

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

PRINTED: 05/29/2015
FORM APPROVAL
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2015
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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PINE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40504
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F 000 INITIAL COMMENTS

A Recertification Survey was initiated on 04/28/15 and concluded on 05/14/15. Deficiencies were cited with the highest Scope and Severity of a "G".

F 157 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

F 000 Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.

F 157 D

Residents Affected

The physician for Resident # 8 was notified of the rash under the left breast and for the excoriation to the buttocks on 4-30-15 by the charge nurse. Treatment orders were received. A skin assessment for resident #8 was conducted again on 5-6-15 by the unit manager and the condition of the skin issues have improved with less surface area and redness.

The physician for Resident #2 was notified of the red rash and chafing under the abdomen folds, the excoriation between the buttocks and the perineal area on 4-29-15 by the treatment nurse. A skin assessment for resident #8 was conducted again on 5-6-15 by the unit manager and the condition of the skin has improved.

Identification of Other Residents

All residents in the facility has a potential to be affected. On 5-19-15 thru 5-26-15 complete

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>M. B. Hill</i>	TITLE Administrator	(X6) DATE 6/26/2015
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A 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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This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to notify the Physician when there was a significant change in a resident's physical status; or for a need to alter treatment for two (2) of twenty-two (22) sampled residents (Resident #8, and #2).

Resident #8 was observed during a skin assessment performed on 04/29/15, to have an rash under the left breast and excoriation to the buttocks. Interview with the nurse performing the skin assessment revealed the Certified Nursing Assistant (CNA) assigned to Resident #8 had informed him of the changes in the resident's skin condition earlier in the shift. However, record review on 04/30/15, revealed no documented evidence the Physician was notified and an order obtained for treatment to the rash and excoriated area.

Also, Resident #2 was observed during a skin assessment on 04/29/15, to have red rash areas and chafing under the abdominal folds, redness to the perineal area and excoriation between the buttocks. Interview with the nurse performing the skin assessment revealed no evidence the areas had been identified prior to the skin assessment. Review of the medical record on 05/05/15, revealed orders were obtained on 04/29/15 related to the redness to the perineal area and the excoriation between the buttocks. However, further record review revealed no documented evidence the Physician was notified of or an order obtained for treatment of the chafing and rash

F 157 head to toe skin assessments was performed on all the residents by the administrative team which included the DON, Unit managers, Infection Control nurse, QA nurse, and shift supervisors.

The skin assessments completed were reviewed by the DON and the physician was notified of any skin abnormalities and treatment orders were obtained as needed.

Systemic Changes

The RN Nurse educator, QA nurse and the Infection control nurse performed skin assessment competencies on all licensed nurses including RN's, LPN's and CMT's beginning on 5-29-15 and completed on 6-14-15. This skin assessment competency has been added to the facilities new hire orientation program.

An in-service was conducted with the licensed nurses including RN's, LPN's and CMT's on 5-29-15 thru 6-14-15 by the RN Educator and the Infection control nurse regarding completing a thorough skin assessment and notifying the physician immediately if any skin abnormalities identified during a skin assessment and/or any changes of condition. This in-service information has been added to the new hire and agency orientation packet which is currently being provided to the agency personnel by the staffing coordinator.

The infection control nurse began on 6-8-15 reviewing the shower sheets that are being completed by the SRNA's Monday thru Friday; the weekend supervisor reviews the shower sheets on Saturday and Sunday. The treatment nurse is reviewing skin assessments completed by the licensed nurses

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area of the resident's abdominal folds.

The findings include:

Review of the facility's policy titled, "Notification of Changes", undated, revealed it was the policy of the facility to notify the Physician of any changes in a resident's physical, mental or psychosocial well-being.

1. Review of Resident #8's medical record revealed the facility admitted him/her on 03/04/15, with diagnoses which included Colon Cancer and Chronic Obstructive Pulmonary Disease (COPD). Review of the 03/11/15, Admission Minimum Data Set (MDS) Assessment revealed the facility assessed Resident #8 to have a Brief Interview for Mental Status (BIMS) score of ten (10) out of fifteen (15) which indicated moderate cognitive impairment.

Review of a Hospital Discharge Summary, dated 04/16/15, revealed Resident #8 was admitted to the hospital on 04/08/15 and discharged back to the facility on 04/16/15.

Review of the Re-Admission Resident Data Collection Form section titled, "skin condition", completed on 04/22/15 after Resident #8's re-admission, revealed the resident had redness to the left armpit. Review of Resident #8's Re-Admission Physician's Orders revealed orders for: bedrest; palliative care; Remedy Nutrashield with Olivamine (skin protectant lotion) to buttocks and perineal area every shift and as needed (prn); and cleanse reddened area to left armpit with soap.

Observation of Resident #8's skin assessment on

F 157 Monday thru Friday to validate that the physician has been notified of any skin abnormalities including rashes, abdomen chaffing and excoriation and will report findings to the DON daily. The weekend supervisor will review the skin assessments on Saturday and Sunday and submits their audits to the DON on Monday morning

Monitoring
The infection control nurse began on 6-8-15 reviewing the shower sheets completed by the SRNA's Monday thru Friday; the weekend supervisor reviews the shower sheets on Saturday and Sunday.
The treatment nurse is reviewing skin assessments completed by the licensed nurses Monday thru Friday to validate that the physician has been notified of any skin abnormalities including rashes, abdomen chaffing and excoriation and will report findings to the DON daily. The weekend supervisor will review the skin assessments on Saturday and Sunday and submits their audits to the DON on Monday morning.
The DON will submit the findings to the monthly Quality Assurance and Safety Committee meeting which consists of the Medical Director, DON, Administrator, Consultant pharmacist, Infection control nurse, Quality assurance nurse, Social services director and the Dietary manager for review and recommendations.

Date of Correction:

6-26-15

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04/29/15 from 10:50 AM until 11:20 AM, performed by Licensed Practical Nurse (LPN) #2, the nurse assigned to the resident, with CNA #25 assisting, revealed Resident #8 had red excoriation to the buttocks and had a red rashy area under the left breast. Interview with LPN #2 at the time of the skin assessment, revealed CNA #25 had informed him of the areas of skin breakdown earlier in the shift.

Record review revealed no documented evidence the Physician was notified of the rash under Resident #8's left breast or excoriation of his/her buttocks. Review of Resident #8's Physician's Orders revealed no documented evidence of new orders obtained for treatment of the areas until 04/30/15. Review of the Physician's Orders obtained and dated 04/30/15, revealed orders were received for Nystatin Powder to be applied to the resident's left and right breast after cleansing every shift and as needed; and to clean and dry Resident #8's buttock area and apply Calazime Cream (a skin protectant paste) to the reddened area every shift and as needed.

Continued interview on 04/30/15 at 2:30 PM with LPN #2, revealed he did not immediately notify the facility's Wound Nurse or the Physician about the rash area under Resident #8's left breast or the excoriation to the resident's buttocks on 04/29/15. He stated he had not notified them because 04/29/15 was the first day he was assigned to Resident #8, and he was unaware whether the areas were new. Per interview, he did not check Resident #8's medical record, but thought there was already orders in place for treatment of the areas.

2. Review of Resident #2's medical record

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revealed the facility admitted the resident on 09/30/14, with diagnoses which included Cerebral Vascular Accident (CVA), COPD and Diabetes Mellitus. Review of Resident #2's Significant Change MDS Assessment dated 01/27/15, revealed the facility assessed the resident as having a BIMS score of fifteen (15) out of fifteen (15) indicating he/she was cognitively intact.

Review of the Hospital Discharge Summary dated 04/23/15, revealed Resident #2 was admitted to the hospital from 04/03/15 until 04/23/15, where the resident was treated for Lower Extremity Cellulitis with intravenous (IV) antibiotics.

Review of Resident #2's Re-admission Physician's Orders dated 04/23/15, revealed an order for Remedy Nutrashield with Olivamine to the buttocks and perineal area every shift and as needed.

Observation of Resident #2's skin assessment on 04/29/15 at 2:25 PM, performed by LPN #6 (the facility's Wound Nurse), revealed the resident had red rash chafing areas under the abdominal folds, redness to the perineal area and excoriation between the buttocks. Interview with LPN #6, during the skin assessment, revealed she was unaware of Resident #2 having the areas of skin breakdown under the abdominal folds and there was no order for treatment of the area. LPN #6 stated, she was also unaware of the redness to Resident #2's perineal area and the excoriation between the buttocks.

Continued record review revealed Physician's Orders dated 04/29/15, received by LPN #6 to cleanse Resident #2's perineal area with soap and water, pat dry, and apply Remedy Calazime

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F 157	<p>Continued From page 5</p> <p>Cream with every incontinence or voiding episode or every shift for fourteen (14) days. Continued review of the 04/29/15 Physician's Order received by LPN #6 revealed to cleanse Resident #2's coccyx/inner buttocks excoriation area with soap and water and apply Calazime Cream four (4) times a day and as needed for fourteen (14) days. However, further review of the Physician's Orders revealed no documented evidence of new orders received for treatment of the redness and chafing to Resident #2's abdominal folds.</p> <p>Interview with LPN #6/Wound Nurse on 05/06/15 at 5:50 PM, revealed during Resident #2's skin assessment with the Surveyor on 04/29/15, she had failed to write down all the skin issues identified. According to LPN #6/Wound Nurse, therefore, she had not notified the Physician of the redness and chafing of the abdominal folds and obtained orders for treatment of the area.</p> <p>Interview, on 05/01/15 at 4:10 PM, with the Attending Physician for Resident #8 and Resident #2 revealed it was his expectation he be notified for any new areas of skin breakdown.</p> <p>Interview, on 05/02/15 at 8:00 AM, with the Director of Nursing (DON), and on 05/06/15 at 6:10 PM with the Assistant Director of Nursing (ADON), revealed the Physician should be notified of any new areas of skin breakdown in order to obtain treatment to prevent further breakdown, as per the policy.</p>	F 157		
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or</p>	F 241	<p>F 241 D</p> <p>Residents Affected On 5-6-15 Resident #22 medical record was reviewed by the social services director and</p>	

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F 241 : Continued From page 6
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 interview, record review and review of the facility's policy, it was determined the facility failed to ensure residents were treated in a manner which maintained or enhanced each resident's dignity and respect for one (1) of twenty-two (22) sampled residents (Resident #22).

Resident #22 reported to a Certified Nursing Assistant (CNA) that another CNA had called him/her the "N" word during a fire drill procedure. Resident #22's allegation was documented on the facility's Behavior Monitoring Record form for the resident, dated 02/26/15, signed by staff and noted to have been reviewed by the Social Services Director (SSD). At a Care Conference meeting held on 03/12/15, Resident #22 reported the same allegation to staff present, and the CNA identified by the resident was sent to be re-educated on abuse and Residents Rights on 03/13/15. However, the facility failed to determine if other residents residing in the facility were treated with dignity and ensure staff provided care in a manner to maintain each resident's dignity.

The findings include:

Review of the facility's policy titled, "Quality of Life-Dignity", revised November 2010, revealed each resident was to be cared for in a manner that promoted and enhanced his/her quality of life, dignity, respect and individuality. Per the

F 241 : the MDS coordinator for any behaviors not addressed in the comprehensive care plan and social services progress notes. Resident #22 is being addressed properly and in a dignified manner by all staff as evidenced by interviews by the social services director or the administrator weekly and no issues have been voiced by resident #22.

Identification of Other Residents
All residents has the potential to be affected. Interviews were conducted with 52 residents assessed as having a BIMS score of 8 and above for any allegations of dignity concerns starting 5-7-15 thru 5-13-15 which were conducted by the Administrator, Social Services Director and Human Resources Director.
In addition, the social services directors performed a psychosocial well-being check which included any changes in cognition, behaviors, mood changes, or depressive symptoms on 48 the residents with a BIMS score below 8 to identify any signs and symptoms of distress. No concerns were identified. This was completed on 5-13-15.

Systemic Changes
Re-training of the Administrator, Social Services Director and Human Resource Director conducted by the Regional Director of Operations and Regional Director of Clinical Services on reporting and investigating allegations of failure to maintain the resident's dignity on 5-7-15.

In-servicing for all staff in each department began on 5-7-15 through 6-25-15 on reporting, investigating and documenting behaviors and enhancing, protecting and maintaining each

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F 241	<p>Continued From page 7</p> <p>Policy, residents were treated with dignity and respect at all times. The Policy revealed "treated with dignity" meant the resident was assisted in maintaining and enhancing his/her self esteem and self-worth. Further Policy review revealed staff were to speak respectfully to residents at all times.</p> <p>Review of Resident #22's medical record revealed the facility admitted the resident on 08/26/14, and re-admitted him/her on 09/30/14, with diagnoses which included Anemia, Heart Failure, Type II Diabetes, Chronic Kidney Disease Stage III and Muscle Weakness. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 03/27/15, revealed the facility assessed Resident #22 as cognitively intact.</p> <p>Interview, on 05/02/15 at 8:25 AM and 11:41 AM, with Resident #22 revealed an "aide" had called him the "N" word about two (2) months ago, but it had not bothered him/her. Resident #22 revealed he/she reported the incident to staff at the time it occurred, and also reported the incident again at a care conference meeting about two (2) months ago. Further interview with Resident #22 revealed no one from the facility had ever interviewed him/her regarding the incident.</p> <p>Interview, on 05/04/15 at 12:29 PM, with CNA #7 revealed during a fire drill on 02/26/15, Resident #22 got upset when she was closing the resident's door and had yelled, cursed and threw items at her. CNA#7 revealed, after the fire drill, Resident #22 told another CNA, CNA #25, she (CNA #7) had called him/her the "N" word. Continued interview revealed however, it was not true that she had called Resident #22 the "N" word. Per interview, Resident #22 also told CNA</p>	F 241	<p>resident's dignity. The in-servicing will be conducted by the RN nurse educator after receiving education from the Regional Director of Clinical Services. Post- tests were conducted after the in-servicing.</p> <p>The Social Services will start receiving a copy of all physicians' orders each morning to review for any deletion, addition or changes in psychoactive medications and the 24 hour reports each morning for any new and/or escalating behaviors and/or resident psychosocial issues that may need to be reported or investigated. In addition, if escalating behaviors or concerns are identified thru this process, the social services will document findings, review care plans for appropriate behavioral interventions and notify nursing if physician needs to be notified of identified escalating behaviors. The administrative team which would include the Administrator, DON, Social services, Unit managers, QA nurse, Infection control nurse, treatment nurse, shift supervisors, Weekend supervisors and MDS Coordinators are responsible for observation of staff providing care to the residents to ensure they maintain and protect resident's dignity. These observations are on-going daily Monday thru Sunday and any issues identified are reported to the social services department, the DON or the Administrator. Any allegation of failure to maintain the resident's dignity to be reported to OIG by the Social services director and the Administrator.</p> <p>Monitoring The administrative team which would include the Administrator, DON, Social services, Unit</p>	

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#13 and CNA #25 if she (CNA #7) reported him/her for behaviors the resident was going to say she had called him/her the "N" word. Per CNA #7, she and the other CNA's went to the nurse's station after the incident involving Resident #22, and reported the resident's allegation to a nurse who no longer works at the facility. She stated the Behavior Monitor Form, dated 02/26/15 at 9:30 PM was completed, and she had included a written statement with input from CNA #13 and #25, who signed the statement, about what they witnessed and heard. Further interview revealed the next day, 02/27/15, she had informed the SSD of the incident involving Resident #22 and that she had completed the Behavior Monitor Form.

Review of the facility's Behavior Monitor Record form, dated 02/26/15 at 9:30 PM, revealed a written statement signed by CNA #7, CNA #13, and CNA #25, which noted during a fire drill Resident 22 displayed behaviors which included yelling, calling CNA #7 a "bitch" and throwing items. Continued review of the written statement on the back of the document revealed Resident 22 reported to CNA #25 during the incident he/she was called a "nigger" by CNA #7. Further review of the written statement revealed Resident #22 had told CNA #25 he/she had called the "aide" a "bitch" and if the "aide" turned the resident in, he/she was going to turn the "aide" in for calling him/her the name. Review of the Behavior Monitor Record revealed it was signed by a Licensed Practical Nurse (LPN), who no longer worked at the facility, as the supervisor.

Interview, on 05/04/15 at 10:38 AM, with CNA #25 revealed CNA #7 and CNA #13 were standing by Resident #22's door and asked him to check on

F 241: managers, QA nurse, Infection control nurse, treatment nurse, shift supervisors, Weekend supervisors and MDS Coordinators are responsible for observation of staff providing care to the residents to ensure they maintain and protect resident's dignity. These observations are on-going daily Monday thru Sunday and any issues identified are reported to the social services department, the DON or the Administrator. Any allegation of failure to maintain the resident's dignity will be reported to OIG by the Social services director and the Administrator.

The Administrator will be informed of any behaviors resulting in an allegation of failure to maintain the resident's dignity that is reported to the Social Services office, DON or by any other department and will be reported to OIG and then the facility will began investigation.

The Administrator will review grievances Monday thru Friday which have been submitted to social services, or to the DON for review of possible failure to maintain the resident's dignity and OIG reportable occurrences.

The administrator will report findings to the monthly Quality Assessment and Safety Committee meetings which consists of the Medical Director, DON, Administrator, Consultant pharmacist, Infection control nurse, Quality assurance nurse, Social services director and the Dietary for review of compliance and recommendations.

Date of Correction:

6-26-15

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F 241	<p>Continued From page 9</p> <p>the resident. CNA #25 revealed when he went in Resident #22's room the resident reported calling CNA #7 the "B" word and she (CNA #7) called him/her the "N" word. Per interview, he had told Resident #22 to report the incident, and was told by the resident if CNA #7 turned him/her in then the resident was going to report her in for calling him/her the "N" word. Continued interview revealed all three (3) CNA's went to the nurse's station and he explained everything to the nurse there; however, could not recall the nurse's name. CNA #25 revealed the nurse had CNA #7 complete the Behavior Monitor record and she and CNA #13 signed as witnesses.</p> <p>Interview, on 05/04/15 at 1:15 PM, with CNA #13 revealed after the fire drill CNA #7 had told her Resident #22 was upset and throwing things at her. Per interview, when she went to check on Resident #22, while CNA#7 stayed outside the room, the resident yelled he did not want that "B" in back in his/her room. CNA #13 revealed Resident #22 was very upset and CNA #7 said she was going to fill out a Behavior Report. Continued interview revealed Resident #22 then stated if CNA #7 told on him/her, then the resident was going to tell she had called him/her the "N" word. CNA#13 stated she got Resident #22 to calm down, went to the nurse's station and CNA #7 wrote the statement about what happened and she and CNA #25 signed as witnesses. Further interview revealed they had signed the written statement because Resident #22 had told CNA #25 he/she was going to tell the facility CNA #7 had called him/her an "N".</p> <p>Interview, 05/02/15 at 12:15 PM and on on 05/03/15 at 9:15 AM, with the SSD revealed Resident #22 reported an "aide" called him/her</p>	F 241		

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the "N" word and he discussed the incident with the resident. Per interview, during the discussion Resident #22 did not appear to be in any emotional distress. The SSD revealed the "aide" had documented the incident on the Behavior Monitor sheet, on 02/26/15, which he had reviewed. According to the SSD, since he knew both Resident #22 and the "aide" he looked at the incident only as a behavior episode, as both the resident and "aide" reported they were called a name. Continued interview revealed the SSD was also aware Resident #22 reported the incident at a care conference meeting, on 03/12/15, which was attended by the facility's other Social Worker (SW). The SSD revealed the other SW went to the Administrator and reported what Resident #22 had said in the care conference; however, the incident was viewed as a resident behavior.

Interview, on 05/04/15 at 11:48 AM, with SW #1 revealed she was at the care conference, on 03/12/15, when Resident 22 reported he/she and CNA #7 had exchanged words. Per interview, Resident #22 stated during the care conference when the "aide" exited the room she had mumbled the "N" word; however, the resident was not upset when discussing the incident. SW #1 revealed after the care conference she talked to the Unit Coordinator (UC) about the incident reported by Resident #22, and later the Administrator asked her what had happened at the care conference.

