

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

PRINTED: 01/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2015
NAME OF PROVIDER OR SUPPLIER PROVIDENCE RICHWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 166 SS=D	<p>A Recertification Survey was initiated on 01/13/15 and concluded on 01/15/15. The facility was found not meeting the minimum requirements for recertification with deficiencies cited at the highest scope and severity of an "E".</p> <p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and review of the Resident Council Minutes and facility policy, it was determined the facility failed to have an effective system in place to ensure grievances voiced by the Resident Council were followed up on with the Council.</p> <p>The findings include:</p> <p>Review of the policy, presented by the facility as the current policy on 01/13/15, titled Investigating Grievances and Complaints, dated 04/23/10, revealed the resident or person acting in behalf of the resident, would be informed of the findings of the investigation, as well as any corrective actions recommended, within (blank) working days of the filing of the grievance or complaint.</p> <p>Review of the policy, presented on 01/14/15, titled Resident Concern and Grievance Program, dated 12/04/14, revealed the program acknowledged</p>	F 166	<p>Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.</p> <p><i>Residents Affected</i> Specifically all residents who prefer and are physically able to have showers, residents who sit in the hallways and residents who eat their meals in the dining room are affected; in addition all residents with grievances or concerns has a potential to be affected.</p> <p><i>Identification of Other Residents</i> Specifically all residents who prefer and are physically able to have showers, residents who sit in the hallways and residents who eat their meals in the dining room are affected; in addition all residents with grievances or concerns has a potential to be affected. The air temperatures in both shower rooms, the dining room and hallways throughout the facility are being monitoring with testing of air temperatures daily by the maintenance director to ensure air temperatures are within acceptable range of 71-81 degrees F.</p> <p>Administrator initiated a resident council meeting was held on 2-5-15 by the social services director and activities director to ensure that resolutions and action items were reported to the group and followed-up with their concerns for the last 3 monthly resident council meetings.</p> <p><i>Systemic Changes</i> The maintenance director is checking air temperatures</p>	2-16-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE 2/18/15

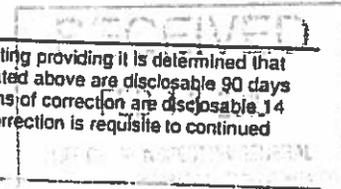
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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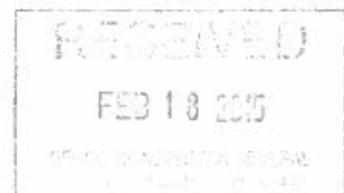
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F 166	<p>Continued From page 1</p> <p>the right of residents to voice concerns and the expectation of prompt efforts by the facility to resolve them. The policy further stated the program was supported by the Resident Council. However, the policy did not contain information, direction, responsible person, or follow up to any grievance voiced by the Resident Council. It further did not state how, when, or by who would be responsible for that follow up to ensure the Resident Council was afforded the the right to a prompt resolution.</p> <p>Interview with the Resident Council through the Quality of Life Assessment Group Interview, on 01/13/15 at 2:00 PM, revealed seven (7) residents were in attendance including the President of the Resident Council. During the interview process five (5) of the council members stated that multiple concerns had been voiced regarding the temperature of the facility, in particular, the shower rooms on the A Unit, B Unit and the dining room. The Council stated they had not only voiced the concern during the Council meetings, but during showers and meals to other staff. The Council further stated they did not know what was being done about it and no one had come back to the Council to follow up with them. In addition, the Council stated the concern with the temperature was still a valid concern.</p> <p>Review of the Resident Council minutes, dated 10/14/14, 11/12/14, and 12/10/14, revealed the Council had voiced concerns regarding the temperature of the shower rooms and dining room including the hallways in November and December 2014. The minutes did not reflect any resolution to the Council's concerns. The minutes simply stated old business reviewed with no mention of the cold temperature concerns.</p>	F 166	<p>including both shower rooms, hallways and the dining room daily throughout the facility to ensure air temperatures are within normal range.</p> <p>The air temperatures are being logged on a daily audit sheet by the Maintenance Director; if the temperature is found to be below 71 degrees, the administrator will be notified immediate corrective action will be taken.</p> <p>The Administrator has delegated the responsibility of conducting a monthly resident council to the Activities Director with the Social Services to be present at the meeting to record any grievances/concerns. A new resident council minutes form was implemented on 2/5/15 which includes the following information; Officers in attendance, residents in attendance, staff members invited by resident council to attend, minutes from the previous meeting which includes check boxes to ensure the previous minutes are read and approved, read and approved as corrected and any council concerns from previous meeting were reviewed and corrected.</p> <p>Also contains old business which includes listing follow up items from previous minutes and the identified staff person responsible for correction. Also includes new business consisting of listing issues, action taken and person responsible. Form also includes compliments or notes of appreciation, which resident's rights were reviewed and a reporting on any policies or procedures developed/ revised/updates in the last 30 days. A date and time is set for the next meeting and a signature is required from resident secretary.</p> <p>By utilizing this form, all previous minutes, concerns, grievances, corrections and persons responsible for corrections will be read out loud to Resident Council. The Social Service Director is responsible to ensure the Resident Council is kept informed of progress as described below in the new implemented grievance procedures. This new form will be utilized at each resident council by the Activities Director at each meeting and copies will be given to the Administrator following the meeting. All grievances will go through the grievance procedure described below.</p> <p>The facility has implemented a new Grievance/Concern Program which consist of the following components: The Administrator has delegated the responsibility of grievance and/or complaint investigation to the social services department including resident council concerns, grievances or complaints. The social services</p>		



