

Amended

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

PRINTED: 12/10/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 11/23/2015
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NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977
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F 000	INITIAL COMMENTS  An abbreviated standard survey (KY24014, KY24022, KY24047, KY24082) was initiated on 11/16/15 and concluded on 11/23/15. All of the complaints were substantiated and deficient practice was identified with the highest scope and severity at "G" level.	F 000	Mountain View Nursing & Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of the quality of care of residents. This Plan of Correction is submitted as a written allegation of compliance. Mountain View Nursing and Rehabilitation Center's response to this statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Mountain View Nursing and Rehabilitation Center reserves the right to submit documentation to refute any of the deficiencies through informal dispute resolution, formal appeal procedures and/or any other administrative or legal proceeding.	
F 151 SS=D	483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL  The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.  The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.  This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure residents were afforded the opportunity to exercise their rights in the facility related to medication administration for one (1) of twelve (12) sampled residents (Resident #4). Registered Nurse #1 stated she administered thirteen (13) doses of an "as needed" pain medication to Resident #4 without the resident's knowledge even though the resident told staff that pain medication "makes (the resident) constipated."  The findings include:  Review of the facility's policy titled "Residents' Rights Policy," dated January 2009, revealed the Administrator assumed the responsibility for the	F 151	F 151 On December 1, 2015, the Director of Nurses (DON) made Resident # 4 aware that he was given as needed medication without his consent or request and that he would be afforded the right to ask/request/refuse his prescribed "as needed" medications.	F-151 01/06/16

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

*Uwian Lambert*

TITLE

*Administrator*

DATE

*01/06/2016*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients (See instructions) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility If deficiencies are cited, an approved plan of correction is requisite to continued program participation

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F 151	<p>Continued From page 1</p> <p>implementation of resident rights in the facility. The policy did not outline the rights of the residents of the facility.</p> <p>Review of Resident #4's medical record revealed the facility admitted the resident on 09/23/15 with diagnoses that included Constipation and Chronic Pain. Review of the resident's Minimum Data Set (MDS) assessment dated 10/19/15 revealed the resident was assessed to be alert and oriented with a Brief Interview for Mental Status (BIMS) score of 15.</p> <p>Review of Resident #4's physician's orders dated October 2015 revealed the resident had physician's orders to receive Hydrocodone (a narcotic pain medication) 7.5 milligrams (mg) one tablet by mouth every six hours as needed for pain. Review of Resident #4's Controlled Substance Record revealed the resident received 18 doses of Hydrocodone 7.5 mg from 10/10/15 until 10/29/15. Continued review of the resident's Controlled Substance Record revealed Registered Nurse (RN) #1 had administered 13 of the 18 doses of pain medication to Resident #4; the last dose RN #1 administered was dated 10/28/15.</p> <p>Interview with Resident #4 on 11/18/15 at 2:10 PM revealed he/she stated that he/she did not take "pain pills" because "they mess with my digestive tract." The resident further stated that he/she had not had pain medication in "a month or longer."</p> <p>Interview with RN #1 on 11/20/15 at 11:00 AM revealed she administered Hydrocodone 7.5 mg to Resident #4, a total of 13 doses in October 2015. The RN acknowledged she had violated</p>	F 151	<p>All in-house residents were either interviewed or their medication administration records for the last 2 weeks were reviewed related to administration of "as needed" medications.</p> <p>Between December 1-23, 2015 residents with a BIMS score of 8-15 were interviewed by the DON to ensure they had not been administered "as needed" medications without their knowledge or consent. No additional concerns were identified. On, December 17, 2015 all other in-house residents, December medication administration records (MARS) were reviewed, by the DON, Assistant Director of Nurses (ADON), the Quality Indicator (QI) nurse, or the Staff Development Coordinator (SDC) to ensure that any "as needed" medications had "reason" for being administered and "effectiveness" was assessed. No additional concerns were noted. RN # 1 no longer works at the facility.</p> <p>On December 3, 2015 and December 17, 2015, licensed nursing staff and certified medication aides (CMAS) were educated related to the administration of "as needed" medications, by the SDC and Administrator.</p> <p style="text-align: right;">F151 continued</p>		

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F 151	Continued From page 2 Resident #4's rights when she administered a narcotic pain medication to the resident without the resident's knowledge. The RN stated that she stopped administering the pain medication to Resident #4 when a medication aide made a comment that she (RN #1) was the only one administering the pain medication to the resident.  Interview with the Director of Nursing (DON) on 11/20/15 at 1:37 PM revealed RN #1 should not have administered a narcotic pain medication to an alert and oriented resident without the resident's knowledge. The DON acknowledged it was a violation of a resident's rights to administer medication without allowing the resident the right to refuse or accept the medication.  Interview with the Administrator on 11/23/15 at 3:20 PM, revealed it was a violation of a resident's rights and it was not standard nursing practice to administer narcotic pain medication to a resident without the resident's knowledge.	F 151	The education included that all residents within the facility were to be afforded their resident rights to be informed of "as needed" medications and that they had a right to "refuse" those "as needed" medications if they chose to. The education, also included, that residents who were unable to "ask for" or "request" "as needed" medications are to have "reasons", "indications" and "effectiveness" of "as needed" medications assessed and documented on the medication administration record. Any licensed nursing staff member not attending this education will receive it prior to working. This education will also be added to orientation for newly hired nursing staff. On, December 15, 2015 the Resident's Rights Policy, dated January 2009 was amended by the Administrator to include Resident Rights.		
F 157 SS=D	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	F 157	All other staff was educated by the Administrator on December 17, 2015 of the policy addendum. All employees not attending the in-service will receive education prior to working and upon hire for new employees. <i>F151 continued</i>		

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F 157	<p>Continued From page 3</p> <p>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).</p> <p>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.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to notify the resident's legal representative or an interested family member for two (2) of twelve (12) residents (Residents #1 and #2) when there was an accident that resulted in injury (Resident #1) and when a resident was named as a victim in a substantiated allegation of abuse (Resident #2).</p> <p>Resident #1 sustained a fall on 11/08/15, and was transferred to the hospital. The resident sustained multiple traumatic fractures as a result of the fall. Interviews with the resident's family member and facility staff revealed staff failed to notify the resident's family of the change in the resident's condition.</p>	F 157	<p>The Administrator attended the Resident Council Meeting on December 17, 2015. 21 residents attended the meeting. The Administrator read each of the resident's "Federal Rights" and "My Rights" to the residents and re-assured the resident's, while in the facility, they would be afforded their rights to "exercise those rights" without fear of interference, coercion, discrimination or reprisal from the facility. No concerns were reported at the meeting. The Administrator informed residents that she was available to meet with them individually if they had any concerns to discuss about exercising their rights as an individual, while in the facility. On December 21, 2015 signage was posted in each resident's room, for viewing by residents, family members and other visitors related to resident's being afforded the right to exercise their rights without fear of interference, coercion, discrimination or reprisal from facility staff.</p> <p>The DON, ADON, QI Nurse, SDC or the SSD will either interview residents or audit the resident's medication administration records (MARs) for 10 residents per the following schedule. Weekly x 1 month, then bi-weekly x 1 month, then monthly x 3 months. Any</p>		