Interview, on 05/14/15 at 1:45 PM, with both the SSD and SW #1, revealed staff's alleged use of the "N" word reported by Resident #22 was considered labeling and disrespectful. Both revealed if there was a possible concern or

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incident regarding residents' dignity by staff, other residents were interviewed to determine if they also had dignity concerns. They stated staff were also re-educated if a concern or incident happened; however, neither the SSD or SW #1 could verify staff re-education had been completed after Resident #22 made the allegation. Further interview revealed they were not sure if the facility needed to interview other interviewable residents related to how they were treated by staff based on this particular incident.

Interview, on 05/04/15 at 12:30 PM and on 05/14/15 at 12:50 PM, with Registered Nurse (RN) #2/Unit Coordinator (UC) revealed she had not known about the allegation until days later when called into the Administrator's office and questioned about the incident on 02/26/15. RN #2/UC revealed the "N" word was derogatory and not a dignified way to speak to a resident. Continued interview revealed the Administrator was comfortable allowing the "aide" to work after she had received the re-education on abuse. Further interview revealed she was not aware of other residents being asked if they had dignity concerns or of staff being in-serviced; however, that was something which should have been done.

Further interview with CNA #7, on 05/04/15 at 12:29 PM, revealed sometime later after the incident, she met with both the Administrator and the Unit 2 Coordinator. Per interview, she told them about the incident involving Resident #22 which she had reported to the the nurse, and told them she documented the incident on the Behavior Report. CNA #7 revealed the Administrator then sent her to do "hands on" training on abuse.

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F 241	Continued From page 12 Personnel record review revealed CNA #7 was trained on 03/13/15, by the Staff Development Coordinator (SDC) on information which included the Centers for Medicare and Medicaid's (CMS) module titled, "Hand in Hand: What is Abuse"? Interview with the SDC, on 05/14/15 at 1:25 PM, revealed she trained staff during orientation and annually on Resident Rights and dignity. The SDC revealed staff were trained to treat residents with dignity and respect and were not to label residents. Per interview, she was unaware of any dignity/abuse incident, but had been told to train CNA#7 on abuse and dignity. Continued interview revealed staff using the "N" word was a dignity issue for a resident, and this was not acceptable. The SDC stated if an allegation was reported, the facility needed to talk to other residents to see if they had any dignity issues and staff should be inserviced. Further interview revealed she had provided staff annual inservices on abuse and Resident Rights between January and March 2015. Interview, on 05/14/15 at 1:00 PM, with the Director of Nursing (DON) revealed all staff were to treat residents with dignity and respect and they had inserviced nursing staff related to dignity, Resident Rights, on 03/27/15. The DON stated however, she was unsure why the facility had provided the inservicing on 03/27/15. Continued interview revealed the use of the "N" word by staff was both labeling a resident and not respectful. Per interview, however, she was not aware of the allegation made by Resident #22. The DON revealed with any allegation in which staff talked to a resident inappropriately, all interviewable residents should be interviewed	F 241		

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F 241	<p>Continued From page 13</p> <p>about staff's treatment of them. Further interview revealed all staff should be inserviced related to the alleged incident.</p> <p>Interview with the Administrator, on 05/02/15 at 12:21 PM, revealed the incident involving Resident #22 was brought to his attention, and he spoke with CNA #7 who told him the resident was upset she closed the door during the fire drill. Per interview, CNA #7 also told him Resident #22 threw things at her and called her the "B" word. The Administrator revealed CNA #7 reported Resident #22 told other CNA's if she reported him/her, then the resident was going to tell CNA #7 had used the "N" word. Continued interview revealed CNA #7 denied calling Resident #22 the "N" word. Per the Administrator, he believed Resident #22's statement was a threat of retaliation against CNA #7, and he viewed the incident as a resident behavior. Further interview revealed the Administrator was proactive and sent CNA #7 to be inserviced on resident verbal behaviors; however, he had never discussed the incident with Resident #22.</p> <p>Additional interview with the Administrator, on 05/14/15 at 2:00 PM, revealed in order to determine if use of the "N" word by staff was considered a dignity and respect issue, the person being called the name would have to be asked about it. The Administrator revealed the facility had not determined the "N" word was used by the staff person. According to the Administrator, the facility had not interviewed other interviewable residents, after the incident and prior to the current survey, regarding any dignity concerns. Further interview revealed all staff were inserviced on dignity from January to March.</p>	F 241		

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F 279 SS=G 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure a Comprehensive Care Plan was developed for each resident which included measurable objectives and timetables to meet a resident's medical and nursing needs identified through the comprehensive assessment for one (1) of twenty-two (22) sampled residents (Resident #8).

Review of Resident #8's Comprehensive Care Plan revealed the facility had assessed and care planned the resident as at risk for injury. Review

F 279 F 279 G

Residents Affected
The comprehensive care plan for Resident # 8 has been developed to include the bed alarm utilized in her fall risk category on 5-4-15 by the MDS coordinator. In addition, the care plan includes checking for placement and functioning of the alarm each shift. The SRNA care plan, SRNA pocket care plans, and the treatment administration record (TAR) also has instruction to check placement and function of the alarms each shift. This was completed on 6-2-15 by the QA nurse.

Identification of Other Residents
All residents are required to have a comprehensive care plan to address current and potential problems and interventions, therefore all residents may be potentially affected.
All resident's care plans were reviewed and revised as needed by the MDS coordinators on 4-28-15 thru 5-8-15 for appropriate care plan interventions including fall risk management. The residents utilizing alarms have care plan interventions to include checking for placement and functioning of the alarms each shift.
The SRNA care plan, SRNA pocket care plans, and the Treatment Administration Record (TAR) also has instruction to check placement and function of the alarms at the beginning of each shift. This was completed on 6-2-15 by the QA nurse.

Systemic Changes
The DON, MDS coordinators, Unit Managers, Shift supervisors, Weekend supervisor and the QA nurse was in-serviced by the Regional Director of Clinical Services on 5-18-15

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of the risk for injury care plan revealed no documented evidence it was developed to be individualized and specific regarding Resident #8's Physician ordered bed alarm which was in place; the need for checking the alarm for placement and function; or, when and how often the bed alarm needed to be checked. Staff interviews revealed Resident #8 had a bed alarm; however, the bed and chair alarms were not always checked at the beginning of their shifts to ensure the alarms were functioning properly.

On 04/17/15, Resident #8's bed alarm was not checked at the beginning of day shift by Licensed Practical Nurse (LPN) #12 and Certified Nursing Assistant (CNA) #27, who were assigned to the resident's care. At 7:50 AM on 04/17/15, Resident #8 experienced an unwitnessed fall which resulted in the resident being transferred to the hospital emergency room (ER) and admitted to the hospital with diagnoses of hip and pelvis fractures.

The findings include:

Review of the facility's policy titled, "Safety Alarms", undated, revealed it was the facility's policy to utilize bed and/or chair alarms to alert staff when a resident was trying to get up unassisted. The Policy revealed the facility's Interdisciplinary Team (IDT) or the nurse could decide whether a resident needed a bed/chair alarm which might alert the staff if the resident was trying to get up out of the bed or chair unassisted. Further review of the Policy revealed the Physician was to be notified and the resident's care plan was to be updated if alarms were to be used. Additional review of the Policy, revealed no documented evidence of when and

F 279 regarding specific individualized comprehensive care plans, SRNA care plans, SRNA pocket care plans and the TAR including specific instructions when utilizing fall prevention alarms which should include checking for placement and functioning of the alarms each shift.

The licensed nurses were in-serviced by the RN nurse educator regarding when receiving physician's orders for fall prevention alarms that the orders should include checking for placement and functioning each shift and this specific information should be included on the comprehensive care, SRNA care plan, SRNA pocket care plans and the TAR. The in-services were started on 6-7-15 and completed on 6-14-15.

The facility utilizes a 3 part form for physician's orders. One section of the form immediately updates the comprehensive care plan, one section is used for the nurse's notes and one section is the actual physician orders. As a second check, a new QA audit was developed by the DON on 6-4-15 to have the QA Nurse to audit physician orders Monday thru Friday to validate that the comprehensive care plans, SRNA care plan, SRNA pocket care plan and are updated and revised as needed. This audit is turned into the DON daily for review and compliance.

A new QA audit was developed on 6-8-15 by the DON for the unit managers, shift supervisors and weekend supervisor to check for proper alarm placement and functioning each shift Monday thru Sunday. The audit includes Resident name, fall prevention alarms ordered by the physician, proper placement

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how often alarms were to be checked to ensure the alarms were functioning properly.

Review of the facility's, "Fall Management Program", undated, revealed residents' Comprehensive Care Plans would reflect the resident's risk for falls and include goals and intervention which were resident specific.

Review of the facility's, "Care Plans-Comprehensive" Policy, revised September 2010, revealed an individualized Comprehensive Care Plan which included measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs was developed for each resident. Per the Policy, each resident's Comprehensive Care Plan was designed to: incorporate identified problem areas; incorporate risk factors associated with identified areas; reflect treatment goals, timetables and objectives in measurable outcomes; and aid in preventing or reducing declines in the resident's functional status and/or functional level.

Record review revealed the facility admitted Resident #8 on 03/04/15, with diagnoses which included Chronic Obstructive Pulmonary Disease and Malignant Neoplasm of the Colon. Review of Resident #8's Admission Minimum Data Set (MDS) Assessment dated 03/11/15, revealed the facility assessed Resident #8 to have a Brief Interview for Mental Status score of ten (10) out of fifteen (15) which indicated moderate cognitive impairment. Continued review of the MDS revealed the facility was unable to determine if Resident #8 had experienced a fall in the past six (6) months prior to admission. Further review of the MDS Assessment revealed the facility assessed Resident #8 to require extensive

F 279 and proper functioning. These audits are turned into the DON daily for review and compliance.

Monitoring

The DON will submit the results of the QA audits completed daily by the QA nurse and the results of the audits completed each shift by the unit managers and shift supervisors to the monthly Quality Assurance and Safety Committee meeting for review and recommendations.

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F 279	<p>Continued From page 17</p> <p>physical assistance of two (2) staff for transfers and for ambulation in the corridors.</p> <p>Review of the MDS Care Area Assessment (CAA) Worksheet, dated 03/17/15, revealed falls had triggered due to Resident #8's unsteady gait and balance. Continued review of the CAA Worksheet revealed Resident #8 was noted to have generalized weakness from her/his medical conditions and was receiving assistance with all Activities of Daily Living (ADL's). Per the CAA Worksheet, Resident #8's primary mode of locomotion was a wheelchair and the resident was ambulating with Physical Therapy. Further review of the CAA Worksheet revealed safety measures were in place as per the Physician's Orders.</p> <p>Review of the Resident #8's "Resident Fall Risk" dated 03/04/15, revealed the facility assessed the resident as at risk for falls due to problems with functional status, a history of falls in the past six (6) months and the use of medications which potentially predisposed him/her to falls.</p> <p>Review of Resident #8's monthly April 2015 Physician's Orders revealed an order for the resident to have a bed sensor alarm and a chair tab alarm.</p> <p>Review of Resident #8's Comprehensive Care Plan dated 03/17/15, revealed the facility had care planned the resident as at risk for an accident, injury, or fall related to his/her weakness and impaired mobility. Continued review of the at risk for accident, injury or fall revealed interventions which included: staff to orient the resident to the facility as needed; educate him/her about safety and help maintain</p>	F 279		

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safe environment; ensure correct use of "sensory aides"; observe for safety and intervene as needed; and ensure appropriate assistance with care and mobility. Further review revealed no documented evidence however, Resident #8's at risk for accident, injury or fall care plan was specific and individualized with interventions to include the resident's Physician ordered bed alarm.

Review of the CNA Care Plan Record for April 2015, revealed Resident #8 was to have a sensor alarm to the bed; however, there was no documented evidence it addressed the need for checking the alarm for placement and function, or for when and how often to do alarm checks.

Review of a Hospital Discharge Summary dated 04/16/15, revealed Resident #8 had been admitted to the hospital on 04/08/15, with diagnoses which included Pneumonia, Urinary Tract Infection (UTI) and Hydronephrosis (a swollen kidney which results from failure of normal urine drainage from the kidney to the bladder). Further review of the Discharge Summary revealed Resident #8 was discharged back to the facility on 04/16/15.

Review of Resident #8's Re-admission Physician's Orders dated 04/16/15, revealed no documented evidence the resident's bed sensor alarm and chair tab alarm had been re-ordered.

Review of the Nurse's Note dated 04/17/15 at 07:50 AM, revealed the nurse heard Resident #8 fall and immediately ran into the resident's room. Continued review of the Note revealed the nurse found Resident #8 lying on his/her left side on the floor beside the roommate's bed. The Note

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revealed there were alarm sensors on the bed and wheelchair which had not sounded. Further review of the Note revealed EMT (Emergency Medical Technicians) arrived at 8:15 AM and transferred Resident #8 to the hospital.

Review of the Hospital Discharge Summary dated 04/22/15, revealed Resident #8 was admitted on 04/17/15 after experiencing a fall in the facility. Continued review revealed Resident #8 was diagnosed at the hospital with Acute Left Inferior Pubic Ramus Fracture (pelvis fracture), and a Mildly Displaced Transverse Fracture through the superior portion of the Left Greater Trochanter (Hip Fracture).

Interview with LPN #12 on 04/28/15 at 12:45 PM, during initial tour, revealed Resident #8 had experienced a recent fall at the facility which had resulted in fractures of the resident's pelvis and hip. LPN #12 revealed she was the nurse assigned to Resident #8 on 04/17/15, at the time of the fall. According to LPN #12, on 04/17/15, she was near Resident #8's room in the hallway and heard a loud noise in the resident's room. Per interview, she went to Resident #8's room and was the first person there. She stated she found Resident #8 lying on his/her left side on the floor. Continued interview revealed Resident #8 must have gotten out of bed on his/her own without assistance. She stated Resident #8's call bell was not ringing and the bed alarm was not sounding when she entered the resident's room. Per LPN #12, if Resident #8's bed alarm had been sounding she would have heard it in the hallway and responded to it which might have prevented the resident's fall. She clarified she had not checked Resident #8's bed alarm when she started work on the day shift at 7:00 AM, prior

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PINE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40504		
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F 279	<p>Continued From page 20</p> <p>to the resident's fall at 7:50 AM.</p> <p>Interview with CNA #27 on 04/29/15 at 9:50 AM, revealed when she came to work on day shift at 7:00 AM on 04/17/15, she did not get to check on Resident #8 as the breakfast trays came out early that morning, at 7:10 AM. According to CNA #27, she was assigned to Resident #8 that day, and had been delivering a breakfast tray to a room near Resident #8's room, when she heard a loud crash and entered the resident's room. Per interview, when she went into Resident #8's room, LPN #12 was already there. CNA #27 revealed Resident #8's roommate's wheelchair was in front of the bathroom door and the resident was lying on his/her left hip in front of the wheelchair near the roommate's bed. She revealed Resident #8's bed alarm was not sounding when she entered the resident's room. Per CNA #27, Resident #8 told her and LPN #12 he/she was trying to go to the bathroom at the time of the fall.</p> <p>Interview with LPN #13 on 04/29/15 at 6:00 PM, who was assigned to Resident #8 on the night shift on 04/16/15 until 7:30 AM on 04/17/15, revealed she checked the residents' bed and chair alarms herself at the beginning of her shift to make sure the alarms were hooked in and were working. She stated this would have included Resident #8's bed alarm on 04/016/15 when she began her shift. According to LPN #13, she could not recall Resident #8 ever attempting to get out of bed on his/her own without assistance. Further interview revealed she recalled Resident #8 being taken to the bathroom for toileting on 04/17/15 between 5:00 AM and 6:00 AM, and then was assisted back to bed.</p>	F 279		

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F 279	<p>Continued From page 21</p> <p>Phone interview with CNA #28 on 04/30/15 at 11:30 PM, who was assigned to Resident #8 on the night shift on 04/16/15 until 7:30 AM on 04/17/15, revealed she checked her residents' bed and chair alarms at the beginning of her shift to make sure they were working properly and then also checked the alarms with each round performed. According to CNA #28, night shift did not ever get Resident #8 out of bed, and checked and changed the resident in the bed for incontinence care during the night. Per interview, she started her last rounds on her residents between 5:00 AM and 6:00 AM and completed her rounds by 6:30 AM each morning. Further interview revealed Resident #8 was still in bed when she performed her last rounds.</p> <p>Interview with the Unit Coordinator (UC) for Unit 2 on 04/28/15 at 8:00 PM and 04/30/15 at 11:00 AM, where Resident #8 resided, revealed nurses checked the residents' alarms each shift, but not necessarily at the beginning of their shift. The UC stated CNA's also checked residents' alarms; however, there was no set time for them to check the alarms. According to the UC, it was best if the nurses and CNA's checked the alarms during their first rounds on their shift, for placement and functioning. Per interview and review of the record, the UC revealed Resident #8 had the care plan in place noting "sensory aides" which could possibly mean his/her bed and chair alarms. The UC revealed however, the care plan should be specific to include the bed and chair alarms which had not been discontinued.</p> <p>Interview with MDS Coordinator #1 on 05/01/15 at 4:43 PM, revealed the MDS Coordinators had the responsibility for development of residents' Comprehensive Care Plans. MDS Coordinator</p>	F 279		

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F 279 Continued From page 22

#1 review Resident #8's medical record and stated the resident had orders for bed and chair alarms. Per interview, she was unable to find a care plan regarding the alarms until 04/28/15, when a care plan update was added. Continued interview revealed the MDS Coordinators should have developed a care plan which included interventions for the bed and chair alarms though when the alarms were ordered in March 2015. According to MDS Coordinator #1, the "sensory aides" intervention on Resident #8 care plan was in reference to glasses or hearing aides if the resident had those in use. Further interview revealed when the MDS Coordinators were developing a resident's care plan, they reviewed the resident's entire chart, especially Physician's Orders and Progress Notes for all disciplines. MDS Coordinator #1 revealed the residents' Comprehensive Care Plans should be developed to be individualized and specific for each resident.

Interview, on 05/04/15 at 11:10 AM, with the Quality Assurance (QA) Nurse, revealed residents' Comprehensive Care Plans, as well as, the CNA Care Plans should state bed and chair alarms were to be checked at the beginning of each shift for placement and function. Per interview, nurses and CNA's should be performing the alarm checks.

Interview with the DON on 05/01/15 at 12:09 PM, revealed nurses and CNA's both had the responsibility for checking alarms for placement and function which should be performed during the first rounds of their shifts and throughout the shift. Per interview, Resident #8's Comprehensive Care Plan should have included the chair and bed alarms since the alarms were ordered on the admission orders dated 03/04/15.

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F 279 Continued From page 23
Continued interview with the DON revealed Monday through Friday, residents' falls were brought to the Interdisciplinary Team (IDT) Meeting which included the UCs and herself. She stated Monday through Friday, after the IDT Meeting, falls were also further discussed in the morning meeting to review the interventions in place and to come up with additional interventions to try to prevent further falls. The DON revealed falls were also discussed in the facility's weekly standards of care meeting with the interventions reviewed to ensure they were effective. Further interview revealed however, the facility staff present in the meetings had not recognized during the review of residents' care plans interventions, that the care plan interventions did not include interventions for the use of the bed and chair alarms.

F 279

Interview, on 05/04/15 at 4:30 PM, with the Administrator revealed all residents' Comprehensive Care Plans should be developed to be individualized, thorough, and according to the resident's assessed needs.

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO
SS=E PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility

F 280 F 280 E

Residents Affected

The care plan for Resident #2 has been revised to address the PICC line insertion during a hospital stay. The care plan revision includes the PICC line dressing changes and assessment for signs and symptoms of infection. The PICC line dressing changes are scheduled to be changed every 7 days and there are no signs or symptoms of infection at the PICC line site. The care plan was updated/revised on 5-1-15 by the MDS coordinator. Resident's PICC was discontinued on 6-5-15 and again care plan was revised by the MDS coordinator on 6-5-15.

