

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

PRINTED: 05/25/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/22/2015
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 151 SS=B	<p>483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL</p> <p>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy review, it was determined the facility failed to ensure residents were given the opportunity to vote in the most recent election, for three (3) of sixteen (16) sampled residents (Residents #1, #9 and #11) and three (3) of five (5) unsampled residents (Unsampled Residents C, D and E).</p> <p>The findings include:</p> <p>Review of the Voting Rights Policy, revised 2006, revealed the facility would help residents expressing a desire to exercise their right to vote achieve that right. The Activity Services Department would help residents with voting registration, obtaining absence ballots and or</p>	F 151		

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

TITLE

(X6) DATE

06/18/2015

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 151	<p>Continued From page 1</p> <p>obtain transportation to the voting sites. All requests for voting information should be directed to the Activity Services Department.</p> <p>1. Interview conducted during Resident Council, on 05/19/15 at 4:20 PM, revealed Resident #11, and Unsampled Residents C, D, and E all voiced they were not aware of the election and would have liked the opportunity to have voted.</p> <p>Interview with the Life Enrichment Assistant (Activity Department), on 05/22/15 at 4:30 PM, revealed the facility normally provided absentee ballots to the residents. The Life Enrichment Assistant, stated she was not aware there was an election, but was aware it was the rights of the residents to be able to vote. The Life Enrichment Assistant stated she normally received information through the mail about the election and she would then request for absentee ballots. She stated no residents had voiced the desire to vote that she was aware.</p> <p>Interview with the Admissions Marketing Director (who currently serves as the interim Activity Director), on 05/22/15 at 4:30 PM, revealed she had been in her position a week and was not aware of any residents who wanted to vote.</p> <p>2. Review of Resident #1's clinical record revealed the facility re-admitted the resident on 08/06/14 with the diagnosis of Hypothyroidism, Hypertension and Polyarthritis.</p> <p>Review of Resident #1's Annual Minimum Data Set (MDS) assessment, completed on 05/11/15 revealed the facility assessed the resident</p>	F 151			

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F 151	<p>Continued From page 2</p> <p>utilizing the Brief Interview of Mental Status (BIMS) as being moderately impaired; BIMS score was ten (10) of fifteen (15).</p> <p>Observation, on 05/19/15 at 3:00 PM, of Resident #1 revealed she/he was in the dining area, seated at a table with peers actively engaged in Bingo.</p> <p>Interview with Resident #1, on 05/20/15 at 11:20 AM, and at 11:50 AM, revealed an interest in the outcome of the recent election, with the resident stating they wondered how that election turned out. Resident #1 stated he/she always voted before living here. He/she expressed the desire to have voted this time provided the opportunity had been offered. Resident #1 stated he/she was not offered the opportunity to vote in the most recent election.</p> <p>3. Review of Resident #9's clinical record revealed the facility re-admitted the resident on 04/04/14 with diagnosis of Depressive Disorder, Anxiety, Mental Disorder and Anemia.</p> <p>Review of Resident #9's Quarterly MDS assessment, completed on 02/16/15 revealed the facility assessed the resident utilizing the BIMS. The facility assessed Resident #9's BIMS score as fourteen (14) of fifteen (15), being cogintively intact.</p> <p>Observation of Resident #9, on 05/19/15 at 4:50 PM, revealed he/she was seated in his/her wheelchair. He/she was inside of Resident #1's door entrance engaged in conversation with Resident #1.</p> <p>Interview with Resident #9, on 05/20/15 at 3:30 PM, revealed he/she had always voted before</p>	F 151			

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F 151	Continued From page 3 moving here. Resident #9 stated he/she had always voted and had not voted since he/she moved here. Interview with the Administrator, on 05/22/15 at 5:26 PM, revealed the Activities Director was responsible to coordinate the voting. The Administrator stated the residents had the right to vote and no residents had voiced any concerns about not being given the opportunity to vote. Further interview with the Administrator, on 05/22/15 at 5:50 PM, revealed she was not aware the residents were not given the opportunity to vote. She stated it was every citizen's right to vote and should have been afforded to each person desiring to do so.	F 151			
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review, it was determined the facility failed to promptly resolve grievances such as complaints for the use of bingo bucks and housekeeping services for one (1) of sixteen (16) sampled residents (Resident #11) and three (3) of five (5) unsampled residents (Unsampled Residents C, D and E). The Findings include:	F 166			

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F 166	Continued From page 4 Review of the Bill of Resident Rights policy, effective 07/01/09, revealed residents have the right to voice grievances with respect to treatment or care that was or failed to be furnished, without discrimination or reprisal for voicing the grievance. The resident has the right to prompt efforts by the center to resolve grievances, including those with respect to the behavior of other residents. Review of the Grievance/Complaint Log Policy, revised August 2008, revealed all disposition of all resident grievances and/or complaints would be recorded on the facility's resident Grievance/Complaint Log. The Administrator or designee would be responsible to record and maintain the log. The following information at a minimum must be recorded: the date the grievance/complaint was recieved; the name of the resident filing the grievance/complaint; the date the alleged incident took place; the date the resident, or interested party was informed of the findings and the disposition of the grievance. Interview conducted during Resident Council, on 05/19/15 at 4:20 PM, revealed Resident #11 and Unsampled Residents C, D, and E all voiced they were allowed to spend their bingo bucks only two (2) times a year and sometimes they were not allowed to recieve their bingo bucks because the computer was down. They stated the Activity Director was aware of their concern, but no information was provided. Further interview with Resident #11, revealed most residents who had won bingo bucks were discharged from the facility before they could utilize their bingo bucks. Resident #11 further stated who wanted to go a full year without utilizing their bingo money.	F 166			

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F 166	Continued From page 5 Interview with the Life Enrichment Assistant, on 05/21/15 at 3:46 PM, revealed when the residents won games, the residents were given the opportunity to win bingo bucks. The residents were suppose to be able to cash the bingo bucks every month, but the last time the bingo bucks were utilized was in December of 2014. The Life Enrichment Assistant stated she had not heard any complaints about the bingo bucks until the bingo activity was finished on 05/21/15. The residents stated they complained to the Activity Director. The Life Enrichment Assistant stated she was not sure what had happened with that complaint. The Life Enrichment Assistant stated when residents were discharged from the facility she would let the residents utilize their bingo bucks by picking out a gift. Interview with the Administrator, on 05/22/15 at 3:15 PM, revealed Bingo Bucks was started by a previous Activity Director to encourage residents to participate. There was no set time to utilize the bingo the bucks. The thought was one (1) time a month or every quarter but nothing consistant. The short term residents were given items by the Activity Director to ensure they could spend their bingo bucks. The Administrator stated no residents had voiced concerns about the bingo bucks and the Activity Director never mentioned it. Interview conducted during Resident Council, on 05/19/15 at 4:20 PM, revealed Residents #11 complained about the floors being dirty and the commodes overflowing. Unsampled Resident E complained the sinks in the bathrooms were dirty and he/she had to request for another housekeeper to clean the room because	F 166			

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F 166	<p>Continued From page 6</p> <p>Housekeeper #1 had not cleaned the room completely. Unsamped Resident E stated the Maintenance Director was notified about Houskeeper #1 not completing the cleaning of his/her room.</p> <p>Interview on 05/21/15 at 3:20 PM with the Life Enrichment Assistant, revealed she had worked at the facility for six (6) years but had been on leave for the last few months. She stated the facility hadn't had the Bingo Bucks store open since December 2014; however, no residents complained to her regarding the store not available.</p> <p>On 05/21/15 at 3:25 PM, while interviewing the Activities Assistant, Unsamped Residents C and D approached and stated they had complained to the former Activities Director about not having the Bingo Bucks store.</p> <p>An interview with the former Activities Director could not be completed as she no longer worked at the facility.</p> <p>Interview with Laundry Staff #1, on 05/22/15 at 4:00 PM, revealed she was aware that Unsamped Resident E had complained to another housekeeper that the housekeeper assigned to clean his/her room on the past Saturday and Monday did not clean the residents room when asked. Laundry Staff #1 stated it was reported to the Maintenance Supervisor.</p> <p>Interview, on 05/22/15 at 4:10 PM, with the Maintenance Supervisor revealed she had received the complaint and went to the</p>	F 166			

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F 166	Continued From page 7 housekeeper and instructed them to clean the room. She stated she had not reported the grievance to the Administration or completed a grievance because she addressed it immediately and it was fixed. She stated if the housekeeper had not cleaned the room she would have reported that to the Administrator. Interview, on 05/22/15 at 5:23 PM, with the Administrator revealed she had not been informed of complaints about Bingo Bucks and Housekeeping. She showed evidence of other grievances she had received with individual forms that were completed with a follow up. She stated she should have been informed, and especially housekeeping, because it was more than one resident. She stated her staff had been trained on the grievance process and it was covered during abuse training. She stated she can't fix what she didn't know about.	F 166			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility failed to promote care for residents in a manner and in an environment that maintained or enhanced each residents dignity and respect as it related to two (2) of sixteen (16) sampled residents. Resident #3 as it related to the signage	F 241			