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F 157	<p>Continued From page 4</p> <p>Resident #2 was named as a victim in an allegation of abuse, which occurred on 10/27/15. The allegation was substantiated by the facility; however, the resident's family was not notified that the resident was involved in a substantiated allegation of abuse.</p> <p>Furthermore, the facility failed to ensure a policy was in place that addressed the requirement to notify a resident's family when changes in the resident's condition occurred and/or there was a need to alter a resident's treatment.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Notification of Physician for Change in Residents' Condition," dated August 2012, revealed it was the policy of the facility to notify the physician when a significant change in a resident's condition occurs. However, the facility's policy failed to address notification of the resident's family member of changes in the resident's condition and/or a need to alter the resident's treatment.</p> <p>1. Review of the medical record for Resident #1 revealed the facility admitted the resident on 10/17/13, with diagnoses that included Osteoarthritis and Anemia. Review of the resident's Annual Minimum Data Set (MDS) Assessment dated 10/22/15, revealed the resident utilized a walker and wheelchair to assist with mobility, and required no setup or physical help from staff. Continued review of the medical record revealed the resident had no history of falls in the facility, and was continent of bowel and bladder.</p> <p>Further review of Resident #1's medical record</p>	F 157	<p>concerns will be addressed at the time of the interview/review by the designated employee performing the interview/review and reported to the DON.</p> <p>The DON will report results of the interviews and reviews to the Quality Improvement (QI) Committee based on the described audit schedule for any recommendations. The QI Committee consists of the Administrator, DON, QI Nurse, SDC, SSD and others as warranted by topic/discussion. The Executive QI Committee will review the audits quarterly and recommend any additional monitoring. The Executive Committee consists of all members of the QI Committee plus the facility Medical Director.</p> <p>F 157</p> <p>Residents #1 and #2 are no longer at the facility.</p> <p>On December 4-8, 2015, a chart review of progress notes and incident reports, for the past 60 days, for all residents, was completed by the Director of Nursing (DON), the Assistant Director of Nursing (ADON) or the Quality Improvement (QI) Nurse, for the purpose of verifying notification of interested family</p>	<p>F-157 01/03/16</p>
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F 157	<p>Continued From page 5</p> <p>revealed on 11/08/15, the resident sustained a fall at the facility and was assessed to have complaints of pain to his/her left shoulder. Resident #1 was transferred to a local hospital.</p> <p>Review of Resident #1's hospital record revealed the resident expired at the hospital on 11/09/15 (diagnoses included Septic Shock likely secondary to Urinary Tract Infection). Therefore, the resident was not observed and/or interviewed.</p> <p>On 11/16/15 at 2:10 PM, an interview with Family Member #1, listed in Resident #1's medical record as the first emergency contact, revealed staff had not notified her that the resident had suffered a fall with injury on 11/08/15 or that the resident was transferred to the hospital. The family member stated she was notified by the hospital staff that the resident had a fall with injury "hours after the fall had occurred."</p> <p>Interview with Licensed Practical Nurse (LPN) #4 on 11/16/15 revealed she was caring for Resident #1 when the resident fell on 11/08/15. LPN #4 acknowledged she had not notified the resident's family members that the resident had sustained a fall with injury, or that the resident had been transferred to the hospital. The LPN stated the resident was his/her own responsible party. LPN #4 stated she had not been trained to notify family members of changes in a resident's condition if a resident was their own responsible party.</p> <p>Interview with the Director of Nursing on 11/16/15 at 1:50 PM revealed staff was not required to call family members related to a change in the resident's condition, "unless they have a responsible party listed" in the resident's medical record. The DON was not aware an interested</p>	F 157	<p>member, unless the resident requested otherwise. Any concerns identified through the review of the progress notes and incident reports were resolved by notification of resident, resident legal representative or an interested family member, unless the resident requested otherwise.</p> <p>On December 3, 2015, licensed nursing staff were educated on family notification, by the Staff Development Coordinator (SDC).</p> <p>This education included notification of the family of an alert and oriented resident, if the resident leaves the facility due to an accident, unless the resident requests otherwise. Any licensed staff member not attending this education will receive it prior to working. This education will also be added to orientation for newly hired licensed staff.</p> <p>On December 15, 2015, the facility policy on notification of physician of changes in a resident's condition was amended by the Administrator to include notification of Resident, Physician, Resident's Legal Representative or an interested family member.</p> <p style="text-align: right;">F157 cont</p>	
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F 157	<p>Continued From page 6</p> <p>family member was required to be notified when a change in a resident's condition occurred.</p> <p>2. Review of the medical record for Resident #2 revealed the facility admitted the resident on 09/24/15, with diagnoses that included Malignant Neoplasm of the Prostate and Schizophrenia.</p> <p>Review of the resident's Admission MDS Assessment dated 09/30/15 revealed staff assessed the resident to require extensive assistance of two staff members with transferring and toileting and to always be incontinent of bowel and bladder. Resident #2 was not interviewable. The facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 4.</p> <p>Review of Resident #2's medical record revealed the resident expired on 11/01/15 and was unable to be interviewed or observed.</p> <p>Review of a facility abuse investigation, dated 11/16/15, along with witness statements, revealed on 10/27/15 State Registered Nurse Aide (SRNA) #8 reported that SRNA #3 told Resident #2 that "[the resident] was not doing that again" referring to Resident #2 "urinating." SRNA #3 was also observed to have "took [the resident's] legs" and stated to Resident #2 "you are setting up" even though the resident stated he/she did not want to get out of bed at that time. Continued review of the investigation revealed the allegation against SRNA #3 was substantiated and his/her employment was terminated from the facility.</p> <p>Interview with the Director of Nursing (DON) on 11/16/15 at 3:55 PM revealed she had conducted the investigation related to the allegation of abuse</p>	F 157	<p>On December 17, 2015, the Administrator educated nursing staff on the policy addendum related to notification of Resident, Physician, Resident's legal representative or an interested family member, unless a resident requested other wise. If any nursing staff did not attend the education session they will be educated prior to working. The information will also be given to new employees during orientation.</p> <p>On December 17, 2015 the Administrator attended the Resident's Council Meeting. There were 21 residents in attendance. The Administrator informed the residents that the facility policy on notification had been amended to include notification of the Resident, Physician, Legal Representative, and/or, if known, an interested family member. The Administrator further explained to the resident council that residents who were their own responsible party would continue to be afforded the right to exercise their rights of "not notifying" an interested family member if they chose that option. Resident's were encouraged, if they chose for an interested family member not to be notified, to put that request in writing for inclusion in their medical record. Which</p>	
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F 157	<p>Continued From page 7</p> <p>which involved Resident #2. The DON stated she had not contacted the resident's niece, who was listed on the resident's Admission Transcript as an emergency contact, because the resident was his/her own responsible party. The DON stated she had not been trained to contact residents' family members when residents were involved in allegations of abuse, substantiated or unsubstantiated, in the facility.</p> <p>F 225 SS=E 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p>	F 157	<p>would allow SSD and Licensed Nursing Staff to know their wishes related to family notification. The resident's were further informed that the SSD was available to assist them if they desired to add the option of "not" notifying an interested family member to their medical records. Only one Resident had a question about exercising his rights. The SSD informed the resident that she would discuss the concern with him in private. The SSD informed the Administrator that actions were already being taken for the resolution of that particular resident's concern. There were no further concerns voiced by the residents related to the informing of family members. The Administrator informed the resident's that she was available to them individually, if desired to discuss any concerns or questions.</p> <p>The DON, ADON, QI Nurse or SDC, will review all progress notes, and incident reports to ensure family notification of appropriate parties, unless requested otherwise by a resident. The following schedule of audits will be utilized: 5 times a week for 2 weeks, then 3x a week for 2 weeks, then weekly for 4 weeks, then monthly for 3 months. Any</p>	
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FIGURE 1

