

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

PRINTED: 06/08/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/22/2015
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	This Plan of Correction constitutes our facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	
F 151 SS=B	<p>483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL</p> <p>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy review, it was determined the facility failed to ensure residents were given the opportunity to vote in the most recent election, for three (3) of sixteen (16) sampled residents (Residents #1, #9 and #11) and three (3) of five (5) unsampled residents (Unsampled Residents C, D and E).</p> <p>The findings include: Review of the Voting Rights Policy, revised 2006, revealed the facility would help residents expressing a desire to exercise their right to vote achieve that right. The Activity Services Department would help residents with voting registration, obtaining absence ballots and or obtain transportation to the voting sites. All</p>	F 151	<p>F151 Completion Date: 6/19/2015 SS=B Resident Rights 483.10 Exercise Rights as a Citizen --- Voting</p> <p>The specific residents that were cited in the statement of deficiency as having been affected were as follows: Residents #s 1, 9, 11, and unsampled Residents C, D, and E</p> <p>Administrator completed education/training regarding residents' right to vote to the Director of Admissions/Marketing, Activity Assistant, and the new Activity Director and the facility's responsibility to assist with this. This was completed by 6/2/2015.</p> <p>Director of Admissions/Marketing met individually with Residents #s 1, 9, 11, and unsampled Residents C, D, and E to explain to them that in the future they would be given the opportunity to vote in May and November elections in Kentucky This was completed by 6/8/2015.</p>	

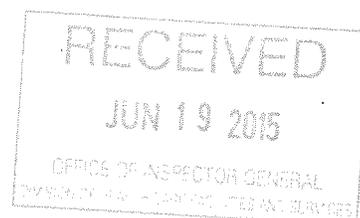
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Administrator* (X6) DATE: *6/18/2015*

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

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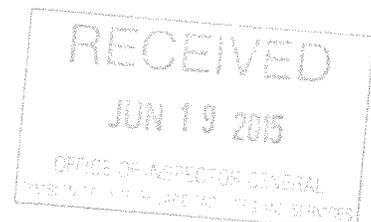
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F 151	<p>Continued From page 1</p> <p>requests for voting information should be directed to the Activity Services Department.</p> <p>1. Interview conducted during Resident Council, on 05/19/15 at 4:20 PM, revealed Resident #11, and Unsamped Residents C, D, and E all voiced they were not aware of the election and would have liked the opportunity to have voted.</p> <p>Interview with the Life Enrichment Assistant (Activity Department), on 05/22/15 at 4:30 PM, revealed the facility normally provided absentee ballots to the residents. The Life Enrichment Assistant, stated she was not aware there was an election, but was aware it was the rights of the residents to be able to vote. The Life Enrichment Assistant stated she normally received information through the mail about the election and she would then request for absentee ballots. She stated no residents had voiced the desire to vote that she was aware.</p> <p>Interview with the Admissions Marketing Director (who currently serves as the interim Activity Director), on 05/22/15 at 4:30 PM, revealed she had been in her position a week and was not aware of any residents who wanted to vote.</p> <p>2. Review of Resident #1's clinical record revealed the facility re-admitted the resident on 08/06/14 with the diagnosis of Hypothyroidism, Hypertension and Polyarthrits.</p> <p>Review of Resident #1's Annual Minimum Data Set (MDS) assessment, completed on 05/11/15 revealed the facility assessed the resident utilizing the Brief Interview of Mental Status</p>	F 151	<p>The other residents that were identified to be at risk for this deficient practice were as follows:</p> <p>Administrator completed education/training regarding residents' right to vote to the Director of Admissions/Marketing, Activity Assistant, and the new Activity Director and the facility's responsibility to assist with this. This was completed by 6/2/2015.</p> <p>The Director of Admissions/Marketing interviewed the other cognitive residents (with BIM scores higher than 8) to ask them if they wanted to exercise their right to vote in elections; especially for the upcoming November election. There were six other residents that were identified as having a desire to exercise their right to vote in elections. Their names were added to the list of residents wanting to vote that is maintained by the facility's activity department. This was completed by 6/12/2015.</p> <p>The measures that were put into place or systemic changes made to ensure that this deficient practice does not recur included the following:</p> <p>Administrator revised the orientation training checklist for the Director of Admissions/Marketing, Activity Director, and Activity Assistant to include "Residents Right To Vote and Facility Process for</p>		



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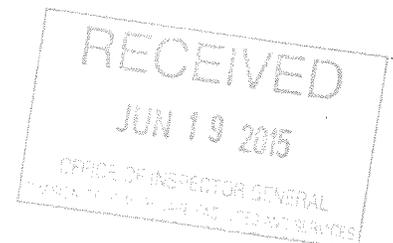
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/22/2015
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F 151	<p>Continued From page 2</p> <p>(BIMS) as being moderately impaired; BIMS score was ten (10) of fifteen (15).</p> <p>Observation, on 05/19/15 at 3:00 PM, of Resident #1 revealed she/he was in the dining area, seated at a table with peers actively engaged in Bingo.</p> <p>Interview with Resident #1, on 05/20/15 at 11:20 AM, and at 11:50 AM, revealed an interest in the outcome of the recent election, with the resident stating they wondered how that election turned out. Resident #1 stated he/she always voted before living here. He/she expressed the desire to have voted this time provided the opportunity had been offered. Resident #1 stated he/she was not offered the opportunity to vote in the most recent election.</p> <p>3. Review of Resident #9's clinical record revealed the facility re-admitted the resident on 04/04/14 with diagnosis of Depressive Disorder, Anxiety, Mental Disorder and Anemia.</p> <p>Review of Resident #9's Quarterly MDS assessment, completed on 02/16/15 revealed the facility assessed the resident utilizing the BIMS. The facility assessed Resident #9's BIMS score as fourteen (14) of fifteen (15), being cognitively intact.</p> <p>Observation of Resident #9, on 05/19/15 at 4:50 PM, revealed he/she was seated in his/her wheelchair. He/she was inside of Resident #1's door entrance engaged in conversation with Resident #1.</p> <p>Interview with Resident #9, on 05/20/15 at 3:30 PM, revealed he/she had always voted before moving here. Resident #9 stated he/she had</p>	F 151	<p>Resident Voting." This was completed by 6/5/2015.</p> <p>Director of Admissions/Marketing placed on the Activity Department's Master Annual Calendar to include the process and specific tasks to start each March and September to ensure that residents wishing to exercise their right to vote in elections are given this opportunity. This was completed by 6/1/2015.</p> <p>Director of Admissions/Marketing developed a process for the facility's activity department for assisting residents to vote. Activity Assistant received this education/training on 6/1/2015 and the new Activity Director received this education/training as part of her orientation on 6/2/2015. This process was effective immediately (6/2/2015).</p> <p>The following monitoring has been put into place to ensure for compliance with this regulation included the following:</p> <p>Administrator instructed the new Activity Director to complete a monthly report by the 5th of each month to report the outcomes and summary of the activity department's involvement with facility residents. This was completed by 6/5/2015.</p> <p>Administrator will give an activity department monthly report to the facility</p>	



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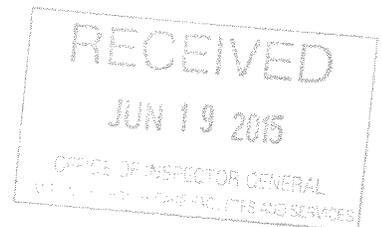
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F 151	Continued From page 3 always voted and had not voted since he/she moved here. Interview with the Administrator, on 05/22/15 at 5:26 PM, revealed the Activities Director was responsible to coordinate the voting. The Administrator stated the residents had the right to vote and no residents had voiced any concerns about not being given the opportunity to vote. Further interview with the Administrator, on 05/22/15 at 5:50 PM, revealed she was not aware the residents were not given the opportunity to vote. She stated it was every citizen's right to vote and should have been afforded to each person desiring to do so.	F 151	(PI) Quality Committee. First report will be completed for the June 2015 meeting. This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed monthly (until the next facility's annual survey) and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance. If monitoring compliance is sustained for this period, then the PI Quality Committee will determine at that time to (continued on Page 4A).	
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review, it was determined the facility failed to promptly resolve grievances such as complaints for the use of bingo bucks and housekeeping services for one (1) of sixteen (16) sampled residents (Resident #11) and three (3) of five (5) unsampled residents (Unsampled Residents C, D and E). The Findings include:	F 166	F166 Completion Date: 6/19/2015 SS=E Gricvances 483.10(f)(1)(2) Residents Voicing Grievances The specific residents that were cited in the statement of deficiency as having been affected were as follows: Residents #s 11 and unsampled Resident C, D, and E. Social Service Director met individually with the residents (#s11, C, D, and E) regarding the concerns they addressed with the OIG surveyors regarding the cleanliness of their bathrooms so the facility could address their specific concerns. This was completed by 6/2/2015. Administrator instructed the Housekeeping Supervisor that he was to oversee the deep	



(continued from Page 4)

either continue monthly monitoring as outlined, reduce monitoring, or discontinue monitoring. The membership of this committee consist of at least the medical director, pharmacy consultant, director of nursing, assistant director of nursing, business office manager, unit manager, and the administrator. The PI Quality Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the PI Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.

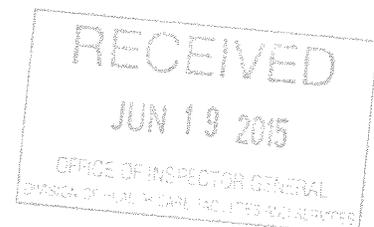
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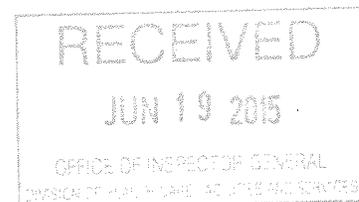
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F 166	<p>Continued From page 4</p> <p>Review of the Bill of Resident Rights policy, effective 07/01/09, revealed residents have the right to voice grievances with respect to treatment or care that was or failed to be furnished, without discrimination or reprisal for voicing the grievance. The resident has the right to prompt efforts by the center to resolve grievances, including those with respect to the behavior of other residents.</p> <p>Review of the Grievance/Complaint Log Policy, revised August 2008, revealed all disposition of all resident grievances and/or complaints would be recorded on the facility's resident Grievance/Complaint Log. The Administrator or designee would be responsible to record and maintain the log. The following information at a minimum must be recorded: the date the grievance/complaint was received; the name of the resident filing the grievance/complaint; the date the alleged incident took place; the date the resident, or interested party was informed of the findings and the disposition of the grievance.</p> <p>Interview conducted during Resident Council, on 05/19/15 at 4:20 PM, revealed Resident #11 and Unsamped Residents C, D, and E all voiced they were allowed to spend their bingo bucks only two (2) times a year and sometimes they were not allowed to receive their bingo bucks because the computer was down. They stated the Activity Director was aware of their concern, but no information was provided. Further interview with Resident #11, revealed most residents who had won bingo bucks were discharged from the facility before they could utilize their bingo bucks. Resident #11 further stated who wanted to go a full year without utilizing their bingo money.</p>	F 166	<p>cleaning on the residents' rooms and bathrooms (#1, C, D, and E). This was completed on 6/2/2015.</p> <p>Housekeeping Supervisor and staff completed the deep cleaning on the residents' rooms and bathrooms (#s 11, C, D, and E) by 6/5/2015.</p> <p>Administrator checked with the residents (#1, C, D, and E) after the deep cleaning was completed to determine their satisfaction with the cleaning. The residents were pleased and satisfied. This was completed on 6/5/2015.</p> <p>During the Resident Council Meeting of 5/29/2015, with the resident council's president's permission, there were two agenda items added to the meeting --- Bingo Buck Store and Cleanliness of Resident Bathrooms. The purpose of these added agenda items were to get input from the residents regarding the Bingo Buck Store and to address their issues with bathroom cleanliness. This meeting was attended by the facility Activity Assistant and the Local Ombudsman.</p> <p>The other residents that were identified to be at risk for this deficient practice were as follows:</p> <p>Social Service Director met individually with other cognitive residents to determine if they had any issues regarding the cleanliness of their bathrooms and the Bingo Buck Store</p>	