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F 241	<p>Continued From page 8</p> <p>above the bed stating for the resident to be fed, total care, incontinent, advanced dementia and family does the laundry etc. In addition, Resident #8 had a sign above the bed stating to shave the resident daily and not to lay the resident flat in the bed.</p> <p>The findings include:</p> <p>Review of the Bill of Resident Rights Policy, effective 07/01/09, revealed residents have the right to receive care from the center in a manner and in an environment that promoted, maintained and or enhanced dignity and respect in full recognition of the individual. The resident has the right to choose activities, schedules and health care consistent with the interests, assessments and plans of care and to make choices about aspects of the residents life in the nursing center that were significant to them.</p> <p>1. Record review of Resident #8's record revealed Resident #8 was admitted on 07/01/12 with a diagnosis of Asphasia, Quadriplegia, Spasm of Muscle, Non Psychotic Brain Syndrome and Pain of the Joint. Resident #8's Quarterly Minimum Data Set (MDS) Assessment, completed on 05/05/15, revealed Resident #8's Brief Interview of Mental Status (BIM) score could not be assessed.</p> <p>Observation of Resident #8, on 05/19/15 at 2:33 PM, revealed Resident #8 was lying flat in the bed with facial hair. A sign posted above Resident #8's bed read; Please do not leave head flat and must be shaved everyday.</p> <p>Observation of Resident #8, on 05/20/15 at 7:52 AM, revealed Resident #8 was sitting up in a</p>	F 241			

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F 241	<p>Continued From page 9</p> <p>chair in the television room and again observed with facial hair.</p> <p>Interview with Certified Nursing Assistant (CNA) #8, on 05/22/15 at 4:15 PM, revealed there was a sign above Resident #8's bed to shave daily. CNA #8 stated she worked on the Wednesday of 05/20/15 and observed Resident #8 to have stubble and she did not shave Resident #8.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 05/22/15 at 12:35 PM, revealed she was not aware Resident #8 was to be shaved daily.</p> <p>Interview with LPN #4, on 05/22/15 at 9:00 PM, revealed the sign could be a dignity concern, but he thought it could also be a reminder to the staff to complete this task. LPN #4 stated if the resident was shaved daily, then there would be no need to post care reminders above Resident #8's bed. LPN #4 stated the residents family had not complained about Resident #8 not being shaved.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 05/22/15 at 9:10 PM, revealed if the staff completed shaving daily, the sign would not need to be posted above Resident #8's bed. The family should not have to post a sign above the residents bed to encourage staff to complete their job.</p> <p>2. Review of the medical record for Resident #3, revealed the facility admitted the resident on 12/15/14 with Diagnosis including Dementia without behaviors, Anxiety and Hearing Loss.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment for Resident #3, dated 04/16/15, revealed the facility assessed the</p>	F 241			

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F 241	<p>Continued From page 10</p> <p>residents' cognition using the BIMS assessment. The facility assessed the residents BIMS score of three (3) of fifteen (15), severely cognitively impaired.</p> <p>Observation, on 05/19/15 at 11:30 AM, and on 05/22/15 at 9:15 PM, revealed Resident #3 had a sign posted above the bed that said: Feeder, total care, incontinent, advanced dementia, family does laundry (marked out), spare PJ's (pajamas) in drawer (marked out), matched outfits in the closet, wears glasses, and must speak in right ear.</p> <p>Interview on 05/22/15 at 9:15 PM with Certified Nursing Assistant (CNA) #8, revealed there was a sign over the bed of Resident #3 that explained what the resident's needs were. She stated they did have that information in the daily care guide. She stated she didn't think it was a dignity issue if that was what the family wanted.</p> <p>Interview, on 05/22/15 at 9:25 PM, with Licensed Practical Nurse (LPN) #5 revealed she did not know how long the sign had been over the bed for Resident #3. She stated she believed the resident's wife must have put it there. She stated it could be a Health Insurance Portability and Accountability Act (HIPAA) violation or dignity issue. She stated the sign was well intended but not appropriate, and acknowledged it was not necessary if staff were following the daily care guide.</p> <p>Interview, on 05/22/15 at 9:30 PM, with the Assistant Director of Nursing revealed she was not aware the sign, with the included items listed, was over the bed for Resident #3. She stated Resident #3's wife must have place it there;</p>	F 241			

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F 241	Continued From page 11	F 241			
F 252 SS=E	<p>however, it was a dignity issue and should not be there.</p> <p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, it was determined, the facility failed to ensure four (4) of twenty (20) resident bathrooms were clean and sanitary, (rooms #4, #9, #14, and #28).</p> <p>The findings include:</p> <p>Review of the facility policy Cleaning and Disinfection Residents' Rooms, revised August 2011, revealed housekeeping surfaces will be cleaned on a regular basis. Clean medical waste containers intended for reuse daily or when visually contaminated.</p> <p>Observation, on 05/19/15 during the initial tour, revealed the bathroom in Room #28 smelled of a strong urine odor. There was a brownish substance around the base of the toilet bowl.</p> <p>Observation, on 05/20/15 at 1:36 PM, revealed Room #28's bathroom had a strong odor of urine, with dark debris around the toilet bowl. There was dried brownish black substance on the toilet</p>	F 252			

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F 252	<p>Continued From page 12 seat.</p> <p>Observation, on 05/20/15 at 3:15 PM, revealed Room 28's bathroom continued to have a strong odor of urine with dark debris around the toilet bowl. The dried brownish black substance continued present on the toilet seat.</p> <p>Observation, on 05/21/15 at 9:47 AM, revealed Room #4's bathroom smelled of a strong urine odor.</p> <p>Observation, on 05/22/15 at 9:16 AM, during the environmental tour with the Housekeeping Supervisor, the Maintenance Supervisor and the Administrator, revealed Room #4's bathroom smelled of urine and the toilet was dirty. Room #9's bathroom toilet had a dark ring around the base of the toilet. Room #14's bathroom had a hole in the door and a foul odor was present. Room #28's bathroom appeared visually clean, but had a mild odor of urine present.</p> <p>Interview, on 05/22/15 at 9:16 AM during the environmental tour, with the Housekeeping Manager revealed the facility had replaced all the floors in the bathrooms and some had to be replaced again. He stated they had not gotten to caulk around the toilet bowels. He stated some rooms were to be checked every hour due to high usage of residents in those bathrooms. The Housekeeping Manager stated rooms #4, #19, #22 and #28's bathrooms were checked every hour; however, there was no documentation of the one (1) hour checks. He stated he had two (2) full-time housekeepers and one (1) part-time housekeeper. The housekeepers worked 6:00 AM to 2:30 PM everyday. He stated when housekeeping was not in the building the Certified</p>	F 252			

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F 252	Continued From page 13 Nursing Assistants (CNA's) were to check the bathrooms for cleanliness.	F 252			
F 257 SS=D	<p>Interview, on 05/22/15 at 5:23 PM, with the Administrator revealed there were still some problems with the environment and she believed the Housekeeping Supervisor had changed the hours of the housekeepers to a 7:00 AM to 3:00 PM schedule so they could be there later in the day. She stated after housekeeping left for the day, nursing should have been checking the bathrooms, but not every hour.</p> <p>483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS</p> <p>The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to ensure air temperatures were comfortable for the residents in one (1) of three (3) common areas. The dining room was identified by a resident as too cold for comfort.</p> <p>The findings include:</p> <p>The facility did not provide a policy regarding the air temperatures in the facility. However, an email provided revealed the state regulations were followed, citing 902 KAR 20:046 stating a minimum temperature of seventy-two (72)</p>	F 257			

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F 257	<p>Continued From page 14</p> <p>degrees Fahrenheit (F) shall be provided for in all occupied areas in winter conditions. A maximum temperature of 85 degrees F shall be provided for occupied areas in summer conditions.</p> <p>Review of the facility's Logbook Documentation of Air Temperatures, dated 09/05/14, revealed resident room # 17 was 69 degrees Fahrenheit (F) and resident room #21 was 70 F. The facility documented the room temperature on Heritage Hall in resident room #16, on 01/05/15, as 67 F. Review of the facility's documented air temperature, on 03/24/15, located on Lincoln Lane, in resident room #21 revealed a recorded temperature of 69 F.</p> <p>Observation in the dining room, on 05/20/15 at 7:30 AM, revealed two (2) residents engaged in a conversation. Unsampled Resident B voiced to Unsampled Resident D he/she was cold and stated it was always cold in there.</p> <p>Observation of Resident #6's room, on 05/20/15 at 10:53 AM, revealed the air conditioning unit was set at 68 degrees F. Resident #6 was lying in the bed, dressed in a long sleeved fleece jacket and grey sweat pants. In addition, a fleece blanket was over his/her upper legs.</p> <p>Observation of the Dining Room temperature, on 05/20/15 at 7:35 AM, revealed the dining room temperature during breakfast services was 69 F.</p> <p>Interview with Unsampled Resident B, on 05/20/15 at 7:50 AM, revealed he/she was always cold in the dining area; it was always cold in there. He/she stated a person just freezes to death in there.</p>	F 257			