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F 225	<p>Continued From page 8</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>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 all alleged violations involving mistreatment, neglect, abuse, and misappropriation of resident property were thoroughly investigated and reported immediately to the administrator and state agencies as required for one (1) of twelve (12) sampled residents (Resident #3). Staff reported to the Director of Nursing that Resident #3's Fentanyl patch (utilized to treat pain) was missing and not on the resident as ordered by the physician, at an unknown date and time, approximately two (2) months ago. However, no evidence was provided that the incident was reported or investigated to ensure the resident was free from neglect or misappropriation of his/her ordered pain medication.</p> <p>Staff interviews revealed the DON had been notified by two (2) staff members that Registered Nurse (RN) #2 reported to work and was suspected to be under the influence of alcohol and/or drugs, and the RN declined to take a urine drug screen and just "went home" (unable to recall exact date). No evidence was provided</p>	F 225	<p>concerns will be addressed at the time of the audit by the nurse performing the review, and reported to the DON. The results of these audits will be reported to the Quality Improvement (QI) Committee, weekly by the DON, for any recommendations. The QI committee consists of the Administrator, the DON, ADON, SDC, QI Nurse, SSD and other members as warranted by topics/discussion. The Executive Quality Improvement Committee will review the audits quarterly and recommend any additional monitoring. The Executive Quality Improvement Committee consists of all members of the QI Committee plus the facility Medical Director.</p> <p>F225</p> <p>On, December 3, 2015 Resident #3's Fentanyl patch placement was verified by the DON and ADON.</p> <p>On November 30, 2015 the DON assessed all Resident's with ordered Fentanyl patches, to verify placement as ordered of the pain patches. No additional concerns were observed.</p> <p>The concern related to RN # 2 was investigated by the DON and Administrator December 10-14.</p>	<p>F225 01/03/16</p>
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F225 continued

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977		
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F 225	<p>Continued From page 9</p> <p>that the incident was investigated or reported to state agencies as required to ensure residents were free from potential abuse/neglect.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Abuse, Neglect, or Misappropriation of Resident Property Policy," last revised 05/01/13, revealed facility staff would investigate all allegations. The policy stated the Administrator was responsible to direct the investigation process and would ensure appropriate state agencies were notified as required.</p> <p>1. Review of Resident #3's medical record revealed the facility admitted the resident on 06/03/08, with diagnoses that included Chronic Pain Syndrome and Anxiety. Review of the resident's Quarterly Minimum Data Set Assessment (MDS) dated 10/22/15, revealed the facility assessed the resident to not be interviewable with a Brief Interview for Mental Status (BIMS) score of 6.</p> <p>Review of Resident #3's physician's orders dated November 2015 revealed the resident had a physician's order for a Fentanyl 50-microgram (mcg) patch (narcotic pain medication) to be applied to the resident every 72 hours related to a diagnosis of pain.</p> <p>Interview with LPN #1 on 11/17/15 at 1:50 PM, revealed approximately two months earlier, Resident #3 did not have his/her physician ordered Fentanyl patch on for pain as required. The LPN stated the DON was immediately notified that the resident's Fentanyl patch was not on the resident as ordered, and was "missing."</p>	F 225	<p>2015. The Administrator and DON concluded that RN # 2 could return to work, if released by physician to return to full duty. RN # 2 returned to work on December 14, 2015.</p> <p>On November 30, 2015, the DON was educated by the Facility Registered Nurse (RN) Consultant, on the facility policy for reporting and investigating abuse allegations, to include reports of missing medications. This education included, interviewing of residents and staff, suspension of the accused perpetrator, drug screen and statement to be completed prior to accused perpetrator leaving the facility, statements from all staff working at the time, statements from any residents involved, reporting to Facility Administrator and reporting to Office of Inspector General and Adult Protective Services. The education also included reporting conclusions of investigation to involved residents and/or an interested family member.</p> <p>Between December 3-23, 2015, staff were educated on the facility abuse policy, by the Staff Development Coordinator (SDC) This education included a review of the facility's policy on Abuse, Neglect or Misappropriation of</p>		

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F 225	<p>Continued From page 10</p> <p>According to LPN #1, she had reported the missing Fentanyl patch to the DON because it was suspected the medication had been misappropriated. The LPN stated the DON stated, "No big deal. Probably was lost in the sheets. Just put another one on the resident." No further directions were given to the LPN to ensure Resident #3's medication had not been misappropriated.</p> <p>Interview with the DON on 11/20/15 at 1:37 PM revealed she was notified that Resident #3's Fentanyl pain patch was missing. The DON acknowledged she should have "further investigated, but I had assumed it had come off in the linens." The DON acknowledged allegations of misappropriation were required to be reported to state agencies and investigated per facility policy.</p> <p>2. Interview with Certified Medication Aide (CMA) #4 on 11/19/15 at 3:45 PM revealed (unknown date) she observed RN #2 report to work approximately 30 minutes late, and appeared to be under the influence. The CMA stated the RN fell "...over a medicine cart and was slurring her words." The CMA stated she immediately reported her suspicions to RN #3, who was in the facility at the time the incident occurred. CMA #4 stated when she came to work the next day, she reported her concerns related to RN #2 reporting to work potentially under the influence to the DON. The CMA stated the DON stated, "Yes," she had received phone calls about the incident and, "It's taken care of."</p> <p>Interview with RN #3 on 11/19/15 at 4:30 PM revealed CMA #4 reported to her that she suspected RN #2 was working under the</p>	F 225	<p>Resident Property, as well as following the chain of command for reporting abuse if the staff felt the situation was not handled appropriately. Any staff member not attending this education will receive it prior to working. On December 8, 2015, licensed nurses were educated by the SDC on the steps to take when an allegation of abuse is reported to them. This education included removing the alleged perpetrator, if known, to keep resident safe, notification of administrator and DON, assessment of the resident, notification of resident's representative as indicated, written statements from staff and/or residents. Any licensed nursing staff not attending this education will receive it prior to working.</p> <p>On December 17, 2015 the Administrator attended the Resident's council meeting. 21 residents were in attendance. The resident's rights were reviewed which included the resident's rights to be free of abuse, neglect and misappropriation of resident property. The Administrator informed residents that she was available to meet individually if they desired.</p> <p>On December 21, 2015 the DON, ADON, QI Nurse, SDC and MDS</p>		

