of a hoyer lift for transfers. SRNA #7 stated when she came in later that same day at approximately 2:00 PM and asked about Resident #1, she realized the fall had not been reported. Interview with Registered Nurse (RN) #1, on 08/25/16 at 9:49 AM, revealed she was assigned to Resident #1 on 08/18/16 from 7:00 PM to 08/19/16 at 7:00 AM. She stated she passed medication to Resident #1 the morning of 08/19/16 and the resident did not express pain, did not appear to be in any pain, and no falls had been reported to her. Further interview revealed she was unaware Resident #1 had sustained a fall until she came in to work the evening of 08/19/16. Continued interview revealed it was her expectation for SRNA's to always follow resident care plans related to transfers and care provided. Interview with SRNA #2, on 08/24/16 at 1:17 PM, revealed she worked with Resident #1 in restorative dining on the morning of 08/19/16 and noticed when she turned the wheelchair around the resident grimaced as in pain. SRNA #2 stated she asked the resident if he/she was in pain and received no response, and when asked about pain a little later, stated his/her leg hurt.

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

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F 0282 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) SRNA #2 revealed she informed RN #2 of the resident's complaints of pain and RN #2 questioned Resident #1, then administered medication to Resident #1 which was approximately 7:30 AM. Further interview revealed Resident #1's Nurse Aide Care Plan had an intervention for two (2) staff to assist with the hoyer lift for transfers. She stated the Nurse Aide Care Plans were located at the nursing stations, and she always made a copy to carry with her for reference for care. Interview with SRNA #3, on 08/25/16 at 1:28 PM, revealed she transferred Resident #1 with assistance of another SRNA using the hoyer lift after lunch on 08/19/16 at approximately 12:15 PM, as per the Nurse Aide Care Plan. She revealed the resident cried out in pain when they were attempting to provide incontinence care after lunch, and she informed RN #2, who assessed Resident #1. Further interview revealed SRNA #3 revealed she was unaware Resident #1 had sustained a fall during the previous shift when she was caring for the resident on 08/19/16. Further interview revealed care plans were located in a book at the nurse's station and staff was required to carry a copy with them to ensure they were aware of resident care needs. Interview with RN #2, on 08/25/16 at 10:09 AM, revealed the morning of 08/19/16, she was informed by SRNA #2, Resident #1 was complaining of leg pain and she administered Tylenol medication at 8:07 AM, which was prescribed for the resident's Arthritis pain. RN #2 further revealed when she followed up with Resident #1 approximately thirty (30) minutes later, the resident indicated the pain was gone. Continued interview revealed the SRNA's were attempting to provide incontinence care to Resident #1 on 08/19/16 after lunch, and she was again alerted Resident #1 was in pain, and completed a head to toe skin assessment, noting the resident's left hip was slightly larger than his/her/right hip, and he/she was grabbing at the hip in obvious pain. Further interview with RN #2, revealed she obtained physician's orders [REDACTED]. Continued interview revealed the X-Rays were completed at 8:10 PM, and the results of the X-Rays were received at 10:09 PM on 08/19/16, at which time Resident #1 was sent to the local hospital Emergency Department (ED) for evaluation. Interview with the Administrator and Director of Nursing (DON), on 08/25/16 at 2:50 PM, revealed based on the facility investigation and statements from SRNA #10 and SRNA #7, it was concluded SRNA #10 attempted to transfer Resident #1 without using the hoyer lift and without requesting assistance on 08/19/16, and the resident sustained [REDACTED].#10 nor SRNA #7 reported the resident sustained [REDACTED].#1 from the floor to the wheelchair without an assessment completed by the nurse. Continued interview revealed Resident #1's Care Plan was not followed related to transferring the resident with a hoyer lift and with the assistance of two (2) staff. Further interview revealed it was their expectation that SRNA's review resident care plans at the beginning of the shift and follow the care plans. The facility provided an acceptable QA Plan, which alleged correction of the deficient practice on 08/23/16. Review of the QA Plan revealed the facility implemented the following corrective actions: 1. An incident of potential neglect of Resident #1 was reported to the office of Inspector General on 08/22/16. The facility's investigation of the incident was initiated on 08/19/16 and included the following: Resident #1 was assessed by RN #2 for signs of abuse or injury related to pain on 08/19/16; the ARNP was notified of the assessment performed by RN #2 and an X-ray was ordered and obtained showing a [MEDICAL CONDITION] Hip; Resident #1 was sent to the ED for further evaluation on 08/19/16 at 10:45 PM and diagnosed with [REDACTED].#10 on 08/19/16, and a follow-up interview with SRNA #10 was conducted by the Administrator on 08/20/16; SRNA #10 was terminated by the facility on 08/22/16; and the Maintenance Director assessed all lifts on 08/20/16 to determine they were in proper working order and weekly assessments of the lifts were in place and up to date. 2. All residents with a BIMS greater than (>)7 were interviewed for abuse/neglect or any care concerns on 08/20/16 by the Quality of Life Director. Residents with a BIMS of less than eight (<8) were physically assessed beginning 08/19/16 and concluding on 08/20/16 by Unit Managers. All assessments, interviews and questionnaires were reviewed by the Administrator on 08/20/16 for any concerns. 