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F 257	Continued From page 15 Observation of Lincoln Lane, on 05/20/15 at 10:59 AM, revealed the thermostat was set at 70 F. Observation of the thermostat at the end of Lincoln Lane, near the therapy department, on 05/20/15 at 11:00 AM, revealed the mark for the temperature reading was between 65 and 70 F. The Director of Nursing was unavailable for interview. She was out of the country during the survey process. Interview with the Maintenance Director, on 05/20/15 at 4:40 PM, revealed she had worked here for nine (9) years, was in this position since December, 2014 and did not know what the room temperatures were supposed to be. She reported she was not aware of the locked box in the dining room. The Maintenance Director stated each hall had a thermostat located mid-way down the hall and one was across from the dining room. Interview with the Administrator, on 05/22/15 at 5:00 PM, revealed she was not aware of the acceptable temperature range for the facility. She stated she was not aware of anyone complaining of being cold, nor what the temperatures in the facility were.	F 257			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facilities Corporate Standards of Practice, it	F 281			

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F 281	<p>Continued From page 16</p> <p>was determined the facility failed to apply barrier cream with proper technique for one (1) of sixteen (16) sampled residents (Resident #3).</p> <p>The findings include:</p> <p>Review of facility's Corporate Standards of Practice, undated, revealed when applying topical barrier cream, smear it evenly over the skin and apply front to back.</p> <p>Review of the medical record for Resident #3 revealed the facility admitted the resident on 12/15/14 with Diagnosis including Dementia without behaviors, Anxiety and Hearing Loss.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment for Resident #3, dated 04/16/15, revealed the facility assessed the resident's cognition using the Brief Interview for Mental Status (BIMS) assessment. The facility assessed the resident's BIMS score of three (3) of fifteen (15), severely cognitively impaired. The facility assessed the resident's bowel and bladder as always incontinent.</p> <p>Review of the Comprehensive Care Plan for Resident #3 revealed the facility developed a care plan on 01/26/15 for Potential for impaired skin. Interventions included incontinent care as needed and barrier cream as indicated.</p> <p>Observation, on 05/21/15 at 1:15 PM, revealed Certified Nursing Assistant (CNA) #2 applied barrier cream for Resident #3, after incontinent care, on the buttocks area then went on to apply the cream to the genital area.</p> <p>Interview, on 05/22/15 at 12:27 PM, with CNA #2</p>	F 281			

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F 281	Continued From page 17 revealed she acknowledged she should have applied the barrier cream to the genital area first then to the buttocks area. She stated there was a potential for cross contamination for the resident. Interview, on 05/22/15 at 12:33 PM, with Licensed Practical Nurse (LPN) #2 revealed she observed CNA #2's improper application of the barrier cream for Resident #3 when she went from the back to the front, but didn't think she was allowed to stop the CNA. She stated the risk to the resident was contamination. Interview, on 05/22/15 at 3:30 PM, with the Assistant Director of Nursing (ADON) revealed she was the infection control nurse. She stated the last training on Peri Care included application of barrier creams. She stated staff were trained to wash and apply creams to the peri area from front to back. She stated the risk to the resident was the spread of infection due to infection control breaches.	F 281			
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to follow the care plans for seven (7) of sixteen (16) sampled residents. Residents #1, #6, #7, #8, #9, #12 and #13 were not followed in relationship	F 282			

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F 282	<p>Continued From page 18</p> <p>with the falls. Resident #7's care plan was not followed pertaining to isolation precautions. In addition, Resident #8's care plan was not followed for hygiene needs.</p> <p>The findings include:</p> <p>Review of the facility's care plan policy titled, "Care Plan Policy Statement", not dated, revealed an individual comprehensive care plan that included measurable objectives and time tables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Any licensed nurse or interdisciplinary team member can update the care plan to reflect changes. The comprehensive care plan is based on a through assessment that included, but not limited to the Minimum Data Set (MDS). Each resident's comprehensive care plan was designed to incorporate identified problem areas and associated risk factors, build on the resident's strengths, reflect the resident's expressed wishes regarding care and treatment goals, aid in preventing or reducing declines in the resident's functional status or functional levels. Reflect currently recognized standards of practice for problems areas and conditions. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change.</p> <p>1. Review of Resident #1's clinical record revealed the facility re-admitted the resident on 08/06/14 with the diagnosis of Hypothyroidism, Hypertension and Polyarthritis.</p> <p>Review of Resident #1's Annual Minimum Data Set (MDS) assessment, completed on 05/11/15</p>	F 282			

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F 282	<p>Continued From page 19</p> <p>revealed the facility assessed the resident utilizing the Brief Interview of Mental Status (BIMS) as being moderately impaired; BIMS score was ten (10) of fifteen (15).</p> <p>Review of the Comprehensive Care Plan for Resident #1, revealed the facility developed a care plan dated 01/11/15, for potential for falls related to impaired mobility, strength, balance and endurance related Degenerative Joint Disease, Hypertension. The interventions included: Physical and Occupational therapy to continue treating, keep the call light within reach with reminders for use, identify where the call light is before leaving the resident's room, monitor for potential hazards in the environment, and assist resident to wear soled shoes when out of bed. In addition, the Treatment Sheet, dated May/2015, included the chair alarm to the recliner with staff initials for a 7AM-7 PM and 7 PM-7AM each day was initiated on 05/05/15 during the 7 PM-7 AM shift.</p> <p>Record review of Resident #1's Activities of Daily Living Plan (ADL) of Care (in the Accu-Nurse system, which was the facilities computer system), print date 05/20/15, revealed Resident #1 was not checked for test and reapply bed or chair alarm.</p> <p>Observation, on 05/20/15 at 7:30 AM, of Resident #1 revealed she/he was initatially seated in his/her recliner with feet elevated. When he/she proceeded to rise from the recliner and ambulate independently to the closet area. The alarm did not sound once the resident arose from the recliner.</p> <p>Interview with Resident #1, on 05/20/15 at 8:07</p>	F 282			

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F 282	<p>Continued From page 20</p> <p>AM, revealed he/she did not like the beeping of the alarm when he/she gets out of the chair (recliner). He/she reported the beeping of the alarm makes me nervous.</p> <p>2. Review of Resident #6's clinical record revealed the facility re-admitted the resident on 07/01/12 with the diagnosis of Osteoporosis, Anxiety State, Dementia with Behavior Disturbances, Iron Deficiency Anemia, Hypothyroidism, Osteoporosis, Syncope and Collapse.</p> <p>Review of the Physician Orders for a Chair Alarm, dated 01/01/15, for Resident #6 revealed an updated order for a sensor alarm to the bed and wheelchair related to an increased fall risk.</p> <p>Review of Resident #6's Quarterly MDS assessment, completed on 04/27/15 revealed the facility assessed the resident utilizing the BIMS. The facility assessed Resident #6's BIMS score as four (4) of fifteen (15), being severely impaired cognitively.</p> <p>Review of the Comprehensive Care Plan for Resident #6, revealed the facility developed a care plan for the high possibility of falls, on 02/09/15, with updated goals and target dates for 05/09/15 potential for falls. The resident had several falls in recent months without injury. Resident #6 has impaired safety awareness related to Dementia. The interventions included: Ensure a safe environment, free of clutter, adequate lighting. Non-skid socks and/or well fitting shoes when out of the bed. Also, keep call light with in reach when in bed with cues and reminders for use. In addition, the facility developed a care plan for the resident unable to</p>	F 282			

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F 282	<p>Continued From page 21</p> <p>meet his/her own ADL/self-care needs, related to cognitive deficits and left sided weakness (Transient Ischemia Attacks (TIA)), on 02/11/15, with updated goals and target dates for 08/11/15. The interventions included: provided oversight for bed mobility, transfers and ambulation. Monitor the need for physical assistance and for assistance with wheelchair for any trips on or off the unit.</p> <p>Review of the AccuNurse, Activities of Daily Living (ADL) Plan of Care-Transfers for Resident #6, print dated 05/22/15, revealed monitoring of the alarms, included test and reapply bed or chair alarm; however, the facility did not provide documentation of any alarm monitoring.</p> <p>Observation of Resident #6, on 05/19/15 at 12:35 PM, revealed the resident was seated in a wheelchair at a table in the dining area with an alarm attached to the back of the wheelchair.</p> <p>Observation of Resident #6, on 05/19/15 at 1:40 PM, revealed the resident laid in his/her bed. The resident was laid on his/her right side, facing the window. The window blind was closed. An alarm was in place and attached to the bed.</p> <p>Observation of Resident #6, on 05/20/15 at 7:30 AM and at 7:40 AM, revealed the resident was seated in his/her wheelchair at the table in the main dining area. The wheelchair had an alarm attached to the back of the wheelchair.</p> <p>An unsuccessful interview was attempted with Resident #6, on 05/20/15 at 10:15 AM.</p> <p>3. Review of Resident #9's clinical record revealed the facility re-admitted the resident on</p>	F 282			