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F 225	<p>Continued From page 11</p> <p>influenza (unable to recall exact date). RN #3 stated RN #2 had a cough but had difficulty standing up and was "unsteady on her feet." RN #3 stated RN #2 was assigned to administer medications the night the incident occurred so RN #3 confronted RN #2 related to her suspicions she might possibly be under the influence. When RN #3 discussed her concerns with RN #2, RN #2 refused a drug screen at that time, stated she was "sick," and exited the facility. RN #3 stated the facility's policy was if any employee was suspected of being under the influence of drugs or alcohol, staff could request that employee to submit to a drug test. RN #3 notified the DON that RN #2 had reported to work possibly under the influence, and that RN #2 had not submitted to a drug screen when requested. RN #3 stated the DON did not direct her to initiate an investigation. RN #3 stated RN #2 continued to be employed at the facility.</p> <p>Attempts on 11/19/15, 11/20/15, and 11/21/15 to reach RN #2 for an interview were unsuccessful.</p> <p>Interview with the DON on 11/20/15 at 1:37 PM revealed, "It was told to me that she (RN #2) staggered and was really sick." The DON stated, "It wasn't told to me like she refused a drug screen." However, the DON acknowledged if facility staff was suspected to be under the influence, they "shouldn't be able to refuse a drug screen." The DON further stated a CMA had voiced concerns to her that RN #2 had reported to work "under the influence" and she informed the CMA that "I was already looking into it" However, the DON acknowledged there had been no investigation related to the incident that had been reported to her, and that RN #2 continued to maintain employment at the facility.</p>	F 225	<p>Nurses (Administrative Nurses) were educated by the Administrator. The education included immediately beginning an investigation, as well as, documentation of alleged concerns related to violations of the facility's expectations of a drug free workplace.</p> <p>Between December 21-23, 2015 Licensed Nurses were re-educated by the DON related to the facility's expectations of a drug free workplace, as well as investigation and documentation of concerns/statements. If nurses were not available to attend meeting they will be educated by DON prior to working.</p> <p>The DON, ADON, QI Nurse or SDC, will review 100% of progress notes, and incident reports for any possible allegation that was not reported, 5 times a week for 2 weeks, then 3x a week for 2 weeks, then weekly for 4 weeks, then monthly for 3 months. Any concerns will be addressed at the time of the audit by the nurse performing the review, and reported to the DON and Administrator. The results of these audits will be reported to the Quality Improvement (QI) Committee, weekly by the DON,</p>	
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F225 unit

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F 225	Continued From page 12	F 225	for any recommendations. The QI committee consists of the Administrator, the DON, ADON, QI Nurse, SDC, SSD and other staff as warranted by topic/discussion. The Executive Quality Improvement Committee will review the audits quarterly and recommend any additional monitoring. The Executive Quality Improvement Committee consists of all members of the QI Committee plus the facility Medical Director.		
F 241 SS=G	<p>Interview with the Administrator on 11/23/15 at 3:20 PM, revealed he had not been notified that any medications were potentially misappropriated in the facility. The Administrator stated all allegations that were reported to administrative staff should be thoroughly investigated and reported to state agencies as required.</p> <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 enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy it was determined the facility failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect for one (1) of twelve (12) sampled residents (Resident #11). Interview with Resident #11 conducted on 11/18/15 revealed, "a while back" (unable to recall dates/times) after the resident reported Licensed Practical Nurse (LPN) #5 to the Social Worker, the LPN came into the resident's room, "stuck her finger in my face, and asked me why I had reported her." The resident stated the incident made him/her "feel stupid and like I meant nothing here." Resident #11 was observed to be tearful at different intervals throughout the interview. Interviews with staff revealed the resident was "shaking all over" after the incident and stated LPN #5 talked to him/her "like a dog."</p>	F 241	<p>The Administrative Nurses will report immediately to the DON and complete a monthly report x 3 months for the Administrator related to any concerns that have been verbalized to them related to violations of a drug free work place. Then as directed by Executive QI Committee.</p> <p>F241</p> <p>Resident #11 was interviewed on November 24, 2015, by the DON and SSD regarding any additional concerns with how staff communicated with him or treated him. No additional concerns were identified.</p>	<p>F241 01/03/16</p>	

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F 241	Continued From page 13  The findings include:  Review of the facility's policy titled "Dignity," dated October 2005, revealed care and treatment was to be provided to facility residents in a manner that helped preserve their dignity, self-esteem, and self-respect. Facility staff was also required to ensure each resident was valued as an individual, and that staff interactions with facility residents were conducted respectfully.  Review of the medical record for Resident #11 revealed the facility admitted the resident on 12/09/11 with diagnoses that included Anxiety and Major Depressive Disorder. Review of Resident #11's Annual Minimum Data Set Assessment (MDS) dated 11/04/15 revealed staff assessed the resident to be interviewable with a Brief Interview for Mental Status (BIMS) score of 15.  Interview with Resident #11 on 11/18/15 at 3:00 PM revealed he/she had reported to the Social Worker that Licensed Practical Nurse (LPN) #5 had verbally abused him/her "a while back" (unable to recall dates/times). The resident stated "a few minutes" after the report was made to the social worker, LPN #5 came into his/her room, "stuck her finger in my face, and asked me why I had reported her." The resident stated the incident made him/her "feel stupid and like I meant nothing here." The resident further stated, "I will never report anything else that happens here again." Resident #11 was observed to be tearful at different times throughout the interview.  Interview with Certified Medication Aide (CMA) #2 on 11/18/15 at 11:30 AM revealed she had entered Resident #11's room to administer	F 241	On, December 2, 2015 the DON conducted interviews with all residents having a BIMS score of 8-15, for concerns related to staff interactions with resident, and treatment of residents by staff. No additional concerns were reported.  On, December 18, 2015 the DON, ADON, SDC and QI Nurse conducted a body audit of all residents who had a BIMS score of 99 or 7 and under to assess for any potential indications of abuse/neglect. No concerns were identified  LPN # 5 no longer works at the facility.  On December 3, 2015, all staff were educated on treating residents with dignity and in a courteous fashion, by the SDC. This education included tone of voice, being respectful, reporting and investigation of alleged violations of resident dignity. Any staff member not attending this education will receive it prior to working. This education will also be added to orientation for newly hired staff.		

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F 241	<p>Continued From page 14</p> <p>medications "a few months ago" (unable to recall exact date) and the resident was observed to be "shaking all over." CMA #2 stated that the resident told her, "She talked to me like a dog, she shouldn't work with people like us" (referring to LPN #5). The CMA stated that the resident told her that after he/she reported the incident to the Social Worker, LPN #5 came back to Resident #11's room and "jumped all over" him/her.</p> <p>Interview with LPN #3 on 11/18/15 at 10:50 AM revealed she had reported to the DON "over and over" that LPN #5 was rude and "hateful" to residents. However, the LPN stated the DON took no action related to the reports of concern of resident treatment by LPN #5.</p> <p>Interview with State Registered Nurse Aide (SRNA) #12 on 11/19/15 at 12:15 PM revealed LPN #5 was "short and hateful with residents." The SRNA stated she had reported it "a while back" to a nurse (unable to recall who); however, she was told, "She's been reported and nothing's been done, so just forget it." The SRNA was unable to recall any residents involved.</p> <p>Interview with the Social Worker (SW) on 11/18/15 at 4:15 PM revealed Resident #11 stated he/she felt like LPN #5 was rude and had offended him/her, and that could be a dignity issue for the resident. The SW acknowledged that LPN #5 had "talked" to the resident about the allegations made against her.</p> <p>Interview with LPN #5 on 11/19/15 at 2:35 PM revealed she denied being rude or verbally abusive to Resident #11. The LPN stated she had been notified by the Social Worker or</p>	F 241	<p>On December 17, 2015 the Administrator educated staff on actions that should never be taken by them such as confronting a resident if the resident had voiced a concern or made an allegation against them. The staff was informed that the alleged perpetrator would be informed of investigation conclusions, as it related to them. Staff members not available on this day for education will be educated by the DON prior to working.</p> <p>On December 17, 2015 the Administrator attended the resident's council meeting to discuss the residents rights. The administrator informed the residents that they had the right to be treated with dignity, respect and in a courteous manner. The Administrator encouraged the residents to practice that same philosophy with their neighbors in the facility.</p> <p>None of the residents felt they were being abused or neglected. A few concerns were voiced such as "not all staff knock on their doors and/or provide privacy for residents". There were no names of staff reported to the administrator. The Administrator informed the</p>		