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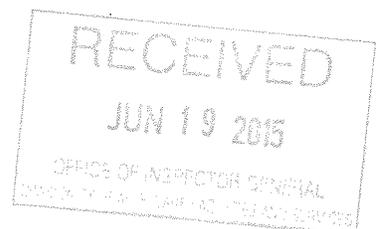
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F 166	<p>Continued From page 5</p> <p>Interview with the Life Enrichment Assistant, on 05/21/15 at 3:46 PM, revealed when the residents won games, the residents were given the opportunity to win bingo bucks. The residents were suppose to be able to cash the bingo bucks every month, but the last time the bingo bucks were utilized was in December of 2014. The Life Enrichment Assistant stated she had not heard any complaints about the bingo bucks until the bingo activity was finished on 05/21/15. The residents stated they complained to the Activity Director. The Life Enrichment Assistant stated she was not sure what had happened with that complaint. The Life Enrichment Assistant stated when residents were discharged from the facility she would let the residents utilize their bingo bucks by picking out a gift.</p> <p>Interview with the Administrator, on 05/22/15 at 3:15 PM, revealed Bingo Bucks was started by a previous Activity Director to encourage residents to participate. There was no set time to utilize the bingo the bucks. The thought was one (1) time a month or every quarter but nothing consistent. The short term residents were given items by the Activity Director to ensure they could spend their bingo bucks. The Administrator stated no residents had voiced concerns about the bingo bucks and the Activity Director never mentioned it.</p> <p>Interview conducted during Resident Council, on 05/19/15 at 4:20 PM, revealed Residents #11 complained about the floors being dirty and the commodes overflowing. Unsampled Resident E complained the sinks in the bathrooms were dirty and he/she had to request for another housekeeper to clean the room because Housekeeper #1 had not cleaned the room</p>	F 166	<p>so the facility could address their specific concerns. This was completed by 6/8/2015.</p> <p>During the Resident Council Meeting of 5/29/2015, with the resident council's president's permission, there were two agenda items added to the meeting --- Bingo Buck Store and Cleanliness of Resident Bathrooms. The purpose of these added agenda items were to get input from the residents regarding the Bingo Buck Store and to address their issues with bathroom cleanliness. This meeting was attended by the facility Activity Assistant and the Local Ombudsman.</p> <p>The measures that were put into place or systemic changes made to ensure that this deficient practice does not recur included the following:</p> <p>Administrator completed education/training to administration management (Director of Nursing, Assistant Director of Nursing, LPN Unit Manager, Social Service Director, Business Office Manager, HR/Payroll Coordinator, Director of Admission/Marketing, Dietary Manager, Activity Director, Maintenance Supervisor, Housekeeping/Laundry Supervisor, LPN MDS Coordinator, and Supply/Medical Records Coordinator) regarding the residents' right to voice a grievance or concern, the facility grievance policy and staff's responsibility to assist a resident and reviewed the grievance/concern form where</p>	



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F 166	<p>Continued From page 6 completely. Unsampled Resident E stated the Maintenance Director was notified about Houskeeper #1 not completing the cleaning of his/her room.</p> <p>Interview on 05/21/15 at 3:20 PM with the Life Enrichment Assistant, revealed she had worked at the facility for six (6) years but had been on leave for the last few months. She stated the facility hadn't had the Bingo Bucks store open since December 2014; however, no residents complained to her regarding the store not available.</p> <p>On 05/21/15 at 3:25 PM, while interviewing the Activities Assistant, Unsampled Residents C and D approached and stated they had complained to the former Activities Director about not having the Bingo Bucks store.</p> <p>An interview with the former Activities Director could not be completed as she no longer worked at the facility.</p> <p>Interview with Laundry Staff #1, on 05/22/15 at 4:00 PM, revealed she was aware that Unsampled Resident E had complained to another housekeeper that the housekeeper assigned to clean his/her room on the past Saturday and Monday did not clean the residents room when asked. Laundry Staff #1 stated it was reported to the Maintenance Supervisor.</p> <p>Interview, on 05/22/15 at 4:10 PM, with the Maintenance Supervisor revealed she had received the complaint and went to the housekeeper and instructed them to clean the</p>	F 166	<p>the grievance/concern is to be documented. This was completed by 6/2/2015.</p> <p>The following administration/management staff, who supervise other staff (Director of Nursing, Assistant Director of Nursing, Dietary Manager, and Housekeeping/Laundry Supervisor) provided the grievance education/training to their staff. This was completed by 6/12/2015.</p> <p>Administrator revised the department/position orientation checklist to include grievance education/training upon hire. This was completed by 6/12/2015.</p> <p>The following monitoring has been put into place to ensure for compliance with this regulation included the following:</p> <p>Monthly Resident Council Meetings will have as a standing agenda item – regarding any grievance/concerns they have addressed and feel are still unresolved. This information will be placed in the meeting minutes so that Administrator can be aware of them and ensure they are addressed and resolved; reviewed; and analyzed for patterns and trends. This will be effective for the June 2015 meeting.</p> <p>Administrator will report to the facility (PI) Quality Committee regarding any unresolved grievances/concerns that were identified at monthly Resident Council</p>		



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F 166	Continued From page 7 room. She stated she had not reported the grievance to the Administration or completed a grievance because she addressed it immediately and it was fixed. She stated if the housekeeper had not cleaned the room she would have reported that to the Administrator. Interview, on 05/22/15 at 5:23 PM, with the Administrator revealed she had not been informed of complaints about Bingo Bucks and Housekeeping. She showed evidence of other grievances she had received with individual forms that were completed with a follow up. She stated she should have been informed, and especially housekeeping, because it was more than one resident. She stated her staff had been trained on the grievance process and it was covered during abuse training. She stated she can't fix what she didn't know about.	F 166	Meetings and what was done with these. This will be effective for the June 2015 meeting. This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed monthly (until the next facility's annual survey) and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance. If monitoring compliance is sustained for this period, then the PI Quality Committee will determine at that time to either continue monthly monitoring as outlined, reduce monitoring, or discontinue (continued on Page 8A)	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility failed to promote care for residents in a manner and in an environment that maintained or enhanced each residents dignity and respect as it related to two (2) of sixteen (16) sampled residents. Resident #3 as it related to the signage above the bed stating for the resident to be fed,	F 241	F241 Completion Date: 6/19/2015 SS= D Quality of Life 483.15(a) Dignity --- Promoting Care in the Environment The specific residents that were cited in the statement of deficiency as having been affected were as follows: Residents #s 3 and 8. LPN MDS Coordinator removed the signage identified by the OIG surveyors posted on residents' # 3 and 8 room walls on 5/26/2015.	



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Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100161	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/22/2015
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NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITA	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701
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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) COMPLETE DATE
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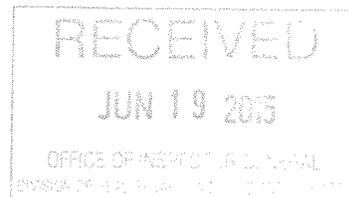
N 044	Continued From page 7 Interview, on 05/22/15 at 5:23 PM, with the Administrator revealed she had not been informed of complaints about Bingo Bucks and Housekeeping. She showed evidence of other grievances she had received with individual forms that were completed with a follow up. She stated she should have been informed, and especially housekeeping, because it was more than one resident. She stated her staff had been trained on the grievance process and it was covered during abuse training. She stated she can't fix what she didn't know about.	N 044	Meetings and what was done with these. This will be effective for the June 2015 meeting. This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed monthly (until the next facility's annual survey) and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance. If monitoring compliance is sustained for this period, then the PI Quality Committee will determine at that time to either continue monthly monitoring as outlined, reduce monitoring, or discontinue (continued on Page 8A)	
N 113	902 KAR 20:300-6(1) Section 6. Quality Of Life (1) Dignity. The facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This requirement is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility failed to promote care for residents in a manner and in an environment that maintained or enhanced each residents dignity and respect as it related to two (2) of sixteen (16) sampled residents. Resident #3 as it related to the signage above the bed stating for the resident to be fed, total care, incontinent, advanced dementia and family does the laundry etc. In addition, Resident #8 had a sign above the bed stating to shave the resident daily and not to lay the resident flat in the bed. The findings include:	N 113	N113 Completion Date: 6/19/2015 902 KAR 20:300-6(1) Section 6:Quality of Life The specific residents that were cited in the statement of deficiency as having been affected were as follows: Residents #s 3 and 8. LPN MDS Coordinator removed the signage identified by the OIG surveyors posted on residents' # 3 and 8 room walls on 5/26/2015.	

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(continued from Page 8)

monitoring. The membership of this committee consist of at least the medical director, pharmacy consultant, director of nursing, assistant director of nursing, business office manager, unit manager, and the administrator. The PI Quality Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the PI Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.

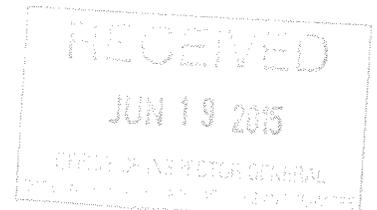
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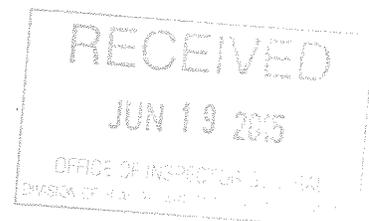
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/22/2015
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
F 241	<p>Continued From page 8</p> <p>total care, incontinent, advanced dementia and family does the laundry etc. In addition, Resident #8 had a sign above the bed stating to shave the resident daily and not to lay the resident flat in the bed.</p> <p>The findings include:</p> <p>Review of the Bill of Resident Rights Policy, effective 07/01/09, revealed residents have the right to receive care from the center in a manner and in an environment that promoted, maintained and or enhanced dignity and respect in full recognition of the individual. The resident has the right to choose activities, schedules and health care consistent with the interests, assessments and plans of care and to make choices about aspects of the residents life in the nursing center that were significant to them.</p> <p>1. Record review of Resident #8's record revealed Resident #8 was admitted on 07/01/12 with a diagnosis of Aphasia, Quadriplegia, Spasm of Muscle, Non Psychotic Brain Syndrome and Pain of the Joint. Resident #8's Quarterly Minimum Data Set (MDS) Assessment, completed on 05/05/15, revealed Resident #8's Brief Interview of Mental Status (BIM) score could not be assessed.</p> <p>Observation of Resident #8, on 05/19/15 at 2:33 PM, revealed Resident #8 was lying flat in the bed with facial hair. A sign posted above Resident #8's bed read; Please do not leave head flat and must be shaved everyday.</p> <p>Observation of Resident #8, on 05/20/15 at 7:52 AM, revealed Resident #8 was sitting up in a chair in the television room and again observed</p>	F 241	<p>Since Resident 3's wife had posted this signage on the wall, the LPN MDS Coordinator contacted her to let her know why we were taking it down and how we would ensure that staff knew this information. Wife was okay with this. This was completed on 5/26/2015.</p> <p>Social Service Director notified Resident 8's responsible party to let this individual know that the signage had been removed and explained why it was being removed. It was explained how staff would be aware of this to provide care to the resident. This was completed on 5/26/2015.</p> <p>The other residents that were identified to be at risk for this deficient practice were as follows:</p> <p>Social Service Director completed an audit of resident rooms to ensure that no other residents were affected by this deficient practice. The results of this audit determined that 8 other residents were affected. All of this signage found in other resident rooms was removed. Resident responsible parties were contacted and notified of why we were removing this signage information. This was completed by 5/28/2015.</p> <p>The measures that were put into place or systemic changes made to ensure that this deficient practice does not recur included the following:</p>