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F 280	<p>Continued From page 24</p> <p>for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</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 the Comprehensive Care Plan was revised for four (4) of twenty-two (22) sampled residents (Residents #2, #6, #8 and #22)</p> <p>Resident #2 had a Peripherally Inserted Central Catheter (PICC) line in place on re-admission to the facility; however, there was no documented evidence the resident's Comprehensive Care Plan was revised related to the PICC line to ensure the PICC line dressing was changed and the PICC line site was assessed for signs and symptoms of infection.</p> <p>Resident #6 sustained a right ankle fracture on 02/27/15, and was ordered to be non-weight bearing for six (6) weeks, then re-evaluated. However, there was no documented evidence Resident #6's Comprehensive Care Plan was revised to reflect the resident's transfer status which changed from a one (1) person transfer to a non-weight bearing status.</p> <p>In addition, there was no documented evidence</p>	F 280	<p>The care plan for Resident #6 has been revised for the right ankle fracture and the non-weight status for 6 weeks. The re-evaluation of the weight bearing status occurred on 5-27-15 with no weight bearing changes ordered. The care plan was also revised to include the resident's transfer status from one person assist to non-weight bearing status. The care plan was additionally revised for the change of the fiberglass knee to toe cast on 3-13-15 related to the resident removing the splint. Currently the resident has a boot to the right lower extremity while OOB, and her transfer status is with a Vander lift and assistance of 2. Resident #6 care plan was also revised to remove her oxygen which was discontinued on 5-8-15. The care plan was also revised to remove the valium medication which was not reordered on readmission on 1-8-15. The care plan was updated/revised on 6-2-15 by the MDS coordinator.</p> <p>The care plan for Resident #8 was revised to address her bed rest status due to the hip/pelvic fracture. The resident's current status is bedrest and on Hospice services. The care plan has also been corrected to remove the cast from the care plan which she didn't have on readmission. The care plan has also been revised to remove assisted with ambulation, she is currently a non-ambulatory status. The care plan was updated/revised on 5-4-15 by the MDS coordinator.</p> <p>The care plan for Resident #22 has been updated to include his verbal behaviors toward others by the social services director and the MDS coordinator on 5-15-15.</p>	

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the Comprehensive Care Plan was revised when Resident #6's splint was changed to a knee to toe Fiberglass cast on 03/13/15, related to the resident removing the splint.

Also, there was no documented evidence Resident #6's Comprehensive Care Plan was revised when the resident's oxygen (O2) and Valium (an antianxiety medication) were discontinued.

Resident #8 experienced a hip/pelvic fracture; however, there was no documented evidence the resident's Comprehensive Care Plan was revised to address the resident's order to be on bed rest. Review of the facility's care plan update/Immediate Care Plan dated 04/22/15 for Resident #8, completed after his/her return from the hospital, revealed the resident was to be assisted with ambulation. In addition, Resident #8 was care planned for a cast; however, the resident had no cast in place on re-admission from the hospital.

Resident #22 displayed verbal and physical behaviors towards others; however, the resident's behavior care plan was not revised to address the behaviors displayed on 02/26/15.

The findings include:

Review of the facility's policy titled, "Care Plans-Comprehensive", revised September 2010, revealed an individualized Comprehensive Care Plan was developed to meet the resident's medical, nursing, mental and psychological needs. The Policy revealed the assessment of residents was ongoing and care plans were revised as information about the resident and the

F 280 **Identification of Other Residents**
All residents are required to have a comprehensive care plan and revision to that care plan according to current care needs, therefore all residents may be potentially affected.
All resident's care plans were reviewed and revised as needed by the MDS coordinators for appropriate care plan interventions; the care plan reviews and revisions were completed on 5-8-15.

Systemic Changes
The MDS coordinators were re-inserviced on 6-10-15 by the RN Regional Clinical Director on the MDS process to ensure ongoing compliance.
A new Interdisciplinary Plan of Care (IPOC) program was implemented on 5-7-15 by the DON. The IPOC team members includes the DON, Unit managers, Social Services, QA nurse, MDS Coordinator and the Administrator and meets Monday thru Friday. If an admission or readmission occurs on the weekends, the house supervisor will audit the medical record utilizing the QA nurse's new admission/readmission audit form and turn the audit into the DON on Monday. The IPOC program was implemented to review of new admission residents, resident's readmissions, 24-hour reports, incident reports, all physician orders obtained in the last 24 hours, pharmacy orders, lab reports, and any other related information essential to planning the care for a resident.
The MDS coordinators are responsible to ensure that the comprehensive care plans are being updated Monday thru Friday using the physician's orders and the 24 hour report before the IPOC meetings and if additional

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resident's condition changed. Further review revealed the Care Planning/Interdisciplinary Team (IDT) was responsible for the review and updating of care plans when there was a significant change in the resident's condition or the resident was re-admitted from a hospital stay.

Review of the facility's, "Updating Care Plans" procedure, undated, revealed the facility utilized a three (3) part Physician Order form. Per the Procedure the three (3) part Physician Order form was completed and after an order was received one of the three (3) copies went to the resident's Comprehensive Care Plan for immediate updates of the care plan. Further review revealed the Comprehensive Care Plans were also reviewed and updated with the scheduled Minimum Data Set (MDS) Assessments.

1. Review of Resident #2's medical record revealed the facility admitted him/her on 09/30/14, with diagnoses which included Diabetes Mellitus, Cerebral Vascular Accident and Chronic Obstructive Pulmonary Disease. Review of the 01/27/15 Significant Change Minimum Data Set (MDS) Assessment revealed the facility assessed Resident #2 to have a Brief Interview for Mental Status (BIMS) score of a fifteen (15) which indicated no cognitive impairment.

Review of the Hospital Discharge Summary, dated 04/23/15, revealed Resident #2 was admitted to the hospital from 04/03/15 through 04/23/15. Continued review revealed Resident #2 was treated with intravenous (IV) antibiotics for lower extremity Cellulitis. Per the Discharge Summary, the discharge diagnoses included Venous Stasis, Diabetes Mellitus, Bilateral Heel Ulcers, Status Post Debridement and Xenograft

F 280 care planning is identified during the IPOC meetings, a list of care planning needs are written on the IPOC follow-up sheet and care plans are updated either during the IPOC meeting if the medical record is present or the care plan will be updated immediately following the IPOC meeting by the MDS coordinators.

The facility utilizes a 3 part form which includes the physician's order, nurse's note and care plan update/revision Monday thru Sunday. One section of the form immediately updates the comprehensive care plan, one section is used for the nurse's notes and one section is the actual physician orders. As a second check, a new QA audit was developed by the DON on 6-4-15 to have the QA Nurse to audit physician orders Monday thru Friday and the weekend house supervisors on Saturday and Sunday to validate that the physician's orders are on the medication administration record (MAR) and the treatment administration record (TAR) and that the comprehensive care plans, SRNA care plan, SRNA pocket care plan are updated and are being followed as ordered. This audit is turned into the DON daily for review and compliance.

Monitoring
The MDS coordinators are responsible to ensure that the comprehensive care plans are being updated Monday thru Friday using the physician's orders and the 24 hour report before the IPOC meetings and if additional care planning is identified during the IPOC meetings, a list of care planning needs are written on the IPOC follow-up sheet and care

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- Application (surgical tissue grafting) and Heel Infection with Carbapenem Resistant Enterobacteriaceae (CRE), a bacteria resistant to most available antibiotics, and Methicillin Resistant Staphylococcus Aureus (MRSA), an antibiotic resistant bacteria.
- Review of Resident #2's 04/23/15 Re-admission Physician's Orders revealed orders for the resident to have Contact Precautions and for Zosyn (an antibiotic medication) 3.375 milligrams IV via the PICC line every six (6) hours for seven (7) more days. Continued review of the Orders written on 04/23/15, revealed no documented evidence of orders related to dressing changes for the PICC line.
- Observation, on 04/30/15 at 8:00 AM, of Resident #2 revealed the PICC line was in place in the resident's left arm and the PICC line dressing in place was dated 04/29/15.
- Review of Resident #2's Comprehensive Care Plan revealed a care plan for "Contact Precautions" with a goal for the resident "to be free of infection transmission to self or others", dated 04/23/15. Continued review of the "Contact Precautions" care plan revealed interventions which included treatment as ordered, medications as ordered, follow contact precautions as per the facility policy, keep the resident's hands clean, and keep the resident's room and surroundings clean. However, further review of Resident #2's Comprehensive Care Plan revealed no documented evidence of a care plan to address the resident's PICC line which included interventions for assessing the PICC line site for signs and symptoms of infection, or for performing dressing changes to the PICC line.

F 280 plans are updated either during the IPOC meeting if the medical record is present or the care plan will be updated immediately following the IPOC meeting by the MDS coordinators.

The facility utilizes a 3 part form which includes the physician's order, nurse's note and care plan update/revision Monday thru Sunday. One section of the form immediately updates the comprehensive care plan, one section is used for the nurse's notes and one section is the actual physician orders.

As a second check, a new QA audit was developed by the DON on 6-4-15 to have the QA Nurse to audit physician orders Monday thru Friday and the weekend house supervisors on Saturday and Sunday to validate that the physician's orders are on the medication administration record (MAR) and the treatment administration record (TAR) and that the comprehensive care plans, SRNA care plan, SRNA pocket care plan are updated and are being followed as ordered. This audit is turned into the DON daily for review and compliance.

The DON will submit the results of the QA audits completed daily by the QA nurse to the monthly Quality Assurance and Safety Committee meeting which consists of the Medical Director, DON, Administrator, Consultant pharmacist, Infection control nurse, Quality assurance nurse, Social services director and the Dietary for review and recommendations.

Date of Correction:

6-26-15

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Interview with MDS Coordinator #1 on 05/01/15 at 4:43 PM, revealed residents' care plans were to be automatically updated from the Physician's Orders since they were a three (3) part system which contained the Physician's Order, the Condition Change and the Care Plan update. She stated the MDS Coordinators updated the care plans quarterly with the MDS schedule and the copy from the three (3) part Physician's Orders stood as an update for the care plans until the next MDS Assessment was completed. Continued interview revealed there was a copy of the Physician's Order on 04/23/15 related to Resident #2's IV antibiotic medication administered via the PICC line; however, she revealed could not find a copy of a Physician's Order for the PICC line dressing. She stated there should have been an order for the PICC line dressing change in order for Resident #2's care plan to be updated/revised. Per interview, as even though residents' care plans were updated/revised from the copies of Physician's Orders, the MDS nurses did not always receive the copies of the orders for updating/revising residents' care plans. Further interview revealed she could find no evidence Resident #2's Comprehensive Care Plan was updated/revised to address the resident's PICC line. She stated however, the Comprehensive Care Plan should have been revised/updated however, with a care plan for the PICC line to include monitoring for the signs and symptoms of infection at the PICC line site and for dressing changes to be performed to the PICC line site.

Interview, on 05/06/15 at 6:10 PM, with the Assistant Director of Nursing (ADON) in the absence of the DON, revealed Resident #2's

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F 280 Continued From page 29
Comprehensive Care Plan should have been revised to include a care plan to address the resident's PICC line with interventions which included monitoring of and dressing changes to the PICC line site.

F 280

2. Review of Resident #6's medical record revealed the facility re-admitted the resident on 03/02/15, with diagnoses which included Status Post Right Ankle Fracture, Dementia, Chronic Dizziness and Generalized Osteoarthritis. Review of the Annual MDS Assessment dated 03/20/15, revealed the facility assessed Resident #6 with a Brief Interview for Mental Status (BIMS) score of twelve (12) out of fifteen (15), which indicated he/she was interviewable.

Review of the Hospital Discharge Summary dated 03/02/15, revealed Resident #6 had sustained a Comminuted (a bone injury that results in more than two {2} separate components) Fracture of the Distal Fibula and the Medial Malleolus (prominence on the inner side of the ankle, formed by the lower end of the tibia) on 02/27/15, and was ordered to be non-weight bearing for six (6) weeks, then to be re-evaluated.

Review of the April 2014 Physician's Orders revealed orders for Resident #6 which included: to be a full body lift dated 03/07/11; have bed baths until the Orthopaedic Surgeon said otherwise dated 03/02/15; have oxygen at two (2) liters per nasal cannula at all times dated 03/02/15; and the right lower extremity splint was to stay on at all times dated 03/02/15.

Review of Resident #6's Comprehensive Care Plan revealed a fracture aftercare care plan related to the resident's right ankle fracture dated

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03/07/15, which had a goal of the resident to have less risk for complications associated with the right ankle fracture. Continued review of the fracture aftercare care plan revealed no documented evidence the care plan was revised to include Resident #6's transfer status of being non-weight bearing. Review of Resident #6's self-care deficit care plan dated 05/06/14, revealed it was revised on 03/07/15, to include an intervention which stated "change to transfer status"; however, there was no documented evidence the care plan was revised to include what the transfer status change was.

Continued review of Resident #6's fracture aftercare care plan dated 03/07/15, revealed an intervention stating the resident was to have "splint to (R)LE (right lower extremity) at all x's (times)". However, review of the care plan revealed no documented evidence it was revised after Resident #6's splint was changed to a knee to toe Fiberglass cast on 03/13/15, related to the resident removing splint.

Further review of Resident #6's Comprehensive Care Plan revealed a risk for alteration in respiratory function care plan dated 05/06/14, with an intervention of "O2 (oxygen) as ordered" dated 01/03/15. Continued review of the alteration in respiratory function care plan revealed no documented evidence it was revised when Resident #6's O2 was discontinued 03/02/15.

Continued record review revealed Resident #6 was admitted to the hospital from 01/03/15 to 01/08/15, and had discharge diagnoses which included Nursing Home Acquired Pneumonia and Congestive Heart Failure. Review of Resident

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#6's Re-Admission Physician's Orders dated 01/08/15, revealed no documented evidence of an order for Valium. Review of Resident #6's Physician's Orders prior to the resident's hospitalization revealed an order dated 10/17/14, for Valium two (2) milligram (mg) by mouth once daily as needed for worsening dizziness.

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Additional review of Resident #6's Comprehensive Care Plan revealed an at risk for adverse side effects related to psychotropic drug use "receives Valium (an anti-anxiety medication) r/t (related to) vertigo" (dizziness) care plan, undated. Continued review of the at risk for adverse side effects care plan revealed interventions which included: to administer medication as ordered; observe for adverse side effects of medication and report to Physician if they were present; pharmacy to review medications periodically for possible dose reductions; observe for change in mood and behavior and report to Physician and Social Services; observe for change in condition and notify Physician's and family; report unresolved altered mood to Social Services; and "Rx" (prescriptions) as ordered. However, there was no documented evidence the care plan was revised when Resident #6's Valium was not re-ordered on his/her readmission to the facility on 01/08/15.

Continued interview with MDS Coordinator #1 on 05/01/15 at 4:43 PM, revealed the purpose of a resident's Comprehensive Care Plan was to ensure the resident received individualized care. She stated the MDS staff should have assessed Resident #6, and ensured his/her Comprehensive Care Plan was revised and updated with an necessary changes. Per interview, Resident #6's

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Comprehensive Care Plan should have been revised and updated for the change in the resident's transfer status, when the resident's splint was changed to a cast, when the oxygen was discontinued and when the Valium was not re-ordered in January 2015.

3. Review of Resident #8's medical record revealed the facility admitted the resident on 03/04/15, with diagnoses which included Malignant Neoplasm of the Colon and Chronic Obstructive Pulmonary Disease (COPD). Review of the Admission MDS Assessment dated 03/11/15, revealed the facility assessed Resident #8 as having a BIMS of a ten (10) out of fifteen (15) which indicated moderate cognitive impairment.

Review of the Hospital Discharge Summary dated 04/22/15, revealed Resident #8 was admitted to the hospital on 04/17/15, after sustaining a fall at the facility. Continued review of the Discharge Summary revealed Resident #8 had been diagnosed with hip and pelvis fractures. The Discharge Summary revealed Resident #8 was seen by Orthopedics while in the hospital, and Orthopedics had deemed the resident not a surgical candidate. Per the Discharge Summary, Resident #8's family wanted the resident to have palliative care (specialized medical care for people with serious illnesses which focuses on providing patients with relief from symptoms and stress of a serious illness to improve the quality of life).

Review of the Re-Admission Physician's Orders dated 04/22/15, revealed orders for palliative care and bedrest. However, review of the 04/22/15 "Initial/Immediate Care Plan" (the acute care plan used by the facility for resident re-admitted to be

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used in conjunction with the Comprehensive Care Plan in place previously) revealed the facility had identified a problem for Resident #8 for "impaired mobility/positioning" with interventions which included "assist with ambulation". Even though Resident #8 had a Physician's Order for bedrest. Observation of Resident #8 on 04/29/15 at 10:50 AM, during a skin assessment, revealed the resident did not have a cast in place. Further record review revealed no documented evidence Resident #8 had a cast on when re-admitted on 04/22/15, or after being re-admitted to the facility. However, further review of the "Initial/Immediate Care Plan" revealed a problem titled "fracture" which had interventions which included "cast care".

Interview, on 05/01/15 at 4:00 PM, with the Physical Therapist (PT) revealed when Resident #8 was initially admitted to the facility he/she ambulated in the hallway one hundred (100) feet with the assistance of one (1) person and another person with the wheelchair behind the resident in case he/she needed to sit down. The PT revealed however, after Resident #8 was re-admitted to the facility on 04/22/15, after sustaining the fracture, the resident had been on bedrest and palliative care as per the Hospital Discharge Summary.

Further interview, on 05/01/15 at 4:43 PM, with MDS Coordinator #1, revealed Resident #8 was now on palliative care and bed rest and no longer ambulated. MDS Coordinator #1 reviewed Resident #8's "Initial/Immediate Care Plan" dated 04/22/15, and stated it was an acute care plan completed by the nurse re-admitting the resident, and it was to be used in conjunction with Resident #8's Comprehensive Care Plan which was

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already in place. Per interview, the "Initial/Immediate Care Plan" should not have been stated assist with ambulation, it should have been revised to include the order for Resident #8 to be on bed rest. MDS Coordinator #1 revealed the "Initial/Immediate Care Plan" should not have indicated cast care as Resident #8 had not had a cast when re-admitted or afterwards. She revealed the care plan should have been revised to reflect no cast.

Interview with the DON on 05/02/15 at 8:00 AM, revealed an "Initial/Immediate Care Plan" could be done when a resident was re-admitted from the hospital and was used in conjunction with the resident's Comprehensive Care Plan which was in place prior to hospitalization. She stated Resident #8's "Initial/Immediate Care Plan" should have been revised for bed rest, and assist with ambulation and cast care should not have been interventions.

4. Review of Resident #22's medical record revealed the facility re-admitted the resident on 09/30/14, with diagnoses which included Muscle Weakness, Heart Failure, Type II Diabetes and Chronic Kidney Disease. Review of the Quarterly MDS, dated 03/27/15, revealed the facility assessed Resident #22 as cognitively intact. Continued review of the MDS Assessment revealed the facility had not assessed Resident #22 as having behavioral symptoms directed towards others.

Review of Resident #22's Comprehensive Care Plan revealed the facility had care planned the resident for "resident has socially inappropriate behavior r/t (related to) sexual comments/actions", dated March 2015, with a

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F 280	<p>Continued From page 35</p> <p>goal of the resident would have reduced risk for inappropriate behavior through July 2015. Continued review of the socially inappropriate behavior care plan revealed interventions which included: approach resident in calm manner and explain all procedures; if resident becomes socially inappropriate try to redirect; try to determine the circumstances around the behavior and prevent the circumstances; and remove the resident from socially inappropriate situation as needed, stay calm and protect the dignity of the resident and others.</p> <p>Interview, on 05/04/15 at 10:38 AM with Certified Nursing Assistant (CNA) #25, at 12:29 PM with CNA #7 and at 1:15 PM with CNA #13 revealed on 02/26/15, Resident #22 displayed verbal and physical behaviors towards CNA #7. Per interview, Resident #22 cursed at CNA #7, and yelled and threw items at her. The CNA's revealed a nurse instructed CNA #7 to initiate a Behavior Monitor form for Resident #22 regarding his/her behaviors. CNA #7 revealed she reported Resident #22's behaviors to the Social Services Director (SSD) the next day, 02/27/15.</p> <p>Review of the facility's Behavior Monitor Record form, dated 02/26/15 at 9:30 PM, revealed it contained a written statement signed by CNA #7, CNA #13, and CNA #25, which noted during a fire drill that day Resident 22 displayed behaviors which included yelling and throwing items and calling CNA #7 a "bitch". Continued review of the three (3) CNA's written statement revealed Resident 22 reported to CNA #25 during the behavior incident CNA #7 called him/her a "nigger" and he/she had called CNA #7 a "bitch".</p> <p>Further review of Resident #22's Comprehensive</p>	F 280		

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Care Plan revealed no documented evidence it was revised to include the resident's behaviors displayed on 02/26/15.