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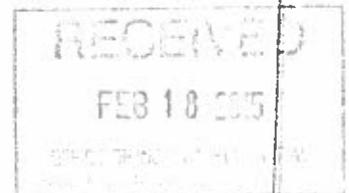
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F 166	Continued From page 2 Interview with the Activities Director (AD), on 01/14/15 at 8:40 AM, revealed the Council's concerns were written in the minutes. The next day the concerns were presented in the morning meeting to the respective department head. The responsible department head was to write a plan of correction and return it to the Activities Director. The department heads write something in the Social Services log. However, he was not sure what that was. The AD further explained at the beginning of each meeting he went over old business; however, he would ask the Council if they had any old business and did not verbalize what those concerns were from the last meeting. He further stated he did not follow up with the Resident Council on resolutions to concerns in between meetings and thought the Director of Nurses or Social Services did that. Interview with the Social Services Director (SSD), on 01/14/15 at 9:05 AM, revealed concerns are received in the morning meetings and each area is investigated by the department head responsible. A plan of correction is developed, returned to the Activities Director and then to her. She reviews to see if it was resolved and if not, then she would address the concern. She stated she only followed up with the individual. A log was kept of concerns, the log tracked the concern, summary of the plan of correction, and the actual resolution was kept in the binder as well. Interview with the Interim Director of Nursing, (DON), on 01/14/15 at 9:11 AM, revealed the DON and Administrator speak with the resident as an individual, not as a Council. She stated she was not involved in follow up with the Council that it was discussed as old business in the Resident	F 166	department may obtain assistance from the department the grievance originated. Upon receipt of a grievance and/or complaint, the social services department, with any assistance needed from the other departments, will investigate the allegations and submit a written report of such findings to the Administrator within five (5) working days of receiving the grievance and/or complaint. The Administrator will review the findings with the person investigating the complaint to determine what corrective actions, if any, need to be taken. The resident, resident council concerns, or person filing the grievance and/or complaint on behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. The Administrator, Social Service Director or Activities Director will make such reports orally within (7) working days of the filing of the grievance or complaint with the facility. The social services director or social serviced assistant will conduct a follow-up with the resident including resident council members, concerning the resolution of the grievance in (7) to (10) days after action plan was implemented to ensure corrective action was successful and grievance is resolved. Should the resident not be satisfied with the result of the investigation or if grievance/concern/complaint not resolved, a new grievance will be initiated by the social services department and a new action plan for resolution will be implemented. In addition all resident concerns/grievances will be discussed in the daily Continuous Quality Improvement (CQI) meetings. (previously referred to as daily QA meetings). The grievance logs, resident council minutes and action plans will be submitted to the monthly QAA meetings to oversee that grievances are resolved. In-service training on the new Grievance Program was conducted with the Social Services Director, and the Facilities Department Managers on 2-9-15 by the Administrator. <i>Monitoring</i> The air temperature log will be given to the administrator by the maintenance director daily to ensure air temperatures are acceptable. All progress of completed repairs and needed repairs will be reviewed in the daily Continuous Quality		