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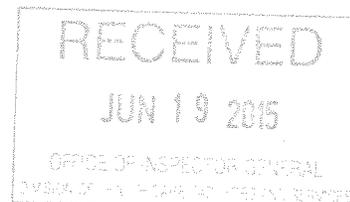
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F 241	<p>Continued From page 9 with facial hair.</p> <p>Interview with Certified Nursing Assistant (CNA) #8, on 05/22/15 at 4:15 PM, revealed there was a sign above Resident #8's bed to shave daily. CNA #8 stated she worked on the Wednesday of 05/20/15 and observed Resident #8 to have stubble and she did not shave Resident #8.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 05/22/15 at 12:35 PM, revealed she was not aware Resident #8 was to be shaved daily.</p> <p>Interview with LPN #4, on 05/22/15 at 9:00 PM, revealed the sign could be a dignity concern, but he thought it could also be a reminder to the staff to complete this task. LPN #4 stated if the resident was shaved daily, then there would be no need to post care reminders above Resident #8's bed. LPN #4 stated the residents family had not complained about Resident #8 not being shaved.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 05/22/15 at 9:10 PM, revealed if the staff completed shaving daily, the sign would not need to be posted above Resident #8's bed. The family should not have to post a sign above the residents bed to encourage staff to complete their job.</p> <p>2. Review of the medical record for Resident #3, revealed the facility admitted the resident on 12/15/14 with Diagnosis including Dementia without behaviors, Anxiety and Hearing Loss.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment for Resident #3, dated 04/16/15, revealed the facility assessed the residents' cognition using the BIMS assessment.</p>	F 241	<p>Administrator completed education/training to administration management (Director of Nursing, Assistant Director of Nursing, LPN Unit Manager, Social Service Director, Business Office Manager, HR/Payroll Coordinator, Director of Admission/Marketing, Dietary Manager, Activity Director, Maintenance Supervisor, Housekeeping/Laundry Supervisor, LPN MDS Coordinator, and Supply/Medical Records Coordinator) regarding the residents' right to Promote care in the resident environment with dignity, which meant no signage should be posted in resident rooms to prompt staff members regarding care. This was completed by 6/2/2015.</p> <p>The following administration/management staff, who supervise other staff (Director of Nursing, Assistant Director of Nursing, Dietary Manager, and Housekeeping/Laundry Supervisor) provided the education/training to their staff. This was completed by 6/12/2015.</p> <p>Administrator revised the department/position orientation checklist to include promoting care in the resident environment (no signage posted in resident rooms). This was completed by 6/12/2015.</p> <p>The following monitoring has been put into place to ensure for compliance with this regulation included the following:</p>		



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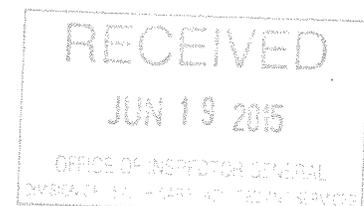
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F 241	<p>Continued From page 10</p> <p>The facility assessed the residents BIMS score of three (3) of fifteen (15), severely cognitively impaired.</p> <p>Observation, on 05/19/15 at 11:30 AM, and on 05/22/15 at 9:15 PM, revealed Resident #3 had a sign posted above the bed that said: Feeder, total care, incontinent, advanced dementia, family does laundry (marked out), spare PJ's (pajamas) in drawer (marked out), matched outfits in the closet, wears glasses, and must speak in right ear.</p> <p>Interview on 05/22/15 at 9:15 PM with Certified Nursing Assistant (CNA) #8, revealed there was a sign over the bed of Resident #3 that explained what the resident's needs were. She stated they did have that information in the daily care guide. She stated she didn't think it was a dignity issue if that was what the family wanted.</p> <p>Interview, on 05/22/15 at 9:25 PM, with Licensed Practical Nurse (LPN) #5 revealed she did not know how long the sign had been over the bed for Resident #3. She stated she believed the resident's wife must have put it there. She stated it could be a Health Insurance Portability and Accountability Act (HIPAA) violation or dignity issue. She stated the sign was well intended but not appropriate, and acknowledged it was not necessary if staff were following the daily care guide.</p> <p>Interview, on 05/22/15 at 9:30 PM, with the Assistant Director of Nursing revealed she was not aware the sign, with the included items listed, was over the bed for Resident #3. She stated Resident #3's wife must have place it there; however, it was a dignity issue and should not be</p>	F 241	<p>Social Service Director will complete a monthly audit of resident rooms to ensure that facility remains in compliance with promoting care in the resident environment by making sure there is no signage posted in resident rooms. Results of monthly auditing will be given to the Administrator. This will be effective for the month of June 2015; starting 6/1/2015.</p> <p>Administrator will review the report and will report findings to the facility (PI) Quality Committee. This will be effective for the June 2015 meeting.</p> <p>This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed monthly (until the next facility's annual survey) and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance. If monitoring compliance is sustained for this period, then the PI Quality Committee will determine at that time to either continue monthly monitoring as outlined, reduce monitoring, or discontinue monitoring. The membership of this committee consist of at least the medical director, pharmacy consultant, director of nursing, assistant director of nursing, business office manager, unit manager, and the administrator. The PI Quality Committee will review the effect of the</p>



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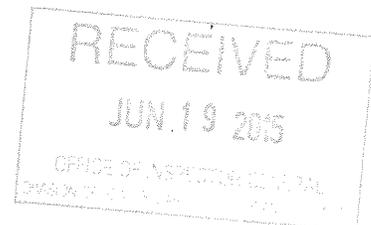
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F 241 F 252 SS=E	<p>Continued From page 11 there.</p> <p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, it was determined, the facility failed to ensure four (4) of twenty (20) resident bathrooms were clean and sanitary, (rooms #4, #9, #14, and #28).</p> <p>The findings include:</p> <p>Review of the facility policy Cleaning and Disinfection Residents' Rooms, revised August 2011, revealed housekeeping surfaces will be cleaned on a regular basis. Clean medical waste containers intended for reuse daily or when visually contaminated.</p> <p>Observation, on 05/19/15 during the initial tour, revealed the bathroom in Room #28 smelled of a strong urine odor. There was a brownish substance around the base of the toilet bowl.</p> <p>Observation, on 05/20/15 at 1:36 PM, revealed Room #28's bathroom had a strong odor of urine, with dark debris around the toilet bowl. There was dried brownish black substance on the toilet seat.</p>	F 241 F 252	<p>implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the PI Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.</p> <p>F252 Completion Date: 6/19/2015 SS=E Environment 483.15 (h)(1) Housekeeping Regarding Cleanliness Resident Bathrooms</p> <p>The specific residents that were cited in the statement of deficiency as having been affected were as follows: Residents #s 4, 9, 14, and 28 (in regards to the bathrooms connected to these residents' rooms)</p> <p>Housekeeping Supervisor and staff deep cleaned the cited resident bathrooms by 6/5/2015 that included sweeping, mopping, and sanitizing floors to eliminate urine odors, getting stains up, and toilets were cleaned and sanitized.</p> <p>Maintenance Supervisor removed old stained caulk from the cited resident bathrooms around the basin of the commodes and replaced with new caulking by 6/16/2015.</p> <p>Administrator audited the results of the housekeeping staffs work and the maintenance supervisors work to ensure</p>	



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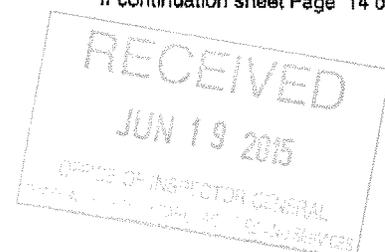
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F 252	Continued From page 12 Observation, on 05/20/15 at 3:15 PM, revealed Room 28's bathroom continued to have a strong odor of urine with dark debris around the toilet bowl. The dried brownish black substance continued present on the toilet seat. Observation, on 05/21/15 at 9:47 AM, revealed Room #4's bathroom smelled of a strong urine odor. Observation, on 05/22/15 at 9:16 AM, during the environmental tour with the Housekeeping Supervisor, the Maintenance Supervisor and the Administrator, revealed Room #4's bathroom smelled of urine and the toilet was dirty. Room #9's bathroom toilet had a dark ring around the base of the toilet. Room #14's bathroom had a hole in the door and a foul odor was present. Room #28's bathroom appeared visually clean, but had a mild odor of urine present. Interview, on 05/22/15 at 9:16 AM during the environmental tour, with the Housekeeping Manager revealed the facility had replaced all the floors in the bathrooms and some had to be replaced again. He stated they had not gotten to caulk around the toilet bowls. He stated some rooms were to be checked every hour due to high usage of residents in those bathrooms. The Housekeeping Manager stated rooms #4, #19, #22 and #28's bathrooms were checked every hour, however, there was no documentation of the one (1) hour checks. He stated he had two (2) full-time housekeepers and one (1) part-time housekeeper. The housekeepers worked 6:00 AM to 2:30 PM everyday. He stated when housekeeping was not in the building the Certified Nursing Assistants (CNA's) were to check the	F 252	compliance with this regulation on 6/16/2015. The other residents that were identified to be at risk for this deficient practice were as follows: Housekeeping Supervisor did an audit on the remaining sixteen resident bathrooms. There were an additional two resident bathrooms added to the list that needed frequent re-checks through the day. The problem areas identified through this audit were corrected by housekeeping staff by 6/12/2015 to be in compliance with this regulation. Administrator audited the results of the housekeeping staffs work on 6/16/2015 to ensure the work was in compliance with this regulation. The measures that were put into place or systemic changes made to ensure that this deficient practice does not recur included the following: Housekeeping Supervisor did observations with resident room and bathroom daily cleaning with housekeeping staff. Housekeeping Supervisor identified some areas for improvements with their cleaning and provided additional cleaning education and training to housekeeping staff. This was completed by 6/12/2015.		