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F 282	<p>Continued From page 22</p> <p>04/04/14 with diagnosis of Depressive Disorder, Anxiety, Mental Disorder and Anemia.</p> <p>Review of the nursing notes, dated 01/16/15 at 1:59 AM, revealed Resident #9 has bed and chair sensor alarms which he/she was non-compliant with and turns off the alarms him/herself.</p> <p>Review of the Comprehensive Care Plan for Resident #9, revealed the facility developed a care plan for the high possibility of falls, on 02/16/15, with updated goals and target dates for 08/13/15 potential for injury related to impaired mobility, strength, balance and endurance, confusion secondary to Dementia. He/she has had recurring attempts to self transfer and has had multiple falls since admission. The interventions included: Bed and chair alarms in place and to check frequently to make sure they are working. Chair alarm to increase safety awareness.</p> <p>Review of the Resident Incident for Resident #9, dated 01/15/15 at 10:46 PM, revealed the resident was found in the floor at the foot of the bed. The incident report revealed the resident was awake in a confused state concerned the television on the wall was falling. The post-incident report stated the resident had bed and chair sensor alarms. In addition, the report stated the resident was non-compliant all day turning the alarms off. There was no report of injury.</p> <p>Review of the Physician Orders for a Chair Alarm, dated 02/09/15, for Resident #9 revealed the chair alarm was to increase safety awareness. The facility was to check functioning and placement every shift.</p>	F 282			

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F 282	<p>Continued From page 23</p> <p>Review of Resident #9's Quarterly MDS assessment, completed on 02/16/15 revealed the facility assessed the resident utilizing the BIMS. The facility assessed the Resident #9's BIMS score as fourteen (14) of fifteen (15), being cognitively intact.</p> <p>Observation of Resident #9, on 05/19/15 at 11:48 AM, revealed he/she was seated in his/her wheelchair in the hallway near the resident's room. An alarm was attached to the back of his/her wheelchair.</p> <p>Observation of Resident #9, on 05/19/15 at 4:50 PM, revealed he/she was seated in his/her wheelchair. He/she was inside of Resident #1's door entrance engaged in conversation with Resident #1. An alarm was attached to the back of his/her wheelchair.</p> <p>Review of the AccuNurse, Activities of Daily Living (ADL) Plan of Care-Transfers for Resident #9, print dated 05/22/15, revealed monitoring of the alarms, included test and reapply bed or chair alarm; however, the facility did not provide documentation of any alarm monitoring.</p> <p>4. Review of Resident #13's clinical record revealed the facility re-admitted the resident on 03/25/13 with diagnosis of Symbolic Dysfunction, Muscle Weakness, Congestive Heart Failure, Atrial Fibrillation, Hypertension, Anxiety State, Dysphagia, Oropharyngeal and Mild Cognitive Impairment.</p> <p>Review of Resident #13's Quarterly MDS assessment, completed on 04/21/15 revealed the facility assessed the resident utilizing the BIMS.</p>	F 282			

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F 282	<p>Continued From page 24</p> <p>The facility assessed Resident #13's BIMS score as thirteen (13) of fifteen (15), being cognitively intact.</p> <p>Review of the Comprehensive Care Plan for Resident #13, revealed the facility developed a care plan for the high possibility of falls, on 02/12/15, with updated goals and target dates for 05/13/15 potential for fall related to chronically impaired mobility, strength, balance and endurance related to Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, Hypertension, Weakness and Hypoxia. The interventions included: Bed and clip chair alarms. However, the care plan did not address the resident's non-compliance with the bed and chair alarms. Bed against the wall.</p> <p>Review of the AccuNurse, Activities of Daily Living (ADL) Plan of Care-Transfers for Resident #13, print dated 05/22/15, revealed monitoring of the alarms, included test and reapply bed or chair alarm; however, the facility did not provide documentation of any alarm monitoring.</p> <p>Review of the Post Incident actions for Resident #13, dated 04/07/15 at 2:20 PM, revealed the resident was found in the floor in the dining room. The investigation revealed the resident's chair alarm was under the roho cushion. The post-incident report stated the wires on the chair alarm were frayed and did not work. The facility completed an assessment of the resident, included a neurological assessment. There were no report of injuries.</p> <p>Observation of Resident #13, on 05/20/15 at 5:41 PM, revealed he/she laid in a low bed with the head of the bed elevated. The side of the bed</p>	F 282			

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F 282	<p>Continued From page 25</p> <p>was position next to the wall. Resident #13 had his/her eyes closed and mouth open while wearing a nasal cannula.</p> <p>Observation of Resident #13, on 05/21/15 at 8:25 AM, revealed he/she was seated in his/her wheelchair in the hallway near the resident's room. An alarm was attached to the back of his/her wheelchair.</p> <p>Interview with Certified Nurse Aide (CNA) #10, on 05/21/15 at 1:10 PM, revealed stated staff must watch the residents wearing alarms very closely. She stated everyone was a fall risk. She stated she checked the resident alarms every shift. She did not know if the alarms were suppose to have a flashing light on them or not. She stated she was not sure if the lights meant anything or not.</p> <p>Interview with CNA #4, on 05/21/15 at 2:15 PM, revealed Resident #1 did have an alarm attached to her recliner. She stated the resident does take the alarm off, so it does not alarm at times. She reported each of the aides working check on the alarms as they provide care to ensure the alarms are working when they are caring for the residents. She stated there are some resident that remove their alarms. She reported the AccuNurse system does not include the alarms as part of the resident needs when cares were provided. She reported Resident #1 and #9, both remove their alarms. She stated they have been in-serviced to look at the alarms and to make sure they are fully functional and working when the alarms are checked. Especially when getting the residents up and or putting the to bed.</p> <p>Interview with Registered Nurse (RN) #2, on 05/22/15 at 10:00 AM, revealed Resident #9</p>	F 282			

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F 282	<p>Continued From page 26</p> <p>frequently turns his/her alarms off. The residents sometimes turn off their alarms. She stated the care plans are developed to meet the needs of the residents. the alarms are suppose to be checked everyday. The alarms use to be on the Treatment Administration Record (TAR) for the nurses to check. The alarms are now on the AccuNurse for the CNAs to check everyday. She reported the alarms are still on the TAR for Resident #1. The alarm checks are on some of the TARs, but not all.</p> <p>Interview with CNA #5, on 05/22/15 at 10:15 AM, revealed the AccuNurse system tells you everything about the resident. She stated the alarms were included; however, the system does not tell you when to check on the alarms. She stated there was not a reminder in the system to direct the staff to check on the alarms.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 05/22/15 at 10:40 AM, state the alarms were checked every two (2) hours on rounds by the CNAs and nurses. The alarms we checked for functioning properly once per shift. The AccuNurse was where the alarms were checked by the CNAs. She stated the every two hour checks on the residents were the CNA standards of care. She reported the alarms to check were entered on the nurses treatment sheet; however, that was changed by the Director of Nurses, back some time ago. She stated she was unable to recall the date the documentation was changed to the AccuNurse system for the CNA task. She reported AccuNurse was implemented prior to the last survey and the facility continues to expand the use of AccuNurse. She stated the AccuNurse system does not print off monitoring of the alarms. There was not any</p>	F 282			

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F 282	<p>Continued From page 27</p> <p>documentation to support the checks were completed. The monitoring and checking of the alarm should be on the AccuNurse system and not on the Treatment Administration Record.</p> <p>The Director of Nursing was unavailable for interview. She was out of the country during the survey process.</p> <p>5. Review of the clinical record for Resident #7, revealed the resident was admitted to the facility, on 03/24/15 with the diagnoses of Congestive Heart Failure, Chronic Airway obstruction, Hypertension, Cerebrovascular Accident, and Viral Pneumonia. Further review of the record revealed the resident was put in contact isolation for C-Diff on 05/18/15.</p> <p>Review of the Comprehensive Care Plan for Resident #7, dated 05/18/15, revealed the facility developed a care plan for C-Diff infection with interventions including isolation per Centers for Disease Control (CDC).</p> <p>Observation of Resident #7, on 05/19/15 at 2:35 PM, revealed Personal Protective Equipment (PPE) hanging on the front of the resident's door. The resident was in the room lying in bed. The Social Services Director (SSD) was beside the resident's bed, sitting in the resident's wheelchair conversing with the resident. The SSD was not wearing any PPE.</p> <p>Continued observation of Resident #7, on 05/19/15 at 2:45 PM, revealed the SSD exited the resident's room without washing her hands.</p> <p>Interview with the SSD, on 05/19/15 at 2:45 PM, revealed she knew Resident #7 was in isolation for C-Diff and PPE was to be worn while in the</p>	F 282			