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F 166	Continued From page 3 Council meetings. Any concerns are addressed on an individual basis. She further stated if more than one resident had a concern then she would seek to see if other residents had the same concern. She stated the concerns were taken to Quality Assurance and follow up was completed as quickly as possible depending on the action taken; however, it was with the individual and not the Council as a whole.	F 166	Improvement (CQI) meetings, previously referred to as daily QA meetings. The results of the daily water temperature monitoring will be reported at the monthly QAA meeting by the administrator. In addition all resident concerns/grievances will be discussed in the daily CQI meetings and the grievance logs, resident council minutes and action plans will be submitted to the monthly QAA meetings to oversee that grievances have been resolved.		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ Individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements. <i>Residents Affected</i> Resident #14 was observed and assessed on 1-14-15, 1-15-15 and 1-16-15 by charge nurse and the social services director completed a psychosocial evaluation on 1-16-15 since the incident and no new areas of concern have been identified. The nurse completing the physical assessment on resident #14 after the abuse allegation was given one on one training by the Administrator to ensure all documents are fully completed on 1-16-15. The abuse investigation was re-opened on 2-4-15 and was completed on 2-9-15 to include interviewing of all staff working on that unit the night of the complaint; no new findings	2-16-15	



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F 225	<p>Continued From page 4</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility's abuse investigation tool, it was determined the facility failed to ensure the safety of all residents after an allegation of abuse was made. The facility failed to promptly remove the alleged perpetrators from the resident care area and not allow them to return until the allegation was determine to be substantiated or not. In addition, a complete nursing assessment of the potential victim of harm was not documented and all potential staff witnesses were not interviewed for one (1) of twenty-one (21) sampled residents (Resident #14) and one (1) of one (1) unsampled residents (Unsample Resident A).</p> <p>The findings include: Review of facility's policy Abuse Investigation Tool, not dated, revealed the individual conducting the investigation would, at minimum, review the resident medical record to determine events leading up to the incident; interview the person(s) reporting the incident; interview any witnesses to the incident; interview the resident; interview staff members (on all shifts) who have</p>	F 225	<p>identified.</p> <p>On 2-9-15 all interviewable residents on that unit have been questioned by the social services director for any concerns with any staff members; no further concerns identified.</p> <p><i>Identification of Other Residents</i> All residents receiving care at our facility are potentially affected; any alleged abuse which would include: verbal, physical, mental, sexual, emotional, involuntary seclusion and neglect are being thoroughly investigated which consists of: reviewing the residents medical record to determine events leading up to the incident, interviewing the person reporting the incident, interviewing any witnesses to the incident, interviewing the resident (as medically appropriate), interview attending physician as needed, interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident, interview roommate, family members and visitors, interview other residents to whom the accused employec provides care or services, review all events leading up to incident, determent what residents were affected by the incident, other circumstances that may effected the incident, obtain witness reports in writing and obtained before leaving the building, inform Ombudsman, cnsure during investigation the accused individuals NOT employed will be denied unsupervised access to the residents, the accused will be suspended from the facility during the investigation, keep resident and/or representative informed of progress, complete the "Resident Abuse Investigation Report Form" and report within the 5 days of investigation to OIG, local police department Ombudsman and any required state and local agency required by law.</p> <p>The facilities abuse policy was updated by the Administrator on 2/13/15 to suspend accused</p>		