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F 252	Continued From page 13 bathrooms for cleanliness.	F 252	Administrator provided education and training to the Housekeeping/Laundry Supervisor on 6/8/2015 regarding the regulation tag F252 to define environment, the intent of the regulation, guidelines for preventing spread of infection, definition of sanitary, what should be involved with cleaning a resident bathroom and maintaining it, frequency of daily cleaning and deep cleans, and documentation checklist for what housekeeping staff clean daily and with deep cleans. This was completed by 6/12/2015. (continued on Page 14A)	
F 257 SS=D	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to ensure air temperatures were comfortable for the residents in one (1) of three (3) common areas. The dining room was identified by a resident as too cold for comfort. The findings include: The facility did not provide a policy regarding the air temperatures in the facility. However, an email provided revealed the state regulations were followed, citing 902 KAR 20:046 stating a minimum temperature of seventy-two (72) degrees Fahrenheit (F) shall be provided for in all	F 257	F257 Completion Date: 6/19/2015 SS=D Air Temperatures 483.15(h)(6) Comfortable and Safe Temperature Levels There were no specific residents that were cited in the statement of deficiency as having been affected; however the first day of the survey census was at 57.	



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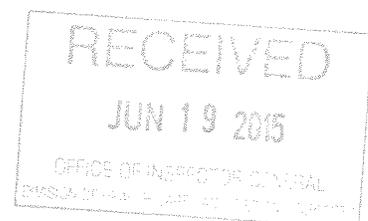
Administrator revised the housekeeping daily cleaning checklist to include more specifically what a bathroom and resident room clean consisted of; checklist now requires more documentation of what was completed, times of cleaning; and requires documentation for the frequency of bathroom checks that were done, what action they had to take to keep bathroom clean. This means that each bathroom check has to be documented. Those resident bathrooms that are on the list that Housekeeping Supervisor gives to housekeeping staff are the resident bathrooms that need 3-5 checks during the shift with required documentation. This was completed by 6/3/2015.

Housekeeping Supervisor educated and trained the housekeeping staff to F252 as described previously and introduced them to the revised daily cleaning documentation checklist and the list of resident bathrooms that need 4-5 checks for the shift. This was accomplished by 6/12/2015.

The following monitoring has been put into place to ensure for compliance with this regulation in relation to resident bathrooms:

(continued on Page 14B)

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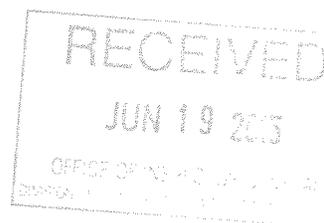
Effective for the week of 6/15/2015, Housekeeping Supervisor will audit the cleaning and housekeeping staffs' rechecks on residents on the list for frequent bathroom checks (days in the facility which is normally 5 per week) to ensure that housekeeping staff are maintaining the bathrooms and to ensure for on-going compliance with this regulation.

Effective 6/15/2015, Housekeeping Supervisor (days in the facility which is normally 5 per week) will complete rechecks of those resident bathrooms that are on the list for bathroom rechecks, after housekeeping staff leave for the day, up to the time the Housekeeping Supervisor leaves the facility for the day. These rechecks are to be documented to include date, time rechecked, findings, action taken to correct problems, and signed.

Each week the administrator will review this audit documentation to ensure that on-going monitoring and compliance regarding resident bathroom cleaning is sustained for compliance with this regulation and that rechecks are being done. This will start 6/15/2015.

(continued on Page 14C)

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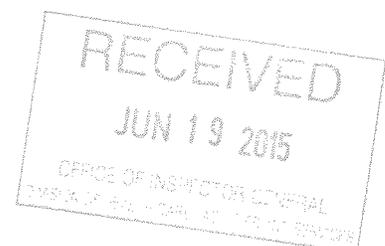
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President of Resident Council, gave permission for a standing agenda item to be added to their meeting agenda regarding if residents have any on-going issues with cleanliness of resident bathrooms. This was started at the 5/29/2015 Resident Council Meeting and will be on-going. Any issues identified will be addressed by the Administrator and appropriate department managers/supervisors.

Administrator will provide a report to the facility's (PI) Quality Committee to ensure that oversight is completed for compliance and residents' satisfaction. This will be effective for the June 2015 meeting.

This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed monthly (until the next facility's annual survey) and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance. If monitoring compliance is sustained for this period, then the PI Quality Committee will determine at that time to either continue monthly monitoring as outlined, reduce monitoring, or discontinue monitoring. The membership of this
(Continued on Page 14D)

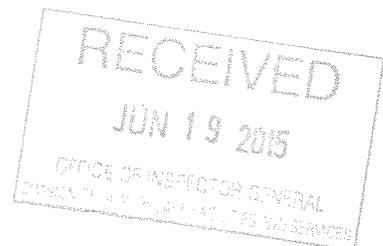
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committee consist of at least the medical director, pharmacy consultant, director of nursing, assistant director of nursing, business office manager, unit manager, and the administrator. The PI Quality Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the PI Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.

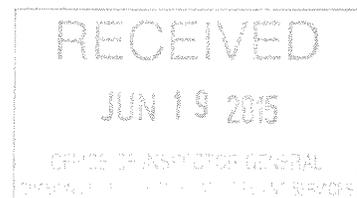
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/22/2015
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 257	<p>Continued From page 14</p> <p>occupied areas in winter conditions. A maximum temperature of 85 degrees F shall be provided for occupied areas in summer conditions.</p> <p>Review of the facility's Logbook Documentation of Air Temperatures, dated 09/05/14, revealed resident room # 17 was 69 degrees Fahrenheit (F) and resident room #21 was 70 F. The facility documented the room temperature on Heritage Hall in resident room #16, on 01/05/15, as 67 F. Review of the facility's documented air temperature, on 03/24/15, located on Lincoln Lane, in resident room #21 revealed a recorded temperature of 69 F.</p> <p>Observation in the dining room, on 05/20/15 at 7:30 AM, revealed two (2) residents engaged in a conversation. Unsampled Resident B voiced to Unsampled Resident D he/she was cold and stated it was always cold in there.</p> <p>Observation of Resident #6's room, on 05/20/15 at 10:53 AM, revealed the air conditioning unit was set at 68 degrees F. Resident #6 was lying in the bed, dressed in a long sleeved fleece jacket and grey sweat pants. In addition, a fleece blanket was over his/her upper legs.</p> <p>Observation of the Dining Room temperature, on 05/20/15 at 7:35 AM, revealed the dining room temperature during breakfast services was 69 F.</p> <p>Interview with Unsampled Resident B, on 05/20/15 at 7:50 AM, revealed he/she was always cold in the dining area; it was always cold in there. He/she stated a person just freezes to death in there.</p> <p>Observation of Lincoln Lane, on 05/20/15 at</p>	F 257	<p>Administrator requested that the Maintenance Supervisor take air room temperatures when it was identified that it was cool in the dining room area for the breakfast meal on 5/20/2015. Initial temperature taken was at 69 degrees F. Maintenance Supervisor turned the central air conditioner up a few degrees to reduce the coolness and increase the air room temperature. Any resident that complained of being cool was given a sweater, jacket, or blanket by staff.</p> <p>No other residents were identified to be at risk for this deficient practice; however first day of survey census was at 57.</p> <p>Administrator requested that the Maintenance Supervisor take air room temperatures when it was identified that it was cool in the dining room area for the breakfast meal on 5/20/2015. Initial temperature taken was at 69 degrees F. Maintenance Supervisor turned the central air conditioner up a few degrees to reduce the coolness and increase the air room temperature. Any resident that complained of being cool was given a sweater, jacket, or blanket by staff.</p> <p>The measures that were put into place or systemic changes made to ensure that this deficient practice does not recur included the following:</p>	



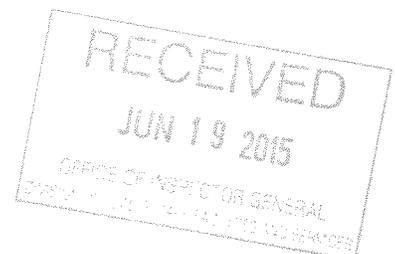
(continued from Page 16)

The following monitoring has been put into place to ensure for compliance with this regulation included the following:

Administrator will review the air room temperatures that have been documented in the TELS System monthly to ensure for compliance. Summary Reporting will go to the facility's (PI) Quality Committee for review and oversight. This will be effective for the June 2015 meeting.

This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed monthly (until the next facility's annual survey) and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance. If monitoring compliance is sustained for this period, then the PI Quality Committee will determine at that time to either continue monthly monitoring as outlined, reduce monitoring, or discontinue monitoring. The membership of this committee consist of at least the medical director, pharmacy consultant, director of nursing, assistant director of nursing, business office manager, unit manager, and the administrator. The PI Quality
(continued on Page 15B)

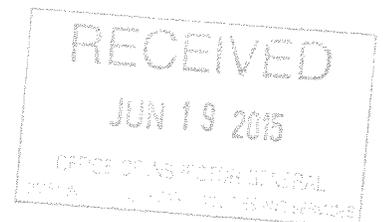
Page 16A



(continued from Page 16A)

Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the PI Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.

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NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701	
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F 257	Continued From page 15 10:59 AM, revealed the thermostat was set at 70 F. Observation of the thermostat at the end of Lincoln Lane, near the therapy department, on 05/20/15 at 11:00 AM, revealed the mark for the temperature reading was between 65 and 70 F. The Director of Nursing was unavailable for interview. She was out of the country during the survey process. Interview with the Maintenance Director, on 05/20/15 at 4:40 PM, revealed she had worked here for nine (9) years, was in this position since December, 2014 and did not know what the room temperatures were supposed to be. She reported she was not aware of the locked box in the dining room. The Maintenance Director stated each hall had a thermostat located mid-way down the hall and one was across from the dining room. Interview with the Administrator, on 05/22/15 at 5:00 PM, revealed she was not aware of the acceptable temperature range for the facility. She stated she was not aware of anyone complaining of being cold, nor what the temperatures in the facility were.	F 257	Administrator provided education/training to the Maintenance Supervisor regarding the regulation that the facility is to provide a comfortable and safe temperature levels for resident in the facility and that air temperatures need to be managed at a range of 71 – 81 degrees F. When the temperatures are out of this range then action needs to be taken to get the air temperature back within acceptable range. This was completed on 5/27/2015. Starting 5/27/2015, the Maintenance Supervisor is responsible for taking air room temperatures in the dining room, two resident rooms per hallway (one in front and one in back of hallway) and the therapy room. This is to be completed at least three times weekly. This will be documented in the TELS System for monitoring. Anytime temperatures are out of the acceptable range then documentation must be completed for the action taken to get the room temperatures back within the acceptable range. (continued on Page 16A)	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facilities Corporate Standards of Practice, it was determined the facility failed to apply barrier	F 281	F281 Completion Date: 6/19/2015 SS=D Professional Standards of Care 483.20(k)(3) Services Provided Must Meet Professional Standards of Quality Care The specific resident that was cited in the statement of deficiency as having been affected was as follows: Residents # 3.	



