

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>445190</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>05/16/2018</b>
NAME OF PROVIDER OF SUPPLIER <b>CAMBRIDGE HOUSE, THE</b>		STREET ADDRESS, CITY, STATE, ZIP <b>250 BELLEBROOK RD BRISTOL, TN 37620</b>	
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 <b>F 0656</b>	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
<p><b>Level of harm - Actual harm</b></p> <p><b>Residents Affected - Few</b></p>	<p><b>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</b></p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** &gt;</b></p> <p>Based on facility policy review, medical record review, review of the facility's investigation, observation, and interview, the facility failed to implement the care plan for appropriate use of the mechanical lift for transfers for 1 resident (#18) resulting in Harm, and failed to develop comprehensive care plans for the use of oxygen for 2 residents (#6, #71) of 21 sampled residents.</p> <p>The findings included:</p> <p>Review of the facility policy, Safe Lifting and Movement of Residents, revised (MONTH) (YEAR), revealed, .In order to protect the safety and well-being of .residents .this facility uses appropriate techniques and devices to lift and move residents .Resident safety .will be incorporated into goals and decisions regarding the safe lifting and moving of residents .Nursing staff .shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan. Such assessment shall include .Resident's mobility (degree of dependency) .All equipment design and use will meet or exceed guidelines and regulations concerning resident safety .Safe lifting and movement of residents is part of an overall facility employee health and safety program .</p> <p>Review of the facility policy, Fall Prevention Program, dated (MONTH) 2001, revealed, .It is the policy of this facility to identify residents at risk for falls, develop plans of care that address the risk and implement procedures to assist in preventing falls .Maintain equipment and assistive devices in safe working order .</p> <p>Medical record review revealed Resident #18 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].</p> <p>Medical record review of the Annual Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #18 was cognitively intact. Further review revealed Resident #18 was totally dependent on 2 or more person physical assist for bed mobility, and transfers, and had impaired mobility in upper and lower extremities.</p> <p>Medical record review of Resident #18's comprehensive care plan dated 2/28/18 revealed, .potential for falls r/t (related to) dependent on staff for transfers via mechanical lift and 4 person assist . Further review revealed, .transfer (Resident #18) via mechanical lift and 4 person assist .</p> <p>Medical record review of the Physician Recapitulation Orders dated 5/1/18 - 5/31/18 revealed, .Mech (mechanical) lift for transfers .</p> <p>Medical record review of the Nurse's Notes dated 5/2/18 at 5:00 AM revealed, .called to room by CNA (Certified Nurse Aide #1). Rsd (resident) in floor .(No) injuries voiced. Rsd (resident) lowered to floor by CNA .assessed .assisted back to bed .</p> <p>Medical record review of the Nurse's Notes dated 5/2/18 at 11:30 AM revealed, .NP (Nurse Practitioner) saw resident r/t (related to) .(increased) pain. New order .(right) ankle xray .</p> <p>Medical record review of the Radiology Interpretation dated 5/2/18, revealed, .Impression: Acute bony avulsion (when a tendon or ligament comes away from the bone often pulling a small piece of bone with it) to the medial malleolus (the round bony prominence on inner side of the ankle joint) .</p> <p>Medical record review of the Physician's Telephone Orders dated 5/2/18 at 4:20 PM revealed, .send to (named hospital) ER (emergency room ) for eval (evaluation) (and) tx (treat) for (right) ankle X-Ray .</p> <p>Medical record review of the Radiology Report of the X-Ray of the Right Ankle - 3 View, performed at the Emergency Department on 5/2/18 revealed, .lucency (technical term for an area that lets X-rays through the tissue and as a result appears darker on the picture) noted through the posterior aspect of the calcaneus (heel bone) on lateral projection raising the possibility of fracture .Impression: Questionable calcaneal (heel bone) fracture .