Interview, on 05/05/15 at 5:02 PM, with LPN #7 revealed Resident #22 had some behaviors at times where he/she yelled at staff and was borderline verbally abusive. LPN #7 revealed Resident #22 had a behavior care plan related to making inappropriate sexual comments to female staff; however, the care plan had not been revised to address Resident #22's behaviors displayed on 02/26/15.

Interview, on 05/05/15 at 5:45 PM, with LPN #6 revealed she cared for Resident #22 before and sometimes the resident had behaviors of cursing at staff he/she did not like. Further interview with LPN #6 revealed when a resident displayed verbal and physical behaviors towards others it should be care planned to assist staff in "dealing" with the behaviors.

Interview, on 05/04/15 12:30 PM, with RN #2/UC revealed the nurse assigned to Resident #22 on 02/26/15, when the CNA's reported the behaviors displayed by the resident was who had been responsible to update/revise the resident's care plan related to behaviors. RN #2/UC revealed when a resident displayed behaviors, the nurse was to notify the Physician of the behaviors and update/revise the resident's care plan with any related orders and with interventions to attempt to prevent further behaviors.

Interview, on 05/04/15 at 11:21 AM, with MDS Coordinator #2 revealed she had attended a care plan conference with Social Services and Resident 22, on 03/12/15, and at the end of the

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meeting the resident reported an incident of name calling between him/her and a staff person. MDS Coordinator #2 revealed however, Resident #22's Comprehensive Care Plan was not updated/revised to include the behavior.

Interview, 05/02/15 at 12:15 PM and on on 05/03/15 at 9:15 AM, with the Social Services Director (SSD) revealed he was aware of the Behavior Monitor Report form dated 02/26/15. Per interview, Resident #22's behaviors should have care planned through the revision of his/her inappropriate sexual behavior care plan, or through creating a new behavior care plan.

Interview with the DON on 05/02/15 at 8:00 AM, revealed she had noticed concerns with revising residents' care plans and the facility was in the process of looking at this through the Quality Assurance (QA) Program. Continued interview with the DON via a phone interview, on 05/05/15, revealed she was unaware of the behaviors displayed by Resident #22. Per interview, residents' Comprehensive Care Plans were individualized and when specific behaviors were displayed by residents the care plan should be updated/revised with the behaviors and related interventions. The DON revealed Resident #22's care plan needed to be revised if he/she had displayed verbal and physical behaviors. Continued interview revealed when an incident occurred, it was brought to Interdisciplinary Team (IDT) morning meeting and discussed by Administration, the SSD, UCs and MDS nurses. The DON further revealed the IDT reviewed and revised residents' care plans with interventions. Per the DON, that should have been done for Resident #22 related to the behavior incident.

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F 280	Continued From page 38 Interview, on 05/05/15 at 8:10 PM, with the Administrator revealed Social Services went to residents' care plan meetings and had an active part in care plan development and revision. Per interview, he was not a Social Worker and deferred to Social Services regarding the revision of care plans related to verbal and physical behaviors.	F 280		
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, record review and review of the "Lippincott's Nursing Procedures" manual, it was determined the facility failed to ensure services provided met professional standards of quality for one (1) of twenty-two (22) sampled residents (Resident #2). Resident #2 was re-admitted from the hospital on 04/23/15 with a PICC line (peripherally inserted central catheter for intravenous access) in place for intravenous (IV) antibiotics; however, there was no documented evidence of a Physician's Order obtained for a PICC line dressing change. The findings include: Review of the "Lippincott's Nursing Procedures-Sixth Edition" manual, (professional standard used by the facility) revealed a PICC dressing should be changed at least every seven (7) days if a transparent semipermeable dressing	F 281 F 281 D	<i>Residents Affected</i> Resident #2 has physician's orders for dressing changes for the PICC line every 7 days. This physician order was obtained by the unit manager. The PICC line was discontinued on 6-5-15. <i>Identification of Other Residents</i> All residents in the facility has a potential to be affected. All the resident's medical records were audited which included reviewing hospital discharging summary, admission orders, physician orders, skin assessments, lab results and the comprehensive care plans by the MDS coordinators on 4-28-15 thru 5-8-15 to ensure physician orders were present for all care needs including PICC line dressing changes. All audit corrections including obtaining physician orders if needed were completed by the MDS coordinators and the QA nurse. <i>Systemic Changes</i> A new Interdisciplinary Plan of Care (IPOC) program was implemented on 5-7-15 by the DON. The IPOC team members includes the DON, Unit managers, Social Services, QA nurse, MDS Coordinator and the	

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F 281	<p>Continued From page 39</p> <p>was used. Continued review revealed if a patient was diaphoretic or the site was bleeding or oozing, a gauze dressing should be used instead of a semipermeable dressing. Further review revealed the gauze dressings should be changed every two (2) days.</p> <p>Review of the facility's policy titled, "Med Care-Dressing Change for Vascular Access Devices", dated 06/01/99, revealed dressing changes would be done at established intervals for Vascular Access Devices. Continued review revealed transparent membrane dressings were changed every week and as needed, and gauze and tape dressings were changed every forty-eight (48) hours and as needed.</p> <p>Review of Resident #2's medical record revealed the facility admitted the resident on 09/30/14, with diagnoses including Diabetes Mellitus, Cerebral Vascular Accident and Chronic Obstructive Pulmonary Disease (COPD). Review of the Significant Change Minimum Data Set (MDS) Assessment dated 01/27/15, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) indicating no cognitive impairment.</p> <p>Review of the 04/23/15 Hospital Discharge Summary revealed Resident #2 was admitted to the hospital from 04/03/15 to 04/23/15 for treatment of lower extremity Cellulitis. Continued review revealed the Cellulitis was treated with IV antibiotics. Further review revealed the discharge diagnoses included Status Post Debridement and Xenograft Application (a surgical tissue graft), and Heel Infection with Carbapenem Resistant Enterobacteriaceae (a bacteria resistant to most available antibiotics) and Methicillin Resistant</p>	F 281	<p>Administrator and meets Monday thru Friday. If an admission or readmission occurs on the Saturday and Sunday, the house supervisor will audit the medical record utilizing the QA nurse's new admission/readmission audit form and turn the audit into the DON on Monday. The IPOC program was implemented to review of new admission residents, resident's readmissions, 24-hour reports, incident reports, all physician orders obtained in the last 24 hours, pharmacy orders, lab reports, and any other related information essential to planning the care for a resident.</p> <p>The facility utilizes a 3 part form which includes the physician's order, nurse's note and care plan update/revision Monday thru Sunday. One section of the form immediately updates the comprehensive care plan, one section is used for the nurse's notes and one section is the actual physician orders. As a second check, a new QA audit was developed by the DON on 6-4-15 to have the QA Nurse to audit physician orders Monday thru Friday and the weekend house supervisors on Saturday and Sunday to validate that the physician's orders are on the medication administration record (MAR) and the treatment administration record (TAR). This audit is turned into the DON daily for review and compliance.</p> <p>Monitoring A new Interdisciplinary Plan of Care (IPOC) program was implemented on 5-7-15 by the DON. The IPOC team members includes the DON, Unit managers, Social Services, QA nurse, MDS Coordinator and the</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/14/2015
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PINE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40504		
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F 281	<p>Continued From page 40</p> <p>Staphylococcus Aureus (an antibiotic resistant bacteria).</p> <p>Review of Resident #2's Re-admission Physician's Orders dated 04/23/15, revealed orders for Contact Precautions and Zosyn (an antibiotic medication) 3.375 milligrams (mgs) IV via the PICC line every six (6) hours for seven (7) more days. Further review of the orders written 04/23/15, revealed there was no documented evidence of an order related to dressing changes for Resident #2's PICC line.</p> <p>Review of Resident #2's Medication Administration Record (MAR) dated April 2015, revealed the order for the Zosyn IV via the PICC line. However, review of the Treatment Administration Record (TAR) for April 2015, which was initiated on 04/23/15, revealed no documented evidence of interventions related to changing Resident #2's PICC line dressing.</p> <p>Observation of Resident #2 on 04/30/15 at 8:00 AM, revealed the PICC line was in place in the resident's left arm, and the PICC line dressing was dated 04/29/15.</p> <p>Interview, on 04/30/15 at 8:00 AM, with Registered Nurse (RN) #2/Unit Coordinator (UC), the unit on which Resident #2 resided, revealed she could not find a Physician's Order for the PICC line dressing change; however, there should be an order. Continued interview revealed there was also no intervention on the TAR to change the PICC line dressing or to monitor the site for signs and symptoms of infection, but should have been. Per interview, the nurse who re-admitted Resident #2 should have obtained the order for the PICC line dressing change.</p>	F 281	<p>Administrator and meets Monday thru Friday. If an admission or readmission occurs on the Saturday and Sunday, the house supervisor will audit the medical record utilizing the QA nurse's new admission/readmission audit form and turn the audit into the DON on Monday. The IPOC program was implemented to review of new admission residents, resident's readmissions, 24-hour reports, incident reports, all physician orders obtained in the last 24 hours, pharmacy orders, lab reports, and any other related information essential to planning the care for a resident.</p> <p>The facility utilizes a 3 part form which includes the physician's order, nurse's note and care plan update/revision Monday thru Sunday. One section of the form immediately updates the comprehensive care plan, one section is used for the nurse's notes and one section is the actual physician orders.</p> <p>As a second check, a new QA audit was developed by the DON on 6-4-15 to have the QA Nurse to audit physician orders Monday thru Friday and the weekend house supervisors on Saturday and Sunday to validate that the physician's orders are on the medication administration record (MAR) and the treatment administration record (TAR). This audit is turned into the DON daily for review and compliance.</p> <p>The DON will submit the results of the QA audits completed daily by the QA nurse to the monthly Quality Assurance and Safety Committee meeting which consists of the Medical Director, DON, Administrator, Consultant pharmacist, Infection control nurse, Quality assurance nurse, Social services director and the Dietary for review and recommendations.</p>	

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F 281 Continued From page 41

Interview, on 05/06/15 at 6:10 PM, with the Assistant Director of Nursing (ADON) in the absence of the DON, revealed there should have been an order obtained for the PICC line dressing change and the order then transcribed to the TAR.

F 281 *Date of Correction:*

6-26-15

F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN
SS=E

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, record review and review of the facility's policy, it was determined the facility failed to ensure residents' Comprehensive Care Plans were followed for five (5) of twenty-two (22) sampled residents (Resident #2, #3, #6, #8 and #11).

Observation of a skin assessment on 04/29/15, revealed Resident #2 had chafing and redness to the abdominal folds. However, Resident #2's Comprehensive Care Plan interventions to notify the Physician of any areas of skin concern was not implemented to ensure orders were received for treatment of the area.

Resident #3's Comprehensive Care Plan revealed the resident was care planned to be at risk for impaired skin due to impaired mobility and included an intervention to assist him/her with turning and repositioning with care. However,

F 282

Residents Affected

Resident #2, #3, #6, #8, #11 medical records were audited which included reviewing hospital discharging summary, admission orders, physician orders, skin assessments, lab results and comprehensive care plans by the MDS coordinators on 4-28-15 thru 5-8-15 to ensure physician orders were present for all care needs. The care plans were compared to the MAR, TAR, SRNA care plans and the SRNA pocket care plans to ensure care plan interventions are being followed.

The physician was notified for Resident #2 of the chafing and redness to abdominal folds on 5-5-15 by the treatment nurse and orders for Interdry was obtained and applied to these areas. The resident's current skin condition is unchanged as of 6-5-15.

Resident #3 is being assisted with turning and repositioning and is receiving his meal trays with assistance as needed. Resident #3's skin condition is stable with a foot wound secondary to peripheral vascular disease and his weight is

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F 282	<p>Continued From page 42</p> <p>observation and interviews revealed on 04/28/15, the facility failed to implement the intervention to assist Resident #3 with turning and repositioning from 2:50 PM until after 7:00 PM. In addition, Resident #3's Care Plan was not followed related to setting up the tray and providing total assistance. Observation of the evening meal on 04/28/15 revealed staff failed to provide the resident with a dinner tray or to assist with the meal until surveyor intervention.</p> <p>Resident #6's Comprehensive Care Plan revealed staff failed to implement the interventions to assist the resident with meal service, and to assist the resident with repositioning and toileting after he/she returned from an appointment and was transferred to another unit on 04/29/15.</p> <p>Observation of a skin assessment on 04/29/15 revealed Resident #8 had excoriation to the buttocks and a rash under the breast. However, the resident's Comprehensive Care Plan interventions to notify the Physician of any areas of skin concern was not implement to ensure orders were received to treat the areas.</p> <p>Resident #11's Comprehensive Care Plan revealed the resident was care planned to be at risk for elopement related to wandering behaviors with interventions which included ensuring the resident had a pink bracelet to identify him/her as a wanderer. However, observation on 05/01/15 and interview revealed staff failed to implement the intervention as Resident #11 had no pink bracelet on.</p> <p>The findings include:</p>	F 282	<p>212.5 with a weight gain of 4 pounds since April.</p> <p>Resident #6 is receiving meals before, during and after appointment visits as she desires. Resident #6 weight is 163 pounds as of May 1 with no weight loss. She is receiving assistance with repositioning and toileting before, during and after appointment visits and her skin condition as of 6-5-15 is clear.</p> <p>The physician for Resident #8 was notified of the excoriation to the buttocks and a rash under the breast on 4-30-15 by the floor nurse and orders for Nystatin powder and Calazime ointment was obtained and applied to these areas. The resident's current skin condition is unchanged as of 6-5-15.</p> <p>Resident #11 is wearing her pink bracelet to identify her at risk for wandering and exit seeking behaviors. In addition, a pink bracelet has been applied to her walker as well.</p> <p>Identification of Other Residents All residents have the potential to be affected. Skin assessments have been performed on all residents on 5-20-15 thru 5-30-15 by the Administrative nurses which includes the Unit managers, QA nurse, Infection control nurse and Treatment nurse. The skin assessments have been reviewed by the DON for any skin issues identified and treatment orders obtained as needed.</p>	

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F 282	<p>Continued From page 43</p> <p>Interview, on 04/30/15 at 5:00 PM, with the Director of Nursing (DON) revealed the facility had no policy for following residents' care plans; however, her expectation was staff would follow the care plan interventions.</p> <p>1. Review of Resident #2's medical record revealed the facility admitted the resident on 09/30/14, with diagnoses which included Cerebral Vascular Accident, Chronic Obstructive Pulmonary Disease and Diabetes Mellitus. Review of Resident #2's Significant Change Minimum Data Set (MDS) Assessment dated 01/27/15, revealed the facility assessed Resident #2 as having a Brief Interview for Mental Status (BIMS) of a fifteen (15) out of fifteen (15) which indicated no cognitive impairment.</p> <p>Review of the 04/23/15, Hospital Discharge Summary revealed Resident #2 was admitted to the hospital from 04/03/15 until 04/23/15, where he/she was treated with intravenous (IV) antibiotics for Lower Extremity Cellulitis.</p> <p>Review of the Re-admission Physician's Orders dated 04/23/15, revealed orders for Remedy Nutrashield with Olivamine (skin protectant lotion) to the buttocks and perineal area every shift and as needed.</p> <p>Review of Resident #2's Comprehensive Plan of Care dated 10/09/14, revealed the resident was at risk for impaired skin integrity related to impaired mobility and Diabetes Mellitus. Continued review revealed the goal stated Resident #2 would maintain intact skin integrity and interventions included staff to report any areas of skin concern to the Physician and Wound Nurse.</p>	F 282	<p>All residents were assessed again for elopement risk by the QA nurse and only 5 residents were assessed as wandering/elopements risk. Each of the 5 resident has a pink bracelet on for identification for staff and visitors. A new daily audit was created on 6-3-15 by the DON to check the bracelets on each resident each shift Monday thru Sunday to validate that the 5 residents are wearing the pink bracelets. The QA nurse will perform the audit on day shift Monday thru Friday; the shift supervisions will do the audit Monday thru Friday and the weekend supervisors will perform the audit on Saturday and Sunday. The audits will be turned into the DON daily for review and compliance.</p> <p>Meal service is now being monitored Monday-Sunday at breakfast, lunch and dinner by the restorative aides to validate that every resident receives their meal tray as ordered and care planned and receiving the assistance as needed.</p> <p>The appointment clerk is now responsible for notifying the dietary department of all appointments as of 6-3-15 for the following day for sack lunch and drink to be provided to take with the resident and the escort on their appointments.</p> <p>The nursing department including RN's, LPN's, CMT's and SRNA's have been in-serviced on 6-5-15 thru 6-14-15 by the DON the Unit</p>	

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F 282 Continued From page 44

Observation of Resident #2's skin assessment on 04/29/15 at 2:25 PM, performed by Licensed Practical Nurse (LPN) #6, the facility's Wound Nurse, revealed the resident was observed to have red rash chafing areas under the abdominal folds, redness to the perineal area and excoriation between the buttocks. Interview with LPN #6/Wound Nurse, during the skin assessment, revealed she was unaware of the skin breakdown under the resident's abdominal folds and there was no treatment order for the areas. She further stated she was also unaware of the redness to Resident #2's perineal area and the excoriation between the buttocks.

Interview, on 04/29/15 at 5:30 PM, with LPN #2, the nurse assigned to Resident #2's care, revealed he was unaware of the resident having a rash to the abdominal folds, redness to the perineal area or excoriation between the buttocks.

Interview, on 04/30/15 at 2:50 PM, with CNA #25 who was assigned to Resident #2 on 04/29/15, revealed the resident received perineal care yesterday and he was unaware of any skin concerns. CNA #25 revealed however, if a new area of skin breakdown was observed he was to notify the nurse.

Review of the Nursing Assessment dated 04/28/15, performed by LPN #7, revealed there was no documented evidence Resident #2 having red rash and chafing areas under the abdominal folds or redness to the perineal area; however, according to the body diagram on the Assessment there was redness/pinkness to the resident's buttocks.

F 282 managers and shift supervisors regarding following each resident's care plan including turning and repositioning, toileting, and assisting with meals.

Systemic Changes
In-service with the licensed nurses regarding doing thorough skin assessments and promptly notifying the physician of any skin abnormalities and obtaining treatment orders and head to toe skin assessment competencies and a wound care quiz was completed on each licensed nurse on 5-29-15 thru 6-14-15 by the Infection Control nurse. This new skin assessment competency and the wound care quiz has been added to the facilities new hire and the in-service information and wound quiz has been added to the agency orientation program.