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F 281	<p>Continued From page 16</p> <p>cream with proper technique for one (1) of sixteen (16) sampled residents (Resident #3).</p> <p>The findings include:</p> <p>Review of facility's Corporate Standards of Practice, undated, revealed when applying topical barrier cream, smear it evenly over the skin and apply front to back.</p> <p>Review of the medical record for Resident #3 revealed the facility admitted the resident on 12/15/14 with Diagnosis including Dementia without behaviors, Anxiety and Hearing Loss.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment for Resident #3, dated 04/16/15, revealed the facility assessed the resident's cognition using the Brief Interview for Mental Status (BIMS) assessment. The facility assessed the resident's BIMS score of three (3) of fifteen (15), severely cognitively impaired. The facility assessed the resident's bowel and bladder as always incontinent.</p> <p>Review of the Comprehensive Care Plan for Resident #3 revealed the facility developed a care plan on 01/26/15 for Potential for impaired skin. Interventions included incontinent care as needed and barrier cream as indicated.</p> <p>Observation, on 05/21/15 at 1:15 PM, revealed Certified Nursing Assistant (CNA) #2 applied barrier cream for Resident #3, after incontinent care, on the buttocks area then went on to apply the cream to the genital area.</p> <p>Interview, on 05/22/15 at 12:27 PM, with CNA #2 revealed she acknowledged she should have</p>	F 281	<p>Assistant Director of Nursing meet with the Nursing Assistant who performed the peri-care on Resident # 3 to instruct her how to apply barrier cream. This was completed on 6/8/2015.</p> <p>Assistant Director of Nursing instructed her regarding proper procedure that should have been followed with this incident to ensure that infection control standards and practices were followed. This was completed on 6/8/2015.</p> <p>Assistant Director of Nursing completed a peri-care audit for return demonstration for peri-care on a resident with this nursing assistant. This was completed on 6/8/2015. Nursing Assistant performed this task properly.</p> <p>No other residents were identified to be at risk for this deficient practice; however on the first day of the survey census was 57. Therefore; incontinent residents requiring peri-care and barrier cream have the potential to be at risk. Assistant Director of Nursing did education/training for nursing assistants regarding the proper procedure and technique in doing peri-care. This was completed by 6/18/2015.</p> <p>Assistant Director of Nursing completed peri-care observations with nursing assistants to ensure they understood proper procedure and techniques. The nursing</p>		



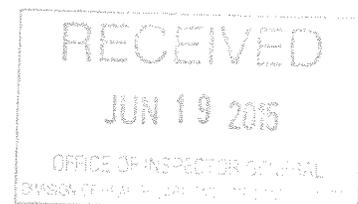
(continued from Page 18)

The following monitoring has been put into place to ensure for compliance with this regulation included the following:

Administrator will review the monthly pericare audits and will analyze for any patterns and trends and will report to the facility (PI) Quality Committee. This will be effective for the June 2015 meeting.

This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed monthly (until the next facility's annual survey) and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance. If monitoring compliance is sustained for this period, then the PI Quality Committee will determine at that time to either continue monthly monitoring as outlined, reduce monitoring, or discontinue monitoring. The membership of this committee consist of at least the medical director, pharmacy consultant, director of nursing, assistant director of nursing, business office manager, unit manager, and the administrator. The PI Quality Committee will review the effect of the implemented changes and the audit findings, (continued on Page 18B)

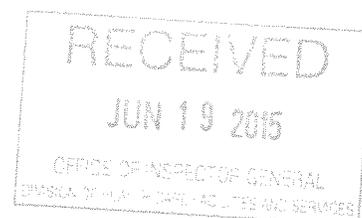
Page 18A



(continued from 18A)

and if at any time concerns are identified during this monitoring process, the PI Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.

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NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701
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F 281	Continued From page 17 applied the barrier cream to the genital area first then to the buttocks area. She stated there was a potential for cross contamination for the resident. Interview, on 05/22/15 at 12:33 PM, with Licensed Practical Nurse (LPN) #2 revealed she observed CNA #2's improper application of the barrier cream for Resident #3 when she went from the back to the front, but didn't think she was allowed to stop the CNA. She stated the risk to the resident was contamination. Interview, on 05/22/15 at 3:30 PM, with the Assistant Director of Nursing (ADON) revealed she was the infection control nurse. She stated the last training on Peri Care included application of barrier creams. She stated staff were trained to wash and apply creams to the peri area from front to back. She stated the risk to the resident was the spread of infection due to infection control breaches.	F 281	assistant performed this task properly. This was completed by 6/18/2015. The measures that were put into place or systemic changes made to ensure that this deficient practice does not recur included the following: Nursing Administration (Director of Nursing, Assistant Director of Nursing, and/or Nurse Unit Managers) will complete 5 monthly audits for peri-care return demonstration on nursing assistants. Any problems identified will be addressed immediately and will be documented on the audit tool. This will be effective for 6/18/2015. (continued on Page 18A)	
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to follow the care plans for seven (7) of sixteen (16) sampled residents. Residents #1, #6, #7, #8, #9, #12 and #13 were not followed in relationship with the falls. Resident #7's care plan was not	F 282	F282 Completion Date: 6/19/2015 SS=D Care Plans 483.20(k)(3)(ii) --- Resident Care Planning to Reflect Care to Provide The specific residents that were cited in the statement of deficiency as having been affected were as follows: Residents #s 1, 6, 7, 8, 9, 12, and 13. Director of Nursing corrected the issues with falls for Resident #s 1, 6, 9, 12, and 13. These residents were reassessed for fall interventions to determine the effectiveness and appropriateness. The bed/chair alarms	



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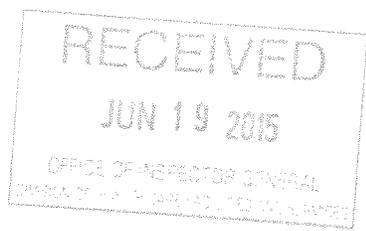
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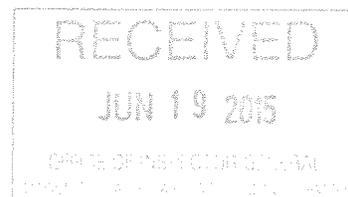
F 282	<p>Continued From page 18 followed pertaining to isolation precautions. In addition, Resident #8's care plan was not followed for hygiene needs.</p> <p>The findings include:</p> <p>Review of the facility's care plan policy titled, "Care Plan Policy Statement", not dated, revealed an individual comprehensive care plan that included measurable objectives and time tables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Any licensed nurse or interdisciplinary team member can update the care plan to reflect changes. The comprehensive care plan is based on a through assessment that included, but not limited to the Minimum Data Set (MDS). Each resident's comprehensive care plan was designed to incorporate identified problem areas and associated risk factors, build on the resident's strengths, reflect the resident's expressed wishes regarding care and treatment goals, aid in preventing or reducing declines in the resident's functional status or functional levels. Reflect currently recognized standards of practice for problems areas and conditions. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change.</p> <p>1. Review of Resident #1's clinical record revealed the facility re-admitted the resident on 08/06/14 with the diagnosis of Hypothyroidism, Hypertension and Polyarthritis.</p> <p>Review of Resident #1's Annual Minimum Data Set (MDS) assessment, completed on 05/11/15 revealed the facility assessed the resident</p>	F 282	<p>for monitoring the placement and functioning was placed on the Medication Treatment Records (MARS) for these residents and nursing staff were educated/trained regarding their responsibilities for checking placement and functioning. This was completed by 6/18/2015.</p> <p>Assistant Director of Nursing corrected the issues with isolation precautions for Resident # 7. This was completed by 6/8/2015.</p> <p>Assistant Director corrected the issues with hygiene for Resident # 8. This was completed by 6/8/2015.</p> <p>The other residents that were identified to be at risk for this deficient practice were as follows:</p> <p>Assistant Director of Nursing and the LPN MDS Coordinator completed an audit on active residents' care plans to ensure they were current and up-to-date regarding any interventions that had been put into place, making sure interventions were dated for when started and when discharged, that interventions are reassessed for appropriateness and effectiveness, that current physician orders and care plans match, and to make sure that fragmentation between the electronic medical record and the Accunurse Documentation Systems match. This was completed by 6/18/2015.</p>	
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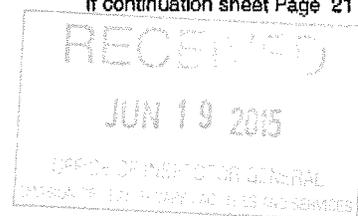
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F 282	<p>Continued From page 19</p> <p>utilizing the Brief Interview of Mental Status (BIMS) as being moderately impaired; BIMS score was ten (10) of fifteen (15).</p> <p>Review of the Comprehensive Care Plan for Resident #1, revealed the facility developed a care plan dated 01/11/15, for potential for falls related to impaired mobility, strength, balance and endurance related Degenerative Joint Disease, Hypertension. The interventions included: Physical and Occupational therapy to continue treating, keep the call light within reach with reminders for use, identify where the call light is before leaving the resident's room, monitor for potential hazards in the environment, and assist resident to wear soled shoes when out of bed. In addition, the Treatment Sheet, dated May/2015, included the chair alarm to the recliner with staff initials for a 7AM-7 PM and 7 PM-7AM each day was initiated on 05/05/15 during the 7 PM-7 AM shift.</p> <p>Record review of Resident #1's Activities of Daily Living Plan (ADL) of Care (in the Accu-Nurse system, which was the facilities computer system), print date 05/20/15, revealed Resident #1 was not checked for test and reapply bed or chair alarm.</p> <p>Observation, on 05/20/15 at 7:30 AM, of Resident #1 revealed she/he was initalially seated in his/her recliner with feet elevated. When he/she proceeded to rise from the recliner and ambulate independently to the closet area. The alarm did not sound once the resident arose from the recliner.</p> <p>Interview with Resident #1, on 05/20/15 at 8:07 AM, revealed he/she did not like the beeping of</p>	F 282	<p>The measures that were put into place or systemic changes made to ensure that this deficient practice does not recur included the following:</p> <p>The process for keeping the resident care plans up-to-date; information in the electronic medical record, and in Accunurse was revised to ensure for the following: interventions put into place have start and discharge dates; interventions are care planned; interventions are re-assessed for appropriateness and effectiveness; appropriate physician orders are care planned; and that all of this information complements each other in the electronic medical record and the Accunurse Documentation System. This was completed by the Administrator, Director of Nursing, Assistant Director of Nursing, and LPN MDS Coordinator. This was completed by 6/18/2015.</p> <p>The facility Inter-Disciplinary Clinical Team (Director of Nursing, Assistant Director of Nursing, LPN MDS Coordinator, Social Service Director, Dietary Manager, and Activity Director) were provided education/training to the revised care planning process on 6/11/2015. This revised process was effective for 6/11/2015.</p> <p>The following monitoring has been put into place to ensure for compliance with this regulation included the following:</p>	



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F 282	<p>Continued From page 20</p> <p>the alarm when he/she gets out of the chair (recliner). He/she reported the beeping of the alarm makes me nervous.</p> <p>2. Review of Resident #6's clinical record revealed the facility re-admitted the resident on 07/01/12 with the diagnosis of Osteoporosis, Anxiety State, Dementia with Behavior Disturbances, Iron Deficiency Anemia, Hypothyroidism, Osteoporosis, Syncope and Collapse.</p> <p>Review of the Physician Orders for a Chair Alarm, dated 01/01/15, for Resident #6 revealed an updated order for a sensor alarm to the bed and wheelchair related to an increased fall risk.</p> <p>Review of Resident #6's Quarterly MDS assessment, completed on 04/27/15 revealed the facility assessed the resident utilizing the BIMS. The facility assessed Resident #6's BIMS score as four (4) of fifteen (15), being severely impaired cognitively.</p> <p>Review of the Comprehensive Care Plan for Resident #6, revealed the facility developed a care plan for the high possibility of falls, on 02/09/15, with updated goals and target dates for 05/09/15 potential for falls. The resident had several falls in recent months without injury. Resident #6 has impaired safety awareness related to Dementia. The interventions included: Ensure a safe environment, free of clutter, adequate lighting. Non-skid socks and/or well fitting shoes when out of the bed. Also, keep call light with in reach when in bed with cues and reminders for use. In addition, the facility developed a care plan for the resident unable to meet his/her own ADL/self-care needs, related to</p>	F 282	<p>Administrator revised the Departmental Orientation Training Checklist (for Administrator, Director of Nursing, Assistant Director of Nursing, MDS LPN Coordinator, Social Service Director, Dietary Manager, and Activity Director --- this is the interdisciplinary team) to include care planning process and responsibilities. This was completed by 6/12/2015.</p> <p>LPN MDS Coordinator will complete an audit on three active residents monthly to ensure that their care plans have be revised and are up-to-date according to the revised care planning process. Any problems will be addressed, corrected, and documented. Audit findings will be documented and reported to the Administrator. This will be effective for 6/18/2015.</p> <p>Administrator will review the audit results and documentation to analyze for any patterns and trends and report to the facility (PI) Quality Committee. This will be effective for the June 2015 meeting.</p> <p>This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed monthly (until the next facility's annual survey) and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance. If monitoring compliance is</p>		