3. All Incident/Accident Reports and Nurse's Progress Notes for the past thirty (30) days were reviewed by the Corporate Consultant with no concerns identified. 4. All personnel files of personnel involved in the care of Resident #1 were audited for any abuse concerns on 08/20/16 and all audit results were reviewed by the Administrator. 5. All resident Care Plans and SRNA Care Plans were reviewed and updated as needed, to include the use of mechanical lifts, bed mobility, and transfers on 08/20/16 by MDS Nurses. 6. All staff were re-educated by the DON on the facility's care plan policy, gait belt policy, resident lift policy, accidents and incidents policy, and falls policy beginning on 08/19/16 and concluding on 08/22/16. Staff was not allowed to return to work until completion of re-education, and all staff who was not re-educated by 08/22/16 was sent a certified letter explaining they would not be allowed to work until the training was complete. Training for all staff included a competency test on use of gait belts, transferring residents to wheelchair, and use of lifts. 7. Beginning on 08/21/16, the DON observed staff care delivery for five (5) different residents daily to include observation of transfers using the mechanical lift, and will continue to observe daily. All results will be reported at the weekly QA meeting, where the determination of the frequency of continued audits will be made. Any concerns identified during the audits will be addressed immediately and reported to the Administrator. 8. Beginning on 08/22/16, ten (10) charts were audited daily by the DON to ensure Comprehensive Care Plans reflected resident assessments and Nurse Aide Care Plan interventions matched Comprehensive Care Plans. All results will be reported at the weekly QA meeting, where the determination of the frequency of continued audits will be made. Any concerns identified during the audits will be addressed immediately and reported to the Administrator. 9. Beginning 08/21/16, five (5) skin assessments were conducted each day by the DON, and five (5) resident interviews were conducted by the Social Services Director. All results will be reported at the weekly QA meeting, where the determination of the frequency of continued audits will be made. Any identified concerns will be addressed immediately and reported to the Administrator. 10. A QA meeting was held on 08/20/16 to review the QA plan, and a second QA meeting was held on 08/22/16 to review the progress made on the QA plan. QA meetings will continue to be scheduled each week to monitor progress, and to determine the need for continuing frequency of ongoing audits. Per the Performance Improvement Plan, the Signature Clinical Consultant and/or the Regional Vice President will provide corporate oversight three (3) times a week. The State Survey Agency validated the implementation of the facility's Action Plan as follows: 1. Review of the State Agency Intake Form revealed the initial report was received from the facility on 08/22/16. Review of the Incident Report, dated 08/19/16 and signed by the Administrator, revealed a failure by SRNA #10 and SRNA #7 to report an event involving Resident #1. Further review revealed both SRNAs had been suspended immediately upon report of the incident. Review of the Final Report, dated 08/23/16 and signed by the Administrator, revealed SRNA #10 and SRNA #7 failed to report a fall witnessed by SRNA #10 on the morning of 08/19/16. Resident #1 indicated pain during the following shift, and was given pain medication and assessed for effectiveness, and X-Rays were ordered on [DATE] as a result of Resident #1's pain. The Radiology Report dated 08/19/16 revealed a Introchanteric Left Femoral Neck Fracture and the resident was transferred to the local hospital ED for further evaluation and admitted to the hospital. Review of a Witness Statement from SRNA #10, dated 08/19/16, revealed she attempted to transfer Resident #1 from the bed to the wheelchair without using a lift or getting assistance, and when Resident #1 fell , instead of alerting a nurse she asked for assistance from SRNA #7 in transferring Resident #1 from the floor to the wheelchair. Interview with SRNA #7, on 08/25/16 at 9:08 AM, revealed she had started her 5:00 AM rounds on the morning of 08/19/16 SRNA #10 came into the room where she was working and stated she needed assistance as Resident #1 was in the floor. SRNA #7 stated she assisted SRNA #10 in transferring Resident #1 from the floor to the wheelchair without a mechanical lift, at which point Resident #1 complained of leg pain. SRNA #7 revealed she did not normally provide care for Resident #1 and did not know what his/her care plan stated related to transfers. She further revealed she made the assumption SRNA #10 had already reported the fall and the nurse had assessed Resident #1 prior to asking for her assistance. She stated when she returned to the facility that afternoon at approximately 2:00 PM, and inquired as to how Resident #1 was feeling, she found out the fall had not been reported. She revealed she provided a statement at that time and was informed over the phone shortly thereafter, she was suspended. Interview with RN #2, on 08/25/16 at 10:09 AM, revealed Resident #1 had refused breakfast on the morning of 08/19/16 and stated he/she was in pain. RN #2 revealed she believed Resident #1 to be experiencing arthritic pain, as he/she had before, so gave him/her Tylenol, with a later reassessment revealing the pain was gone. RN #2 further stated when the SRNA's were assisting Resident #1 to lye down after lunch, Resident #1 complained of leg pain, at which point RN #2 assessed the resident, which revealed the resident was holding the left hip which was slightly larger than the right, but there was no redness or bruising. RN #2 revealed, based on her assessment she notified the ARNP and obtained orders for an X-Ray. Per