The infection control nurse began on 6-8-15 reviewing the shower sheets to ensure showers are being given and to detect any potential or actual skin abnormalities that may require medical or nursing intervention that are being completed by the SRNA's Monday thru Friday; the weekend supervisor reviews the shower sheets on Saturday and Sunday.
The treatment nurse is reviewing skin assessments completed by the licensed nurses Monday thru Friday to validate that the physician has been notified of any skin abnormalities including rashes, abdomen chaffing

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F 282	<p>Continued From page 45</p> <p>Interview, on 05/06/15 at 4:45 PM, with LPN #7 revealed she had completed the skin assessment section of the Nursing Assessment dated 04/28/15, and on performing the skin assessment she did not observe any chafing or redness under the abdominal folds, redness to the perineal area or excoriation between the buttocks. LPN #7 stated if she had observed any changes in Resident #2's skin condition she would have notified the Physician for treatment and notified the wound nurse, as per the care plan.</p> <p>Continued record review revealed a Condition Change Form placed in the Nurse's Notes completed on 04/29/15, by LPN #6/Wound Nurse which noted Resident #2 had redness to the perineal area and inner buttocks excoriation. However, continued review of the Nurse's Notes revealed no documented evidence the red rash chafing areas to the abdominal folds was noted. Review of the Physician's Orders received on 04/29/15, revealed orders to treat Resident #2's the redness to the resident's perineal area and inner buttocks excoriation. However, there was no documented evidence the Physician was notified of the chafing and red rash areas to the resident's abdominal folds, as per the care plan, and orders received for treatment of the areas.</p> <p>Interview with LPN #6/Wound Nurse on 05/06/15 at 5:50 PM, revealed she had not written down all Resident #2's skin issues observed during the skin assessment on 04/29/15. Per interview, she also had not written a Note or notified the Physician related to the red rash and chafing of the resident's abdominal folds. However, she revealed she did recall Resident #2 having the chafing and redness to the abdominal folds, and</p>	F 282	<p>and excoriation and will report findings to the DON daily. The weekend supervisor will review the skin assessments on Saturday and Sunday and submits their audits to the DON on Monday morning</p> <p>A new daily audit was created on 6-4-15 by the DON to check the bracelets on each resident each shift Monday thru Sunday to validate that the 5 residents are wearing the pink bracelets. The QA nurse will perform the audit on day shift Monday thru Friday; the shift supervisions will do the audit Monday thru Friday and the weekend supervisors will perform the audit on Saturday and Sunday. The audits will be turned into the DON daily for review and compliance.</p> <p>The appointment clerk is now responsible for notifying the dietary department of all appointments as of 6-3-15 for the following day for sack lunch and drink to be provided to take with the resident and the escort on their appointments. The facilities back up process for the appointment clerk's responsibilities is the staffing coordinator Monday thru Friday. The facility currently has one resident going to dialysis on Saturday morning at 6:30 a.m. and the Friday night 11-7 shift supervisor is responsible for assuring a sack lunch is taken with him. The appointment clerk utilizes a form which consist of the resident's name, appointment time, dietary notification, escort name and the food and drink that is taken</p>	

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F 282 Continued From page 46
would notify the Physician for an order for treatment.

Interview, on 05/02/15 at 8:00 AM, with the DON, and review of Resident #2's record revealed the CNA's performing care such as perineal care and baths should report any new skin concern areas to the nurses. Per interview, the nurses performing treatments or skin assessments should report any new areas of skin breakdown to the Physician. She revealed staff should have followed Resident #2's care plan intervention and notified the Physician of all areas of skin concern.

2. Review of Resident #3's medical record revealed the facility re-admitted him/her on 03/13/12, with diagnoses which included Diabetes, Alzheimer's Disease, Parkinson's Disease and Dementia. Review of the Quarterly MDS Assessment, dated 02/06/15, revealed the facility assessed Resident #3 as severely cognitively impaired, to have limited range of motion in his/her upper and lower extremities and to require extensive physical assistance of one (1) staff for eating.

Review of Resident #3's Comprehensive Care Plan revealed the facility care planned the resident as at risk for impaired skin related to impaired mobility and incontinence. Continued review of the risk for impaired skin care plan revealed interventions which included assisting Resident #3 with turning and repositioning during care rounds. Review of Resident #3's CNA Care Plan revealed staff were to turn the resident every two (2) hours and he/she needed total assistance with eating.

Observation of Resident #3, on 04/28/15 at 2:50

F 282 with them on the appointment. This form is turned into the administrator daily for compliance.

The meal service is now being monitored Monday-Sunday at breakfast, lunch and dinner by the restorative aides to validate that every resident receives their meal tray as ordered and care planned. Meal service round sheets are turned into the DON daily for review and compliance.

The nursing department which included RN's, LPN's CMT's and SRNA's have been in-serviced on 6-5-15 thru 6-14-15 by the DON the Unit managers and 3-11 and 11-7 shift supervisors regarding following each resident's care plan including turning and repositioning, toileting, and assisting with meals.

The Unit managers will be auditing turning and repositioning during day shift Monday thru Friday; the 3-11 and 11-7 shift supervisor will be auditing turning and repositioning Monday thru Friday and the weekend supervisors will be auditing turning and repositioning on Saturday and Sundays. The audits will be turned into the DON daily for review and compliance.

Monitoring
The infection control nurse began on 6-8-15 reviewing the shower sheets to ensure showers are being given and to

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F 282 Continued From page 47
PM, 4:14 PM, 5:32 PM, 5:52 PM and at 7:00 PM, revealed the resident was lying on the bed on his/her back during all observations.

Interview, on 04/28/15 at 6:45 PM, with CNA #23 revealed she was caring for Resident #3, and the resident was currently positioned on his/her back. CNA #23 revealed Resident #3 had not been repositioned to his/her side at 3:00 PM, by the day shift CNA. Per interview, she was not informed during shift change rounds Resident #3 had not been turned towards the window as per the turn schedule. CNA #23 revealed at about 4:00 PM, she observed Resident #3 on his/her back and should have turned the resident; however, had not turned him/her because at 5:00 PM, residents were positioned on their back for the dinner meal.

Interview, on 04/29/15 at 2:31 PM, at 2:31 PM, with CNA #30, who worked day shift and was assigned to Resident #3's care on 04/28/15, revealed the resident was supposed to be turned and repositioned about every two (2) hours, to prevent bed sores. According to CNA #30, the facility had a directional turning schedule and at 3:00 PM residents, in bed, were repositioned towards the window. CNA #30 revealed the last time she cared for Resident #3 on 04/28/15, was at 2:30 PM, and had not repositioned the resident because it was before 3:00 PM. Per interview, she reported to the second shift CNA, Resident #3 had not been repositioned according to the schedule. Further interview revealed if Resident #3 had not been repositioned by CNA #30, the second shift CNA was to ensure the resident was turned towards the window at 3:00 PM.

Interview, on 04/29/15 at 3:42 PM, with LPN #8

F 282 detect any potential or actual skin abnormalities that may require medical or nursing intervention that are being completed by the SRNA's Monday thru Friday; the weekend supervisor reviews the shower sheets on Saturday and Sunday. The treatment nurse is reviewing skin assessments completed by the licensed nurses Monday thru Friday to validate that the physician has been notified of any skin abnormalities including rashes, abdomen chaffing and excoriation and will report findings to the DON daily. The weekend supervisor will review the skin assessments on Saturday and Sunday and submit their audits to the DON on Monday morning. The results of the audits will be reported to the monthly Quality Assurance and Safety committee meetings by the DON for review and recommendations.

The appointment clerk is now responsible for notifying the dietary department of all appointments as of 6-3-15 for the following day for sack lunch and drink to be provided to take with the resident and the escort on their appointments. The facilities back up process for the appointment clerk's responsibilities is the staffing coordinator Monday thru Friday. The facility currently has one resident going to dialysis on Saturday morning at 6:30 a.m. and the Friday night 11-7 shift supervisor is responsible for assuring a sack lunch

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F 282	<p>Continued From page 48</p> <p>revealed she had provided care for Resident #3 before, and knew the resident was at risk of Pressure Ulcers and was supposed to be turned every two (2) hours. LPN #8 revealed nurses on the floor were supposed to monitor to ensure residents were turned and repositioned, as per the care plan.</p> <p>Interview, on 04/30/15 at 2:55 PM, with Registered Nurse (RN) #1/Unit Coordinator (UC) revealed Resident #3 had a care plan to turn and reposition the resident with care, about every two (2) hours to prevent skin breakdown. RN #1/UC revealed the facility had scheduled turn positions at two (2) hour intervals and at 3:00 PM, when second shift started, residents were turned to face the window. Per interview, the nurses supervised the CNA's and monitored resident positioning. Further interview revealed if Resident #3 was not repositioned between 3:00 PM and 7:00 PM, his/her care plan was not followed.</p> <p>Interview, on 05/04/15 at 11:21 AM, with MDS Coordinator #2 revealed residents' Comprehensive Care Plans were developed based on the assessed needs of each resident. MDS Coordinator #2 revealed Resident #3's care plan for skin integrity included turning/repositioning with care as a preventive measure to relieve pressure. Per interview, staff were supposed to reposition Resident #3 with each round which was every two (2) hours. MDS Coordinator #2 revealed if Resident #3 was not turned and repositioned then staff had not followed the care plan intervention, but should have.</p> <p>Interview, on 05/01/15 at 4:05 PM, with the DON</p>	F 282	<p>is taken with him. The appointment clerk utilizes a form which consist of the resident's name, appointment time, dietary notification, escort name and the food and drink that is taken with them on the appointment. This form is turned into the administrator daily for compliance. The results of the audits will be reported to the monthly Quality Assurance and Safety committee meetings by the Administrator for review and recommendations.</p> <p>A new daily audit was created on 6-4-15 by the DON to check the bracelets on each resident each shift Monday thru Sunday to validate that the 5 residents are wearing the pink bracelets. The QA nurse will perform the audit on day shift Monday thru Friday; the shift supervisions will do the audit Monday thru Friday and the weekend supervisors will perform the audit on Saturday and Sunday. The audits will be turned into the DON daily for review and compliance. The results of the audits will be reported to the monthly Quality Assurance and Safety committee meetings by the DON for review and recommendations.</p> <p>The meal service is now being monitored Monday-Sunday at breakfast, lunch and dinner by the restorative aides to validate that every resident receives their meal tray as ordered and care planned. Meal service round sheets are turned into the DON daily for review and</p>	

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F 282 Continued From page 49
revealed Resident #3 had a skin integrity care plan and was supposed to be turned and repositioned every two (2) hours, as per the care plan. The DON revealed the facility had a turning schedule to ensure residents were turned. Further interview revealed if Resident #3 was positioned on his/her back from 3:00 PM through 7:00 PM, his/her care plan intervention was not followed; however, should have been.

Continued review of Resident #3's Comprehensive Care Plan revealed the facility care planned the resident for eating/nutritional status related to conditions which included Parkinson's Disease and Dementia. Further review of the eating/nutritional status care plan revealed interventions which included staff providing Resident #3 with total assistance with his/her meals.

Additional observation on 04/28/15 at 5:32 PM and 5:52 PM revealed Resident #3 was not served a dinner meal tray until Surveyor intervention. Observation revealed Resident #3 did not have his/her dinner meal tray provided until 7:00 PM.

Interview, on 04/28/15 at 6:45 PM with CNA #23, at 7:03 PM with CNA#12 and at 7:12 PM with CNA #4, revealed Resident #3 normally ate in the restorative dining room; however had not for the dinner meal. Per CNA #4, if residents were not in restorative dining, their trays were on the meal tray cart and were served by the CNA's. Per the CNA's, residents requiring meal assistance trays usually were on the floor between 5:30 PM and 6:00 PM. CNA #23 revealed Resident #3 required assistance with his/her meals and she had observed the resident not having a meal tray

F 282 compliance. The results of the audits will be reported to the monthly Quality Assurance and Safety committee meetings by the DON for review and recommendations.

The unit managers will be auditing turning and repositioning during day shift Monday thru Friday; the 3-11 and 11-7 shift supervisor will be auditing turning and repositioning Monday thru Friday and the weekend supervisors will be auditing turning and repositioning on Saturday and Sundays. The audits will be turned into the DON daily for review and compliance. The results of the audits will be reported to the monthly Quality Assurance and Safety committee meetings which consists of the Medical Director, DON, Administrator, Consultant pharmacist, Infection control nurse, Quality assurance nurse, Social services director and the Dietary manager by the DON for review and recommendations.

Date of Correction:
6-26-15

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F 282	<p>Continued From page 50</p> <p>after most of the other residents had already eaten. According to CNA #23, she was going to notify the kitchen to get Resident #3 a meal tray. CNA #12 revealed a tray with no meal ticket to identify whose tray it was had been left on the meal tray cart. Per CNA #12, staff were supposed to ensure all residents received a meal tray and the assistance required. CNA #4 revealed Resident #3 should have been served before 7:00 PM.</p> <p>Interview, on 05/04/15 at 3:15 PM, with LPN #4 revealed on 04/28/15, she was in the dining hall when dinner meal trays were served on Resident #3's hall. According to LPN #4, CNA's were supposed to ensure all residents got a meal tray. Per interview, Resident #3 was care planned to be assisted with meal tray set up and with his/her meals by staff; however, the resident's care plan was not followed as the resident had not receive the meal tray, until Surveyor intervention.</p> <p>Continued interview, on 05/04/15 at 11:21 AM, with MDS Coordinator #2 revealed Resident #3 was assessed as needing total assistance with meals and had a nutrition care plan which included the intervention of total assistance with his/her meal. However, MDS Coordinator #2 revealed Resident #3's care plan was not followed if someone had not ensured the resident had received and was assisted with his/her meal.</p> <p>3. Review of Resident #6's medical record revealed the facility re-admitted the resident on 03/02/15, with diagnoses which included Dementia, Right Ankle Fracture, Neuropathy and Chronic Dizziness. Review of the Annual MDS Assessment dated 03/20/15, revealed the facility assessed the resident as having a Brief Interview</p>	F 282		

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F 282	<p>Continued From page 51</p> <p>for Mental Status (BIMS) of a twelve (12) indicating moderate cognitive impairment. Further review revealed the facility assessed the resident as requiring total assistance of two (2) staff for transfers, extensive assistance of two (2) for toileting, and as frequently incontinent of urine and always continent of bowel.</p> <p>Review of Resident #6's Comprehensive Care Plan, dated 05/06/18, revealed the facility care planned the resident as needing assistance with toileting and being occasionally incontinent with a goal of the resident would have decreased risk for incontinence. Continued review of the care plan revealed interventions which included encouraging assistance with toileting upon arising, before and after meals, at night and as needed. Review of the nutritional risk care plan, dated 03/15/15, revealed a goal for the resident to have reduced risk for weight loss and nutritional deficit with interventions which included diet as ordered, encourage the resident to eat and drink and provide assistance as needed. Further review of the Comprehensive Plan of Care revealed care plan for the resident being at risk for impaired skin integrity related to decreased mobility dated 05/06/14, with a goal for the resident's skin to remain intact. Continued review of the at risk for impaired skin integrity care plan revealed interventions which included staff to assist with turning and repositioning with care and rounds and as needed, and to ensure the resident's skin was clean and did not have excess moisture.</p> <p>Observations on 04/29/15 at 9:30 AM, 10:30 AM, 11:30 AM and 2:00 PM revealed Resident #6 was out of his/her assigned room, 606-1, for an orthopedic appointment to have his/her cast</p>	F 282		

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removed. Continued observation at 3:30 PM revealed Resident #6 had not returned to room 606-1.

Interview, on 04/29/15 at 4:57 PM, with CNA #4, Unit I, second shift CNA, revealed she was assigned to Resident #6 and she was unaware if the resident had received a lunch meal tray upon return to the facility.

Interview with LPN #2, on 04/29/15 at 3:30 PM, who was the nurse assigned to Resident #6's care on the facility's Unit II, revealed Resident #6 had been transferred to another room on the facility's Unit 1. Per interview, he was unaware Resident #6 was being transferred to another room on Unit I after the resident returned from the orthopedic appointment around noon, until he saw housekeeping moving the resident's bed from room 606-1. LPN #2 revealed he immediately gave report to the Unit 1 nurse and explained Resident #6 was transferred to a private room, room 104, on Unit I related to a new diagnosis of Vancomycin Resistant Enterococcus (an antibiotic resistant bacteria) in his/her stool. LPN #2 further stated he was unaware if Resident #6 had received a lunch tray upon return from the appointment.

Interview, on 04/29/15 at 3:45 PM and 04/30/15 at 10:40 AM, with LPN #8 on Unit 1, where Resident #6 was transferred to, revealed she was not notified when the resident was moved into room 104, on Unit I. She stated Resident #6's medical record and appointment paperwork were brought to Unit I at about 12:30 PM on 04/29/15. Continued interview revealed when she found out Resident #6 was on the unit, she "peeked" in on him/her but did not do any type of assessment,

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and this was at approximately 2:00 PM. She stated the Unit I Manager had told her Resident #6 had eaten lunch prior to being transferred to room 104.

Interview with the Unit I Nurse Manager on 04/30/15 at 10:50 AM, revealed she was unaware if Resident #6 had eaten lunch on 04/29/15, when he/she was transferred to room 104 around 12:00 PM to 12:30 PM.

Even though Resident #6 had Comprehensive Care Plan interventions for his/her diet as ordered, to encourage the resident to eat and drink and provide assistance as needed; staff did not ensure the resident received a meal tray after returning from an appointment on 04/29/15.

Observation on 04/29/15 at 3:46 PM revealed Resident #6 sitting in a wheelchair in his/her room, with the right leg extended and his/her eyes closed. Interview with Resident #6 on 04/29/15 at 4:44 PM, revealed he/she had returned to the facility between noon and 12:30 PM and was taken to his/her new room shortly after returning. Continued interview revealed Resident #6 had not received a lunch meal tray, nor had a sack lunch been provided to the resident prior to the appointment. Continued observation of Resident #6 revealed he/she did not received a meal tray until the dinner meal when his/her meal tray was served between 6:00 PM and 6:30 PM.

Further observations on 04/29/15 at 3:46 PM, 4:15 PM, 4:44 PM, 5:30 PM and 6:00 PM revealed Resident #6 remained sitting up in his/her wheelchair. Observation at 6:15 PM revealed staff assisted Resident #6 to bed and was performing incontinence care, and the

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resident's buttocks were observed to be red and the resident's brief was wet. Interview with CNA#4 revealed this was the first time incontinence care for Resident #6 had been provided since she had come on shift at 3:00 PM, three (3) hours and fifteen (15) minutes earlier.

Even though Resident #6 had care plan interventions to assist with toileting, to ensure the resident's skin was clean and did not have excess moisture and to assist with turning and repositioning, staff failed to ensure the interventions were implemented when the resident returned to the facility from an appointment and was transferred to another room.

Interview with the DON, on 04/30/15 at 5:00 PM, revealed there had been a breakdown in communication regarding Resident #6's room transfer on 04/29/15. Per interview, as a result of the breakdown in communication there had been a delay in care and services for Resident #6, such as, not being repositioned/toileted and not receiving the lunch meal. Continued interview with the DON revealed if Resident #6 returned at 1:30 PM and was still up at 4:30 PM, that was a long time to sit up without being toileted and repositioned, and not receiving something to eat/drink. Further interview revealed it was the DON's expectation staff follow residents' care plans; however, she revealed Resident #6's care plan interventions had not been followed related to re-positioning, incontinence care and nutrition. She stated it was the nurse's responsibility to ensure residents' care plan interventions were followed.

4. Review of Resident #8's medical record

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revealed the facility admitted the resident on 03/04/15, with diagnoses which included Malignant Neoplasm of the Colon. Review of the Admission MDS Assessment dated 03/11/15, revealed the facility assessed Resident #8 as having a BIMS of a ten (10) out of fifteen (15) indicating moderate cognitive impairment.

Review of the Hospital Discharge Summary dated 04/22/15, revealed Resident #8 was admitted from 04/17/15 to 4/22/15, with a diagnoses which included pelvic and hip fractures.

Review of Resident #8's Re-Admission Physician's Orders dated 04/22/15, revealed orders for: bedrest; palliative care; Remedy Nutrashield with Olivamine (skin protectant) to buttocks and perineal area every shift and as needed (prn); and to cleanse the reddened area to the resident's left armpit with soap and water, pat dry, apply Nystatin Powder three (3) times a day.

Review of the Re-Admission Resident Data Collection form, of the section labeled "skin condition", completed on re-admission on 04/22/15, revealed Resident #8 had redness to the left armpit.

Review of the Comprehensive Care Plan revealed the facility care planned the resident as at high risk for impaired skin related to impaired mobility dated 03/17/15, with a goal for the resident to maintain intact skin. Continued review of the care plan revealed interventions which included reporting any areas of skin concern to the Physician and Wound Care Nurse.