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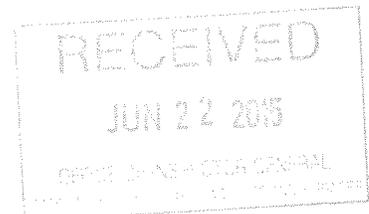
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F 282	<p>Continued From page 21</p> <p>cognitive deficits and left sided weakness (Transient Ischemia Attacks (TIA)), on 02/11/15, with updated goals and target dates for 08/11/15. The interventions included: provided oversight for bed mobility, transfers and ambulation. Monitor the need for physical assistance and for assistance with wheelchair for any trips on or off the unit.</p> <p>Review of the AccuNurse, Activities of Daily Living (ADL) Plan of Care-Transfers for Resident #6, print dated 05/22/15, revealed monitoring of the alarms, included test and reapply bed or chair alarm; however, the facility did not provide documentation of any alarm monitoring.</p> <p>Observation of Resident #6, on 05/19/15 at 12:35 PM, revealed the resident was seated in a wheelchair at a table in the dining area with an alarm attached to the back of the wheelchair.</p> <p>Observation of Resident #6, on 05/19/15 at 1:40 PM, revealed the resident laid in his/her bed. The resident was laid on his/her right side, facing the window. The window blind was closed. An alarm was in place and attached to the bed.</p> <p>Observation of Resident #6, on 05/20/15 at 7:30 AM and at 7:40 AM, revealed the resident was seated in his/her wheelchair at the table in the main dining area. The wheelchair had an alarm attached to the back of the wheelchair.</p> <p>An unsuccessful interview was attempted with Resident #6, on 05/20/15 at 10:15 AM.</p> <p>3. Review of Resident #9's clinical record revealed the facility re-admitted the resident on 04/04/14 with diagnosis of Depressive Disorder,</p>	F 282	<p>sustained for this period, then the PI Quality Committee will determine at that time to either continue monthly monitoring as outlined, reduce monitoring, or discontinue monitoring. The membership of this committee consist of at least the medical director, pharmacy consultant, director of nursing, assistant director of nursing, business office manager, unit manager, and the administrator. The PI Quality Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the PI Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/22/2015	
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701		
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F 282	<p>Continued From page 22 Anxiety, Mental Disorder and Anemia.</p> <p>Review of the nursing notes, dated 01/16/15 at 1:59 AM, revealed Resident #9 has bed and chair sensor alarms which he/she was non-compliant with and turns off the alarms him/herself.</p> <p>Review of the Comprehensive Care Plan for Resident #9, revealed the facility developed a care plan for the high possibility of falls, on 02/16/15, with updated goals and target dates for 08/13/15 potential for injury related to impaired mobility, strength, balance and endurance, confusion secondary to Dementia. He/she has had recurring attempts to self transfer and has had multiple falls since admission. The interventions included: Bed and chair alarms in place and to check frequently to make sure they are working. Chair alarm to increase safety awareness.</p> <p>Review of the Resident Incident for Resident #9, dated 01/15/15 at 10:46 PM, revealed the resident was found in the floor at the foot of the bed. The incident report revealed the resident was awake in a confused state concerned the television on the wall was falling. The post-incident report stated the resident had bed and chair sensor alarms. In addition, the report stated the resident was non-compliant all day turning the alarms off. There was no report of injury.</p> <p>Review of the Physician Orders for a Chair Alarm, dated 02/09/15, for Resident #9 revealed the chair alarm was to increase safety awareness. The facility was to check functioning and placement every shift.</p>	F 282		



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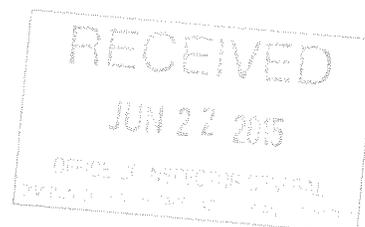
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F 282	<p>Continued From page 23</p> <p>Review of Resident #9's Quarterly MDS assessment, completed on 02/16/15 revealed the facility assessed the resident utilizing the BIMS. The facility assessed the Resident #9's BIMS score as fourteen (14) of fifteen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

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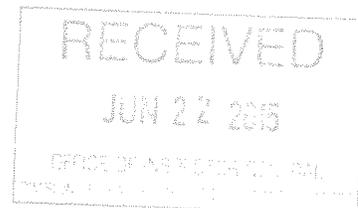
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F 282	<p>Continued From page 24 as thirteen (13) of fifteen (15), being cognitively intact.</p> <p>Review of the Comprehensive Care Plan for Resident #13, revealed the facility developed a care plan for the high possibility of falls, on 02/12/15, with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



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



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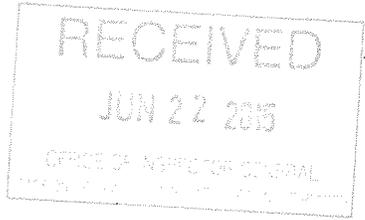
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F 282	<p>Continued From page 26</p> <p>sometimes turn off their alarms. She stated the care plans are developed to meet the needs of the residents. the alarms are suppose to be checked everyday. The alarms use to be on the Treatment Administration Record (TAR) for the nurses to check. The alarms are now on the AccuNurse for the CNAs to check everyday. She reported the alarms are still on the TAR for Resident #1. The alarm checks are on some of the TARs, but not all.</p> <p>Interview with CNA #5, on 05/22/15 at 10:15 AM, revealed the AccuNurse system tells you everything about the resident. She stated the alarms were Included; however, the system does not tell you when to check on the alarms. She stated there was not a reminder in the system to direct the staff to check on the alarms.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 05/22/15 at 10:40 AM, state the alarms were checked every two (2) hours on rounds by the CNAs and nurses. The alarms we checked for functioning properly once per shift. The AccuNurse was where the alarms were checked by the CNAs. She stated the every two hour checks on the residents were the CNA standards of care. She reported the alarms to check were entered on the nurses treatment sheet; however, that was changed by the Director of Nurses, back some time ago. She stated she was unable to recall the date the documentation was changed to the AccuNurse system for the CNA task. She reported AccuNurse was implemented prior to the last survey and the facility continues to expand the use of AccuNurse. She stated the AccuNurse system does not print off monitoring of the alarms. There was not any documentation to support the checks were</p>	F 282		
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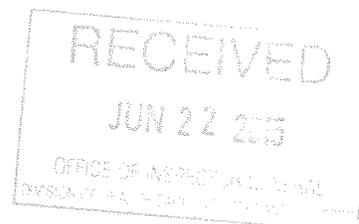
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F 282	<p>Continued From page 27 completed. The monitoring and checking of the alarm should be on the AccuNurse system and not on the Treatment Administration Record.</p> <p>The Director of Nursing was unavailable for interview. She was out of the country during the survey process.</p> <p>5. Review of the clinical record for Resident #7, revealed the resident was admitted to the facility, on 03/24/15 with the diagnoses of Congestive Heart Failure, Chronic Airway obstruction, Hypertension, Cerebrovascular Accident, and Viral Pneumonia. Further review of the record revealed the resident was put in contact isolation for C-Diff on 05/18/15.</p> <p>Review of the Comprehensive Care Plan for Resident #7, dated 05/18/15, revealed the facility developed a care plan for C-Diff infection with interventions including isolation per Centers for Disease Control (CDC).</p> <p>Observation of Resident #7, on 05/19/15 at 2:35 PM, revealed Personal Protective Equipment (PPE) hanging on the front of the resident's door. The resident was in the room lying in bed. The Social Services Director (SSD) was beside the resident's bed, sitting in the resident's wheelchair conversing with the resident. The SSD was not wearing any PPE.</p> <p>Continued observation of Resident #7, on 05/19/15 at 2:45 PM, revealed the SSD exited the resident's room without washing her hands.</p> <p>Interview with the SSD, on 05/19/15 at 2:45 PM, revealed she knew Resident #7 was in isolation for C-Diff and PPE was to be worn while in the resident's room. The SSD stated she forgot to</p>	F 282		

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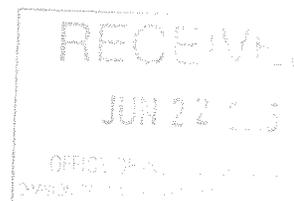
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F 282	<p>Continued From page 28</p> <p>put on the PPE and wash her hands. The SSD further stated by not wearing the appropriate PPE and washing her hands, the spread of infection to other residents could occur. She stated she had attended in-services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



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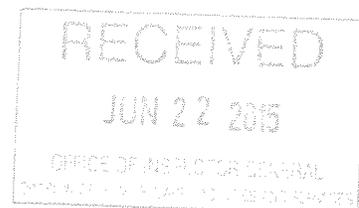
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F 282	<p>Continued From page 29</p> <p>revealed on 08/02/14 the resident scooted to the wall in the wheelchair and pull self up. The chair alarm was not sounding. The wheelchair rolled back and the resident sat on the floor. There was no report of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



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



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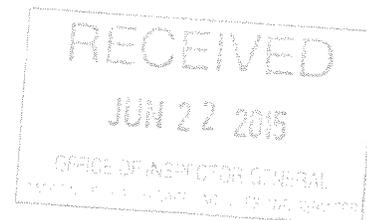
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F 282	Continued From page 31 on 05/22/15 at 4:45 PM, revealed he was aware Resident #8 was to be shaved daily and expected the CNA's to shave Resident #8 daily. LPN #4 stated he was not aware that shaving was on Resident #8's care plan. LPN #4 stated he wanted Resident #4 to be clean and neat. Interview with the Minimum Data Set (MDS) Coordinator, on 05/22/15 at 5:17 PM, revealed she did not update the Accu-Nurse care sytem. The MDS Coordinator stated it was the responsibility of the Director of Nursing (DON). The MDS Coordinator stated she expected the staff to follow the Care Plans. She stated she wanted Resident #8 shaved because it was a part of his/her hygiene and grooming. Interview with the Assistant Director of Nursing (ADON), on 05/22/15 at 4:50 PM, revealed she expected the staff to follow the plan of care. The ADON stated the Acitivities of Daily Living Care Plan was updated by the Director of Nursing (DON). The ADON stated she wanted to make sure Resident #8 was shaved because of his/her right and family requests. The DON was not available for interview, due to out of town during the survey.	F 282			
F 310 SS=D	483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activitles of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and	F 310	F310 SS=D Completion Date: 6/19/2015 Activities of Daily Living 483.25(a) Grooming/Shaving The specific resident that was cited in the statement of deficiency as having been affected was as follows: Residents # 8.		