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F 0282 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 2) interview, as the X-ray still had not been performed several hours later, she obtained an order for [REDACTED]. Interview with the DON, on 08/25/16 at 4:20 PM, revealed she was aware Resident #1 was experiencing leg pain and an X-Ray had been ordered prior to finding out on the afternoon of 08/19/16, the Resident #1 had suffered a fall that morning. She revealed she immediately had SRNA #7 who reported the fall, speak to the Administrator, and began educating staff and started auditing care shortly after. Review of the Stakeholder Termination Notice revealed the facility informed SRNA #10 of termination from employment on 08/22/16. Continued review revealed the reason for termination was violation of facility policy. The Termination Notice was signed by SRNA #10 on 08/22/16. Review of the Logbook for lift inspections revealed a routine inspection of all lifts was completed by the Maintenance Director on 08/20/16 with no concerns noted. 2. Review of the facility's QA Plan Binder revealed all residents with a BIMS >7 were interviewed for abuse/neglect or any care concerns on 08/20/16 by the Quality of Life Director. Questionnaires included questions regarding resident treatment by staff and questions regarding any concerns residents might express. Continued review of the binder revealed all residents with a BIMS < 8 received a skin assessment by 08/20/16 per the Unit Managers. No concerns were identified through questioning or assessments. 3. Interview with the Administrator, on 08/25/16 at 2:50 PM, revealed the Corporate Consultant reviewed all Incident/Accident Reports and Nursing Progress Notes for the past thirty (30) days and did not find anything that had gone unreported. 4. Five (5) personnel files were reviewed, with appropriate and timely background checks in place and evidence of training documented. 5. Four (4) resident care plans and nurse aide care plans were reviewed and interventions compared to the latest MDS Assessments, with all four (4) showing consistency related to required resident care and transfer assistance required. 6. Sign in sheets and copies of certified letters were reviewed and compared to employee listings, with all employees accounted for. Additionally, interviews with SRNA #1 on 08/24/16 at 1:03 PM, SRNA #2 on 08/24/16 at 1:17 PM, SRNA #3 on 08/24/16 at 1:28 PM, LPN #1 on 08/24/16 at 2:12 PM, LPN #2 on 08/25/16 at 7:43 AM, SRNA #5 on 08/25/16 at 8:13 AM, LPN #3 on 08/25/16 at 8:29 AM, SRNA #6 on 08/25/16 at 8:53 AM, SRNA #7 on 08/25/16 at 9:08 AM, RN #1 on 08/25/16 at 9:49 AM, RN #2 on 08/25/16 at 10:09 AM, SRNA #8 on 08/25/16 at 10:29 AM, SRNA #9 on 08/25/16 at 10:47 AM, LPN #4 on 08/25/16 at 1:14 PM, Quality of Life Director on 08/25/16 at 1:22 PM, Housekeeping #1 on 08/25/16 at 1:30 PM, LPN #5 on 08/25/16 at 1:34 PM, RN #3 on 08/25/16 at 1:41 PM, LPN #6 on 08/25/16 at 1:48 PM, Dietary #1 on 08/25/16 at 1:53 PM, and the Social Services Director on 08/25/16 at 2:01 PM revealed all had received the mandatory inservice training on following the care plan; incidents and accidents; falls and importance of reporting; the use of gait belts; mechanical lifts; and lift policy. Several SRNA's revealed they had been observed by the DON, sometimes daily, providing resident care according to the care plan and using gait belts and mechanical lifts. Interview with the Administrator, on 08/25/16 at 2:50 PM, revealed any staff who was not re-educated by 08/22/16 would not be allowed to return to work until they had received the required education. 7. On 08/25/16 the State Survey Agency Representative observed use of the hoyer lift by SRNAs with Resident #3 being transferred from bed to wheelchair at 9:35 AM; and use of the hoyer lift by two (2) different SRNA's with Resident #4 being transferred from wheelchair to bed at 10:54 AM. No concerns were noted during observations, and later review of resident Comprehensive Care Plans confirmed care was provided accordingly. Additionally, audit logs were reviewed from 08/21/16 through 08/25/16 of staff care delivery with no concerns identified. Competency checklists for use of the gait belt; transferring to wheelchair; and full body lift bed to wheelchair were reviewed for all SRNAs, dated 08/20/16 through 08/22/16. 8. Audit logs were reviewed of ten (10) charts audited daily by the DON from 08/22/16 through 08/25/16 to ensure care plans reflected resident assessments and Nurse Aide Care Plan interventions matched Care Plans. Interview with the Administrator, on 08/25/16 at 2:50 PM, revealed there had been no inconsistencies or concerns identified so far during chart audits. 9. Skin assessment results were reviewed, and five (5) skin assessments were conducted each day beginning 8/21/16, with no concerns identified. 10. Interview with the Administrator, on 08/25/16 at 2:50 PM, revealed a QA plan was presented and reviewed during a QA meeting on 08/20/16, and reviewed during a second QA meeting on 08/22/16. Interview revealed QA meetings would continue to be scheduled each week to monitor progress, and to determine the continuing frequency of ongoing audits. Continued interview with the Administrator, revealed corporate oversight would be provided three (3) times a week by the Signature Clinical Consultant and/or the Regional Vice President.