</p> <p>Medical record review of the Emergency Department Physician's Report dated 5/2/18 revealed, .patient is a [AGE] year-old female who presents with right foot and ankle pain. Patient is non-ambulatory, had a fall while being transferred (at) the nursing home. Patient has swelling noted to her foot, diffuse (spread over a wide area) dorsal (upper side) tenderness, and lateral malleolus (bony prominence on the outside of the ankle) tenderness. X-rays today show evidence of definitive acute fracture. Patient will be placed [MEDICATION NAME] in a boot, she is given instructions follow up close with her primary care physician. She will be discharge with strict return precautions for worsening symptoms or other concerns .</p> <p>Medical record review of the Nurse's Notes dated 5/2/18 at 11:15 PM revealed, .returned from ER (emergency room ) .(No) new orders ntd (noted). MD (Medical Doctor) to see Rsd (resident) in 2 days. Rsd (Resident) (with) brace on to wore ( be worn) 6 weeks .</p> <p>Medical record review of the Nurse Practitioner Progress Note dated 5/2/18 revealed, .(right) ankle avulsion fx (fracture) s/p (status [REDACTED]).(with) orthoboot .</p> <p>Review of the facility investigation dated 5/2/18 revealed at approximately 5:00 AM on 5/2/18 Certified Nursing Aide (CNA) #1 was transferring Resident #18 with a mechanical lift. Further review revealed during transfer the left rear wheel .locked up . and the lift tilted forward. Continued review revealed CNA #1 was unable to return the lift to an upright position and Resident #18 was lowered to the floor. Further review revealed as the day progressed Resident #18 complained of pain and at that time an X-ray was performed of the resident's right ankle which showed an avulsion fracture.</p> <p>Interview with Resident #18 on 5/14/18 at 12:15 PM, and again at 4:09 PM, in the resident's room, confirmed on the day of the incident (5/2/18) only 1 staff member (CNA #1) assisted with the transfer using the mechanical lift, and since the fall it has been 4 staff members every time. Continued interview revealed prior to the fall, it was usually 1 person.</p> <p>Interview with the Director of Nursing (DON) on 5/14/18 at 3:57 PM, in the DON's office revealed Resident #18's care plan, dated 2/28/18, was accurate, and Resident #18 required assistance of 4 staff for transfers with the mechanical lift. Further interview confirmed at the time of the fall on 5/2/18 the facility failed to follow Resident #18's care plan for transferring the resident using the mechanical lift and assistance of 4 persons.</p> <p>Interview with the Medical Director on 5/15/18 at 9:59 AM, in the conference room, confirmed his expectation was for staff to follow the plan of care while providing care to all residents, and the facility's failure to follow the plan of care while transferring Resident #18 with a mechanical lift resulted in an ankle fracture (actual physical harm.)</p> <p>Interview with CNA #1 via phone on 5/15/18, at 4:40 PM, confirmed she was aware Resident #18 required 4 staff for transfers but stated the rest of the staff was really busy. Continued interview confirmed she knew now not to transfer her alone and received training following the incident.</p> <p>Review of a facility policy, Care Plans, Comprehensive Person - Centered, revised (MONTH) (YEAR), revealed .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented .Describe the services that are to be furnished to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being .</p>		
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 0656  <b>Level of harm - Actual harm</b>  <b>Residents Affected - Few</b>	<p>(continued... from page 1) Review of a facility policy, Oxygen Administration, revised (MONTH) 2010, revealed .Review the care plan to assess for any special needs of the resident . Medical record review revealed Resident #6 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Medical record review of a Quarterly MDS dated [DATE] revealed Resident #6 received oxygen therapy. Medical record review of a Physician's Recapitulation Orders dated 5/1/18 - 5/31/18, revealed .O2 (oxygen) @ (at) 2 lpm (liters per minute) to keep O2 Sats (saturation - amount of oxygen in bloodstream) 90% (percent) or above .Change humidifier bottle every month and PRN (as needed) . Medical record review of Resident #6's care plan dated 11/13/17 revealed no documentation indicating Resident #6 received oxygen. Observation of Resident #6 on 5/15/18 at 12:30 PM, in the resident's room, revealed the resident with oxygen applied via nasal cannula (a device used to deliver oxygen through the nares of the nose). Interview with the MDS Coordinator on 5/16/18 at 1:20 PM in the MDS office confirmed the care plan had not been individualized to address the resident's O2 therapy. Medical record review revealed Resident #71 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Medical record review of the Quarterly MDS dated [DATE] revealed, a Brief Interview for Mental Status (BIMS) score of 9 indicating the