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F 282	<p>Continued From page 28</p> <p>resident's room. The SSD stated she forgot to put on the PPE and wash her hands. The SSD further stated by not wearing the appropriate PPE and washing her hands, the spread of infection to other residents could occur. She stated she had attended in-services on infection control and hand hygiene.</p> <p>Interview, on 05/22/15 at 3:30 PM, with the Assistant Director of Nursing (ADON), revealed she was the infection control nurse. She stated the SSD was very passionate about her work and was just focusing on the resident when she breached isolation precautions. She stated staff had been trained on isolation precautions.</p> <p>6. Review of the medical record for Resident #12 revealed the facility admitted the resident on 04/24/13 with Diagnosis including Degenerative Disk Disease, Anxiety, and Dementia with Behavior Disturbances.</p> <p>Review of Physician orders for Resident #12 revealed an order was received on 07/01/13 to place fall mats at the bedside at all times, bed alarm, check placement and function every shift, chair alarm to wheelchair check placement and function every shift.</p> <p>Review of the Comprehensive Care Plan for Resident #12, revealed the facility developed a care plan dated 03/11/15, for potential for injury related to falls, history of falls, chronic weakness, and poor safety awareness. The interventions included: Bed alarm, check function and placement every shift, chair alarm check placement and function every shift.</p>	F 282			

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F 282	<p>Continued From page 29</p> <p>Review of the Resident Incident for Resident #12, revealed on 08/02/14 the resident scooted to the wall in the wheelchair and pull self up. The chair alarm was not sounding. The wheelchair rolled back and the resident sat on the floor. There was no report of injury.</p> <p>Review of the Resident Incident Reported for Resident #12 dated 11/18/14 revealed the resident was found on the fall mat next to bed and the bed alarm was not sounding when discovered by the nurse. There was no report of injury.</p> <p>Continued review of the medical record for Resident #12 revealed no other falls since 11/18/14.</p> <p>Observation on 05/21/15 at 9:25 AM, revealed Resident #12 was lying in bed. The bed sensor pad was in place and found to be working.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 05/22/15 at 12:33 PM, revealed she was responsible to check alarms on all her residents every shift to ensure they were functioning. She stated on the falls investigation she was trained to only documents if the alarm was in place and not whether is was functioning or not.</p> <p>7. Record review of Resident #8's record, revealed Resident #8 was admitted on 07/01/12 with a diagnosis of Asphasia, Quadriplegia, Spasm of Muscle, Non Psychotic Brain Syndrome and Pain of the Joint. Resident #8's Quarterly Minimum Data Set (MDS) Assessment, completed on 05/05/15, revealed Resident #8's BIM score could not be assessed, which meant</p>	F 282			

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F 282	<p>Continued From page 30</p> <p>Resident #8 was not interviewable.</p> <p>Observation of Resident #8, on 05/19/15 at 2:33 PM, revealed Resident #8 lying flat in the bed with facial hair. Observed a sign above Resident #8's bed which read; Please do not leave head flat and must be shaved everyday.</p> <p>Observation of Resident #8, on 05/20/15 at 7:52 AM, revealed Resident #8 was observed to be sitting up in chair in the television room with facial hair.</p> <p>Record review of Resident #8's Activities of Daily Living Plan of Care (in the Accu-Nurse system, which was the facilities computer system), no date given, revealed Resident #8 would be shaved with a razor during night (PM) care.</p> <p>Interview with Certified Nursing Assistant (CNA) #8, on 05/22/15 at 4:15 PM, revealed the Accu-Nurse system did not alert her to what time of day to complete the shaving task. She was not sure if it was a night shift responsibility or a day shift responsibility. CNA #8 stated she worked the day of 05/20/15, she saw Resident #8's stubble but did not shave Resident #8. CNA #8 stated she knew Resident #8 was to be shaved during hygiene. CNA #8 stated the family probably wanted Resident #8 shaved daily to keep Resident #8 nice and clean.</p> <p>Interview with Certified Nursing Assistant (CNA) #7, on 05/22/15 at 9:05 PM, revealed he thought Resident #8 was shaved in the morning daily. CNA #7 stated he did not notice Resident #8 was not shaved. CNA #7 stated the staff was expected to follow the care plan.</p>	F 282			

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F 282	Continued From page 31 Interview with Licensed Practical Nurse (LPN) #4, on 05/22/15 at 4:45 PM, revealed he was aware Resident #8 was to be shaved daily and expected the CNA's to shave Resident #8 daily. LPN #4 stated he was not aware that shaving was on Resident #8's care plan. LPN #4 stated he wanted Resident #4 to be clean and neat. Interview with the Minimum Data Set (MDS) Coordinator, on 05/22/15 at 5:17 PM, revealed she did not update the Accu-Nurse care sytem. The MDS Coordinator stated it was the responsibility of the Director of Nursing (DON). The MDS Coordinator stated she expected the staff to follow the Care Plans. She stated she wanted Resident #8 shaved because it was a part of his/her hygiene and grooming. Interview with the Assistant Director of Nursing (ADON), on 05/22/15 at 4:50 PM, revealed she expected the staff to follow the plan of care. The ADON stated the Acitivities of Daily Living Care Plan was updated by the Director of Nursing (DON). The ADON stated she wanted to make sure Resident #8 was shaved because of his/her right and family requests. The DON was not available for interview, due to out of town during the survey.	F 282			
F 310 SS=D	483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability	F 310			

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F 310	<p>Continued From page 32</p> <p>to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility failed to ensure one (1) of sixteen (16) sampled residents, Resident #8 received grooming as it related to shaving.</p> <p>The findings include:</p> <p>Review of the Shower Policy, revised October 2010, revealed the policy did not address shaving.</p> <p>Observation of Resident #8, on 05/19/15 at 2:33 PM, revealed Resident #8 lying flat in the bed with facial hair. Observation of Resident #8's wall above bed, revealed a sign which read; please do not leave head flat and must be shaved everyday.</p> <p>Observation of Resident #8, on 05/20/15 at 7:52 AM, revealed Resident #8 was observed to be sitting up in the wheelchair in the television room with facial hair.</p> <p>Interview with Certified Nursing Assistant (CNA) #8, on 05/22/15 at 4:15 PM, revealed there was a sign above Resident #8's bed which said Resident #8 was to be shaved everyday. CNA #8 stated she was not sure if she was to shave the resident in the morning or the evening, but knew the task was to be completed daily. CNA #8 stated she worked the Wednesday of 05/20/15 and did observe Resident #8 to have stubble on</p>	F 310			

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F 310	Continued From page 33 his/her face and did not shave Resident #8 that day either. CNA #8 stated the family probably wanted Resident #8 shaved daily to keep Resident #8 nice and clean. Interview with CNA #7, on 05/22/15 at 9:05 PM, revealed he thought Resident #8 was shaved in the morning daily. CNA #7 stated he did not notice Resident #8 was not shaved, nor the sign above the bed. CNA #7 stated the families' of residents would write things above the residents' beds to ensure the staff remembered to complete tasks. Interview with Licensed Practical Nurse (LPN) #4, on 05/22/15 at 4:45 PM, revealed he was aware Resident #8 was to be shaved in the morning daily and expected the CNA's to shave Resident #8 daily. Interview with the Assistant Director of Nursing (ADON), on 05/22/15 at 4:50 PM, revealed she expected the staff to follow the plan of care. The ADON stated she wanted to make sure Resident #8 was shaved because of his/her right and family requests.	F 310			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323			

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F 323	<p>Continued From page 34</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed ensure resident were free from accidents for five (5) of sixteen (16) sampled residents. Resident #1, #6, #9, #12 and #13 falls.</p> <p>The findings include:</p> <p>Review of the facility's care plan policy titled, "Fall Assessment/Intervention Process", revised September/2013, revealed all residents on any admission, re-admission and at least quarterly will be assessed for fall risk and appropriate interventions initiated immediately to reduce the risk of injuries with falls. Any resident who experiences a fall will have a Care Area Assessment (CAA) Summary fall worksheet completed to assure all identified risk factors are taken into consideration.</p> <p>1. Review of Resident #1's clinical record revealed the facility re-admitted the resident on 08/06/14 with the diagnosis of Polyarthritis, Hypothyroidism, and Hypertension.</p> <p>Review of Resident #1's Annual Minimum Data Set (MDS) assessment, completed on 05/11/15 revealed the facility assessed the resident utilizing the Brief Interview of Mental Status (BIMS) as being moderately impaired; BIMS score was ten (10) of fifteen (15).</p> <p>Review of the Comprehensive Care Plan for Resident #1, revealed the facility developed a care plan dated 01/11/15, for potential for falls related to impaired mobility, strength, balance</p>	F 323			