Observation of Resident #8's skin assessment,

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F 282	<p>Continued From page 56</p> <p>on 04/29/15 from 10:50 AM until 11:20 AM, performed by LPN #2, who was the nurse assigned to the resident's care, revealed the resident had red excoriation to the buttocks and had a red rash area under the left breast. Interview with LPN #2, at the time of the skin assessment, revealed CNA #25 had informed him earlier in the shift, of the skin concerns observed.</p> <p>Further review of the medical record on 04/30/15, revealed there was no documented evidence in the Nurse's Notes regarding the Physician or Wound Nurse being notified of the skin breakdown observed during the skin assessment on 04/29/15, as per the care plan, until 04/30/15. Review of the Physician's Orders on 04/30/15, revealed new orders for treatment of the red rash under the resident's left breast and red excoriation were received at 10:00 AM.</p> <p>Interview, on 04/30/15 at 2:30 PM with LPN #2, revealed he did not notify the Wound Nurse or the Physician about the rash area under the resident's breast or the excoriation to the resident's buttocks on 04/29/15, as per the care plan, because 04/29/15 had been the first day he was assigned to the resident and he didn't know if the skin breakdown areas were new or not. Per interview, he thought there was already orders for treatment in place for the skin breakdown areas.</p> <p>Interview, on 05/02/15 at 8:00 AM, with the DON, and review of Resident #8's record revealed the CNA's performing care for resident, such as, perineal care and baths should report any new skin breakdown areas to the nurses. The DON revealed the nurses should report any new areas of skin breakdown to the Physician, as per the care plan.</p>	F 282		
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F 282	Continued From page 57 5. Review of Resident #11's medical record revealed the facility admitted the resident on 03/11/15, with diagnoses which included Alzheimer's Disease, Chronic Obstructive Pulmonary Disease (COPD) and Cardiac Dysrhythmia. Review of the Admission MDS Assessment dated, 03/18/15, revealed the facility assessed Resident #11 as severely cognitively impaired. Review of the facility's Incident Reports revealed Resident #11 had experienced exit seeking behaviors and tried to get out an exit door on 03/30/15 at 11:40 AM, and on 04/10/15 at 4:00 PM. Continued review revealed the facility initiated fifteen (15) minute checks of Resident #11, after each episode, for a twenty-four (24) hour period. Review of Resident #11's Comprehensive Care Plan revealed the facility care planned the resident as an elopement risk, March 2015, related to having wandering behaviors, with interventions to ensure the resident had a pink bracelet in place. However, observation of Resident #11, on 05/01/15 at 2:14 PM, with RN #1/UC revealed Resident #11 had no pink bracelet in place on his/her arm. Continued observation revealed RN #1/UC found a pink bracelet in the first drawer of Resident #11's bedside chest and RN #1/UC then placed the bracelet on the resident's right arm. Interview, on 05/01/15 at 2:43 PM, with RN #1/UC revealed the facility's process for wandering residents included ensuring orders were obtained for a pink bracelet to be placed on the resident	F 282	

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F 282	<p>Continued From page 58</p> <p>and to ensure the order was placed on the Treatment Administration Record (TAR) to ensure the pink bracelet placement was monitored.</p> <p>However, review of Resident #11's April 2015 Physician's Orders revealed no documented evidence of an order for a pink bracelet. Also, review of Resident #11's April 2015 Medication Administration Record (MAR), and TAR revealed no documented evidence nurses had checked Resident 11's pink bracelet for placement.</p> <p>Continued interview, on 05/04/15 at 11:21 AM, with MDS Coordinator #2 revealed Resident #11 had a wandering resident care plan which included an intervention to ensure the resident wore a pink bracelet to alert staff he/she wandered. Per interview, if staff were not checking to ensure the pink bracelet was on the resident each shift, they were not following the care plan.</p> <p>Interview, on 05/04/14 at 3:15 PM, with LPN #4 revealed Resident #11 wandered and had exit seeking behavior and was to wear a pink bracelet. LPN #4 revealed Resident #11 took off the pink bracelet and was unsure if there was an order for the bracelet on the TAR to ensure the nurses monitored it's placement on the resident.</p> <p>Further interview, on 05/01/15 at 2:43 PM, with RN #1/UC revealed Resident #11 had exhibited exit seeking behavior and had a care plan intervention to ensure the resident wore a pink bracelet. Per interview, Resident #11's pink bracelet was not supposed to be in the drawer, and should have been in place, as per the care plan.</p>	F 282		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2015
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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PINE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40504
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(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
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F 282 Continued From page 59
Further interview, on 05/01/15 at 4:05 PM, with the DON revealed Resident #11 had exit seeking behaviors, but there was no order written for the pink bracelet and the MAR/TAR was not updated to ensure the nurses checked placement of the resident's bracelet. The DON revealed Resident #11's care plan was not followed because the pink bracelet was not in place and staff were not monitoring the bracelet. Additional interview with the DON on 05/02/15 at 8:00 AM, revealed it was also the responsibility of her, the Unit Coordinators, Staff Development Nurses to ensure residents' care plan interventions were followed.

F 282

F 309 483.25 PROVIDE CARE/SERVICES FOR SS=D: HIGHEST WELL BEING
Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

F 309 F 309 D
Residents Affected
Resident #2 comprehensive care plan interventions are being followed and the physician was notified of the chafing and redness to abdominal folds on 5-5-15 by the treatment nurse and orders for Interdry was obtained and applied to these areas.

Resident #8 comprehensive care plan interventions are being followed and the physician was notified of the excoriation to the buttocks and a rash under the breast on 4-30-15 by the floor nurse and orders for Nystatin and Calazime was obtained and applied to these areas.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for two (2) of twenty-two (22) sampled residents (Resident #8, and #2).

Identification of Other Residents
All residents have the potential to be affected. Skin assessments have been performed on all residents on 5-20-15 thru 5-30-15 by the Administrative

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F 309	Continued From page 60 Resident #8 was observed on 04/29/15, to have an rash under the left breast and excoriation to the buttocks during a skin assessment. Interview with the nurse performing the skin assessment revealed the Certified Nursing Assistant (CNA) assigned to the resident had informed him of the changes in skin condition earlier in the shift. However, review of the record revealed an order had not been obtained for treatment to the areas until 04/30/15 at 10:00 AM. In addition, the nurse had not documented the new areas of skin breakdown as per the facility's protocol. In addition, Resident #2 was observed on 04/29/15, to have red rash areas and chafing areas under the abdominal folds, redness to the perineal area and excoriation between the buttocks during a skin assessment. Record review revealed no documented evidence the areas had been identified prior to the skin assessment. Also, record review on 05/05/15, revealed no documented evidence Physician's Orders were obtained for treatment of the red rash and chafing areas under Resident #2's abdominal folds, and no documented evidence of the new area of skin breakdown to the abdominal folds, as per the facility's protocol. The findings include: Review of the facility's, "Wound Care Policy-Skin Assessment", undated, revealed the facility should routinely monitor the skin condition of all residents and intervene, as appropriate, to treat skin irregularities upon admission, readmission, when alerted that the CNA's had identified any skin irregularities, and with weekly "head to toe skin body assessments". Further review revealed	F 309	nurses which includes the Unit managers, QA nurse, Infection control nurse and Treatment nurse. The skin assessments have been reviewed by the DON for any skin issues identified and treatment orders obtained as needed. <i>Systemic Changes</i> Skin assessments have been performed on all residents on 5-20-15 thru 5-30-15 by the Administrative nurses which includes the Unit managers, QA nurse, Infection control nurse and Treatment nurse. The skin assessments have been reviewed by the DON for any skin issues identified and treatment orders obtained as needed. In-service with the licensed nurses regarding doing thorough skin assessments and notifying the physician promptly of any skin abnormalities and obtaining treatment orders; and head to toe skin assessment competencies and a wound care quiz was completed on each licensed nurse on 5-28-15 thru 6-14-15 by the Infection Control nurse. This new skin assessment competency and the wound care quiz has been added to the facilities new hire and agency orientation program. The treatment nurse will be auditing the weekly scheduled skin assessments performed by the floor nurses Monday thru Sunday for any skin abnormalities identified and	

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F 309 Continued From page 61

the CNA's were to observe the skin of residents in their care on a daily basis, and report any skin irregularities to the Charge Nurse. Per the Policy, the Charge Nurse or designee was to conduct an assessment of each resident who exhibited any new skin irregularities.

1. Record review revealed the facility admitted Resident #8 on 03/04/15, with diagnoses which included Colon Cancer and Chronic Obstructive Pulmonary Disease (COPD). Review of the Admission Minimum Data Set (MDS) Assessment dated 03/11/15, revealed the facility assessed Resident #8 to have a Brief Interview for Mental Status (BIMS) score of ten (10) out of fifteen (15) which was indicative of moderate cognitive impairment.

Review of the 04/22/15, Hospital Discharge Summary revealed Resident #8 was admitted to the hospital on 04/17/15 after sustaining a fall in the facility. The Hospital Discharge Summary revealed Resident #8 was diagnosed with hip and pelvis fractures. Further review of the Discharge Summary revealed Resident #8 was seen by Orthopedics while in the hospital, and Orthopedics determined the resident was not a surgical candidate, and the family wanted him/her to have palliative care.

Review of Resident #8's Re-Admission Physician's Orders dated 04/22/15, revealed orders for the resident to be on bedrest, to have palliative care, Remedy Nutrashield with Olivamine (a skin protectant paste) to the resident's buttocks and perineal area every shift and as needed (prn), and to cleanse reddened area to the resident's left armpit with soap.

F 309 checking to see if the physician was notified and that a treatment is in place. The audits will be turned into the DON daily for review and compliance.

Monitoring

The treatment nurse will be auditing the weekly scheduled skin assessments performed by the floor nurses Monday thru Sunday for any skin abnormalities identified and checking to see if the physician was notified and that a treatment is in place. The audits will be turned into the DON daily for review and compliance.

The DON will submit the results of the daily skin assessment audits to the monthly Quality Assurance and Safety committee meeting which consist of the Medical Director, DON, Administrator, Consultant pharmacist, Infection control nurse, Quality assurance nurse, Social services director and the Dietary manager for review and recommendations.

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6-26-15

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F 309	Continued From page 62 Review of the Re-Admission Resident Data Collection section labeled "skin condition" completed on readmission 04/22/15, revealed the resident had redness to the left armpit. Observation, on 04/29/15 from 10:50 AM until 11:20 AM, of a skin assessment performed by Licensed Practical Nurse (LPN) #2, nurse assigned to the resident, with CNA #25 assisting, revealed Resident #8 had red excoriation to the buttocks and had a red rash area under the left breast. Per interview, with LPN #2, at the time of the skin assessment, revealed CNA #25 had informed him of the new areas of skin changes earlier in the shift. Review of the Physician's Orders however, revealed no documented evidence of orders to treat the areas observed during the skin assessment on 04/29/15, until 04/30/15 at 10:00 AM. Review of the Physician's Orders dated 04/30/15, revealed orders to apply Nystatin Powder (an anti-fungal antibiotic) to Resident #8's left and right breast after cleaning every shift and as needed. Further review revealed an order to clean and dry the buttocks area and apply Calazime Cream (a skin protectant) to the reddened area every shift and as needed. Also, review of the Nurse's Notes revealed no documented evidence of the areas of skin breakdown observed during the skin assessment on 04/29/15, until 04/30/15. Review of a Change in Condition Form, dated 04/30/15, revealed the "status change" was "L & R" (left and right) breast", and to apply Nystatin Powder every shift and as needed to the reddened area; and "buttocks area", clean and dry and apply Calazime Cream to reddened area every shift	F 309			

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F 309 Continued From page 63
and as needed.

F 309

Interview, on 04/30/15 at 2:30 PM, with LPN #2 revealed he did not notify the Wound Nurse or the Physician about the rash area under Resident #8's breasts or the excoriation to the resident's buttocks on 04/29/15, as it had been his first day caring for the resident and he was not aware the areas observed were new. Per interview, he thought there were already treatment orders in place for the areas. He further stated he also did not document the new areas of skin breakdown in the Nurse's Notes on 04/29/15.

2. Record review revealed the facility admitted Resident #2 on 09/30/14, with diagnoses which included Diabetes Mellitus, Cerebral Vascular Accident and Chronic Obstructive Pulmonary Disease. Review of the resident's Significant Change MDS Assessment dated 01/27/15, revealed the facility assessed Resident #2 to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15) which was indicative of no cognitive impairment. Review of the 04/23/15, Hospital Discharge Summary revealed Resident #2 was admitted to the hospital from 04/03/15 until 04/23/15 and treated with intravenous (IV) antibiotics for Lower Extremity Cellulitis.

Review of the Re-admission Physician's Orders dated 04/23/15, revealed orders for Remedy Nutrashield with Olivamine to the buttocks and perineal area every shift and as needed.

Observation of a skin assessment on 04/29/15 at 2:25 PM, performed by LPN #6/Wound Nurse, revealed Resident #2 was noted to have red rash chafing areas under the abdominal folds,

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F 309	<p>Continued From page 64</p> <p>excoriation between the buttocks and redness to the perineal area. Interview with LPN #6/Wound Nurse, during the skin assessment, revealed she was unaware of Resident #2's having the skin breakdown under the abdominal folds and there was no treatment order for the areas. LPN #6/Wound Nurse revealed she was also unaware of the excoriation between to Resident #2's buttocks and the redness to the perineal area.</p> <p>Review of the Nursing Assessment dated 04/28/15, performed by LPN #7, revealed there was no documented evidence of Resident #2 having red rash areas and chafing under the abdominal folds or redness to the perineal area. Continued review revealed however, the diagram of the body on the Assessment, revealed documentation indicating redness/pinkness to the resident's buttocks.</p> <p>Interview, on 05/06/15 at 4:45 PM, with LPN #7 revealed she had completed the skin assessment section of the Nursing Assessment on 04/28/15. Per interview, she did not notice any chafing or redness under Resident #2's abdominal folds, or redness to his/her perineal area or excoriation between the buttocks. She stated if she had observed any changes in Resident #2's skin condition she would have notified the Physician for treatment and notified the Wound Nurse.</p> <p>Interview, on 04/30/15 at 2:50 PM, with CNA #25, who had been assigned to Resident #2's care on 04/29/15, revealed the resident had been provided perineal care yesterday, and he was not aware of any skin concerns. Per interview, however, if a new area of skin breakdown was observed he would tell the nurse.</p>	F 309		

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F 309 : Continued From page 65

Interview, on 04/29/15 at 5:30 PM, with LPN #2, who was assigned to Resident #2's care, revealed he was not notified of the resident having a rash to the abdominal folds, redness to perineal area or excoriation between the buttocks.

Further record review revealed orders were received and a Condition Change Form placed in the Nurse's Notes completed on 04/29/15, by LPN #6/Wound Nurse which noted Resident #2 had redness to the perineal area and inner buttocks excoriation. Continued review however, revealed no documented evidence of the rash and chafing to the abdominal folds noted in the Nurse's Notes.

Review of the Physician's Orders, dated 04/29/15, revealed to cleanse Resident #2's perineal area with soap and water, pat dry, apply Remedy Calazime with every incontinence/voiding episode or every shift related to the red perineal area for fourteen (14) days, and to cleanse the resident's inner coccyx/buttocks excoriation area with soap and water and apply Calazime four (4) times a day and as needed for fourteen (14) days. However, further review of the Physician's Orders revealed no documented evidence of a treatment order obtained for the rash and chafing to Resident #2's abdominal folds.

Interview with LPN #6/Wound Nurse on 05/06/15 at 5:50 PM, revealed she had failed to document all the skin issues observed during the skin assessment with the Surveyor on 04/29/15. Per interview, she also had not written a Nurse's Note or notified the Physician related to the rash and chafing of Resident #2's abdominal folds.

F 309

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F 309	Continued From page 66 Interview with the Director of Nursing (DON) and review of Resident #8's and Resident #2's medical records on 05/02/15 at 8:00 AM, revealed if CNA's observed any new areas of concern when performing care, such as, perineal care and baths they should report the new areas to the nurse. Per interview, if nurses observed any new areas of skin breakdown when performing treatments or skin assessments they should notify the Physician for treatment to the areas in order to obtain treatment to prevent further breakdown. The DON revealed any new areas of skin breakdown were to be documented in the Nurse's Notes or on the Skin Assessment forms.	F 309	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed residents were served and received assistance with his/her meal to ensure one (1) of twenty-two (22) sampled residents (Resident #3). The facility assessed Resident #3 as needing assistance with his/her meals; however, on 04/28/15 during the dinner meal, the resident did	F 312 F 312 D	<i>Residents Affected</i> Resident #3 comprehensive care plan interventions are being followed and he is receiving his meal trays with assistance as needed. Resident #3's weight is 212.5 pounds as of May 8, 2015 with no weight loss. <i>Identification of Other Residents</i> All residents who is ordered to receive a meal tray has the potential to be affected. The meal service is now being monitored Monday-Sunday at breakfast, lunch and dinner by the restorative aides to validate that every resident receives their meal tray as ordered and care planned and receiving the assistance as needed.

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F 312 Continued From page 67 not receive a dinner meal tray and assistance, until Surveyor intervention.

The findings include:

Review of the facility's policy titled, "Resident Nutrition Services", revised 2009, revealed each resident was to receive prompt meal services and appropriate feeding assistance. Further review of the Policy revealed nursing personnel would ensure residents were served the correct food tray and would report if an incorrect meal was delivered so a new food tray was issued.

Review of Resident #3's medical record revealed the facility re-admitted the resident on 03/13/12, with diagnoses which included Alzheimer's Disease, Dementia, Parkinson's Disease (a progressive nervous system disorder which affects movement) and Diabetes Type II. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 02/06/15, revealed the facility assessed Resident #3 as severely cognitively impaired. Further review of the MDS revealed the facility assessed Resident #3 to have both upper/lower extremity range of motion deficits and to require extensive assistance of one (1) staff with eating.

Review of Resident #3's Comprehensive Care Plan revealed it included a care plan for eating/nutritional status which included an intervention to provide the resident with total assistance with his/her meal.

Observations, on 04/28/15 at 5:32 PM and 5:52 PM, revealed Resident #3 was not served a dinner tray until the Surveyor intervened by inquiring where the meal tray was. Staff provided

F 312 The nursing department including RN's, LPN's, CMT's and SRNA's have been in-serviced on 6-5-15 thru 6-14-15 by the DON the Unit managers and shift supervisors regarding following each resident's care plan including turning and repositioning, toileting, and assisting with meals.

Systemic Changes
The nursing department which included RN's, LPN's CMT's and SRNA's have been in-serviced on 6-5-15 thru 6-14-15 by the DON the Unit managers and shift supervisors regarding following each resident's care plan including turning and repositioning, toileting, and assisting with meals.

The meal service is now being monitored Monday-Sunday at breakfast, lunch and dinner by the restorative aides to validate that every resident receives their meal tray as ordered and care planned. Meal service round sheets are turned into the DON daily for review and compliance.

The facility has added a shower team to the additional current staffing as of 6-8-15 consisting of 4 SRNA's to perform all showers as care planned for each resident. The SRNA's providing direct care to the resident's on the floor will no longer be responsible for giving showers which will allow the SRNA's more time

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F 312 Continued From page 68
Resident #3's meal tray at 7:00 PM.

Interview, on 04/28/15 at 6:45 PM, with CNA #23 revealed she had cared for Resident #3 before, and during the dinner meal that day she had just finished assisting another resident with his/her meal and noticed Resident #3 had not received his/her meal tray. Per interview, by the time she noticed this, most of the other residents had already eaten. CNA #23 revealed she was going to notify the kitchen the resident had not received a tray. Per interview, residents who needed assistance with meals normally had their dinner meal trays delivered to the floor between 5:30 PM and 6:00 PM.

Interview, on 04/28/15 at 7:12 PM, with Certified Nursing Assistant (CNA) #4 revealed Resident #3 normally ate in the restorative dining area, but had not during dinner that day. CNA#4 revealed when residents were not in restorative dining, trays were left in the tray cart and taken to the floor to be served by CNA's. Per interview, she thought the first meal cart went to the floor about 5:30 PM. Further interview revealed Resident #3's meal tray should have been served before 7:00 PM.

Further interview, on 04/28/15 at 7:20 PM, with CNA #23 revealed Resident #3 had eaten 100% of his/her dinner meal after it was received.

Interview, on 04/28/15 at 7:03 PM, with CNA#12 revealed all residents' meal trays had a meal ticket and she had noticed when passing dinner trays earlier one (1) of the meal trays on the cart had no meal ticket to identify whose tray it was. Per interview, someone was supposed to ensure all residents had a dinner meal tray and she didn't

F 312 providing assistance to the residents during meal service.

Monitoring
The results of the meal service round sheets will be reported to the monthly Quality Assurance and Safety committee meetings by the DON for review and recommendations.