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F 241	Continued From page 15 previous Administrator (unable to recall which one) that Resident #11 had "accused me of talking mean and slamming the door in" his/her face. LPN #5 stated, "If I would have done this," it would have been a concern of dignity for a resident. The LPN stated she had gone into the resident's room after the resident had voiced the allegation against her and said the resident stated, "I didn't tell the Social Worker that." The LPN stated that since she was accused of something, she wanted to know what she had done.  Interview with the DON on 11/18/15 at 5:00 PM revealed she denied ever receiving and/or requesting a written statement from any staff member related to any incident that involved LPN #5. The DON denied any staff members had ever reported to her any concerns of LPN #5's treatment of residents or that the LPN was rude or hateful to residents. The DON stated she had not interviewed or discussed the incident with Resident #11 after she had received a report that the resident had stated that LPN #5 had "slammed the door" in his/her face. However, the DON stated, "Looking back, I probably should have interviewed the resident." The DON acknowledged if a resident felt that a staff person had been rude or had offended him/her that was a concern for a resident's dignity.	F 241	residents that she was available to meet with them individually if they needed to discuss any issues.  On December 17, 2015 the Administrator educated the nursing staff on the above issues. If any nursing staff did not attend the meeting they will be educated prior to working.  The DON, ADON, QI Nurse, SDC, or the SSD will interview or conduct a body audit on a total of 20 residents per month for 3 months related to staff treatment of residents and any indication of possible abuse/neglect. Audits/Interviews will focus on ensuring that residents are being treated with courtesy, respect and dignity. After the first 3 months, 30 residents per quarter will be interviewed or have a body audit conducted with a focus on residents being treated with courtesy, dignity and respect for an additional 6 months.. Any concerns will be addressed at the time of the audit/interview by the employee performing the interview/audit and reported to the DON. The results of these audits will be reported to the Quality Improvement (QI) Committee, weekly by the DON, for any recommendations. The QI committee consists of the		
F 312 SS=E	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.	F 312			

F241 Con't

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Continued From page 16

This REQUIREMENT is not met as evidenced by:  
Based on interviews and record reviews it was determined the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene related to receiving assistance with bathing for three (3) of twelve (12) sampled residents (Residents #3, #11, and #12) and three (3) unsampled residents (Residents A, B, and C). Interviews with staff, residents, and a family member revealed facility staff had not provided assistance to residents with bathing; and residents were going five (5) or more days at times without receiving a bath.

The findings include:

Interview with the Director of Nursing (DON) on 11/16/15 at 1:50 PM revealed there was no written policy related to bathing residents in the facility. However, the DON stated that all residents were required to receive two baths a week. She also stated residents should receive adequate assistance to meet their needs in the facility.

1. Review of the medical record for Resident #3 revealed the facility admitted the resident on 06/03/08 with diagnoses that included Morbid Obesity and Anxiety. Review of the resident's Quarterly Minimum Data Set Assessment (MDS) dated 10/22/15 revealed the facility assessed the resident to not be interviewable with a Brief Interview for Mental Status (BIMS) score of 6. The facility assessed Resident #3 to require extensive assistance of two staff members for

F 312

Administrator, the DON, ADON, SDC, QI Nurse, SSD and other staff as warranted by topic/discussion. The Executive Quality Improvement Committee will review the audits quarterly and recommend any additional monitoring. The Executive Quality Improvement Committee consists of all members of the QI Committee plus the facility Medical Director.

F312

Residents #3, 11, 12, A, B, and C were offered and assisted or provided full baths on November 24 and 25, 2015, by staff.

On December 1 and 2, 2015, a 100% review, of resident bath records for the previous week, was completed by the DON and the Facility RN Consultant. 27 Residents were found to not have full baths documented on computer per policy. However, there was documentation on paper that residents had been provided with a full bath per policy, unless the full baths had been refused by the resident. Any resident not having a

F312  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 11/23/2015
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NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDALE APARTMENTS ROAD PINEVILLE, KY 40977
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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 312	<p>Continued From page 17 dressing and bathing.</p> <p>Review of Resident #3's bathing documentation revealed the resident had not received assistance with bathing from 09/30/15 until 10/10/15 (a period of ten days). Further review of the bath sheet revealed the resident received assistance with bathing on 10/14/15; however, no bathing assistance was provided for Resident #3 again until 10/21/15 (a period of six days).</p> <p>Interview with Resident #3's family member on 11/18/15 at 10:05 AM revealed she visited the resident almost daily. The family member stated there had been times that she had visited and could "smell and tell" that the resident had not had a bath. The family member stated she would report to the nurses and voice concerns related to the resident's hygiene. The family member stated that staff would inform her that the "bath team was pulled" and there was not enough staff to bathe the residents. Further interview revealed that bathing has been a concern in the facility for the past few months.</p> <p>2. Review of the medical record for Resident #11 revealed the facility admitted the resident on 12/09/11 with diagnoses that included Anxiety and Major Depressive Disorder. Review of Resident #11's Annual MDS Assessment dated 11/04/15 revealed the facility assessed the resident to be interviewable with a BIMS score of 15. The resident was also assessed to require extensive assistance of one staff member for personal hygiene and bathing.</p> <p>Interview with Resident #11 on 11/18/15 at 10:20 AM revealed the resident stated, "One of the biggest problems here is getting a bath." The</p>	F 312	<p>full bath documented per policy was offered a full bath and either provided with assistance or given a full bath between December 1-4, 2015, unless a resident refused a full bath.</p> <p>On December 3, 2015, nursing staff were educated on the facility bathing policy, by the Staff Development Coordinator (SDC). This education included that residents were to be provided with two full baths per week and partial baths on non-bath days as well as required documentation of the baths and/or refusal of the baths. Any nursing staff member not attending this education will receive it prior to working. This education will also be added to orientation for newly hired licensed staff.</p> <p>The DON, ADON, QI Nurse or SDC, will review 100% of the bath records, to ensure baths are being given and documented per policy, weekly x 2 months, then bi-monthly x 2 months, then monthly x 3 months. Any concerns will be addressed at the time of the audit by the nurse performing the review, and reported to the DON. The</p>	
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F 312	<p>Continued From page 18</p> <p>resident stated he/she should have received a bath "this past Saturday" (11/14/15); however, when he/she requested a bath, he/she was told there was not enough staff to bathe the resident. The resident stated that he/she "...went six or seven days before and no one would help me bath."</p> <p>Review of Resident #11's bathing documentation revealed the resident received assistance with bathing on 09/27/15, 10/04/15, and 10/11/15 (a six-day period between each bath). Resident #11's bathing documentation further revealed the resident received a bath on 10/27/15 and did not receive another bath until 11/03/15 (a period of seven days). Resident #11 received assistance with bathing on 11/11/15, and was not provided a bath again until 11/16/15 (a period of four days).</p> <p>3. Review of Resident #12's medical record revealed the facility admitted the resident on 07/14/14 with diagnoses that included Diabetes and Chronic Pain. Review of Resident #12's Quarterly MDS Assessment dated 10/20/15 revealed the facility assessed the resident to be interviewable with a BIMS score of 8. The facility assessed Resident #12 to be totally dependent upon two staff members for bathing.</p> <p>During an interview with Resident #12 on 11/16/15 at 10:00 AM he/she stated, "I have missed my baths," but he/she was unable to recall the dates/times. The resident further stated if he/she asked for a bath, staff would say, "There's not enough help here."</p> <p>4. Review of Resident A's medical record revealed the facility admitted the resident on 08/14/15 with diagnoses that included Diabetes</p>	F 312	<p>results of these audits will be reported to the Quality Improvement (QI) Committee, weekly by the DON, for any recommendations. The QI committee consists of the Administrator, the DON, ADON, QI Nurse, SDC, SSD and other staff as warranted by topic/discussion. The Executive Quality Improvement Committee will review the audits quarterly and recommend any additional monitoring. The Executive Quality Improvement Committee consists of all members of the QI Committee plus the facility Medical Director.</p>		