resident's cognition was moderately impaired. Further review revealed the resident received oxygen therapy, and experienced shortness of breath or trouble breathing with exertion. Medical record review of Resident #71's care plan dated 2/7/18 revealed no documentation indicating Resident #71 received oxygen. Medical record review of the Physician's Recapitulation Orders dated 5/1/18 - 5/31/18 revealed .O2 (oxygen) @ 6 lpm VIA (by) NC (nasal cannula) CONT (continuous) .Check O2 sats every shift and PRN (as needed) .Change humidifier every month and PRN . Medical record review of the weekly nurse's note dated 5/4/18 revealed, .O2 .3 L/min . Continued review of the nurse's note dated 5/5/18 revealed, .O2 .3L/min .continuous . Multiple observations of Resident #71 on 5/15/18 from 8:50 AM to 1:34 PM, in the resident's room, revealed the resident lying in bed with the O2 concentrator and nasal cannula at the bedside, not in use. Interview with the MDS coordinator on 5/16/18 at 1:29 PM, in the MDS office, confirmed the facility failed to develop a comprehensive care plan for the use of oxygen for Resident #71.</p>		
F 0689  <b>Level of harm - Actual harm</b>  <b>Residents Affected - Few</b>	<p><b>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</b> <b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** &gt;</b> Based on facility policy review, review of the manufacturer's mechanical lift operation manual, medical record review, review of the facility investigation, observation and interview, the facility failed to implement interventions for safe transfers with an assistive device to prevent accidents for 1 resident (Resident #18) of 3 residents reviewed for accidents. The facility's failure resulted in actual physical harm for Resident #18. The findings included: Review of the facility policy, Safe Lifting and Movement of Residents, revised (MONTH) (YEAR), revealed, .In order to protect the safety and well-being of .residents .this facility uses appropriate techniques and devices to lift and move residents .Nursing safety .will be incorporated into goals and decisions regarding the safe lifting and moving of residents .Nursing staff .shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan. Such assessment shall include .Resident's mobility (degree of dependency) .All equipment design and use will meet or exceed guidelines and regulations concerning resident safety .Safe lifting and movement of residents is part of an overall facility employee health and safety program . Review of the facility policy, Fall Prevention Program, dated (MONTH) 2001, revealed, .It is the policy of this facility to identify residents at risk for falls, develop plans of care that address the risk and implement procedures to assist in preventing falls .Maintain equipment and assistive devices in safe working order . Review of the manufacturer's mechanical lift operation manual, not dated, revealed, .before each patient transfer, it is important for staff to inspect the (named mechanical lift) to make sure no parts are missing or overly worn and that all parts work correctly .Transport Procedure .the required number of staff members must be present .certain patients or situation require the help of one or more additional staff members .The presence of more than one staff member increases safety .additional staff to hold onto sling handles .prevents the patient from swaying thereby decreasing the possibility of tipping the (named mechanical lift) .transporting patients in a (named mechanical lift) .requires at least two staff members . Medical record review revealed Resident #18 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Medical record review of the Annual Minimum Data Set ((MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #18 was cognitively intact. Further review revealed Resident #18 was totally dependent on 2 or more person physical assist for bed mobility, and transfers, and had impaired mobility in upper and lower extremities. Medical record review of Resident #18's comprehensive care plan dated 2/28/18 revealed, .potential for falls r/t (related to) dependent on staff for transfers via mechanical lift and 4 person assist . Further review revealed, .transfer (Resident #18) via mechanical lift and 4 person assist . Medical record review of the Physician Recapitulation Orders dated 5/1/18 - 5/31/18 revealed, .Mech (mechanical) lift for transfers . Medical record review of the Nurse's Notes dated 5/2/18 at 5:00 AM revealed, .called to room by CNA (Certified Nurse Aide #1). Rsd (resident) in floor .(No) injuries voiced. Rsd (resident) lowered to floor by CNA .assessed .assisted back to bed . Medical record review of the Nurse's Notes dated 5/2/18 at 11:30 AM revealed, .NP (Nurse Practitioner) saw resident r/t (related to) .