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F 225	<p>Continued From page 5</p> <p>had contact with the resident during the period of the alleged incident; interview the resident's roommate, family members, and visitors; interview other residents to whom the accused employee provided care or services; review all events leading up to the alleged incident; determine any patterns with geography; staffing levels at the time of the incident; determine what residents were affected by the incident; employees during the investigation may be suspended or reassigned to nonresident care duties; and, each interview would be conducted separately and in a private location.</p> <p>Observation of Resident #14, on 01/15/15 at 11:45 AM, revealed the resident was in the dining room. Resident #14's left eye appeared slightly puffed than the right eye. The left eye had what appeared to be a dried red substance in the outer corner of the eyelid.</p> <p>Review of Resident #14's medical record revealed the facility admitted the resident on 02/28/14 with diagnoses of Organic Brain Syndrome, Alzheimer's with Psychotic Disorder, Aphasia and Glaucoma. Review of the Nurse's Notes for Resident #14, dated between 01/09/15 to 01/14/15, revealed nursing did not make any notes in Resident #14's chart about the allegation of abuse to Resident #14 or any assessments completed as a result of the abuse allegation. Review of the Social Service documentation, dated 12/27/14, revealed Resident #14 scored a ninety-nine (99) on the Quarterly Minimum Data Set assessment for cognition, indicating the resident was severely cognitively impaired.</p> <p>Review of the Nurse's Notes for Unsampled Resident A, dated between 01/06/15 to 01/14/15,</p>	F 225	<p>employees immediately to ensure accused employees are removed from any chance of resident care. The phrase "reassign accused employees to nonresident care duties" was omitted from the facility's policy. The administrator in-serviced the department heads of the revision to the abuse policy on 2-13-15.</p> <p><i>Systemic Changes</i> The facilities abuse policy was updated by the Administrator on 2/13/15 to suspend accused employees immediately to ensure accused employees are removed from any chance of resident care. The phrase "reassign accused employees to nonresident care duties" was omitted from the facility's policy. The administrator in-serviced the department heads of the revision to the abuse policy on 2-13-15.</p> <p>The facilities abuse investigation protocol was revised on 1-21-15 to include a section for initiation of a Root-Cause-Analysis determination. This analysis will be conducted by the IDT the following business day from the day the incident is reported and will be completed within 5 days. The Regional Director for Clinical Services conducted an Abuse in-service training on recognizing, determining root cause analysis and investigating abuse allegations for all management staff on 1/22/15.</p> <p>An in-service was conducted on 1-22-15 and was completed on 1-26-15 with all nursing staff by the Director of Nursing on completing incident report, and conducting a head-to-toe physical assessment with completed documentation on all alleged abuse allegations and included the new section of policy.</p> <p>All investigative documents including the Long-Term Care Facility-Self Reported Incident Form, the Abuse Investigation Tool form, and the Resident Abuse Investigation</p>		