Date of Correction:

6-26-15

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F 312 : Continued From page 69

know why Resident #3 had not received his/her dinner meal.

Interview, on 04/28/15 at 6:53 PM, with Registered Nurse (RN) #3 revealed the facility staff were now checking on why Resident #3 was not served a dinner meal tray. RN #3 revealed she was aware there was a tray left on the meal cart with no meal ticket to identify whose it was; however, someone should have checked to see whose it was and ensured it was delivered. Per interview, CNA's were to ensure all residents had a meal tray, but anyone walking the hall should have observed Resident #3 had no dinner tray.

Interview, on 05/04/15 at 3:15 PM, with Licensed Practical Nurse (LPN) #4 revealed she was in the dining hall when supper (dinner) meal trays were served, on 04/28/15. Per interview, the CNA's passing meal trays on the floor were supposed to ensure all residents got a tray. LPN #4 revealed Resident #3 required staff's assistance with his/her meal tray set-up and to consume the meals.

Interview, on 04/30/15 at 2:55 PM, with RN #1/Unit Coordinator (UC) revealed Resident #3's meal tray came out on the meal cart with other residents' trays who required feeding assistance. Per interview, the CNA's delivered the meal trays and were also supposed to assist residents with consuming their meals. RN#1/UC revealed nurses were supposed to walk the hall and ensure all residents had gotten their meal trays. Further interview revealed she was unsure why it had not been identified Resident #3 had never received his/her meal tray during the dinner meal on 04/28/15.

F 312

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/14/2015
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PINE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40504		
(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 312	Continued From page 70 Interview, on 05/04/15 at 8:16 AM, with the Dietary Manager (DM) revealed Resident #3's meal tray was originally sent out with all other trays during the 04/28/15 dinner meal service. However, the DM revealed there was a breakdown in communication. Per interview, the staff on the floor were supposed to ensure all residents' meal trays were passed; however, there was one (1) tray left on the meal cart that day which had no meal ticket to identify who it belonged to. The DM stated no one had notified the kitchen of this information at the time however, and it was late and serving carts had been brought back to the dietary area when it was reported to him staff were unable to find Resident #3's meal ticket. He stated he made Resident #3 another tray and meal ticket which was delivered to the resident. Interview, on 05/01/15 at 4:05 PM, with the Director of Nursing (DON) revealed Resident #3 was not served a dinner meal tray on 04/28/15, because no one had inquired why a tray was left on the cart which had no meal ticket or why Resident #3 had not received his/her meal. The DON revealed no one in the kitchen was notified to get another meal tray until after the meal tray carts were returned to the kitchen. Further interview revealed Resident #3 was unable to communicate with staff and there had been a potential the resident could have missed his/her dinner meal on 04/28/15, if the Surveyor had not intervened.	F 312			
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323	F 323 G <i>Residents Affected</i> The comprehensive care plan for Resident #8 has been developed to include the bed alarm utilized in her fall risk category on 5-4-15 by		

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F 323	Continued From page 71 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for two (2) of twenty-two (22) sampled residents (Resident #8 and #11). The facility did not have an effective system in place to ensure bed alarms and chair alarms were checked for function and placement to ensure they sounded in the event a resident attempted to stand or transfer unassisted. In addition, the facility failed to do a thorough investigation of Resident #8's fall on 04/17/15, and the investigation did not recognize the bed alarm was not sounding at the time of the fall. On 04/17/15 at 7:50 AM, Resident #8 sustained an unwitnessed fall, and the resident was transferred to the hospital emergency room (ER) where he/she was admitted to the hospital with diagnoses of a Fracture of the Left Inferior Pubic Ramus (Pubic Bone Fracture) and Transverse Fracture of the Left Trochanter (Hip Fracture). Interviews with the nurse and Certified Nursing Assistant (CNA) assigned to the resident at the time of the fall, revealed Resident #8 had a bed alarm in place which was not sounding prior to the fall. The nurse and CNA stated however, they had not checked the bed alarm for function at the beginning of the shift, prior to the resident's fall.	F 323	the MDS coordinator. In addition, the care plan includes checking for placement and functioning of the alarm each shift. The SRNA care plan, SRNA pocket care plans, and the treatment administration record (TAR) also has instruction to check placement and function of the alarms each shift. This was completed on 5-4-15 by the QA nurse. The resident currently has fall prevention interventions which includes Bed in low position, bed bolsters, bilateral fall mats, sensor alarm. The resident's current condition is unchanged. The facility's DON will perform a thorough and complete investigation of any additional falls or incident that may occur. Resident #11 comprehensive care plan interventions are being followed and she is wearing her pink bracelet to identify her at risk for wandering and exit seeking behaviors. In addition, a pink bracelet has been applied to her walker as well. When the Beauty shop is open for service to the residents the door is being locked when unattended by the beautician and/or a staff member due to potentially hazardous chemicals that are used in the beauty shop. The facility has installed a key code pad on the door so that the no one can enter the beauty shop without the security code. The beauty shop doors are being checked during routine rounds every 2 hours that the door is locked when unattended Monday thru Thursday 10 am to 4 pm by the Unit 2 Manager and the 3-11 supervisor. The audit is turned into the DON daily.		

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F 323 Continued From page 72

Policy review revealed there was no guidance for staff on when or how often they were to check the alarms. Staff interviews revealed bed and chair alarms were checked during their shift, however, not necessarily at the beginning of each shift. Resident #8's Comprehensive Care Plan was not individualized or specific, and had no interventions related to the resident's bed alarm or for checking the bed alarm for placement and function. After the fall and resulting fractures, Resident #8 had a noted decline in his/her physical status, from being able to ambulate forty (40) feet with a rolling walker, to bed rest and palliative care.

Additionally, observation on 04/29/15 of Resident #8 being turned and repositioned revealed the resident's bed alarm was not sounding, which staff revealed was not working.

Also, the facility failed to ensure Resident #11 received adequate supervision after an episode of exit seeking behavior on 03/30/15. Although Resident #11 was to be placed on fifteen (15) minute checks for twenty-four (24) hours to ensure closer supervision by staff after the episode, record review revealed no documented evidence of observations from 5:00 PM on 03/30/15 until 11:00 PM to ensure the resident remained safe. In addition, per interview if a resident experienced wandering and exit seeking behavior he/she was to have a pink bracelet placed on him/her. However, even though Resident #11 experienced two (2) episodes of exit seeking behavior, observation revealed the resident was not wearing a pink bracelet. Staff interview revealed Resident #11 took the pink bracelet off and the facility failed to ensure he/she wore the pink bracelet to identify the resident as a

F 323 **Systemic Changes**

The DON, MDS coordinators, Unit Managers, 3-11 and the 11-7 Shift supervisors, Weekend supervisor and the QA nurse was in-serviced by the Regional Director of Clinical Services regarding specific individualized comprehensive care plans, SRNA care plans, SRNA pocket care plans and the TAR including specific instructions when utilizing fall prevention alarms which should include checking for placement and functioning of the alarms each shift.

The nursing staff including RN's, LPN's, CMT's and SRNA were in-serviced by the RN nurse educator regarding when receiving physician's orders for fall prevention alarms that the orders should include checking for placement and functioning each shift and this specific information should be included on the comprehensive care, SRNA care plan, SRNA pocket care plans and the TAR; and that the alarms should be physically checked for placement and functioning each shift. The in-services were completed on 6-7-15.

In addition; a new QA audit was developed on 6-8-15 by the DON for the unit managers, 3-11 supervisor, 11-7 supervisor and the weekend supervisor to check for proper alarm placement and functioning each shift as well Monday thru Sunday. The audit includes Resident name, fall prevention alarms ordered by the physician, proper placement and proper functioning. These audits are turned into the DON daily for review and compliance.

A new Interdisciplinary Plan of Care (IPOC) program was implemented on 5-7-15 by the DON. The IPOC team members includes the DON, Unit managers, Social Services, QA nurse, MDS Coordinator and the

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F 323 Continued From page 73
wanderer with exit seeking behavior, as per the facility's process.

Furthermore, the facility failed to ensure the resident's environment remained as free of accident hazards as possible as evidenced by: observation on 04/28/15, revealed the beauty shop was left unattended with the door unlocked from 12:25 PM to 12:38 PM, with containers of potentially hazardous chemicals stored on the sink counter.

The findings include:

1. Review of the facility's policy titled, "Safety Alarms", undated, revealed it was the policy of the facility to utilize bed and/or chair alarms to alert staff when a resident was trying to get up unassisted. Per the Policy, the Interdisciplinary Team (IDT) or the floor nurse could decide a bed/chair alarm might alert staff a resident was trying to get up out of the bed or chair unassisted. Further review revealed if an alarm was to be placed, the Physician was to be notified and the resident's care plan updated to include the alarm. However, there was no documented evidence the policy provided guidance to staff on when and how often to check the alarms.

Review of the facility's, "Fall Management Program" document, undated, revealed it was the policy of the facility to safeguard residents while promoting the highest possible level of independence and quality of life. The Policy revealed the facility would accomplish this through assessment to establish a risk for falls, care planning and implementing appropriate interventions to minimize falls and injuries related to falls. Per the document, a resident's

F 323 Administrator and meets Monday thru Friday. The IPOC program was implemented to review of new admission residents, resident's readmissions, 24-hour reports, incident reports and investigation, physician orders, pharmacy orders, lab reports, and any other related information essential to planning the care for a resident. During the IPOC meetings if any resident's comprehensive care plans are identified as needing development, revisions or interventions it will be updated at that time. The incident investigation will include reviewing the incident report, falls investigation, witness statements if applicable, nurse's notes, notification of physician and POA, obtaining of physician's orders for new interventions, initiation of the 72 hour post fall assessments, neuro checks if an unwitnessed fall, head to toe skin assessment or any injuries, pain assessment, updating of comprehensive care plan, SRNA care plan and SRNA pocket care plans.

A new daily audit was created on 6-3-15 by the DON to check the pink wander bracelets on each resident identified at risk each shift Monday thru Sunday to validate that the 5 residents are wearing the pink bracelets. The QA nurse will perform the audit on day shift Monday thru Friday; the 3-11 and the 11-7 shift supervisions will do the audit Monday thru Friday and the weekend supervisors will perform the audit on Saturday and Sunday. The audits will be turned into the DON daily for review and compliance.

In addition the facility installed a new wander guard system which was completed on 6-14-15 for all the exit doors. The wander guard bracelets have also been applied to these 5 residents on 6-14-15. The QA nurse will perform the audit on day shift Monday thru

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F 323	<p>Continued From page 74</p> <p>Comprehensive Care Plan would reflect the fall risk and interventions for falls and would include goals and interventions which were resident specific. Continued review revealed the Director of Nursing (DON) would review the incident investigation and the incident report for appropriate interventions and documentation after a resident's fall. The Policy noted the findings and recommendations would be submitted to the IDT meetings for revision or adoption of interventions according to the root cause analysis identified for the resident's fall.</p> <p>Review of Resident #8's medical record revealed the facility admitted the resident on 03/04/15, with diagnoses which included Malignant Neoplasm of the Colon and Chronic Obstructive Pulmonary Disease (COPD). Review of the Admission Minimum Data Set (MDS) Assessment dated 03/11/15, revealed the facility assessed Resident #8 as having a Brief Interview for Mental Status (BIMS) of a ten (10) out of fifteen (15) indicating moderate cognitive impairment. Further review of the MDS Assessment revealed the facility also assessed Resident #8 as being able to transfer with extensive physical assistance of two (2) persons, and as able to ambulate in the corridor with extensive assistance of two (2) persons. Review of the monthly April 2015 Physician's Orders revealed Resident #8 was to have a bed sensor alarm and a chair tab alarm.</p> <p>Review of the "Resident Fall Risk" dated 03/04/15, revealed Resident #8 was assessed as at risk for falls related to a history of falls in the past six (6) months, the use of medications which had the potential to predispose to falls, and problems with functional status.</p>	F 323	<p>Friday; the 3-11 and the 11-7 shift supervisions will do the audit Monday thru Friday and the weekend supervisors will perform the audit on Saturday and Sunday. The audits will be turned into the DON daily for review and compliance.</p> <p>The two beauty shop beautician's was in-serviced on April 28, 2015 and again on April 29, 2015 by the Administrator to lock the beauty shop when unattended by them or a staff member. In addition, a sign has been posted on the door to keep door locked if unattended. When the Beauty shop is open for service to the residents the door is being locked when unattended by the beautician and/or a staff member due to potentially hazardous chemicals that are used in the beauty shop.</p> <p>The facility has installed a key code pad on the door so that the no one can enter the beauty shop without the security code.</p> <p>The beauty shop doors are being checked during routine rounds every 2 hours that the door is locked when unattended Monday thru Thursday 10 am to 4 pm by the Unit 2 Manager and the 3-11 supervisor. The audit is turned into the DON daily.</p> <p>Monitoring</p> <p>The DON will submit the results of the QA audits regarding the fall alarm placement and functioning; the pink bracelets and the wander bracelets and the results of each incident investigation, and the beauty shop door audits to the monthly Quality Assurance and Safety Committee meeting which consists of the Medical Director, DON, Administrator, Consultant pharmacist, Infection control nurse, Quality assurance nurse, Social services director and the Dietary for review and recommendations.</p>	

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F 323 Continued From page 75

Review of Resident #8's Comprehensive Care Plan dated 03/17/15, revealed the resident was at risk for an accident, injury or fall related to impaired mobility and weakness, with interventions which included to orient the resident to the facility as needed, and ensure use of "sensory aides". However, continued review of the Care Plan revealed no documented evidence it was not specific and individualized related to Resident #8's bed alarm or the need to check the alarm for placement and function. Review of the CNA Care Plan Record for April 2015, revealed Resident #8 was to have a sensor alarm to the bed.

Interview, on 05/01/15 at 4:00 PM, with the Physical Therapist (PT) revealed upon admission Resident #8 was walking down the hall one hundred (100) feet with the assistance of one (1) person and another person pushing the wheelchair behind him/her in case the resident needed to sit down. The PT stated after Resident #8 reached his/her maximum potential the resident was discharged from Physical Therapy to the facility's Restorative Nursing Program (RNP).

Review of the RNP Plan of Care revealed it was initiated 03/20/15. Review of the April 2015 RNP Plan of Care revealed the interventions included: assisting and cueing Resident #8 to perform Active Range of Motion (AROM) to the bilateral upper extremities for fifteen (15) minutes a day for six (6) days a week; and assisting and cueing the resident to ambulate forty (40) feet with minimum assistance of one (1) for fifteen (15) minutes a day for six (6) days per week. Further review of the April 2015 RNP Plan of Care revealed the interventions were initialed as

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F 323 Continued From page 76
completed from 04/01/15 through 04/07/15, and the resident was transferred to the hospital on 04/08/15.

F 323

Review of a Hospital Discharge Summary, dated 04/16/15, revealed Resident #8 was admitted to the hospital on 04/08/15, with diagnoses of a Urinary Tract Infection, Pneumonia and Hydronephrosis (swelling of a kidney due to a build-up of urine which happens when urine cannot drain out from the kidney to the bladder as a result of a blockage or obstruction) and was discharged back to the facility on 04/16/15. Review of the Re-admission Physician's Orders dated 04/16/15, revealed the order for Resident #8's bed sensor alarm and chair tab alarm had not been carried over.

Review of the Nurse's Note dated 04/17/15 at 7:50 AM, revealed the nurse heard Resident #8 fall and immediately ran into the room and found the resident on the floor lying on her/his left side, beside the roommate's bed. Continued review of the Note revealed there were alarm sensors on Resident #8's bed and wheelchair which had not sounded. According to the Note, Resident #8 stated he/she was going to the bathroom prior to the fall and complained of severe pain of the left hip. Review of the Note revealed a pillow was placed under Resident #8's head and he/she was left lying on the floor, and the Physician and 911 were notified. Further review of the Note revealed the "EMT" (Emergency Medical Technicians) arrived at 8:15 AM and transferred Resident #8 to the hospital.

Review of the Hospital Discharge Summary dated 04/22/15, revealed Resident #8 was admitted to the hospital on 04/17/15, after sustaining a fall at

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F 323 Continued From page 77

the facility. Review of the Assessment portion of the Discharge Summary, revealed Resident #8 had been diagnosed with an Acute Left Inferior Pubic Ramus Fracture and a Mildly Displaced Transverse Fracture through the superior portion of the Left Greater Trochanter. The Discharge Summary further revealed Resident #8 was seen by Orthopedics while in the hospital, and Orthopedics had deemed the resident not a surgical candidate. Further review of the Discharge Summary revealed Resident #8's family wanted the resident to have palliative care (specialized medical care for people with serious illnesses which focuses on providing patients with relief from symptoms and stress of a serious illness to improve the quality of life).

Observation of Resident #8 on 04/28/15 at 2:55 PM, revealed the resident was lying on the bed on his/her back with a bed alarm at the head of the bed, and two (2) and a half padded side rails were up at the head of the bed. Interview was attempted with Resident #8 at the time of observation; however, the resident spoke very quietly and was difficult to understand.

Interview, on 04/29/15 at 9:50 AM, with CNA #27 revealed the CNA's were to check residents' bed and chair alarms at the end of the shift and also, during their shift when assisting the resident up out of bed for the day. She stated on 04/17/15, she came on shift at 7:00 AM, but did not get to check on Resident #8 before breakfast as the meal trays came out early at 7:10 AM that morning. CNA #27 revealed she was passing a breakfast tray to a room nearby Resident #8's room when she heard a loud crash and entered Resident #8's room where she observed the resident lying on the floor near his/her roommate's bed. Per interview, LPN #12 was

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F 323 Continued From page 78
already in Resident #8's room when she entered and the resident's bed alarm was not sounding. Continued interview revealed Resident #8 told staff he/she was trying to go to the bathroom when the fall occurred. CNA #27 revealed Resident #8's roommate's wheelchair was in front of the bathroom door and the resident was lying on his/her left hip on the floor in front of the wheelchair as she recalled. She stated she checked Resident #8's roommate's wheelchair, which also had an alarm on it, and that alarm was not functioning either.

F 323

Interview, on 04/28/15 at 12:45 PM, with Licensed Practical Nurse (LPN) #12, during initial tour, revealed Resident #8 had experienced a recent fall at the facility and had sustained a fractured pelvis and hip. She stated she was assigned to Resident #8 on 04/17/15, at the time of the resident's fall. Per interview, she was in the hall near Resident #8's room when she heard a loud noise and she was the first person to respond to the resident's room. LPN #12 stated Resident #8 was lying on the floor on his/her left side and the resident must have gotten out of bed on his/her own. Continued interview revealed Resident #8's call bell was not ringing at the time of the fall, and the resident's bed alarm was not sounding. She stated if Resident #8's bed alarm had been working she would have heard the alarm and responded, because she was near the resident's room and might have been able to prevent the fall. According to LPN #12, CNA #27, who was assigned to Resident #8 at the time of the fall, and the Unit Coordinator (UC) of Unit 2 came to the resident's room to assist her the morning of the fall. LPN #12 revealed she completed an Incident Report after the fall, but did not remember being questioned about the fall details

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PINE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40504
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F 323 Continued From page 79
by administrative staff or the DON. Per LPN #12, the CNA's coming on at change of shift and the offgoing CNA were to check the bed and chair alarms during shift change when they did the walk through. She revealed the CNA's were to check the alarms for placement and function. LPN #12 stated nurses did not routinely check the residents' alarms; however, residents' Treatment Administration Records (TARs) had a place for an "FYI" (for your information) to alert the nurses when residents had alarms. She clarified she had not checked Resident #8's bed alarm on the day shift prior to the fall at 7:50 AM, and stated her shift started at 7:00 AM.

F 323

Review of the Incident Report, dated 04/17/15, completed by LPN #12, revealed Resident #8 was found lying on the floor beside the roommate's bed on his/her left side and was barefooted. Continued review revealed the section marked "recommended steps to prevent recurrence", noted to remind Resident #8 to utilize staff's assistance and to utilize call light and the resident was sent to the hospital for evaluation and treatment. Review of the Falls Investigation Worksheet completed by LPN #12, revealed on 04/17/15 at 7:50 AM, Resident #8 had experienced an unwitnessed fall when up walking alone not using an assistive device and was found on the floor. Review of the second page of the Falls Investigation Worksheet revealed no documented evidence it had been completely filled out, as it was left blank including an section marked "Environmental" which asked if a safety intervention was in use at the time.