(increased) pain. New order .(right) ankle xray . Medical record review of the Radiology Interpretation dated 5/2/18, revealed, .Impression: Acute bony avulsion (when a tendon or ligament comes away from the bone often pulling a small piece of bone with it) to the medial malleolus (the round bony prominence on inner side of the ankle joint) . Medical record review of the Nurse's Notes dated 5/2/18 at 4:20 PM, revealed, .Received X-Ray. Call placed to N.P. (Nurse Practitioner). New order received . Medical record review of the Physician's Telephone Orders dated 5/2/18 at 4:20 PM revealed, .send to (named hospital) ER (emergency room ) for eval (evaluation) (and) tx (treat) for (right) ankle X-Ray . Medical record review of the Radiology Report of the X-Ray of the Right Ankle - 3 View, performed at the Emergency Department on 5/2/18 revealed, .lucency (technical term for an area that lets X-rays through the tissue and as a result appears darker on the picture) noted through the posterior aspect of the calcaneus (heel bone) on lateral projection raising the possibility of fracture .Impression: Questionable calcaneal (heel bone) fracture . Medical record review of the Emergency Department Physician's Report dated 5/2/18 revealed, .patient is a [AGE] year-old female who presents with right foot and ankle pain. Patient is non-ambulatory, had a fall while being transferred (at) the nursing home. Patient has swelling noted to her foot, diffuse (spread over a wide area) dorsal (upper side) tenderness, and lateral malleolus (bony prominence on the outside of the ankle) tenderness. X-rays today show evidence of definitive acute fracture. Patient will be placed [MEDICATION NAME] in a boot, she is given instructions follow up close with her primary care physician. She will be discharge with strict return precautions for worsening symptoms or other concerns . Medical record review of the Nurse's Notes dated 5/2/18 at 11:15 PM revealed, .returned from ER (emergency room ) .(No) new orders ntd (noted). MD (Medical Doctor) to see Rsd (resident) in 2 days. Rsd (Resident) (with) brace on to wore ( be worn) 6 weeks . Medical record review of the Nurse Practitioner Progress Note dated 5/2/18 revealed, .(right) ankle avulsion fx (fracture) s/p (status [REDACTED]).(with) orthoboot . Review of the facility investigation dated 5/2/18 revealed at approximately 5:00 AM on 5/2/18 CNA #1 was transferring Resident #18 with a mechanical lift. Further review revealed during transfer the left rear wheel .locked up . and the lift tilted forward. Continued review revealed CNA #1 was unable to return the lift to an upright position and Resident #18 was</p>		

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F 0689  <b>Level of harm - Actual harm</b>  <b>Residents Affected - Few</b>	<p>(continued... from page 2)</p> <p>lowered to the floor. Further review revealed as the day progressed Resident #18 complained of increase pain and at that time an X-ray was performed of the resident's right ankle which showed an avulsion fracture.</p> <p>Interview with Resident #18 on 5/14/18 at 12:15 PM, in the resident's room, confirmed on the day of the incident (5/2/18) only 1 staff member (CNA #1) assisted with the transfer using the mechanical lift.</p> <p>Interview with the Director of Nursing (DON) on 5/14/18 at 3:57 PM, in the DON's office revealed Resident #18's care plan, dated 2/28/18, was accurate, and Resident #18 required assistance of 4 staff for transfers with the mechanical lift.</p> <p>Further interview confirmed at the time of the fall on 5/2/18 the facility failed to follow Resident #18's care plan for transferring the resident using the mechanical lift and assistance of 4 persons.</p> <p>Interview with the Medical Director on 5/15/18 at 9:59 AM, in the conference room, confirmed his expectation was for staff to follow the plan of care while providing care to all residents, and the facility's failure to follow the plan of care while transferring Resident #18 with a mechanical lift resulted in an ankle fracture (actual physical harm.)</p> <p>Interview with CNA #1 via phone on 5/15/18, at 4:40 PM, confirmed she was aware Resident #18 required 4 staff for transfers but stated the rest of the staff was really busy. Continued interview confirmed she knew now not to transfer her alone and received training following the incident.</p> <p>Interview with CNA #1 via phone on 5/16/18 at 7:27 AM, confirmed she had not completed a competency with return demonstration on the proper use of transferring residents with a mechanical lift.</p>		