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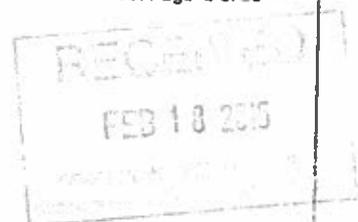
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F 225	<p>Continued From page 6</p> <p>revealed nursing did not make any notes in Unsampld Resident A's chart about the resident reporting abuse.</p> <p>Review of the Resident Abuse Investigation Report Form for Resident #14, dated 01/13/15, revealed Unsampld Resident A made an allegation of abuse against the CNAs who were providing care to his/her roommate, Resident #14. In the section of the Resident Abuse Investigation Report Form to include relevant history, the Administrator included the diagnosis of Unsampld Resident A, the reporting resident. The Administrator documented that he completed an interview with Unsampld Resident A. In the interview, the Administrator asked the resident how his/her stay was going and how his/her night was on 01/13/15. In this interview, the resident stated that his/her stay was fine and that he/she would like to be home with his/her family.</p> <p>Interview with Unsampld Resident A, on 01/15/15 at 10:50 AM, revealed Unsampld Resident A made an allegation of abuse on his/her roommate's behalf. Unsampld Resident A stated that he/she was lying in bed on the evening of 01/13/15 and heard a male staff come into the room to assist his/her roommate to change his/her clothing. Unsampld Resident A stated he/she heard what sounded like a loud slap noise and heard his/her roommate cry out. Unsampld Resident A stated he/she stood up, looked around the privacy curtain, and saw his/her roommate sitting in his/her wheelchair and slumped to one side in the chair. Then the male CNA pulled the privacy curtain. Unsampld Resident A stated he/she yelled at the CNA and he left the room. A staff person who was sitting at the nurses' station came down the hall to find out</p>	F 225	<p>Report Form, all the written statements from accused employees before leaving the building, interviews of persons reporting the incident, interviews of any witnesses, interview of staff members, interviews with resident's roommates, family members and visitors, timeline of event, interviews with other residents, 72-Hour assessments following the incident, notes from root cause analysis and staffing levels will be reviewed by the Administrator to ensure all documentation is completed and that the facilities investigative protocol was followed.</p> <p>The QAA determined that all aspects of an abuse investigation will be reviewed by the facility's Regional Clinical Quality Assurance Director or Regional Director of Operations within 24 hours of the alleged abuse and when the 5 day investigation is completed for future compliance of each investigation, identifying the root cause and completion of all documentation and that a thorough investigation was completed</p> <p><i>Monitoring</i> The QAA determined that all aspects of an abuse investigation will be reviewed by the facility's Regional Clinical Quality Assurance Director or Regional Director of Operations within 24 hours of the alleged abuse and when the 5 day investigation is completed for future compliance of each investigation, identifying the root cause and completion of all documentation and that a thorough investigation was completed This will validate that: any alleged abuse which would include: verbal, physical, mental, sexual, emotional, involuntary seclusion and neglect are being thoroughly investigated which consists of: reviewing the residents medical record to determine events leading up to the incident, interviewing the person reporting the incident,</p>		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 225	<p>Continued From page 7</p> <p>what had happened. Unsampled Resident A stated he/she reported the incident to that staff person. Unsampled Resident A stated that no staff came back to check on his/her roommate and no staff came to talk to him/her again about the incident.</p> <p>Interview with the Unit Manager (UM) on the A Unit, on 01/15/15 at 3:00 PM, revealed Unsampled Resident A reported to her around 9:00 PM that he/she witnessed an African American male treat Resident #14 roughly while putting the resident to bed. The UM also stated Resident #14 was non-verbal, made verbalizations and banged on his/her wheelchair, but was unable to speak words. She stated Unsampled Resident A alleged there was only one (1) staff and he did not use a mechanical lift to transfer the resident. The UM said she started her investigation by reviewing Resident #14's medical record. The UM further stated she and the hall nurse should have documented the allegation in Resident #14's chart. She stated her investigation determined two Certified Nursing Assistants (CNA) actually had put Resident #14 to bed using a lift. She stated she called them both to the nurses' station separately, questioned them regarding care they had provided, and requested that they write a statement. She stated CNA #3, who matched the description, was scheduled to leave at 10:00 PM that evening and CNA #7 at 9:00 PM. She stated CNA #7 completed her statement and then left for the evening; however, she did not inform the aide that she would be re-assigned to non-resident care activities if she returned to work prior to the completion of the investigation or that she was suspended. The UM stated CNA #3 remained at the nurses' station and was not immediately</p>	F 225	<p>interviewing any witnesses to the incident, interviewing the resident (as medically appropriate), interview attending physician as needed, interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident, interview roommate, family members and visitors, interview other residents to whom the accused employee provides care or services, review all events leading up to incident, determine what residents were affected by the incident, other circumstances that may effected the incident, obtain witness reports in writing and obtained before leaving the building, inform Ombudsman, ensure during investigation the accused individuals NOT employed will be denied unsupervised access to the residents and suspended, keep resident and/or representative informed of progress, complete the "Resident Abuse Investigation Report Form" and report within the 5 days of investigation to OIG, local police department Ombudsman and any required state and local agency required by law.</p> <p>All abuse allegations and investigations will be reviewed at the Monthly QAA meetings for compliance and recommendations.</p>	