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PRINTED: 06/08/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/22/2015
NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701		
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F 310	<p>Continued From page 32 ambulate; toilet; eat; and use speech, language, or other functional communication systems.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility failed to ensure one (1) of sixteen (16) sampled residents, Resident #8 received grooming as it related to shaving.</p> <p>The findings include:</p> <p>Review of the Shower Policy, revised October 2010, revealed the policy did not address shaving.</p> <p>Observation of Resident #8, on 05/19/15 at 2:33 PM, revealed Resident #8 lying flat in the bed with facial hair. Observation of Resident #8's wall above bed, revealed a sign which read; please do not leave head flat and must be shaved everyday.</p> <p>Observation of Resident #8, on 05/20/15 at 7:52 AM, revealed Resident #8 was observed to be sitting up in the wheelchair in the television room with facial hair.</p> <p>Interview with Certified Nursing Assistant (CNA) #8, on 05/22/15 at 4:15 PM, revealed there was a sign above Resident #8's bed which said Resident #8 was to be shaved everyday. CNA #8 stated she was not sure if she was to shave the resident in the morning or the evening, but knew the task was to be completed daily. CNA #8 stated she worked the Wednesday of 05/20/15 and did observe Resident #8 to have stubble on his/her face and did not shave Resident #8 that</p>	F 310	<p>Assistant Director of Nursing, and the LPN MDS Coordinator, and the LPN Unit Manager made sure that the frequency of shaving resident was corrected, that care plan for shaving resident was revised, that this was communicated to nursing assistants, and that this information was in the Accunurse Documentation System. This was completed by 6/12/2015.</p> <p>The other residents that were identified to be at risk for this deficient practice were as follows:</p> <p>Assistant Director of Nursing and the LPN MDS Coordinator completed an audit on active residents' for their activities of daily living care plans to ensure they were current and up-to-date regarding their activities of daily living care needs, and to make sure that fragmentation between the electronic medical record and the Accunurse Documentation Systems was corrected. This was completed by 6/18/2015.</p> <p>The measures that were put into place or systemic changes made to ensure that this deficient practice does not recur included the following:</p> <p>Administrator completed education/training to administration management (Director of Nursing, Assistant Director of Nursing, LPN Unit Manager, Social Service Director, Business Office Manager, HR/Payroll Coordinator, Director of</p>		



(continued from Page 34)

The following monitoring has been put into place to ensure for compliance with this regulation included the following:

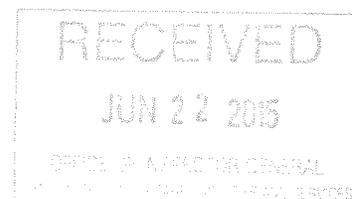
Administrator reviewed the nursing and nursing assistant departmental orientation training checklist and this was already identified as part of training for new staff. This was completed by 6/16/2015.

Nurse Unit Manager will complete an audit on three active residents monthly to ensure that the Accunurse Documentation System for the activities of daily living reflect that care was given as ordered for the past month. Any problems will be addressed, corrected, and documented. Audit findings will be documented and reported to the Administrator. This will be effective for 6/15/2015.

Administrator will review the audit results and documentation to analyze for any patterns and trends and report to the facility (PI) Quality Committee. This will be effective for the June 2015 meeting.

This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed
(continued on Page 34B)

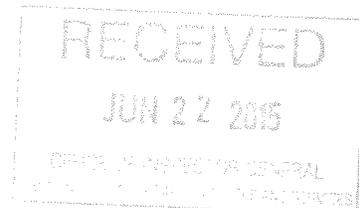
Page 34A



(continued from Page 34A)

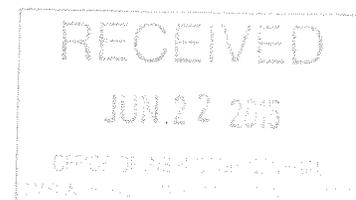
monthly (until the next facility's annual survey) and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance. If monitoring compliance is sustained for this period, then the PI Quality Committee will determine at that time to either continue monthly monitoring as outlined, reduce monitoring, or discontinue monitoring. The membership of this committee consist of at least the medical director, pharmacy consultant, director of nursing, assistant director of nursing, business office manager, unit manager, and the administrator. The PI Quality Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the PI Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.

Page 34B



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F 310	Continued From page 33 day either. CNA #8 stated the family probably wanted Resident #8 shaved daily to keep Resident #8 nice and clean. Interview with CNA #7, on 05/22/15 at 9:05 PM, revealed he thought Resident #8 was shaved in the morning daily. CNA #7 stated he did not notice Resident #8 was not shaved, nor the sign above the bed. CNA #7 stated the families' of residents would write things above the residents' beds to ensure the staff remembered to complete tasks. Interview with Licensed Practical Nurse (LPN) #4, on 05/22/15 at 4:45 PM, revealed he was aware Resident #8 was to be shaved in the morning daily and expected the CNA's to shave Resident #8 daily. Interview with the Assistant Director of Nursing (ADON), on 05/22/15 at 4:50 PM, revealed she expected the staff to follow the plan of care. The ADON stated she wanted to make sure Resident #8 was shaved because of his/her right and family requests.	F 310	Admission/Marketing, Dietary Manager, Activity Director, Maintenance Supervisor, Housekeeping/Laundry Supervisor, LPN MDS Coordinator, and Supply/Medical Records Coordinator) regarding the residents' activities of daily living care needs (to include shaving) which are to be identified, care planned, and communicated to caregivers. Caregivers are to provide assistance and/or perform activities of daily living for residents, as identified. This was completed by 6/2/2015. The following administration/management staff, who supervise or have oversight with nurses and nursing assistants (Director of Nursing, Assistant Director of Nursing, LPN MDS Coordinator, and Nurse Unit Managers) provided the education/training to nursing and nursing assistants staff. This was all completed by 6/12/2015. (continued on Page 34A)		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323	F323 Completion Date: 6/19/2015 SS=E Free of Accident Hazards/Supervision/Devices 483.25(h)(1)(2) — Resident Falls The specific residents that were cited in the statement of deficiency as having been affected were as follows: Residents #s 1, 6, 9, 12, and 13.		





Fax Cover Letter

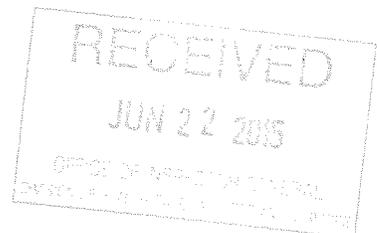
To: Patti Burke From: Kathy Holleman
Fax Number: 1-502-595-4540 Number of Pages: 5
RE: Federal POC - pages 35-38 Date: 6/22/15
for F 323

Comments:

Here are pages 35-38 for F 323 - Page
34 was OK
I reviewed F441 & F514 - they looked
OK.

[Handwritten signature]

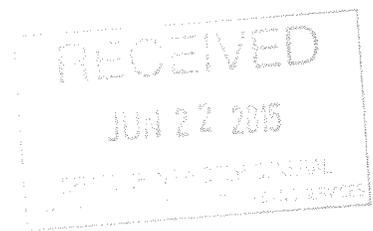
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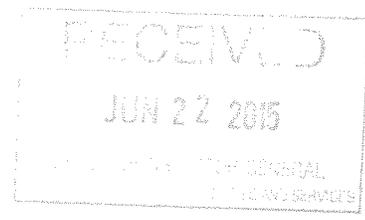
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F 323	Continued From page 34 by: Based on observation, interview and facility policy review, it was determined the facility failed ensure resident were free from accidents for five (5) of sixteen (16) sampled residents. Resident #1, #6, #9, #12 and #13 falls. The findings include: Review of the facility's care plan policy titled, "Fall Assessment/Intervention Process", revised September/2013, revealed all residents on any admisson, re-admission and at least quearterly will be assessed for fall risk and appropriate interventions initiated immediately to reduce the risk of injuries with falls. Any resident who experiences a fall will have a Care Area Assessment (CAA) Summary fall worksheet completed to assure all identified risk factors are taken into consideration. 1. Review of Resident #1's clinical record revealed the facility re-admitted the resident on 08/06/14 with the diagnosis of Polyarthritis, Hypothyroidism, and Hypertension. Review of Resident #1's Annual Minimum Data Set (MDS) assessment, completed on 05/11/15 revealed the facility assessed the resident utilizing the Brief Interview of Mental Status (BIMS) as being moderately impaired; BIMS score was ten (10) of fifteen (15). Review of the Comprehensive Care Plan for Resident #1, revealed the facility developed a care plan dated 01/11/15, for potential for falls related to impaired mobility, strength, balance and endurance related to Degenerative Joint	F 323	Director of Nursing reviewed all of the above residents' falls and investigations(#s 1, 6, 9, 12, and 13) from 8/1/2014 to 5/18/2015 to review the fall interventions (for the start dates and discharge dates regarding interventions); to re-assess where the residents were at present to ensure for all of the following: fall investigations had identified root causes for the falls; interventions, such as bed and chair alarms were still in place, being used, and being checked for placement and functioning by nursing staff; interventions still in place were re-assessed for appropriateness and effectiveness for the residents; appropriate physician orders were in place; and that fall care plans for these residents were up-to-date. This was completed by 6/18/2015. The other residents that were identified to be at risk for this deficient practice were as follows: Director of Nursing completed an audit for all to identify active residents that had experienced falls from 5/1/2015 thru 5/22/2015 and reviewed these resident falls and investigations to review fall interventions (for the start dates and discharge dates regarding interventions); to re-assess where the residents were at present to ensure for all of the following: fall investigations had identified root causes for the falls; interventions, such as bed and chair alarms were still in place, being used, and	



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F 323	<p>Continued From page 35</p> <p>Disease, Hypertension. The interventions included: Physical and Occupational therapy to continue treating, keep the call light within reach with reminders for use, identify where the call light is before leaving the resident's room, monitor for potential hazards in the environment, and assist resident to wear soled shoes when out of bed. In addition, the Treatment Sheet, dated May/2015, included the chair alarm to the recliner with staff initials for a 7AM-7 PM and 7 PM-7AM each day was initiated on 05/05/15 during the 7 PM-7 AM shift.</p> <p>Review of Resident #1's Post Incident Actions, dated 04/29/15 at 1:45 PM, revealed a fall occurred in the resident's room. The facility assessed the resident and no injury was identified.</p> <p>Record review of Resident #1's CAA Fall Investigation Worksheet, dated 04/30/15 at 3:07 PM, was not completed by the facility.</p> <p>Observation, on 05/20/15 at 7:30 AM, of Resident #1 revealed he/she was initially seated in his/her recliner with feet elevated. When he/she proceeded to rise from the recliner and ambulate independently to the closet area. The alarm did not sound once the resident arose from the recliner.</p> <p>Interview with Resident #1, on 05/20/15 at 8:07 AM, revealed he/she did not like the beeping of the alarm when he/she gets out of the chair (recliner). He/she reported the beeping of the alarm makes me nervous.</p> <p>2. Review of Resident #6's clinical record</p>	F 323	<p>being checked for placement and functioning by nursing staff; interventions still in place were re-assessed for appropriateness and effectiveness for the residents; appropriate physician orders were in place; and that fall care plans for these residents were up-to-date. This was completed by 6/18/2015.</p> <p>The measures that were put into place or systemic changes made to ensure that this deficient practice does not recur included the following:</p> <p>Administrator provided education/training to the Director of Nursing regarding: 1) the issues OIG Surveyors identified with resident falls and; 2) reviewed the weekly clinical system process for falls that is to be done with the clinical inter-disciplinary team. The Director of Nursing is responsible for providing the leadership for this clinical system fall process. This was completed by 5/29/2015.</p> <p>Director of Nursing ensured: 1) that appropriate resident treatment administration records were completed when fall interventions for alarms were for nursing staff to check the placement and functioning of alarms on the Treatment Administration. This was completed by 6/18/2015. 2) That nursing staff received education/training regarding their responsibilities with resident treatment administration records in regards to checking the placement and functioning</p>	