F 0726  <b>Level of harm - Actual harm</b>  <b>Residents Affected - Few</b>	<p><b>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</b></p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** &gt;</b></p> <p>Based on review of facility policy, review of the manufacturer's mechanical lift operation manual, review of employee education files, and interview the facility failed to ensure nursing staff were competent in the proper use and technique for transferring residents with a mechanical lift which resulted in a fall with injury for 1 resident (#18) causing actual physical Harm for Resident #18.</p> <p>The findings included:</p> <p>Review of the facility policy, Safe Lifting and Movement of Residents, dated (MONTH) (YEAR), revealed, .In order to protect the safety and well-being of staff and residents, and to promote quality of care, this facility uses appropriate techniques and devices to lift and move residents .resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents .staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices .only staff with documented training on the safe use and care of the machines and equipment used in this facility will be allowed to lift or move residents .staff will be observed for competency in using mechanical lifts and observed periodically for adherence to policies and procedures regarding use of equipment and safe lifting techniques .</p> <p>Review of the manufacturer's mechanical lift operation manual, not dated, revealed, .Before using the (named mechanical lift) to transfer patients, all staff must be trained and authorized to use the (named mechanical lift) .Only staff members who have been trained according to the procedures in this manual, by a manufacturer's representative or by a nurse or professional rehabilitation staff member designated as your facility's mechanical lift trainer, may be allowed to use the (named mechanical lift) .</p> <p>Review of the facility's policy, Staff Training/Education and Competencies, not dated, revealed, .During new hire orientation, all employees are educated on .General Safety Precautions, Accident Prevention and Safety Awareness .Fall Prevention Program .Safe Lifting Techniques .During orientation on the floor, licensed nurses and certified nursing assistants complete a checklist of various skills that is required to perform their job description .</p> <p>Review of Registered Nurse (RN) Unit Manager #1's employee education file revealed a hire date of 3/7/18 (2 months) with no documentation RN Unit Manager #1 had completed a competency on the proper use and technique on transferring a resident with a mechanical lift.</p> <p>Review of RN Unit Manager #2's employee education file revealed a hire date of 11/7/03 ([AGE] years) with no documentation RN Unit Manager #2 had completed a competency on the proper use and technique on transferring a resident with a mechanical lift.</p> <p>Review of Licensed Practical Nurse (LPN) #1's employee education file revealed a hire date of 4/9/90 ([AGE] years) with no documentation LPN #1 had completed a competency on the proper use and technique on transferring a resident with a mechanical lift.</p> <p>Review of LPN #2's employee education file revealed a hire date of 9/12/06 ([AGE] years) with no documentation LPN #2 had completed a competency on the proper use and technique on transferring a resident with a mechanical lift.</p> <p>Review of LPN #4's employee education file revealed a hire date of 12/4/96 ([AGE] years) with no documentation LPN #4 had completed a competency on the proper use and technique on transferring a resident with a mechanical lift.</p> <p>Review of LPN #5's employee education file revealed a hire date of 11/14/00 ([AGE] years) with no documentation LPN #5 had completed a competency on the proper use and technique on transferring a resident with a mechanical lift.</p> <p>Review of Certified Nurse Aide (CNA) #1's employee education file revealed a hire date of 12/7/09 (9 years) with no documentation CNA #1 had completed a competency on the proper use and technique on transferring a resident with a mechanical lift.</p> <p>Review of CNA #2's employee education file revealed a hire date of 2/16/18 (3 months) with no documentation CNA #2 had completed a competency on the proper use and technique on transferring a resident with a mechanical lift.</p> <p>Review of CNA #3's employee education file revealed a hire date of 6/5/14 (4 years) with no documentation CNA #3 had completed a competency on the proper use and technique on transferring a resident with a mechanical lift.</p> <p>Review of CNA #4's employee education file revealed a hire date of 3/21/17 (1 year) with no documentation CNA #4 had completed a competency on the proper use and technique on transferring a resident with a mechanical lift.