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, and review of the facility's policy, it was determined the facility failed to ensure one (1) of four (4) sampled residents (Resident #1) received adequate supervision and assistance devices to prevent a fall when one (1) staff member attempted to transfer the resident without assistance and without use of a mechanical lift as directed by the facility's policy and the resident's Comprehensive Care Plan. On 08/19/16, at approximately 5:00 AM, State Registered Nurse Aide (SRNA) #10 independently attempted to transfer Resident #1 from the bed to the wheelchair without requesting assistance and without utilizing a mechanical lift. Review of the facility's investigation findings, revealed Resident #1 slid off the side of the bed onto the floor during the transfer. After Resident #1 sustained the fall, SRNA #10 failed to report the fall to the nurse in order for the resident to be assessed for injuries, and instead transferred the resident to the wheelchair with a gait belt, with the assistance of SRNA #7. The resident was not assessed for injuries until 08/19/16 at approximately 1:30 PM. an order for [REDACTED]. On 08/19/16 at 10:45 PM Emergency Medical Services (EMS) was contacted to transfer the resident to the local hospital emergency room and the resident was admitted to the hospital. Review of the facility's policy revealed residents unable to transfer themselves independently or with minimum assistance were to be transferred using a lift with at least two (2) trained staff providing the transfer. In addition, review of the Comprehensive Care Plan for Resident #1, revealed instructions for the use of a hoyer lift (mechanical lift) and the assist of two (2) staff for transfers. The facility's failure to ensure it's policies and the Comprehensive Care Plan were followed resulted in actual harm to Resident #1. The facility's Quality Assurance (QA) Plan was received on 08/24/16. Based on validation of the QA Plan, the State Survey Agency determined the deficient practice represented past non-compliance, as it was identified and corrected related to implementation of the facility's policies regarding use of the mechanical lift, reporting falls, and implementation of the Comprehensive Care Plan, prior to initiation of the investigation by the State Survey Agency. The findings include: Review of the facility's Falls Policy, revised 06/01/15, revealed appropriate care plan interventions were to be implemented to minimize fall risk. Further review revealed a resident experiencing a fall was to have an assessment including neuro checks, range of motion, and vital signs, as well as pain evaluations. Per Policy, the physician and family was to be notified and an investigation was to begin. Review of the facility's policy titled Accidents and Incidents - Investigating and Report, undated, revealed accidents were to be investigated, including time and date and circumstances surrounding the accident, and reported to the Administrator and/or Director of Nursing (DON). Review of the facility's Resident Lift Policy, undated, revealed residents unable to transfer themselves independently or with minimum assistance were to be transferred using a lift with at least two (2) trained staff providing the transfer. Review of the Resident #1's medical record revealed the facility admitted the resident on 12/01/15 with [DIAGNOSES REDACTED]. Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed the resident as requiring extensive assistance and two (2) persons physical assist for transfers. Further review of the MDS revealed the facility assessed Resident #1 as unable to complete the Brief Interview for Mental Status (BIMS); as having

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F 0323 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 3) both long and short term memory loss; and as severely impaired for decision-making ability. Review of the Comprehensive Care Plan related to falls revealed Resident #1 was assessed as At Risk for Falls on the care plan initiated April 2015 and updated March 2016, with the goal stating the resident would not have avoidable falls with injury. There were several interventions including two (2) persons to assist with a hoyer lift for transfers. Continued review of the Care Plan revealed the resident was dependent for all needs. Review of the Final Report Incident Form, dated 08/23/16, revealed SRNA #10 attempted to transfer Resident #1 from the bed to the wheelchair without assistance and without using the hoyer lift, when the resident slid from the side of the bed onto the floor. Continued review revealed interventions in place at the time included transferring the resident with a hoyer lift and the assist of two (2) persons. Further review revealed SRNA #10 did not report the fall to the Administrator or DON, and with assistance from SRNA #7, Resident #1 was transferred from the floor to the wheelchair without being appropriately assessed first. Per the Form, Resident #1 complained of pain during breakfast on the following shift and was given Tylenol (pain reliever and fever reducer) with good relief noted. Continued review revealed Resident #1 again complained of pain after lunch, was assessed, and an X-Ray was ordered. Additional review of the Form, revealed following X-Ray results, Resident #1 was sent to the local hospital emergency room for evaluation. Review of Nurse's Notes dated 08/19/16, recorded at 9:24 PM, revealed at 8:00 AM Resident #1 was up in the wheelchair and complained of pain in the right hand and left leg and was given Tylenol six hundred fifty (650) milligrams (mg). Per the Note, at 10:00 AM, Resident #1 was in the wheelchair smiling and nodded when asked if he/she felt better. Continued review revealed at 1:30 PM, Resident #1 was returned to bed and yelled out in pain holding the left hip. Per the Note, there was no redness or bruising noted but the left hip was somewhat swollen compared to the right hip, and there was no internal or external rotation. Tylenol 500 mg was repeated and the ARNP arrived and was notified of the resident's pain and swelling. At 2:00 PM orders were received for