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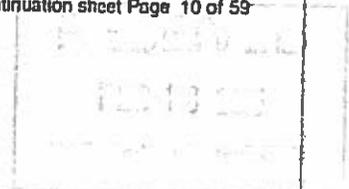
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F 225	<p>Continued From page 8</p> <p>removed from the resident care area. She stated CNA #3 left at his scheduled time and she did not inform him he was suspended or would be re-assigned if he returned to work prior to the conclusion of the investigation.</p> <p>Continued interview, on 01/15/15, with the UM revealed she did not continue her investigation into the allegation of abuse, made by Unsampled Resident A, until she returned to work on 01/14/15. She stated she only interviewed the staff that was assigned to work on that hallway to determine if they had heard or witnessed anything. She stated the reason she did not interview the other staff who had the potential to witness or be aware of the incident was because they were not assigned to provide care to Resident #14.</p> <p>Review of Resident #14's Weekly Nursing Assessment sheet, dated 01/13/14, revealed nursing was to assess vitals, mental status, neurological status, respiratory status, breathing pattern, pain, oral mucous, cardiovascular status, peripheral pulses, edema, abdomen, skin and risk for pressure ulcer. Review of the document revealed the nurse documented under the Comments section, no skin issues noted at this time. The rest of the form was blank.</p> <p>Continued interview with the Unit Manager, on 01/15/15 at 3:00 PM, revealed residents identified to be the victim of an allegation of abuse were to be assessed and she failed to complete the assessment documentation because it was so hectic the night of 01/13/15.</p> <p>Telephone interview with CNA #3, on 01/15/15 at</p>	F 225			



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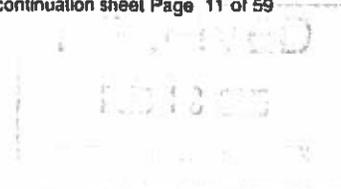
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F 225	<p>Continued From page 9</p> <p>3:40 PM, revealed the Unit Manager questioned him regarding the care he provided Resident #14 and requested he write a statement. He stated he was not suspended or re-assigned to non-resident care activities and he left at his requested time of 10:00 PM.</p> <p>Interview with CNA #7, on 01/15/15 at 6:30 PM, revealed the Unit Manager questioned her regarding the care she provided Resident #14 and requested she write a statement. She stated she was not suspended or re-assigned to non-resident care activities and she left right after completing her statement, sometime after 9:00 PM.</p> <p>Interview with the Administrator, on 01/15/15 at 2:00 PM, revealed he was informed of the allegation of abuse against Resident #14 on the evening of 01/13/14. He stated he had no concerns regarding the nursing assessment documentation; however, he stated a person could be injured in another place besides the skin and that the health assessment was not completed. He stated the allegation was made close to the end of shift and since both employees involved were leaving for the night he instructed staff to send them home. The Administrator stated he did not direct staff to suspend them or ensure they would not be called into work during the night. The Administrator stated he completed the interview with Unsampld Resident A and asked him/her how his/her care was, if he/she had any problems, and how his/her night was. Administrator stated he did not ask specific questions about the alleged abuse to Resident #14. He stated he made his determination on 01/14/15 that the allegation was unsubstantiated and decided no other employee</p>	F 225			



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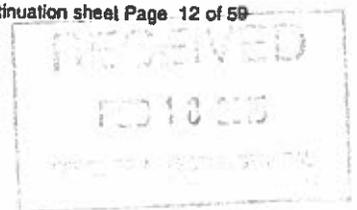
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F 225	Continued From page 10 actions were necessary. He stated he believed the investigation into the allegation of abuse was investigated thoroughly, even though, all potential staff that could have witnessed or been aware of the incident were not interviewed.	F 225	Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements. <i>Residents Affected</i> Resident #14 was observed and assessed on 1-14-15, 1-15-15 and 1-16-15 by the unit managers and the social services director completed a psychosocial evaluation on 1-16-15 since the incident and no new areas of concern have been identified. The nurse completing the physical assessment on resident #14 after the abuse allegation was given one on one training by the Administrator to ensure all documents are fully completed on 1-16-15. The abuse investigation was re-opened on 2-4-15 and was completed on 2-9-15 to include interviewing of all staff working on that unit the night of the complaint; no new findings identified. On 2-9-15 all interviewable residents on that unit have been questioned by the social services director for any concerns with any staff members; no further concerns identified. <i>Identification of Other Residents</i> All residents receiving care at our facility are potentially affected; any alleged abuse which would include: verbal, physical, mental, sexual, emotional, involuntary seclusion and neglect are being thoroughly investigated which consists of: reviewing the residents medical record to determine events leading up to the incident, interviewing the person reporting the incident, interviewing any witnesses to the incident, interviewing the resident (as medically appropriate), interview attending physician as needed, interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident, interview roommate, family members and visitors, interview other residents to whom the accused employee provides care or services, review all events leading up to incident, determine what residents	2-16-15	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's investigation tool, it was determined the facility failed to follow their policy regarding interviewing and protecting residents from further potential abuse for one (1) of twenty-one (21) sampled residents (Resident #14) and one (1) of one (1) unsampled residents (Unsampled Resident A). The findings include: Review of the facility's Abuse Investigation Tool revealed the individual conducting the investigation would, at minimum, review the resident medical record to determine events leading up to the incident; interview the person(s) reporting the incident; interview any witnesses to the incident; interview the resident; interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; interview the resident's roommate,	F 226			