</p> <p>Review of CNA #5's employee education file revealed a hire date of 2/12/16 (2 years) with no documentation CNA #5 had completed a competency on the proper use and technique on transferring a resident with a mechanical lift.</p> <p>Review of CNA #6's employee education file revealed a hire date of 4/16/10 (8 years) with no documentation CNA #6 had completed a competency on the proper use and technique on transferring a resident with a mechanical lift.</p> <p>Review of CNA #7's employee education file revealed a hire date of 11/22/16 (2 years) with no documentation CNA #7 had completed a competency on the proper use and technique on transferring a resident with a mechanical lift.</p> <p>Review of CNA #8's employee education file revealed a hire date of 2/16/18 (3 months) with no documentation CNA #8 had completed a competency on the proper use and technique on transferring a resident with a mechanical lift.</p> <p>Review of CNA #9's employee education file revealed a hire date of 7/12/93 ([AGE] years) with no documentation CNA #9 had completed a competency on the proper use and technique on transferring a resident with a mechanical lift.</p> <p>Review of CNA #10's employee education file revealed a hire date of 8/3/12 (6 years) with no documentation CNA #10 had completed a competency on the proper use and technique on transferring a resident with a mechanical lift.</p> <p>Review of CNA #11's employee education file revealed a hire date of 1/14/14 (4 years) with no documentation CNA #11 had completed a competency on the proper use and technique on transferring a resident with a mechanical lift.</p> <p>Interview with the Staff Development Coordinator (SDC) on 5/15/18 at 3:39 PM, in the SDC's office, confirmed competencies on the proper use and technique on transferring a resident with a mechanical lift had not been completed with the facility's nursing staff.</p> <p>Interview with CNA #1 via phone on 5/16/18 at 7:27 AM, confirmed she had not completed a competency with return demonstration on the proper use of transferring residents with a mechanical lift.</p> <p>Interview with RN Unit Manager #1 on 5/16/18 at 7:30 AM, in the 500 hallway, confirmed she had not completed a return demonstration to prove competence on the proper use and technique for the transferring residents with a mechanical lift.</p> <p>Interview with CNA #8 on 5/16/18 at 7:59 AM, in the 400 hallway, confirmed she had not completed a competency on the proper use and technique for transferring residents with a mechanical lift.</p> <p>Interview with CNA #9 on 5/16/18 at 8:02 AM, in the dining room, confirmed she had not completed a competency on the proper use and technique for transferring a resident with a mechanical lift.</p>		

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<p>F 0726</p> <p><b>Level of harm - Actual harm</b></p> <p><b>Residents Affected - Few</b></p>	<p>(continued... from page 3)</p> <p>Interview with CNA #7 on 5/16/18 at 8:05 AM, in the 200 hallway, confirmed she had not completed a demonstration for competency on the proper use and technique of transferring residents with a mechanical lift.</p> <p>Interview with LPN #4 on 5/16/18 at 8:37 AM, in the 100 hallway, confirmed she had not completed a competency demonstration on the proper use and technique for transferring residents with a mechanical lift.</p> <p>Interview with LPN #3 on 5/16/18 at 8:39 AM, in the 100 hallway, confirmed she had not completed a competency with return demonstration on the proper use and technique for transferring residents with a mechanical lift.</p> <p>Interview with CNA #2 on 5/16/18 at 8:40 AM, in the 200 hallway, confirmed she had not completed a demonstration for competence of the proper use and technique for transferring residents with a mechanical lift.</p> <p>Interview with LPN #2 on 5/16/18 at 8:45 AM, at the 200 nurse's station, confirmed she had not completed a competency that includes return demonstration for the proper use and technique for transferring residents with a mechanical lift.</p> <p>Interview with the Director of Nursing (DON) on 5/16/18 at 1:37 PM, in the conference room, confirmed the facility failed to ensure nursing staff had completed competency evaluations in the proper use and technique of transferring residents using a mechanical lift. Further interview confirmed the facility's failure to ensure nursing staff were competent in the proper use and technique of transferring residents using a mechanical lift was a contributing factor that resulted in a fall with injury causing actual physical harm for Resident #18.</p> <p>Refer to F689</p>		