X-Rays. Further review of the Note, revealed at 4:30 PM the ARNP was in to see the resident and orders were received for stat Norco (narcotic pain medication) which was taken from the E-box (emergency box) and administered. At 6:00 PM the resident hurts when moving. At 7:00 PM the resident was quiet and smiling and X-Ray had not yet arrived, and physician's orders [REDACTED]. Further review of the Note, revealed X-Ray was there at 8:00 PM. Review of physician's orders [REDACTED]. Further review revealed physician's orders [REDACTED]. Continued review revealed physician's orders [REDACTED]. Review of the Radiology Report dated 08/19/16 at 10:01 PM, revealed a Left Intertrochanteric Femur Fracture. Review of Nurse's Notes dated 08/20/16, recorded at 4:49 AM, revealed at 10:45 PM EMS was contacted for transport, and at 11:00 PM report was called to the hospital. Per the Notes, at 1:00 PM the hospital called to state the resident was being admitted . Review of Resident #1's Diagnostic Imaging Report from the ED, dated 08/20/16, revealed a Intertrochanteric Left Femoral Neck Fracture of the Left Hip. Review of a Witness Statement by SRNA #10, dated 08/19/16, revealed she attempted to transfer Resident #1 from the bed to the wheelchair without assistance and without use of the hoyer lift, and after Resident #1 fell , she failed to report the fall to the nurse. Review of a Stakeholder Suspension Form, revealed SRNA #10 was suspended on 08/19/16. Review of a written interview conducted by the Administrator with SRNA #10 on 08/20/16, revealed SRNA #10 knew Resident #1 required two (2) person assist with the hoyer lift, and didn't know why she didn't follow the care plan. Review of a Stakeholder Termination Notice, revealed SRNA #10 was terminated from employment on 08/22/16 for failure to follow facility policy, which resulted in resident fall with injury. The State Survey Agency Representative attempted to reach SRNA #10 by telephone for an interview on 08/24/16 at 3:45 PM and 08/25/16 at 3:00 PM; however, the attempts were unsuccessful. Interview with SRNA #7, on 08/25/16 at 9:08 AM, revealed she was working with an unsampled resident on 08/19/16 just after 5:00 AM when SRNA #10 asked for her help, stating Resident #1 was on the floor. SRNA #7 revealed she ensured the unsampled resident's safety prior to going into Resident #1's room, where Resident #1 was on the floor beside the bed on his/her left side. SRNA #7 stated she asked the resident if he/she was in any pain, and did not receive an answer, which she described as normal behavior for the resident. She stated, she then assisted SRNA #10 in transferring Resident #1 to the wheelchair, with use of a gait belt, at which point Resident #1 did say his/her leg hurt. SRNA #7 stated she looked at Resident #7's leg, but could see no bruising, skin tears or redness. She then revealed she asked SRNA #10 if she needed any further help, and when SRNA #10 said no, she went back to assisting the unsampled resident she had been with previously. Further interview with SRNA #7 revealed she assumed SRNA #10 had reported the fall and Resident #1 had been assessed by a nurse prior to SRNA #10 asking for her help. She revealed she had not worked with Resident #1 and did not know Resident #1 required the assist of two (2) staff and the use of a hoyer lift for transfers. SRNA #7 stated she came in later that same day at approximately 2:00 PM to check on her schedule and asked about Resident #1, and realized at that time no fall had been reported. SRNA #7 revealed, following her report of the incident and giving a statement, she was contacted later that day and suspended over the phone. This was confirmed by review of a Stakeholder Suspension Form dated 08/19/16. Interview with Registered Nurse (RN) #1, on 08/25/16 at 9:49 AM, revealed she worked 08/18/16 from 7:00 PM to 08/19/16 at 7:00 AM and was assigned to Resident #1. She stated she passed medication to Resident #1 the morning of 08/19/16 and Resident #1 did not express any pain to her, did not appear to be in any pain, and no falls had been reported to her. She further stated she was unaware Resident #1 had sustained a fall until she came in to work the evening of 08/19/16. Interview with SRNA #2, on 08/24/16 at 1:17 PM, revealed she worked with Resident #1 in restorative dining the morning of 08/19/16. She revealed she went to get Resident #1 to take him/her to the dining room and Resident #1 grimaced like he/she was in pain when she turned the wheelchair around. SRNA #2 stated she asked Resident #1 if he/she was in any pain and the resident did not respond to the question. She further stated, once she sat down beside Resident #1 and attempted to cue him/her during breakfast, she realized the resident wasn't responding to cues, and when asked again about pain, stated his/her leg hurt. Per interview, SRNA #2 informed RN #2 of the resident's complaints of pain and RN #2 questioned Resident #1, then administered medication to Resident #1 at approximately 7:30 AM. Further interview with SRNA #2 revealed the only other time she saw Resident #1 that day was when staff brought him/her down for lunch; however, Resident #1 refused to eat and would not follow cues, and was taken out of the dining room. Continued interview revealed Resident #1's Nurse Aide Care Plan had an intervention for two (2) staff to assist with the hoyer lift for transfers. She stated the Nurse Aide Care Plans were located at the nursing stations, and she always made a copy to carry with her for reference. Interview with SRNA #3, on 08/25/16 at 1:28 PM, revealed she transferred Resident #1 with the assistance of another SRNA using the hoyer lift after lunch on 08/19/16 at approximately 12:15 PM, as per the Nurse Aide Care Plan. She stated the resident cried out in pain whenever they were attempting to provide incontinence care after lunch, and she informed RN #2, who assessed Resident #1 and ordered X-Rays. SRNA #3 revealed she was unaware Resident #1 had sustained a fall during the previous shift when she was caring for the resident on 08/19/16. Interview with RN #2, on 08/25/16 at 10:09 AM, revealed she worked with Resident #1 on the morning