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F 323	<p>Continued From page 35</p> <p>and endurance related to Degenerative Joint Disease, Hypertension. The interventions included: Physical and Occupational therapy to continue treating, keep the call light within reach with reminders for use, identify where the call light is before leaving the resident's room, monitor for potential hazards in the environment, and assist resident to wear soled shoes when out of bed. In addition, the Treatment Sheet, dated May/2015, included the chair alarm to the recliner with staff initials for a 7AM-7 PM and 7 PM-7AM each day was initiated on 05/05/15 during the 7 PM-7 AM shift.</p> <p>Review of Resident #1's Post Incident Actions, dated 04/29/15 at 1:45 PM, revealed a fall occured in the resident's room. The facility assessed the resident and no injury was identified.</p> <p>Record review of Resident #1's CAA Fall Investigation Worksheet, dated 04/30/15 at 3:07 PM, was not completed by the facility.</p> <p>Observation, on 05/20/15 at 7:30 AM, of Resident #1 revealed he/she was initalially seated in his/her recliner with feet elevated. When he/she proceeded to rise from the recliner and ambulate independently to the closet area. The alarm did not sound once the resident arose from the recliner.</p> <p>Interview with Resident #1, on 05/20/15 at 8:07 AM, revealed he/she did not like the beeping of the alarm when he/she gets out of the chair (recliner). He/she reported the beeping of the alarm makes me nervous.</p>	F 323			

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NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701		
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F 323	<p>Continued From page 36</p> <p>2. Review of Resident #6's clinical record revealed the facility re-admitted the resident on 07/01/12 with the diagnosis of Osteoporosis, Anxiety State, Dementia with Behavior Disturbances, Iron Deficiency Anemia, Hypothyroidism, Osteoporosis, Syncope and Collapse.</p> <p>Review of Resident #6's Quarterly MDS assessment, completed on 04/27/15 revealed the facility assessed the resident utilizing the BIMS. The facility assessed Resident #6's BIMS score as four (4) of fifteen (15), being severely impaired cognitively.</p> <p>Review of the Comprehensive Care Plan for Resident #6, revealed the facility developed a care plan for the high possibility of falls, on 02/09/15, with updated goals and target dates for 05/09/15 potential for falls. The resident had several falls in recent months without injury. Resident #6 had impaired safety awareness related to Dementia. The interventions included: Ensure a safe environment, free of clutter, adequate lighting. Non-skid socks and/or well fitting shoes when out of the bed. Also, keep call light within reach when in bed with cues and reminders for use. In addition, the facility developed a care plan for the resident unable to meet his/her own ADL/self-care needs, related to cognitive deficits and left sided weakness (Transient Ischemia Attacks (TIA)), on 02/11/15, with updated goals and target dates for 08/11/15. The interventions included: provided oversight for bed mobility, transfers and ambulation. Monitor the need for physical assistance and for assistance with wheelchair for any trips on or off the unit.</p>	F 323			

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F 323	<p>Continued From page 37</p> <p>Review of Resident #6's Post Incident Actions, dated 01/16/15 at 11:33 PM, revealed a fall occurred in the resident's room. The facility assessed the resident and no injury was identified.</p> <p>Requested Resident #6's CAA Fall Investigation Worksheet, related to the fall, dated 01/16/15 at 11:33 PM. The facility did not provide the fall investigation worksheet.</p> <p>Observation of Resident #6, on 05/19/15 at 12:35 PM, revealed the resident was seated in a wheelchair at a table in the dining area with an alarm attached to the back of the wheelchair.</p> <p>Observation of Resident #6, on 05/19/15 at 1:40 PM, revealed the resident laid in his/her bed. The resident was laid on his/her right side, facing the window. The window blind was closed. An alarm was in place and attached to the bed.</p> <p>Observation of Resident #6, on 05/20/15 at 7:30 AM and at 7:40 AM, revealed the resident was seated in his/her wheelchair at the table in the main dining area. The wheelchair had an alarm attached to the back of the wheelchair.</p> <p>An unsuccessful interview was attempted with Resident #6, on 05/20/15 at 10:15 AM.</p> <p>3. Review of Resident #9's clinical record revealed the facility re-admitted the resident on 04/04/14 with diagnosis of Depressive Disorder, Anxiety, Mental Disorder and Anemia.</p> <p>Review of the nursing notes, dated 01/16/15 at 1:59 AM, revealed Resident #9 has bed and chair</p>	F 323			

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F 323	<p>Continued From page 38</p> <p>sensor alarms which he/she was non-compliant with and turns off the alarms him/herself.</p> <p>Review of the Comprehensive Care Plan for Resident #9, revealed the facility developed a care plan for the high possibility of falls, on 02/16/15, with updated goals and target dates for 08/13/15 potential for injury related to impaired mobility, strength, balance and endurance, confusion secondary to Dementia. He/she has had recurring attempts to self transfer and has had multiple falls since admission. The interventions included: Bed and chair alarms in place and to check frequently to make sure they are working. Chair alarm to increase safety awareness.</p> <p>Review of the Resident Incident for Resident #9, dated 01/15/15 at 10:46 PM, revealed the resident was found in the floor at the foot of the bed. The incident report revealed the resident was awake in a confused state concerned the television on the wall was falling. The post-incident report stated the resident has bed and chair sensor alarms. In addition, the report stated the resident was non-compliant all day turning the alarms off. There was no report of injury.</p> <p>Review of Resident #9's Post Incident Actions, dated 09/11/14 at 12:10 PM, revealed a fall occurred in the resident's room. The facility assessed the resident and no injury was identified.</p> <p>Review of Resident #9's Post Incident Actions, dated 11/06/14 at 10:40 PM, revealed a fall occurred in the snack room. The facility assessed the resident and no injury was identified.</p>	F 323			

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F 323	Continued From page 39 Requested Resident #9's Fall Investigation Worksheet, related to the falls, dated 09/11/14 at 12:10 PM and 11/06/14 at 10:40 PM. The facility did not provide the fall investigation worksheet. Review of Resident #9's Quarterly MDS assessment, completed on 02/16/15 revealed the facility assessed the resident utilizing the BIMS. The facility assessed the Resident #9's BIMS score as fourteen (14) of fifteen (15), being cognitively intact. Observation of Resident #9, on 05/19/15 at 11:48 AM, revealed he/she was seated in his/her wheelchair in the hallway near the resident's room. An alarm was attached to the back of his/her wheelchair. Observation of Resident #9, on 05/19/15 at 4:50 PM, revealed he/she was seated in his/her wheelchair. He/she was inside of Resident #1's door entrance engaged in conversation with Resident #1. An alarm was attached to the back of his/her wheelchair. 4. Review of Resident #13's clinical record revealed the facility re-admitted the resident on 03/25/13 with diagnosis of Symbolic Dysfunction, Muscle Weakness, Congestive Heart Failure, Atrial Fibrillation, Hypertension, Anxiety State, Dysphagia, Oropharyngeal and Mild Cognitive Impairment. Review of Resident #13's Quarterly MDS assessment, completed on 04/21/15 revealed the facility assessed the resident utilizing the BIMS. The facility assessed the Resident #13's BIMS	F 323			

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F 323	<p>Continued From page 40</p> <p>score as thirteen (13) of fifteen (15), being cognitively intact.</p> <p>Review of the Comprehensive Care Plan for Resident #13, revealed the facility developed a care plan for the high possibility of falls, on 02/12/15, with updated goals and target dates for 05/13/15 potential for fall related to chronically impaired mobility, strength, balance and endurance related to Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, Hypertension, Weakness and Hypoxia. The interventions included: Bed and clip chair alarms. However, the care plan did not address the resident's non-compliance with the bed and chair alarms. Bed against the wall.</p> <p>Review of the AccuNurse, Activities of Daily Living (ADL) Plan of Care-Transfers for Resident #13, print dated 05/22/15, revealed monitoring of the alarms, included test and reapply bed or chair alarm; however, the facility did not provide documentation of any alarm monitoring.</p> <p>Review of the Post Incident actions for Resident #13, dated 04/07/15 at 2:20 PM, revealed the resident was found in the floor in the dining room. The investigation revealed the resident's chair alarm was under the roho cushion. The post-incident report stated the wires on the chair alarm were frayed and did not work. The facility completed an assessment of the resident, included a neurological assessment. There were no report of injuries.</p> <p>Review of Resident #13's Post Incident Actions, dated 04/07/15 at 2:20 PM, revealed a fall occurred in the dining room. The facility assessed the resident and no injury was identified.</p>	F 323			