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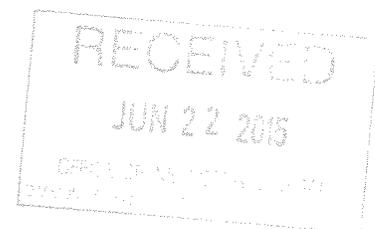
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NAME OF PROVIDER OR SUPPLIER ELIZABETHTOWN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701
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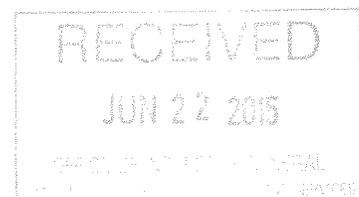
F 323	<p>Continued From page 36</p> <p>revealed the facility re-admitted the resident on 07/01/12 with the diagnosis of Osteoporosis, Anxiety State, Dementia with Behavior Disturbances, Iron Deficiency Anemia, Hypothyroidism, Osteoporosis, Syncope and Collapse.</p> <p>Review of Resident #6's Quarterly MDS assessment, completed on 04/27/15 revealed the facility assessed the resident utilizing the BIMS. The facility assessed Resident #6's BIMS score as four (4) of fifteen (15), being severely impaired cognitively.</p> <p>Review of the Comprehensive Care Plan for Resident #6, revealed the facility developed a care plan for the high possibility of falls, on 02/09/15, with updated goals and target dates for 05/09/15 potential for falls. The resident had several falls in recent months without injury. Resident #6 had impaired safety awareness related to Dementia. The interventions included: Ensure a safe environment, free of clutter, adequate lighting. Non-skid socks and/or well fitting shoes when out of the bed. Also, keep call light within reach when in bed with cues and reminders for use. In addition, the facility developed a care plan for the resident unable to meet his/her own ADL/self-care needs, related to cognitive deficits and left sided weakness (Transient Ischemia Attacks (TIA)), on 02/11/15, with updated goals and target dates for 08/11/15. The interventions included: provided oversight for bed mobility, transfers and ambulation. Monitor the need for physical assistance and for assistance with wheelchair for any trips on or off the unit.</p> <p>Review of Resident #6's Post Incident Actions,</p>	F 323	<p>of alarms that are identified. This was completed by 6/18/2015.</p> <p>The following monitoring has been put into place to ensure for compliance with this regulation included the following:</p> <p>Director of Nursing will present monthly to the facility (PI) Quality Committee summary reporting of resident falls that includes type of injury, time of day, shifts, hallways, number of falls, and results/outcomes for these residents regarding falls. This will be effective for 6/1/2015.</p> <p>Director of Nursing will provide a list of resident falls monthly to the pharmacy consultant upon the monthly visit to the facility so that pharmacy can review these residents medications, as appropriate. This will be effective for 6/1/2015.</p> <p>This plan of correction for monitoring compliance will be integrated into the facility's performance improvement quality system where results will be reviewed monthly (until the next facility's annual survey) and monitored by the Performance Improvement (PI) Quality Committee for ensuring on-going compliance. If monitoring compliance is sustained for this period, then the PI Quality Committee will determine at that time to either continue monthly monitoring as outlined, reduce monitoring, or discontinue</p>	
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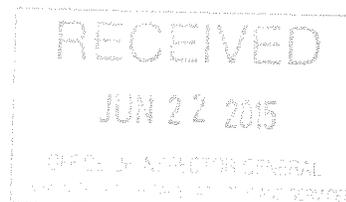
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F 323	Continued From page 37 dated 01/16/15 at 11:33 PM, revealed a fall occurred in the resident's room. The facility assessed the resident and no injury was identified. Requested Resident #6's CAA Fall Investigation Worksheet, related to the fall, dated 01/16/15 at 11:33 PM. The facility did not provide the fall investigation worksheet. Observation of Resident #6, on 05/19/15 at 12:35 PM, revealed the resident was seated in a wheelchair at a table in the dining area with an alarm attached to the back of the wheelchair. Observation of Resident #6, on 05/19/15 at 1:40 PM, revealed the resident laid in his/her bed. The resident was laid on his/her right side, facing the window. The window blind was closed. An alarm was in place and attached to the bed. Observation of Resident #6, on 05/20/15 at 7:30 AM and at 7:40 AM, revealed the resident was seated in his/her wheelchair at the table in the main dining area. The wheelchair had an alarm attached to the back of the wheelchair. An unsuccessful interview was attempted with Resident #6, on 05/20/15 at 10:15 AM. 3. Review of Resident #9's clinical record revealed the facility re-admitted the resident on 04/04/14 with diagnosis of Depressive Disorder, Anxiety, Mental Disorder and Anemia. Review of the nursing notes, dated 01/16/15 at 1:59 AM, revealed Resident #9 has bed and chair sensor alarms which he/she was non-compliant	F 323	monitoring. The membership of this committee consist of at least the medical director, pharmacy consultant, director of nursing, assistant director of nursing, business office manager, unit manager, and the administrator. The PI Quality Committee will review the effect of the implemented changes and the audit findings, and if at any time concerns are identified during this monitoring process, the PI Quality Committee will be convened to analyze and recommend any further interventions, as deemed appropriate.		



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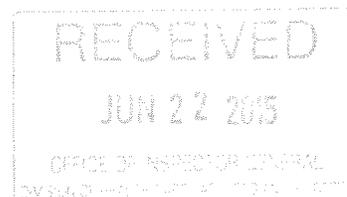
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F 323	<p>Continued From page 38</p> <p>with and turns off the alarms him/herself.</p> <p>Review of the Comprehensive Care Plan for Resident #9, revealed the facility developed a care plan for the high possibility of falls, on 02/16/15, with updated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



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



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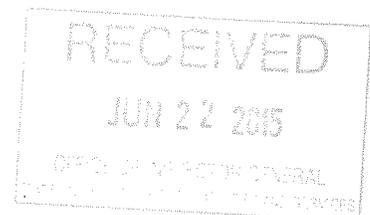
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F 323	<p>Continued From page 40 cognitively intact.</p> <p>Review of the Comprehensive Care Plan for Resident #13, revealed the facility developed a care plan for the high possibility of falls, on 02/12/15, with updated goals and target dates for 05/13/15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



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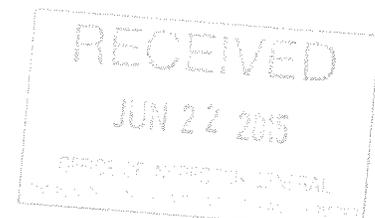
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F 323	<p>Continued From page 41</p> <p>Review of Resident #13's Post Incident Actions, dated 03/19/15 at 11:03 AM, revealed a fall occurred in the resident's room. The facility assessed the resident. Resident #13 had a skin tear above his/her left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



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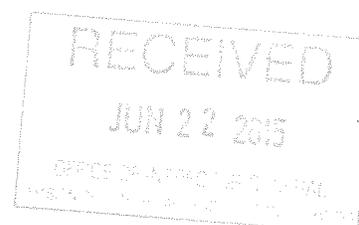
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F 323	<p>Continued From page 42 Behavior Disturbances.</p> <p>Review of Physician orders for Resident #12 revealed an order was received on 07/01/13 to place fall mats at the bedside at all times, bed alarm, check placement and function every shift,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



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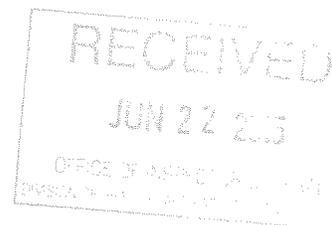
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F 323	<p>Continued From page 43</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 05/22/15 at 12:33 PM, revealed she was responsible to check alarms on all her residents every shift and to ensure they were functioning. She stated on the falls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



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F 323	Continued From page 44 and completed the fall investigations. She stated those are completed sporadically. She stated there was no an investigation for the fall, dated 01/16/15.	F 323			
F 441 SS=D	<p>The Director of Nursing was unavailable for interview. She was out of the country during the survey process.</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which</p>	F 441	<p>F441 Completion Date: 6/19/2015 SS=D Infection Control, Prevent Spread, Linens</p> <p>The specific residents that were cited in the statement of deficiency as having been affected were as follows: Resident #s 3 and 7.</p> <p>Resident # 3 was when the nursing assistant was doing peri-care and applying barrier cream. To correct this and to prevent this from reoccurrence, the Assistant Director of Nursing meet with the Nursing Assistant who performed the peri-care on Resident # 3 to instruct her on how to apply barrier cream. Assistant Director of Nursing instructed her regarding proper procedure to follow to ensure that infection control standards and practices were followed. This was completed on 6/8/2015.</p> <p>Assistant Director of Nursing completed a peri-care audit for return demonstration for peri-care on a resident with this nursing assistant. This was completed on 6/8/2015.</p>		



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F 441	<p>Continued From page 45 hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of facility training/in-services, and facility policy review, it was determined the facility failed to ensure infection control practices were maintained for two (2) of sixteen (16) sampled residents (Resident #3 and Resident #7). A Certified Nursing Assistant (CNA) failed to apply barrier cream correctly, and one (1) staff did not follow isolation precautions for Resident #7.</p> <p>The findings include:</p> <p>1. Review of facility's Corporate Standards of Practice, undated, revealed when applying topical barrier cream, smear it evenly over the skin and apply front to back.</p> <p>Review of the facility's Corporate Standards of Practice titled Providing Proper Perineal Care, revealed do no move from back to front due to the risk of introducing germs from the anal area into the urethra, a source of urinary tract infection.</p>	F 441	<p>Nursing Assistant performed this task properly.</p> <p>Assistant Director of Nursing completed education/training with the Social Service Director regarding isolation precautions and specifically regarding c-diff; five moments of hand hygiene with return demonstration; prevention and early interventions steps regarding hand hygiene; contact precautions for isolation as it relates to infection control and the policy on clostridium difficile. This was completed by 5/20/2015.</p> <p>No other residents were identified to be at risk for this deficient practice; however on the first day of the survey census was 57.</p> <p>Assistant Director of Nursing did education/training for the nursing assistants regarding the proper procedure and technique in doing peri-care. This was completed by 6/18/2015.</p> <p>Assistant Director of Nursing completed peri-care observations with nursing assistants to ensure they understood proper procedure and techniques. The nursing assistants performed this task properly. This was completed by 6/18/2015.</p> <p>Assistant Director of Nursing completed education/training with the Social Service Director regarding isolation precautions and specifically regarding c-diff; five moments</p>		