of 08/19/16, and was informed by SRNA #2, the resident complained his/her leg was hurting. RN #2 revealed she asked Resident #1 if he/she was in any pain, and the resident confirmed leg pain. RN #2 stated she administered Tylenol medication at 8:07 AM, which was prescribed for the resident's Arthritis pain. RN #2 revealed she followed up with Resident #1 approximately thirty (30) minutes later, and Resident #1 smiled and responded that his/her pain was gone. Further interview revealed when the SRNA's were attempting to provide incontinence care to Resident #1 and lye him/her down after lunch, she was again alerted Resident #1 was in pain, and went to assess him/her. RN #2 revealed she did a head to toe skin assessment, and did not see any redness or bruising, although Resident #1's left hip was slightly larger than his/her/right hip, and he/she was grabbing at the hip in obvious pain. Further interview with RN #2, revealed the ARNP was present in the facility at the time she assessed Resident #1, and she obtained orders from the ARNP for an X-ray at 2:00 PM; however, she stated at that point she had not been notified the resident had sustained a fall during the previous shift. She revealed she was notified by the Director of Nursing (DON) on the afternoon of 08/19/16, that Resident #1 had suffered a fall on 08/19/16 at approximately 5:00 AM. RN #2 revealed Resident #1's X-ray had not been obtained by 7:00 PM, so she obtained orders for a stat X-Ray. Continued interview with RN #2 revealed the X-Rays were completed at 8:10 PM, and the results of the X-Rays were received at 10:09 PM on 08/19/16, at which time Resident #1 was sent to the local hospital Emergency Department (ED) for evaluation. Interview with the Administrator and Director of Nursing (DON), on 08/25/16 at 2:50 PM, revealed based on the facility's investigation of the incident, including statements given by SRNA #10 and SRNA #7, it was concluded SRNA #10 attempted to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185277	A. BUILDING _____ B. WING _____	08/25/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE AT HERITAGE HALL REHAB & WELL	331 SOUTH MAIN STREET LAWRENCEBURG, KY 40342

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 4) transfer Resident #1 without using the hoyer lift and without requesting assistance on 08/19/16, and the resident suffered a fall. Further interview revealed neither SRNA #10 nor SRNA #7 reported the resident sustained [REDACTED].#1 from the floor to the wheelchair without an assessment completed by the nurse. Continued interview revealed SRNA #10 and SRNA #7 had been trained on proper performance of lift procedures and policies, but failed to follow facility's policy related to transfers. Per interview, SRNA #10 was terminated by the facility. The facility provided an acceptable QA Plan, which alleged correction of the deficient practice on 08/23/16. Review of the QA Plan revealed the facility implemented the following corrective actions: 1. An incident of potential neglect of Resident #1 was reported to the office of Inspector General on 08/22/16. The facility's investigation of the incident was initiated on 08/19/16 and included the following: Resident #1 was assessed by RN #2 for signs of abuse or injury related to pain on 08/19/16; the ARNP was notified of the assessment performed by RN #2 and an X-ray was ordered and obtained showing a fracture of the Left Hip; Resident #1 was sent to the ED for further evaluation on 08/19/16 at 10:45 PM and diagnosed with [REDACTED].#10 on 08/19/16, and a follow-up interview with SRNA #10 was conducted by the Administrator on 08/20/16; SRNA #10 was terminated by the facility on 08/22/16; and the Maintenance Director assessed all lifts on 08/20/16 to determine they were in proper working order and weekly assessments of the lifts were in place and up to date. 2. All residents with a BIMS greater than (>)7 were interviewed for abuse/neglect or any care concerns on 08/20/16 by the Quality of Life Director. Residents with a BIMS of less than eight (<8) were physically assessed beginning 08/19/16 and concluding on 08/20/16 by Unit Managers. All assessments, interviews and questionnaires were reviewed by the Administrator on 08/20/16 for any concerns. 3. All Incident/Accident Reports and Nurse's Progress Notes for the past thirty (30) days were reviewed by the Corporate Consultant with no concerns identified. 4. All personnel files of personnel involved in the care of Resident #1 were audited for any abuse concerns on 08/20/16 and all audit results were reviewed by the Administrator. 5. All resident Care Plans and SRNA Care Plans were reviewed and updated as needed, to include the use of mechanical lifts, bed mobility, and transfers on 08/20/16 by MDS Nurses. 6. All staff were re-educated by the DON on the facility's care plan policy, gait belt policy, resident lift policy, accidents and incidents policy, and falls policy beginning on 08/19/16 and concluding on 08/22/16. Staff was not allowed to return to work until completion of re-education, and all staff who was not re-educated by 08/22/16 was sent a certified letter explaining they would not be allowed to work until the training was complete. Training for all staff included a competency test on use of gait belts, transferring residents to wheelchair, and use of lifts. 7. Beginning on 08/21/16, the DON observed staff care delivery for five (5) different residents daily to include observation of transfers using the mechanical lift, and will continue to observe daily. All results will be reported at the weekly QA meeting, where the determination of the frequency of continued audits will be made. Any concerns identified during the audits will be addressed immediately and reported to the Administrator. 8. Beginning on 08/22/16, ten (10) charts were audited daily by the DON to ensure Comprehensive Care Plans reflected resident assessments and Nurse Aide Care Plan interventions matched Comprehensive Care Plans. All results will be reported at the weekly QA meeting, where the determination of the frequency of continued audits will be made. Any concerns identified during the audits will be addressed immediately and reported to the Administrator. 