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F 323	Continued From page 41 Review of Resident #13's Post Incident Actions, dated 03/19/15 at 11:03 AM, revealed a fall occurred in the resident's room. The facility assessed the resident. Resident #13 had a skin tear above his/her left elbow. The facility provided steri-strips and covered with tegaderm. Review of Resident #13's Post Incident Actions, dated 03/05/15 at 11:15 PM, revealed a fall occurred in the resident's room. The facility assessed the resident and no injury was identified. Requested Resident #13's CAA Fall Investigation Worksheet, related to the fall, dated 04/07/15 at 2:20 PM, dated 03/19/15 at 11:03 AM and at 03/05/15 at 11:15 PM. The facility did not provide the fall investigation worksheet. Observation of Resident #13, on 05/20/15 at 5:41 PM, revealed he/she laid in a low bed with the head of the bed elevated. The side of the bed was position next to the wall. Resident #13 had his/her eyes closed and mouth open while wearing a nasal cannula. Observation of Resident #13, on 05/21/15 at 8:25 AM, revealed he/she was seated in his/her wheelchair in the hallway near the resident's room. An alarm was attached to the back of his/her wheelchair. 5. Review of the medical record for Resident #12 revealed the facility admitted the resident on 04/24/13 with Diagnosis including Degenerative	F 323			

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F 323	<p>Continued From page 42</p> <p>Disk Disease, Anxiety, and Dementia with Behavior Disturbances.</p> <p>Review of Physician orders for Resident #12 revealed an order was received on 07/01/13 to place fall mats at the bedside at all times, bed alarm, check placement and function every shift, chair alarm to wheelchair and check placement and function every shift.</p> <p>Review of the Comprehensive Care Plan for Resident #12, revealed the facility developed a care plan dated 03/11/15, for potential for injury related to falls, history of falls, chronic weakness, and poor safety awareness. The interventions included: Bed alarm, check function and placement every shift, chair alarm and check placement and function every shift.</p> <p>Review of the Resident Incident for Resident #12, revealed on 08/02/14 the resident scooted to the wall in the wheelchair and pull self up. The chair alarm was not sounding. The wheelchair rolled back and the resident sat on the floor. There was no report of injury.</p> <p>Review of the Resident Incident Reported for Resident #12 dated 11/18/14 revealed the resident was found on the fall mat next to the bed and the bed alarm was not sounding when discovered by the nurse. There was no report of injury.</p> <p>Continued review of the medical record for Resident #12 revealed no other falls since 11/18/14.</p> <p>Observation, on 05/21/15 at 9:25 AM, revealed Resident #12 was lying in bed. The bed sensor</p>	F 323			

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F 323	<p>Continued From page 43</p> <p>pad was in place and found to be working.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 05/22/15 at 12:33 PM, revealed she was responsible to check alarms on all her residents every shift and to ensure they were functioning. She stated on the falls investigation, she was trained to only documents if the alarm was in place, and not whether is was functioning or not.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 05/22/15 at 10:40 AM, state the alarms are checked every two (2) hours on rounds by the CNAs and nurses. The alarms are to checked for functioning properly once per shift. The AccuNurse is where the alarms are checked by the CNAs. She stated the every two hour checks on the residents are the CNA standards of care. She reported the alarms to check were entered on the nurses treatment sheet; however, that was changed by the Director of Nurses, back sometime ago. She stated she was unable to recall the date the documentation was changed to the AccuNurse system for the CNA task. She reported AccuNurse was implemented prior to the last survey and the facility continues to expand the use of AccuNurse. She stated the AccuNurse system does not print off monitoring of the alarms. There is not any documentation to support the checks were completed. The monitoring and checking of the alarm should be on the AccuNurse system and not on the Treatment Administration Record.</p> <p>Interview with Assistant Director of Nursing (ADON) on 05/22/15 at 3:47 PM, stated she completes the quarterly CAA Fall Assessment; however, the Director of Nurses completes the</p>	F 323			

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F 323	Continued From page 44 post fall CAA fall assessment. The DON reviews and completed the fall investigations. She stated those are completed sporadically. She stated there was no an investigation for the fall, dated 01/16/15. The Director of Nursing was unavailable for interview. She was out of the country during the survey process.	F 323			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441			

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F 441	<p>Continued From page 45</p> <p>hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, record review, review of facility training/in-services, and facility policy review, it was determined the facility failed to ensure infection control practices were maintained for two (2) of sixteen (16) sampled residents (Resident #3 and Resident #7). A Certified Nursing Assistant (CNA) failed to apply barrier cream correctly, and one (1) staff did not follow isolation precautions for Resident #7.</p> <p>The findings include:</p> <p>1. Review of facility's Corporate Standards of Practice, undated, revealed when applying topical barrier cream, smear it evenly over the skin and apply front to back.</p> <p>Review of the facility's Corporate Standards of Practice titled Providing Proper Perineal Care, revealed do no move from back to front due to the risk of introducing germs from the anal area into the urethra, a source of urinary tract infection.</p>	F 441			

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F 441	Continued From page 46 Review of the medical record for Resident #3 revealed the facility admitted the resident on 12/15/14 with Diagnosis including Dementia without behaviors, Anxiety and Hearing Loss. Review of the Quarterly Minimum Data Set (MDS) Assessment for Resident #3, dated 04/16/15, revealed the facility assessed the resident's cognition using the Brief Interview for Mental Status (BIMS) assessment. The facility assessed the residents BIMS score of three (3) of fifteen (15), severely cognitively impaired. The facility assessed the resident's bowel and bladder as always incontinent. Review of the Comprehensive Care Plan for Resident #3 revealed the facility developed a care plan on 01/26/15 for Potential for impaired skin. Interventions included incontinent care as needed and barrier cream as indicated. Observation, on 05/21/15 at 1:15 PM, revealed Certified Nursing Assistant (CNA) #2 applied barrier cream for Resident #3, after incontinent care, on the buttocks area then went on to apply the cream to the genital area. Interview, on 05/22/15 at 12:27 PM, with CNA #2 revealed she acknowledged she should have applied the barrier cream to the genital area first then to the buttocks area. She stated there was a potential for cross contamination for the resident. Interview, on 05/22/15 at 12:33 PM, with Licensed Practical Nurse (LPN) #2 revealed she observed CNA #2's improper application of the barrier cream for Resident #3 when she went from the back to the front but didn't think she could stop	F 441			

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F 441	<p>Continued From page 47</p> <p>her. She stated the risk to the resident was contamination.</p> <p>Interview, on 05/22/15 at 3:30 PM, with the Assistant Director of Nursing (ADON) revealed she was the infection control nurse. She stated the last training on Peri Care included application of barrier creams. She stated staff were trained to wash and apply creams to the peri area from front to back. She stated the risk to the resident was the spread of infection due to infection control breaches.</p> <p>2. Review of the facility policy, Clostridium Difficile (C-Diff), dated February 2014, revealed preventative measures will be taken to prevent transmission of C-Diff to others. C-Diff spores can persist on resident-care items and surfaces for several months and are resistant to common cleaning and disinfection methods. Healthcare workers and visitors will wear gloves and gowns when entering the room of a resident with C-Diff infections and wash hands with soap and water upon exiting the room.</p> <p>Review of the clinical record for Resident #7, revealed the resident was admitted to the facility, on 03/24/15 with the diagnoses of Congestive Heart Failure, Chronic Airway obstruction, Hypertension, Cerebrovascular Accident, and Viral Pneumonia. Further review of the record revealed the resident was put in contact isolation for C-Diff on 05/18/15.</p> <p>Review of the Comprehensive Care Plan for Resident #7, dated 05/18/15, revealed the facility developed a care plan for C-Diff infection with interventions including isolation per Centers for Disease Control (CDC).</p>	F 441			

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F 441	Continued From page 48 Review of Staff in-services dated 03/17/15 revealed staff had been trained on C-Diff precautions including the Social Services Director. Observation of Resident #7, on 05/19/15 at 2:35 PM, revealed Personal Protective Equipment (PPE) hanging on the front of the resident's door. The resident was in the room lying in bed. The Social Services Director (SSD) was beside the resident's bed, sitting in the resident's wheelchair conversing with the resident. The SSD was not wearing any PPE. Continued observation of Resident #7, on 05/19/15 at 2:45 PM, revealed the SSD exited the resident's room without washing her hands. Interview with the SSD, on 05/19/15 at 2:45 PM, revealed she knew Resident #7 was in isolation for C-Diff and PPE was to be worn while in the resident's room. The SSD stated she forgot to put on the PPE and wash her hands. The SSD further stated by not wearing the appropriate PPE and washing her hands, the spread of infection to other residents could occur. She stated she had attended in-services on infection control and hand hygiene. Interview, on 05/22/15 at 3:30 PM, with the Assistant Director of Nursing (ADON), revealed she was the infection control nurse. She stated the SSD was very passionate about her work and was just focusing on the resident when she breached isolation precautions. She stated staff had been trained on isolation precautions.	F 441			
F 514	483.75(l)(1) RES	F 514			