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F 312	Continued From page 19 and Chronic Pain. Review of Resident A's Admission MDS Assessment dated 08/20/15, revealed the facility assessed the resident to be interviewable with a BIMS score of 13. The facility assessed Resident A to be totally dependent upon two staff members for bathing.  Interview with Resident A on 11/16/15 at 9:50 AM revealed the resident stated he/she had not received assistance as required with bathing in the facility. The resident stated staff had informed him/her that "they don't have enough staff" to bathe the residents. The resident stated he/she "went ten days without a bath," while he/she has resided at the facility.  Review of Resident A's bathing documentation revealed the resident received assistance with bathing on 09/26/15 and had no bathing documented again until 10/05/15 (eight days without receiving a bath). Review of documentation revealed the resident was bathed on 11/02/15 and no assistance was provided to the resident again until 11/09/15 (a period of six days).  5. Review of Resident B's medical record revealed the facility admitted the resident on 03/02/12 with diagnoses that included Muscle Weakness and Anxiety Disorder. Review of Resident B's Quarterly MDS assessment dated 09/03/15 revealed the resident was assessed to be interviewable with a BIMS score of 8. The facility assessed Resident B to be totally dependant upon two staff members for bathing.  Interview with Resident B on 11/16/15 at 9:45 AM revealed that he/she had not received assistance as required with bathing. Resident B stated staff	F 312			

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F 312	<p>Continued From page 20</p> <p>had informed him/her that "they didn't have time to help me bath" because there was "not enough help." The resident stated he/she could not remember specific dates or timeframes that the baths were missed.</p> <p>Review of Resident B's bathing documentation revealed the resident received assistance with bathing on 09/02/15 and had no bathing documented again until 09/11/15 (eight days without receiving a bath). Review of documentation revealed the resident was bathed on 09/16/15 and no assistance was provided to the resident again until 09/26/15 (a period of nine days).</p> <p>6. Review of Resident C's medical record revealed the facility admitted the resident on 11/09/15 with diagnoses that included Pressure Ulcers and Anxiety Disorder. Resident C had no MDS assessment coded related to his/her new admission status. However, interview with the Social Worker on 11/17/15 at 10:15 AM revealed she had conducted a cognitive assessment and had assessed the resident to be alert and oriented and would score a 14 on the BIMS assessment. Even though the resident's admission MDS Assessment was not complete, review of the resident's initial care plan revealed the resident required assistance of two staff members for bathing.</p> <p>Interview with Resident C on 11/16/15 at 10:15 AM revealed that he/she had not received assistance as required with bathing. Resident C stated staff had informed him/her that there was no one that could give him/her a bath on Saturday (referring to 11/14/15). Resident C stated this was his/her fifth day without a bath.</p>	F 312		

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F 312	Continued From page 21  Review of Resident C's bathing documentation on 11/16/15 revealed the resident received assistance with bathing on 11/11/15 and had no bathing documented after that date (a period of five days).  Interview with State Registered Nurse Aide (SRNA) #2 on 11/16/15 at 2:40 PM revealed the SRNA was scheduled to work on the West Wing on 11/14/15. The SRNA acknowledged that residents on the West Wing had not received their baths on 11/14/15. The SRNA stated this happened "often" because "we don't have enough staff."  Interview with SRNA #13 on 11/16/15 at 3:30 PM revealed the facility's residents "miss getting their baths often." The SRNA stated the facility's bath team was frequently pulled to provide direct care, instead of only providing baths/showers, which leaves the unit "short staffed." The SRNA stated this has been an issue for the past few months.  Interview with SRNA #10 on 11/17/15 at 1:25 PM revealed the West Wing was "short staffed off and on." The SRNA stated residents have voiced concerns related to not receiving their baths. SRNA #10 stated that she had reported the concerns to nursing staff (unable to recall who), as this has been going on "off and on" for months.  Interview with Licensed Practical Nurse (LPN) #3 on 11/18/15 at 10:50 PM revealed the residents on the West Wing had not received their baths twice a week as required. The LPN stated when staff called in, the bath team on the West Wing was pulled to provide direct resident care.	F 312			

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F 312	Continued From page 22 Therefore, adequate staffing was not available to provide assistance with bathing. LPN #3 stated it had been reported that residents had not received their two showers/baths weekly as required. She stated, "Nothing's ever been done" to correct the staffing concern.  Interview with the DON on 11/18/15 at 1:50 PM revealed she was aware that if SRNAs scheduled to provide baths were pulled to provide care, then "there would not be anyone here to give baths." The DON acknowledged that the residents should be receiving two showers/baths every week, and should not be "waiting five or more days to receive assistance with bathing."	F 312		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS  The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.  The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:  Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.  Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of	F 353	F353  Residents #3, 11, 12, A, B, and C were offered and assisted or provided with full baths on November 24 and 25, 2015, by staff, unless the resident refused the bath.  On December 1 and 2, 2015, a 100% review of resident's bath records were conducted for the previous week by the DON and the Facility RN Consultant. 27 Residents were found to not have full baths documented on computer per policy. However, there was documentation on paper that residents had been provided a full bath per policy, unless the full baths had been refused by	F. 353 01/03/16