9. Beginning 08/21/16, five (5) skin assessments were conducted each day by the DON, and five (5) resident interviews were conducted by the Social Services Director. All results will be reported at the weekly QA meeting, where the determination of the frequency of continued audits will be made. Any identified concerns will be addressed immediately and reported to the Administrator. 10. A QA meeting was held on 08/20/16 to review the QA plan, and a second QA meeting was held on 08/22/16 to review the progress made on the QA plan. QA meetings will continue to be scheduled each week to monitor progress, and to determine the need for continuing frequency of ongoing audits. Per the Performance Improvement Plan, the Signature Clinical Consultant and/or the Regional Vice President will provide corporate oversight three (3) times a week. The State Survey Agency validated the implementation of the facility's Action Plan as follows: 1. Review of the State Agency Intake Form revealed the initial report was received from the facility on 08/22/16. Review of the Incident Report, dated 08/19/16 and signed by the Administrator, revealed a failure by SRNA #10 and SRNA #7 to report an event involving Resident #1. Further review revealed both SRNAs had been suspended immediately upon report of the incident. Review of the Final Report, dated 08/23/16 and signed by the Administrator, revealed SRNA #10 and SRNA #7 failed to report a fall witnessed by SRNA #10 on the morning of 08/19/16. Resident #1 indicated pain during the following shift, and was given pain medication and assessed for effectiveness, and X-Rays were ordered on [DATE] as a result of Resident #1's pain. The Radiology Report dated 08/19/16 revealed a Introchanteric Left Femoral Neck Fracture and the resident was transferred to the local hospital ED for further evaluation and admitted to the hospital. Review of a Witness Statement from SRNA #10, dated 08/19/16, revealed she attempted to transfer Resident #1 from the bed to the wheelchair without using a lift or getting assistance, and when Resident #1 fell , instead of alerting a nurse she asked for assistance from SRNA #7 in transferring Resident #1 from the floor to the wheelchair. Interview with SRNA #7, on 08/25/16 at 9:08 AM, revealed she had started her 5:00 AM rounds on the morning of 08/19/16 SRNA #10 came into the room where she was working and stated she needed assistance as Resident #1 was in the floor. SRNA #7 stated she assisted SRNA #10 in transferring Resident #1 from the floor to the wheelchair without a mechanical lift, at which point Resident #1 complained of leg pain. SRNA #7 revealed she did not normally provide care for Resident #1 and did not know what his/her care plan stated related to transfers. She further revealed she made the assumption SRNA #10 had already reported the fall and the nurse had assessed Resident #1 prior to asking for her assistance. She stated when she returned to the facility that afternoon at approximately 2:00 PM, and inquired as to how Resident #1 was feeling, she found out the fall had not been reported. She revealed she provided a statement at that time and was informed over the phone shortly thereafter, she was suspended. Interview with RN #2, on 08/25/16 at 10:09 AM, revealed Resident #1 had refused breakfast on the morning of 08/19/16 and stated he/she was in pain. RN #2 revealed she believed Resident #1 to be experiencing arthritic pain, as he/she had before, so gave him/her Tylenol, with a later reassessment revealing the pain was gone. RN #2 further stated when the SRNA's were assisting Resident #1 to lye down after lunch, Resident #1 complained of leg pain, at which point RN #2 assessed the resident, which revealed the resident was holding the left hip which was slightly larger than the right, but there was no redness or bruising. RN #2 revealed, based on her assessment she notified the ARNP and obtained orders for an X-Ray. Per interview, as the X-ray still had not been performed several hours later, she obtained an order for [REDACTED]. She revealed they received X-Ray results quickly, revealing a fracture, and an order was received for ED transfer at that time. Interview with the DON, on 08/25/16 at 4:20 PM, revealed she was aware Resident #1 was experiencing leg pain and an X-Ray had been ordered prior to finding out on the afternoon of 08/19/16, the Resident #1 had suffered a fall that morning. She revealed she immediately had SRNA #7 who reported the fall, speak to the Administrator, and began educating staff and started auditing care shortly after. Review of the Stakeholder Termination Notice revealed the facility informed SRNA #10 of termination from employment on 08/22/16. Continued review revealed the reason for termination was violation of facility policy. The Termination Notice was signed by SRNA #10 on 08/22/16. Review of the Logbook for lift inspections revealed a routine inspection of all lifts was completed by the Maintenance Director on 08/20/16 with no concerns noted. 2. Review of the facility's QA Plan Binder revealed all residents with a BIMS >7 were interviewed for abuse/neglect or any care concerns on 08/20/16 by the Quality of Life Director. Questionnaires included questions regarding resident treatment by staff and questions regarding any concerns residents might express. Continued review of the binder revealed all residents with a BIMS < 8 received a skin assessment by 08/20/16 per the Unit Managers. No concerns were identified through questioning or assessments. 3. Interview with the Administrator, on 08/25/16 at 2:50 PM, revealed the Corporate Consultant reviewed all Incident/Accident Reports and Nursing Progress Notes for the past thirty (30) days and did not find anything that had gone unreported. 4. Five (5) personnel files were reviewed, with appropriate and timely background checks in place and evidence of training documented. 5. Four (4) resident care plans and nurse aide care plans were reviewed and interventions compared to the latest MDS Assessments, with all four (4) showing consistency related to required resident care and transfer assistance required.