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F 514 SS=D	<p>Continued From page 49</p> <p>RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure medical records were complete and accurate for three (3) of sixteen (16) sampled residents (Residents #6, #8 and #9). Staff documented another residents information into Resident #8's medical record and was unable to complete Resident #8's restraint assessment completely. In addition, Resident #6 and #9's alarm checks could not be printed or reviewed by staff to ensure the alarm checks were being completed daily.</p> <p>The findings include: No Policy could be provided.</p> <p>1. Record review of Resident #8's clinical record,</p>	F 514			

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F 514	<p>Continued From page 50</p> <p>revealed Resident #8 was admitted on 07/01/12 with a diagnosis of Asphasia, Quadriplegia, Spasm of Muscle, Non Psychotic Brain Syndrome and Pain of the Joint. Resident #8's Quarterly Minimum Data Set (MDS) Assessment, completed on 05/05/15, revealed Resident #8's Brief Interview of Mental Status (BIMS) score could not be assessed, which meant Resident #8 was not interviewable. Resident #8 was care planned to be a two (2) person assist with the Hoyer lift.</p> <p>Observation of Resident #8, on 05/19/15 at 12:00 PM, revealed Resident #8 was sitting up in wheelchair. Both of Resident #8's arms were observed to be contracted.</p> <p>Observation of Resident #8, on 05/20/15 at 7:52 AM, revealed Resident #8 sitting up in wheelchair in the television room. Both hands were observed in splints and the residents feet were elevated in Una boots.</p> <p>Review of Resident #8's Nursing Notes written by the Assistant Director of Nursing (ADON), on 02/24/15 at 12:01 PM, revealed Quarterly Care Plan Meeting was held. Resident in attendance and participated with entire discussion. Resident was concerned over getting an appointment with Medical Director (MD) regarding releasing muscle of left leg. The resident had been seen by the MD previously and was told he could possibly be able to walk again with the release of muscle in left leg. Currently awaiting return call from MD office to arrange appointment. Resident was very anxious regarding this issue. Discussed that the resident had a change in medication related to insomnia. The recent change had helped the resident with sleep.</p>	F 514			

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F 514	<p>Continued From page 51</p> <p>Interview with the ADON, on 05/22/15 at 4:50 PM, revealed she remembered writing the nursing note, but meant for the note to be in another residents record. The ADON stated she should have caught the name of the resident before she starting writing the note. The ADON stated the nursing note entry was not accurate to Resident #8 and she was not aware that she had charted on the wrong person.</p> <p>Observation of Resident #8, on 05/20/15 at 7:52 AM, revealed Resident #8 had a lap belt while sitting up in the wheelchair.</p> <p>Review of Resident #8's Safety Device Assessment, dated 05/15/15, revealed when asked what does this enable/restraint enable resident to do? The ADON responded "define boundaries; keeps resident from s".</p> <p>Interview with the ADON, on 05/22/15 at 4:50 PM, revealed the Safety Device Assessment was completed in the AHT (medical record). Further interview with the ADON, on 05/21/15 at 11:17 AM, revealed she thought when she typed onto the AHT system that the system would let her continue to type. The ADON stated "s" meant sliding. The ADON stated she could not say if the staff members would understand what "s" meant if she was not in the facility to explain. The ADON stated she would not say Resident #8's assessment was complete if there was not enough information documented. The ADON stated she was not aware the AHT system would not allow her to type but so far in the system.</p> <p>Interview with the Administrator, on 05/22/15 at 5:26 PM, revealed she was not aware the</p>	F 514			

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F 514	<p>Continued From page 52</p> <p>computer system was not letting staff provide additional information. The Administrator stated when you go into the medical record to document you have to click on a particular resident, and there was no alarm or anything to alert the staff member that they were typing into the wrong record. The Administrator stated she was not aware there were concerns with the AHT computer system.</p> <p>2. Review of Resident #6's clinical record revealed the facility admitted the resident on 07/01/12 with diagnosis of Hypertension, Hypothyroidism, Dementia with Behavior, Anxiety State, Iron Deficiency Anemia and Osteoporosis.</p> <p>Review of the Physician Orders for a Sensor Alarm to bed and wheelchair, dated 01/01/15, for Resident #6 revealed the sensor alarm was ordered related to increased fall risk.</p> <p>Review of Resident #6's Significant Change MDS assessment, completed on 02/11/15, revealed the facility assessed the resident utilizing the BIMS. The facility assessed the Resident #6's BIMS score as four (4) of fifteen (15), being severely impaired cognitively.</p> <p>Review of the AccuNurse (electronic documentation program), Activities of Daily Living (ADL) Plan of Care-Transfers for Resident #6, print dated 05/22/15, revealed monitoring of the alarms, included test and reapply bed or chair alarm; however, the facility did not provide documentation of any alarm monitoring.</p> <p>Observation on 05/19/15 at 1:40 PM and 2:09 PM, of Resident #6 revealed he/she was lying in</p>	F 514			

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F 514	<p>Continued From page 53</p> <p>the bed with the bed alarm attached to the bed. He/she laid on his/her right side facing the window with the curtains closed.</p> <p>Observation on 05/20/15 at 7:40 AM, of Resident #6 revealed he/she was seated in the dining room for breakfast service. He/she was seated in his/her wheelchair at a table with an alarm attached to the back of the wheelchair.</p> <p>3. Review of Resident #9's clinical record revealed the facility re-admitted the resident on 04/04/14 with diagnosis of Depressive Disorder, Anxiety, Mental Disorder and Anemia.</p> <p>Review of Resident #9's Quarterly MDS assessment, completed on 02/16/15 revealed the facility assessed the resident utilizing the BIMS. The facility assessed the Resident #9's BIMS score as fourteen (14) of fifteen (15), being cognitively intact.</p> <p>Review of the Physician Orders for a Chair Alarm, dated 02/09/15, for Resident #9 revealed the chair alarm was to increase safety awareness. The facility was to check functioning and placement every shift.</p> <p>Review of the AccuNurse, Activities of Daily Living (ADL) Plan of Care-Transfers for Resident #9, print dated 05/22/15, revealed monitoring of the alarms, included test and reapply bed or chair alarm; however, the facility did not provide documentation of any alarm monitoring.</p> <p>Observation of Resident #9, on 05/19/15 at 11:48 AM, revealed he/she was seated in his/her wheelchair in the hallway near the resident's room. An alarm was attached to the back of</p>	F 514			

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F 514	<p>Continued From page 54</p> <p>his/her wheelchair.</p> <p>Observation of Resident #9, on 05/19/15 at 4:50 PM, revealed he/she was seated in his/her wheelchair. He/she was inside of Resident #1's door entrance engaged in conversation with Resident #1. An alarm was attached to the back of his/her wheelchair.</p> <p>Interview with Certified Nurse Aide (CNA) #5, on 05/22/15 at 10:15 AM, revealed everything about each resident was documented on the AccuNurse system. The alarms were listed on there also, but there were not any reminders when to check the alarms.</p> <p>Interview with Registered Nurse (RN) #2, on 05/22/15 at 10:15 AM, revealed everything about each resident was documented on the AccuNurse system. The alarms were listed on there also, not any reminders when to check the alarms.</p> <p>Interview with the Assistant Director of Nursing, on 05/22/15 at 10:40 AM, revealed the bed and chair alarms were checked every two hours on rounds by the CNAs. She stated the CNAs check the alarms every shift for functioning. She reported the bed and chair alarms were on the treatment administration record until about a one (1) year ago when the process was changed to the AccuNurse system as a CNAs task. She reported she was unable to provide the documentation the bed and chair alarms were checked.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator, on 05/22/15 at 4:45 PM, revealed the facility was entering the bed and chair alarms under the transfers section on AccuNurse. She</p>	F 514			

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F 514	<p>Continued From page 55</p> <p>stated they were told today the system does not document the testing of the alarms under the transfer section. She stated they were told today by AccuNurse Support the alarms had to be entered on the flow sheet under the ADL Plan of Care, in the bathing, dressing and positioning section for the system to capture the documentation. She stated they were entering the alarms under the devices section which did not document the testing and functioning of the alarms.</p> <p>The Director of Nursing was unavailable for interview. She was out of the country during the survey process.</p> <p>Interview with the Administrator, on 05/22/15 at 5:50 PM, revealed the she was not aware the computer system, AccuNurse, limited the input when the alarms were put under the devices section. She stated they previously had training, but had a lot of turnover. She stated she was not aware of the electronic documentation concerns until today.</p>	F 514			