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F 353	<p>Continued From page 24</p> <p>resident to be cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 6. Staff further assessed Resident #3 to require extensive assistance of two staff members for dressing and bathing.</p> <p>Review of Resident #3's bathing documentation revealed the resident had not received assistance with bathing from 09/30/15 until 10/10/15 (a period of ten days). Further review of the bath sheet revealed the resident received assistance with bathing on 10/14/15; however, no bathing assistance was provided for Resident #3 again until 10/21/15 (a period of six days).</p> <p>Interview with Resident #3's family member on 11/18/15 at 10:05 AM revealed she visited the resident almost daily in the facility. The family member stated there had been times when the family member had visited the resident and could "smell" and "tell" that the resident had not had a bath. The family member stated she would report her concerns to the nursing staff related to the resident's hygiene. The family member stated that staff would inform her that the bath team was being utilized to provide resident care and was unable to provide a bath to Resident #3. The family member stated bathing had been a concern in the facility for the past few months.</p> <p>2. Review of the medical record for Resident #11 revealed staff admitted the resident on 12/09/11 with diagnoses that included Anxiety and Major Depressive Disorder. Review of Resident #11's Annual MDS assessment dated 11/04/15 revealed staff assessed the resident to be interviewable with a BIMS score of 15. The resident was also assessed to require the extensive assistance of one staff member for</p>	F 353	<p>and hiring transition the current licensed nurses, medication aides and nursing assistants are being offered bonuses to ensure that there is sufficient staff to meet the resident's needs.</p> <p>The DON will give a written report to the Administrator bi-weekly for 60 days informing the administrator of the number of available positions. Based on the collected data, action will be taken by the administrator and the DON to recruit additional staff.</p> <p>The DON will present bi-weekly reports to the QI Committee related to available staff positions for 2 months, then monthly for 2 months. The QI Committee consists of the Administrator, DON, ADON, QI Nurse, SDC, SSD and other staff as warranted by topic/discussion. The Executive QI Committee will review the reports quarterly and recommend interventions and additional monitoring. The Executive QI Committee consists of all QI members plus the facility Medical Director.</p>		

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F 353	<p>Continued From page 25 personal hygiene and bathing.</p> <p>Interview with Resident #11 on 11/16/15 at 10:20 AM revealed the resident stated, "One of the biggest problems here is getting a bath." The resident stated he/she should have received a bath "this past Saturday" (11/14/15); however, when he/she requested a bath, he/she was told there was not enough staff to bathe the resident. The resident continued to state he/she "went six or seven days before and no one would help me bath."</p> <p>Review of Resident #11's bathing documentation revealed the resident received assistance with bathing on 09/27/15, 10/04/15, and 10/11/15 (a six-day period between each bath). Resident #11's bathing documentation further revealed the resident received a bath on 10/27/15 and did not receive another bath until 11/03/15 (a period of seven days). Resident #11 received assistance with bathing on 11/11/15, and was not provided a bath again until 11/16/15 (a period of four days).</p> <p>3. Review of Resident #12's medical record revealed the facility admitted the resident on 07/14/14 with diagnoses that included Diabetes and Chronic Pain. Review of Resident #12's Quarterly MDS assessment dated 10/20/15 revealed the resident was assessed to be interviewable with a BIMS score of 8. Staff had assessed Resident #12 to be totally dependent upon two staff members for bathing.</p> <p>Interview with Resident #12 on 11/16/15 at 10:00 AM revealed the resident stated, "I have missed my baths" but was unable to recall dates/times. The resident further stated if he/she asked for a bath, staff would say, "There's not enough help</p>	F 353			

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F 353	<p>Continued From page 28 here."</p> <p>4. Review of Resident A's medical record revealed the resident was admitted to the facility on 08/14/15 with diagnoses that included Diabetes and Chronic Pain. Review of Resident A's Admission MDS assessment dated 08/20/15 revealed the resident was assessed to be interviewable with a BIMS score of 13. Staff had assessed Resident A to be totally dependent upon two staff members for bathing.</p> <p>Interview with Resident A on 11/16/15 at 9:50 AM revealed the resident stated he/she had not received assistance as required with bathing in the facility. The resident stated staff had informed him/her "they don't have enough staff to bath us." The resident stated he/she "went ten days without a bath," while he/she has resided at the facility.</p> <p>Review of Resident A's bathing documentation revealed the resident received assistance with bathing on 09/26/15 and had no bathing documented again until 10/05/15 (eight days without receiving a bath). Review of documentation revealed the resident was bathed on 11/02/15 and no assistance was provided to the resident again until 11/09/15 (a period of six days).</p> <p>5. Review of Resident B's medical record revealed the facility admitted the resident on 03/02/12 with diagnoses that included Muscle Weakness and Anxiety Disorder. Review of Resident B's Quarterly MDS assessment dated 09/03/15 revealed the resident was assessed to be interviewable with a BIMS score of 8. Staff assessed Resident B to be totally dependent</p>	F 353		

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F 353	<p>Continued From page 27 upon two staff members for bathing.</p> <p>Interview with Resident B on 11/16/15 at 9:45 AM revealed the resident stated he/she had not received assistance as required with bathing in the facility. Resident B stated staff had informed him/her that "they didn't have time to help me bath" because there was "not enough help." The resident stated he/she could not remember specific dates or timeframes that the baths were missed.</p> <p>Review of Resident B's bathing documentation revealed the resident received assistance with bathing on 09/02/15 and had no bathing documented again until 09/11/15 (eight days without receiving a bath). Review of documentation revealed the resident was bathed on 09/16/15 and no assistance was provided to the resident again until 09/26/15 (a period of nine days).</p> <p>6. Review of Resident C's medical record revealed the resident was admitted to the facility on 11/09/15 with diagnoses that included Pressure Ulcers and Anxiety Disorder. Resident C had no MDS assessment coded related to his/her new admission status. However, interview with the facility Social Worker on 11/17/15 at 10:15 AM revealed she had conducted a cognitive assessment and had assessed the resident to be alert and oriented and would score a 14 on the BIMS assessment. Even though the resident's admission MDS assessment was not complete, review of the resident's initial care plan revealed the resident required assistance of two staff members for bathing.</p>	F 353		
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F 353	<p>Continued From page 28</p> <p>Interview with Resident C on 11/16/15 at 10:15 AM revealed the resident stated he/she had not received assistance as required with bathing in the facility. Resident C stated staff had informed the resident that there was no one that could give the resident a bath on Saturday (referring to 11/14/15). Resident C stated this was his/her fifth day without a bath.</p> <p>Review of Resident C's bathing documentation on 11/16/15 revealed the resident received assistance with bathing on 11/11/15 and had no bathing documented after that date (a period of five days).</p> <p>Interview with State Registered Nurse Aide (SRNA) #2 on 11/16/15 at 2:40 PM revealed the SRNA was scheduled to work on the West Wing of the facility on 11/14/15. The SRNA acknowledged that residents on the West Wing of the facility had not received their baths on 11/14/15. The SRNA stated this happened "often" because "we don't have enough staff."</p> <p>Interview with SRNA #13 on 11/16/15 at 3:30 PM revealed the facility residents "miss getting their baths often." The SRNA stated the facility's bath team was frequently pulled to provide direct care instead of providing baths/showers. The SRNA stated this has been an issue for the past few months in the facility.</p> <p>Interview with SRNA #10 on 11/17/15 at 1:25 PM revealed the West Wing of the facility was "short staffed off and on." The SRNA stated residents have voiced concerns related to not receiving their baths. The SRNA stated she had reported the concerns to nursing staff (unable to recall who) but stated this had been occurring "off and</p>	F 353	