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	185277	A. BUILDING _____ B. WING _____	**08/25/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE AT HERITAGE HALL REHAB & WELL	**331 SOUTH MAIN STREET LAWRENCEBURG, KY 40342**

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 5) 6. Sign in sheets and copies of certified letters were reviewed and compared to employee listings, with all employees accounted for. Additionally, interviews with SRNA #1 on 08/24/16 at 1:03 PM, SRNA #2 on 08/24/16 at 1:17 PM, SRNA #3 on 08/24/16 at 1:28 PM, LPN #1 on 08/24/16 at 2:12 PM, LPN #2 on 08/25/16 at 7:43 AM, SRNA #5 on 08/25/16 at 8:13 AM, LPN #3 on 08/25/16 at 8:29 AM, SRNA #6 on 08/25/16 at 8:53 AM, SRNA #7 on 08/25/16 at 9:08 AM, RN #1 on 08/25/16 at 9:49 AM, RN #2 on 08/25/16 at 10:09 AM, SRNA #8 on 08/25/16 at 10:29 AM, SRNA #9 on 08/25/16 at 10:47 AM, LPN #4 on 08/25/16 at 1:14 PM, Quality of Life Director on 08/25/16 at 1:22 PM, Housekeeping #1 on 08/25/16 at 1:30 PM, LPN #5 on 08/25/16 at 1:34 PM, RN #3 on 08/25/16 at 1:41 PM, LPN #6 on 08/25/16 at 1:48 PM, Dietary #1 on 08/25/16 at 1:53 PM, and the Social Services Director on 08/25/16 at 2:01 PM revealed all had received the mandatory inservice training on following the care plan; incidents and accidents; falls and importance of reporting; the use of gait belts; mechanical lifts; and lift policy. Several SRNA's revealed they had been observed by the DON, sometimes daily, providing resident care according to the care plan and using gait belts and mechanical lifts. Interview with the Administrator, on 08/25/16 at 2:50 PM, revealed any staff who was not re-educated by 08/22/16 would not be allowed to return to work until they had received the required education. 7. On 08/25/16 the State Survey Agency Representative observed use of the hoyer lift by SRNAs with Resident #3 being transferred from bed to wheelchair at 9:35 AM; and use of the hoyer lift by two (2) different SRNA's with Resident #4 being transferred from wheelchair to bed at 10:54 AM. No concerns were noted during observations, and later review of resident Comprehensive Care Plans confirmed care was provided accordingly. Additionally, audit logs were reviewed from 08/21/16 through 08/25/16 of staff care delivery with no concerns identified. Competency checklists for use of the gait belt; transferring to wheelchair; and full body lift bed to wheelchair were reviewed for all SRNAs, dated 08/20/16 through 08/22/16. 8. Audit logs were reviewed of ten (10) charts audited daily by the DON from 08/22/16 through 08/25/16 to ensure care plans reflected resident assessments and Nurse Aide Care Plan interventions matched Care Plans. Interview with the Administrator, on 08/25/16 at 2:50 PM, revealed there had been no inconsistencies or concerns identified so far during chart audits. 9. Skin assessment results were reviewed, and five (5) skin assessments were conducted each day beginning 8/21/16, with no concerns identified. 10. Interview with the Administrator, on 08/25/16 at 2:50 PM, revealed a QA plan was presented and reviewed during a QA meeting on 08/20/16, and reviewed during a second QA meeting on 08/22/16. Interview revealed QA meetings would continue to be scheduled each week to monitor progress, and to determine the continuing frequency of ongoing audits. Continued interview with the Administrator, revealed corporate oversight would be provided three (3) times a week by the Signature Clinical Consultant and/or the Regional Vice President.