Interview, on 05/01/15 at 12:09 PM, with the DON revealed she, the Quality Assurance (QA) Nurse and the UCs all assisted with the fall

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investigations. The DON reviewed the fall investigation completed by LPN #12 for Resident #8's fall, and stated the Fall Investigation Worksheet back page was not complete and the nurse should have ensured this was completed. Continued interview revealed the back page of the Worksheet included a section labeled "Environmental" which asked if safety intervention were in use at the time of the fall, and this would have specified if alarms were in place and functioning.

F 323

Interview, on 04/28/15 at 8:00 PM and 04/30/15 at 11:00 AM, with the UC for Unit 2, revealed on 04/17/15 shortly after the day shift had began, LPN #12 heard a noise in Resident #8's room and went to check. Per interview, by the time she got there LPN #12 and CNA #27 were already in Resident #8's room. She stated Resident #8 was telling LPN #12 and CNA #27, he/she had gotten up off the bed to go visit his/her roommate when the fall occurred, and had hit his/her head on the dresser. According to the UC, later on Resident #8 also told her he/she fell after getting out of bed. The UC stated she did not check the bed alarm to see if it was functioning properly at the time of Resident #8's fall and was not sure if it had sounded at that time. She stated the Physician was in house and said to send Resident #8 to the hospital ER, because the resident was complaining of hip and leg pain. Continued interview revealed the process for alarms was the nurse checked alarms each shift, but not necessarily at the beginning of their shift. Per the UC, there was no set time for the CNA's to check the alarms, but the CNA's typically checked the alarms as they assisted residents up out of bed in the mornings. She stated it would be best for the nurses and CNA's to check the

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alarms for placement and functioning during their first rounds on their shifts*to ensure the alarms were working properly. Further interview and review of the record with the UC, revealed Resident #8 had a care plan in place for "sensory aides" which could possibly mean bed/chair alarms, but the care plan should be more specific and say bed and chair alarm. She stated the Physician's Orders written 04/16/15, when Resident #8 was re-admitted to the facility after hospitalization for a UTI, Pneumonia and Hydronephrosis, had not had the bed and chair alarms carried over. The UC reviewed Resident #8's TAR for 04/16/15 and 04/17/15, and noted the bed alarm and chair alarms was not on the TAR for those dates. However, per the UC, the orders for the alarms should have been carried over as the alarms would have still been in place on 04/17/15, at the time of the fall, because they had not been discontinued.

Interview, on 04/29/15 at 6:00 PM, with LPN #13, who was assigned to Resident #8 on the night shift on 04/16/15 up to 7:30 AM on 04/17/15, revealed she checked the bed and chair alarms herself when she came on shift to make sure the alarms were present and working properly. She stated she also checked Resident #8's bed alarm when she arrived at work on 04/16/15. Continued interview revealed she did not recall Resident #8 ever attempting to get out of bed on his/her own. LPN #13 revealed she knew Resident #8 was taken to the bathroom to be toileted between 5:00 AM and 6:00 AM on 04/17/15, and assisted back to bed afterwards. Further interview revealed she was never interviewed by the DON or any administrative staff regarding Resident #8's fall on 04/17/15.

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Interview, on 04/30/15 at 11:30 PM, per telephone call, with CNA #28, who was assigned to Resident #8 on the night shift on 04/16/15 until 7:30 AM on 04/17/15, revealed she checked the residents' bed and chair alarms at the beginning of her shift to see if they were working properly. Per interview, she also checked the alarms with each round during her shift. CNA #28 revealed Resident #8 was checked and changed during her shift for incontinence care while lying on the bed. She stated on her shift at night, Resident #8 was not gotten up out of bed because the resident was not on the list of residents who were to be assisted to the dining room for breakfast. Further interview revealed she performed her last rounds on her residents between 5:00 AM and 6:00 AM, and completed her rounds by 6:30 AM each morning. In addition, CNA #28 stated Resident #8 would have still been in bed when she completed her last rounds on 04/17/15.

Interview, on 05/01/15 at 4:43 PM, with MDS Coordinator #1, revealed she and another MDS Coordinator were responsible for developing residents' Care Plans. After reviewing Resident #8's medical record, MDS Coordinator #1 revealed the resident was ordered to have a bed and chair alarm on admission. However, review of the care plan revealed no documented evidence of a care plan for the alarms until a care plan update was added on 04/28/15. Continued interview with MDS Coordinator #1 revealed a care plan should have been developed with approaches for a bed and chair alarm. Further interview revealed the "sensory aides" intervention on the care plan was in reference to glasses or hearing aides if the resident wore those.

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F 323

Review of the Resident Investigation Report Form (RIRF), completed by the DON, dated 04/18/15, revealed a section labeled "summaries of interviews with persons reporting the incident". Review of the RIRF revealed a written statement from LPN #12, which noted the nurse had heard a loud crash sound, went to see what happened and found Resident #8 lying on the floor complaining of pain in the head and hip. Review of the written statement from CNA #27 revealed the CNA heard an alarm and went to Resident #8's room where she found the resident lying on the floor and other staff were in the room. Continued review of the RIRF, of the "summary of findings" section, revealed the information gathered noted: Resident #8 had gotten up unassisted and fell in his/her room; the call light was not used; and request for help was not made.

Interview, on 05/01/15 at 12:09 PM, with the DON revealed she did not have staff write out their own written statements and had documented the staff's statements herself. Per interview, she thought CNA #27 had indicated she heard Resident #8's alarm sounding at the time of the fall. Even though Surveyor interview with CNA #27 and LPN #12 revealed the bed alarm was not sounding, and review of the LPN's Nurses's Note dated 04/17/15, revealed the bed alarm was not sounding. Continued interview with the DON on 05/01/15 at 12:09 PM, revealed she had not recognized during the investigation of Resident #8's fall the bed alarm was not sounding. The DON stated Resident #8 might not have sustained a fall if the bed alarm had been functioning and had sounded on 04/17/15, because staff would have heard the alarm and responded.

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F 323

Interview, on 05/04/15 at 11:10 AM, with the Quality Assurance (QA) Nurse revealed the CNA Care Plans, as well as, residents' Comprehensive Care Plans should have interventions which stated the bed and chair alarms were to be checked each shift for placement and function. Per interview, the nurses, as well as, the CNA's should be checking residents' bed and chair alarms. The QA Nurse revealed she kept an updated list of Physician's Orders of which residents had alarms and she gave the list to the QA CNA. She stated the QA CNA then checked all bed and chair alarms on day shift once a week to ensure the alarms were in place and functioning. The QA Nurse called the QA CNA into the interview. Interview with the QA CNA, in conjunction with the QA Nurse, revealed she (the QA CNA) checked the room of each resident who had alarms on Thursdays. The QA CNA stated during the room checks she ensured the bed and chair alarms were in place and functioning, and ensured the alarm batteries did not need to be replaced. Per the QA CNA, if the alarm battery needed to be replaced it would make a continuous beeping noise; however, she had no set schedule to change the batteries. According to the QA CNA, she also checked four (4) to five (5) resident's rooms daily to ensure the alarms were in place and functioning on the day shift. During the interview, the QA CNA reviewed her alarm check log, and stated the last time she had checked Resident #8's bed and chair alarms was on 04/15/15, while the resident was in the hospital. The QA Nurse also had the Central Supply Clerk (CSC) come into the interview. Per the CSC, she "randomly" checked bed and chair alarms, but did not keep an audit tool and did not check the room of each resident who had alarms

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daily. The CSC stated she did not keep up with when the sensor strips to the alarms needed to be changed; however, revealed the alarm sensor strips were good for a year per the manufacturer's recommendations written on the sensor strips. Further interview with the QA Nurse revealed the facility's system was not effective by just auditing residents' bed and chair alarms on the day shift. Per the QA Nurse, the facility should have been auditing all the alarms on all shifts to make sure they were in place and functioning properly.

Further interview, on 05/01/15 at 12:09 PM, with the DON revealed it was both the nurses and the CNA's responsibility to check placement and function of the bed and chair alarms and the alarms should be checked during first rounds and throughout the shift. She stated Resident #8's chair and bed alarm should have been included on his/her Comprehensive Care Plan. Continued interview revealed the bed alarm should have been written on the 04/16/15 re-admission Physician's Orders because the alarm was still being utilized on those dates and had not been discontinued. The DON stated she had conducted the investigation for the fall Resident #8 sustained on 04/17/15 resulting in the fractures. According to the DON, she was to be notified as soon as a resident experienced a fall, and the nurse assigned to the resident was to put in an immediate intervention to prevent further falls. Per interview, the day after falls occurred, Monday through Friday, the falls were brought to the Interdisciplinary Team (IDT) Meeting for discussion, and this meeting included the UCs and herself. She stated after the IDT Meeting, falls were further discussed in the facility's morning meeting, Monday through Friday, which

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F 323 Continued From page 86
included the UCs, the QA Nurse, the Activities Director, Human Resources (HR) staff, the Rehab Therapy Director, the Staffing Coordinator and the Administrator. The DON revealed during the morning meeting the different disciplines discussed the falls and came up with interventions to prevent further falls. She stated during the meeting they also reviewed the interventions which were already in place for the residents to ensure they were still appropriate and effective. The DON revealed the facility also had a weekly "standards of care" meeting which included the UCs, QA Nurse, Social Services (SS) Director, Assistant Director of Nursing (ADON), Dietary Manager, Dietician, Treatment Nurse and herself. Per the DON, in the "standards of care" meeting they also discussed falls which had occurred during the past week and interventions were also reviewed then to ensure they were effective. The DON revealed Resident 38 had started declining when hospitalized from 04/08/15 to 04/16/15; however, had further declined since the fall with fractures on 04/17/15, and was now on bed rest and palliative care.

F 323

Interview, on 05/04/15 at 4:30 PM, with the Administrator revealed he did not conduct the falls investigations and relied on department heads which he had hired to do the investigations. He stated they had hired a QA CNA to ensure residents' alarms were checked and functioning properly. However, the Administrator stated the facility would make any changes needed to ensure there was an effective system in place to make certain residents' bed and chair alarms were checked for placement and function.

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2. Continued observation of Resident #8 on 04/29/15 at 10:50 AM, during a skin assessment performed by LPN #2 with CNA #5 assisting, revealed two (2) bed alarm boxes at the head of the resident's bed. Observation revealed one (1) of the alarm boxes had a sensor strip hanging down from the box and was not attached to Resident #8's bed. It was observed by the Surveyor, when the LPN and CNA were turning and repositioning Resident #8 during the skin assessment, the bed alarms did not sound. After the skin assessment was completed and the staff asked if there was anything else, the Surveyor interviewed LPN #2 and CNA #5 as to why Resident #8's alarm did not sound. Further observation and interview revealed LPN #2 checked the alarm and the sensor strip, and stated the alarm which was attached to the sensor strip under Resident #8 was not working. Further interview with LPN #2 revealed he checked the bed and chair alarms when he entered residents' rooms to administer medication or to perform treatments and he did not necessarily check them at the beginning of his shift.

Interview, on 04/29/15 at 11:20 AM, with CNA #5 revealed he had checked Resident #8's bed alarm earlier at change of shift with the previous CNA assigned and the alarm was functioning then. He stated he usually checked the alarms every two (2) hours with rounds, and he was unsure why there was two (2) alarm boxes at the head of Resident #8's bed.

3. Review of the facility's policy titled, "Accident Prevention Policy", revised December 2007, revealed resident safety and supervision and assistance to prevent accidents were facility wide

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F 323	<p>Continued From page 88</p> <p>priorities. Further review of the Policy revealed resident supervision was a core component of the systems approach to safety and the type of resident supervision was determined by the individual resident's assessed needs.</p> <p>Review of the facility's policy titled, "Wandering, Unsafe Resident", revised February 2014, revealed the facility strived to prevent unsafe wandering for residents who were at risk for elopement. Further review of the Policy revealed if a resident was identified as a wandering risk, interventions to maintain safety, such as, a detailed monitoring plan was put in place on the resident's care plan.</p> <p>Review of Resident #11's medical record revealed the facility admitted the resident on 03/11/15, with diagnoses which included Alzheimer's Disease, Chronic Obstructive Pulmonary Disease (COPD) and Cardiac Dysrhythmia. Review of the Admission Minimum Data Set (MDS) Assessment dated, 03/18/15, revealed the facility assessed Resident #11, through the use of the Brief Interview for Mental Status assessment, as severely cognitively impaired.</p> <p>Review of the facility's incident reports revealed Resident #11 had experienced exit seeking behaviors and tried to get out an exit door on 03/30/15 at 11:40 AM, and on 04/10/15 at 4:00 PM. Continued review revealed the facility initiated fifteen (15) minute checks of Resident #11, after each episode, for a twenty-four (24) hour period.</p> <p>Interview, on 05/01/15 at 4:05 PM, with the DON revealed after a resident had an episode of exit</p>	F 323	

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F 323	Continued From page 89 seeking behavior, a pink bracelet was placed on the resident and his/her picture was put in the facility's wander book located on each unit. The DON revealed the purpose of the pink bracelet was to ensure auxiliary staff were aware the resident wandered and had experienced exit seeking behavior. Per interview, an order was written and transcribed to the resident's Medication Administration Record (MAR) to ensure nurses checked the pink bracelet to ensure it was in place. In addition, the DON revealed fifteen (15) minute checks were put in place to ensure a resident was monitored more closely after experiencing an episode of exit seeking behavior. However, observation of Resident #11, on 05/01/15 at 2:14 PM, with Registered Nurse (RN) #1/UC revealed Resident #11 had no pink bracelet on his/her body, even though the resident had experienced two (2) episodes of exit seeking behavior for which the DON indicated residents should have a pink bracelet in place. Continued observation of Resident #11 and his/her room, with RN #1/UC, revealed a pink bracelet in the first drawer of the resident's bedside chest which the RN placed on the resident's right arm. Additionally, review of Resident #11's April 2015 Physician's Orders MARs and TARs revealed no documented evidence the pink bracelet order was placed on the resident's MAR or TAR to ensure nurses checked the pink bracelet for placement. Continued review revealed no documented evidence the nurses were monitoring placement of Resident #11's pink bracelet to ensure it was on the resident as indicated by the DON.	F 323			

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Interview, on 04/30/15 at 2:10 PM and on 05/04/15 at 2:46 PM, with LPN #1 revealed on 03/30/15, Resident #11 was on Unit 2 and had attempted to go outside, but had not gotten out the door. LPN #1 revealed after that incident; however, the facility's process was not followed as there was no order for a pink bracelet placed on the resident's TAR to ensure the nurses monitored the placement of the bracelet on the resident. Continued interview revealed Resident #11 also had another elopement attempt, but there was no order placed on the TAR again for a pink bracelet to be placed on the resident and monitored by the nurses. Further interview with LPN #1 revealed after Resident #11's exit seeking episode on 03/30/15, she started the fifteen (15) minute monitoring intervention of the resident which was completed by the nurses.

However, review of the facility's "Observation Charting" form, dated 03/30/15, of the every fifteen (15) minutes checks which were implemented because Resident #11 sounded the door alarm, revealed no documented evidence of monitoring by staff of the resident's location on 03/30/15, from 5:00 PM until 11:00 PM.

Interview, on 05/01/15 at 2:35 PM, with CNA #29 revealed she routinely cared for Resident #11 and knew the resident had wandering behavior. CNA #29 stated however, she was not certain Resident #11 had a pink bracelet which the nurses checked to ensure the pink bracelet was in place. Further interview revealed she was not aware the pink bracelet was in Resident #11's drawer and was not sure how long it had been there.

Interview, on 05/04/14 at 3:15 PM, with LPN #4

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

PRINTED: 05/29/2015
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2015
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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PINE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40504
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(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
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revealed Resident #11 wandered and had exit seeking behavior and was to have a pink bracelet on. LPN #4 revealed Resident #11 took off the pink bracelet; however, the LPN was not sure if there was an order for the pink bracelet on the TAR to ensure the nurses monitored it's placement on the resident.

Interview, on 04/30/15 at 3:45 PM and on 05/01/15 at 2:43 PM, with RN #1/UC revealed if a resident was assessed with wandering behaviors or the resident had an episode of exit seeking behaviors the facility's process was to get an order for a pink bracelet which was placed on the resident's TAR to ensure nurses checked the pink bracelet for placement. RN #1/UC revealed Resident 11's pink bracelet should be on the resident and was not supposed to be in his/her bedside drawer. Per interview, whoever initiated Resident #11's pink bracelet had not followed the facility's elopement process because there was no pink bracelet order on the MAR or TAR to ensure the nurses monitored the bracelet for placement on the resident. According to RN#1/UC, also when a resident had an episode of exit seeking behavior the facility's process was for staff to put the resident on fifteen (15) minute checks which nursing staff documented. Further interview revealed nursing staff documented the resident's location to ensure the resident was safe and not continued the behavior. Additionally, RN #1/UC revealed staff re-directed the resident if needed when performing the fifteen (15) minute checks. Per RN #1/UC, however, the 03/30/15, observation documentation revealed Resident #11 was not monitored by staff every fifteen (15) minutes from 5:00 PM to 11:00 PM the resident was not monitored by staff. Further interview revealed the facility had no formal process to

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

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FORM APPROVED
OMB NO. 0938-0397

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2015
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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PINE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40504
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(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
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ensure the every fifteen (15) minute observation document was completed by staff.

Continued interview, on 05/01/15 at 4:05 PM, with the DON revealed there was a breakdown in the facility's wanderer supervision procedure for Resident #11, as there was no order for the pink bracelet in place to ensure the nurses checked placement of the resident's bracelet. She revealed however, there should have been an order and nurses should have been monitoring the placement. Per the DON, after review of the 03/30/15 observation monitoring document for Resident #11, which was initiated after the resident had an episode of exit seeking behavior, staff had not documented to ensure the resident was supervised every fifteen (15) minutes from 5:00 PM through 10:00 PM. The DON revealed however, staff should have completed the documentation to ensure Resident #11 had been monitored every fifteen (15) minutes.

4. Review of the facility's "Beauty Salon Contract", dated 05/24/11, revealed the contract Salon was responsible for complying with all applicable rules, laws and regulations governing salon operations. Further review revealed the Salon was to be locked at all times when not in operation.

Review of the facility's "Resident Wanderer List", dated 04/24/15, revealed the facility had six (6) residents listed as at "high risk" for wandering and were "safety risks".

Observation, on 04/28/15 at 11:18 AM, during the initial tour of the facility, revealed a resident sitting under a hair dryer with no Beautician or facility staff present. Continued observation revealed

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2015
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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PINE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40504
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(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
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the DON and the Regional Consultant (RC) were standing approximately six (6) feet from the Salon while it was unattended; however, from where they were standing they could not see inside the Salon. Further observation revealed inside the Salon, sitting on the sink counter there was a container of Barbicide (a disinfectant solution) used to clean combs and brushes.

Interview, on 04/28/15 at 11:19 AM, with the DON and RC revealed residents should never be left unattended in the Salon. Continued interview revealed the Salon door should be locked when it was unattended.

Additional observations on 04/28/15 at 12:25 PM revealed the Beautician left the Salon unsecured with the door unlocked, re-entered the Salon at 12:26 PM for approximately thirty (30) seconds, left the Salon again with the door unlocked and the area unsecured. Observation of the Salon revealed LPN #5 entered the Salon at 12:34 PM, and then immediately left it with the door remaining unlocked. Further observation revealed the Salon remained unlocked and unsecured until 12:36 PM, when LPN #5 re-entered the Salon. Additional observation at 12:38 PM, of the Salon area revealed the Barbicide continuing to sit on the sink counter.

Interview, on 04/28/15 at 12:38 PM, with LPN #5 revealed she had observed no one in the Salon and had left to call and see where the Beautician was. She stated she returned to the Salon as soon as possible to guard the area until the Beautician returned. Per interview, the Salon could be a dangerous area for wandering residents who might enter and possibly ingest liquids, such as, the Barbicide on the sink

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