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F 353	Continued From page 29 on" for months.  Interview with Licensed Practical Nurse (LPN) #3 on 11/18/15 at 10:50 PM revealed the residents on the West Wing of the facility had not received their baths twice a week as required. The LPN stated when staff called in, the bath team on the West Wing was pulled to provide direct resident care. Therefore, adequate staffing was not available to provide assistance with bathing. LPN #3 stated it had been reported to Administration that residents had not received their two showers/baths weekly as required and stated, "Nothing's ever been done" to correct the staffing concern.  Interview with the DON on 11/16/15 at 1:50 PM revealed she was aware if SRNAs scheduled to provide baths were pulled to provide care, then "there would not be anyone here to give baths." The DON acknowledged that facility residents should be receiving two showers/baths every week, and should not be "waiting five or more days to receive assistance with bathing." The DON stated that staffing for the West Wing routinely consisted of five SRNAs for day shift. The DON stated that when the bath team was pulled to work with residents on the unit then resident baths were not completed as planned.	F 353			
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH  The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general	F 425	F 425  On November 23, 2015, the Facility RN Consultant reviewed Resident # 4, C, E, G, H, I, J, K, L, and M's current narcotic cards. They were found to be intact with no taped narcotics. On, December 1, 2015, Resident # 4 was made aware, by the DON, that he was administered "as needed" medication without his knowledge or consent.	F.425 01/03/16	

F425 cont

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F 425	<p>Continued From page 30 supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility policy it was determined the facility failed to provide pharmaceutical services that included procedures to assure the accurate administration of all drugs to meet the needs of facility residents for one (1) of twelve (12) sampled residents (Resident #4) and for nine (9) of thirteen (13) unsampled residents (Residents C, E, G, H, I, J, K, L, and M).</p> <p>Observations of the medication carts on 11/20/15 revealed controlled medications packages had clear tape over the foil on the back of the packages. Interviews with Licensed Practical Nurse (LPN) #3 and Certified Medication Aide (CMA) #4 revealed if a medication "popped out" of the package, staff would reinsert the medication and apply tape to the outside to secure the medication in place. However, staff stated they had been trained to waste medications if they had been removed from the</p>	F 425	<p>On November 23, 2015, a review of all narcotic cards was completed by the Facility RN Consultant. No narcotics were found to be taped into the cards.</p> <p>On December 3, 2015, licensed nursing staff and CMAs were educated on the facility policy related to medication administration. The education included no taping of narcotic into packaging and wasting narcotics if package was damaged and/or medications was popped out by accident as well as two signatures being required to waste narcotics.</p> <p>The Administrator educated the Licensed Nurses and the CMAs on December 17, 2015 that card stock should be used between narcotic cards to help protect the bubble/seal from tearing or being punctured. Any Licensed nursing staff member or CMA not attending this education will receive it prior to working. This education will also be added to orientation for newly hired licensed staff.</p>

F 425 Cont

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F 425	<p>Continued From page 31 pharmacy packaging.</p> <p>Review of Resident #4's Controlled Substance Count Sheet dated October 2015 revealed Registered Nurse (RN) #1 administered thirteen (13) of eighteen (18) doses of Hydrocodone 7.5 milligrams (mg) from 10/10/15 until 10/29/15 to Resident #4. However, interview with Resident #4 revealed the resident had not received the medication "in a long time," approximately a month or longer.</p> <p>There was no evidence the facility had a system in place to monitor staff's narcotic medication administration practices.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Medication Administration," not dated, which was provided as the facility's policy for pharmacy services, revealed the policy did not address monitoring medication administration for residents in the facility.</p> <p>1. Observations conducted of the facility's East Wing short hall medication cart revealed a bubble package labeled as Hydrocodone 5 mg/325 mg (a narcotic medication for pain) for Resident G. Further observations revealed the back of the package had been taped in various places.</p> <p>Observations of the East Wing medication cart revealed the following medication packages were taped: A package of medication labeled as Valium (medication to treat anxiety) 2 mg tablets for Resident H, had also been taped in various places on the back of the packaging; Tramadol (medication to treat pain) 50 mg, dispensed from</p>	F 425	<p>The DON or ADON will review 100% of narcotic cards weekly x 1 month, then bi-weekly x 2 months, then monthly x 3 months to ensure there is no taping of narcotic medications into the narcotic cards. The Audits will be forwarded to the QI Committee, by the DON and ADON, per same frequency. The QI Committee consist of Administrator, the DON, ADON, QI Nurse, SDC, SSD and other staff as warranted by topic/discussion. The Executive Quality Improvement Committee will review the audits quarterly and recommend any additional monitoring. The Executive Quality Improvement Committee consists of all members of the QI Committee plus the facility Medical Director.</p>		

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F 425	<p>Continued From page 32</p> <p>Pharmacy for Resident I, had been taped in various places on the back portion of the packaging; Hydrocodone 7.5mg/325 mg, dispensed from the pharmacy for Resident J, was observed to have been taped on the back portion of the packaging.</p> <p>Observations conducted of the West Wing short hall medication cart revealed Norco 7.5 mg/325 mg (narcotic pain medication) had been dispensed to Resident #4, Resident K, and Resident L. Observations of the residents' narcotic pain medication packaging revealed staff had applied tape to the back portion of the residents' medications.</p> <p>Observations of Hydrocodone 7.5 mg/325 mg dispensed to Resident E and Hydrocodone 5 mg/325 mg dispensed to Resident M revealed staff had taped the back portion of the residents' pain medication packs.</p> <p>Observations of Xanax (medication used to treat anxiety) 1 mg tablets for Resident #12 and Xanax 0.5 mg dispensed for Resident C revealed the packaging had been taped on the back portion of the residents' controlled medication packaging.</p> <p>Interview with Certified Medication Aide (CMA) #4 on 11/20/15 at 2:40 PM revealed staff taped narcotic packaging at times, if a pill "popped" out. The CMA stated staff was "supposed to" waste medications if they became dislodged from the pharmacy packaging.</p> <p>Interview with Licensed Practical Nurse (LPN) #3 on 11/20/15 at 3:15 PM revealed she observed narcotic medication packages taped on the back portion of the pack. The LPN stated she had</p>	F 425			

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F 425	<p>Continued From page 33</p> <p>never taped them and that staff was required to waste medications if they had been removed or had "popped" out of the pharmacy packaging.</p> <p>2. Review of Resident #4's Controlled Substance Count Sheet dated October 2015 revealed the resident received 18 doses of Hydrocodone 7.5 mg from 10/10/15 until 10/29/15. The resident's Controlled Substance Record revealed RN #1 had administered 13 of the 18 doses of pain medication to Resident #4. The last dose RN #1 administered was dated 10/28/15.</p> <p>Interview with Resident #4 on 11/18/15 at 2:10 PM revealed the resident had not taken a "pain pill" in a month or longer. The resident stated, "It's been a long time." Resident #4 continued to state pain medication "messes with my digestive tract."</p> <p>Interview with the Director of Nursing (DON) on 11/23/15 at 4:30 PM revealed she conducted "random chart checks" and had not identified a concern related to controlled substance packages being taped. The DON stated she had no system for monitoring facility staff's narcotics administration practices, even though she was aware RN #1 had a history of drug addiction.</p>	F 425			