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F 226	<p>Continued From page 11</p> <p>family members, and visitors; interview other residents to whom the accused employee provided care or services; review all events leading up to the alleged incident; determine any patterns with geography; staffing levels at the time of incident; determine what residents were affected by the incident; employees during the investigation may be suspended or reassigned to nonresident care duties; and, each interview would be conducted separately and in a private location.</p> <p>Interview with Unit Manager (UM) #2, on 01/15/15 at 3:00 PM, revealed she called both CNA #3 and CNA #7 to the nurses' station separately, questioned them regarding the care they had provided, and requested they write a statement. She stated CNA #3, who matched the description, was scheduled to leave at 10:00 PM that evening and CNA #7 at 9:00 PM. She stated CNA #7 wrote her statement and then left for the evening; however, she did not inform the aide that she would be re-assigned to non-resident care activities if she returned to work prior to the completion of the investigation or that she was suspended. The UM stated CNA #3 remained at the nurses' station, while he completed his written statement, and was not immediately removed from the resident care area. She stated CNA #3 left at his scheduled time and she did not inform him he was suspended or would be re-assigned if he returned to work prior to the conclusion of the investigation.</p> <p>Continued interview with the UM, on 01/15/15, revealed she did not continue her investigation into the allegation of abuse, made by Unsampled Resident A, until she returned to work on 01/14/15. She stated she only interviewed the</p>	F 226	<p>were affected by the incident, other circumstances that may effected the incident, obtain witness reports in writing and obtained before leaving the building, inform Ombudsman, ensure during investigation the accused individuals NOT employed will be denied unsupervised access to the residents, keep resident and/or representative informed of progress, complete the "Resident Abuse Investigation Report Form" and report within the 5 days of investigation to OIG, local police department Ombudsman and any required state and local agency required by law.</p> <p>The facilities abuse policy was updated by the Administrator on 2/13/15 to suspend accused employees immediately to ensure accused employees are removed from any chance of resident care. The phrase "reassign accused employees to nonresident care duties" was omitted from the facility's policy. The administrator in-serviced the department heads of the revision to the abuse policy on 2-13-15</p> <p>Systemic Changes The facilities abuse policy was updated by the Administrator 2/13/15 to suspend accused employees immediately to ensure accused employees are removed from any chance of resident care. The phrase "reassign accused employees to nonresident care duties" was omitted from the facility's policy. The facilities abuse investigation protocol was revised on 1-21-15 to include a section for initiation of a Root-Cause-Analysis determination. This analysis be conducted by the IDT the following business day from the day the incident is reported and will be completed within 5 days. The Regional Director for Clinical Services conducted an Abuse in-service training on recognizing, determining root cause analysis and investigating abuse allegations for all management staff on 1/22/15. An in-service was conducted on 1-22-15 and was completed on 1-26-15 with all nursing staff by the Director of Nursing on completing incident report, and conducting a head-to-toe physical assessment with completed documentation on all alleged abuse allegations and included the new section of policy. All investigative documents including the Long-Term Care Facility-Self Reported Incident Form, the Abuse Investigation Tool form, and the Resident Abuse Investigation Report Form, all the written statements from accused employees before leaving the building, interviews of persons reporting the incident, interviews of any witnesses, interview of staff members, interviews with resident's roommates, family members and visitors, timeline of event, interviews with other residents, 72-</p>		



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F 226	<p>Continued From page 12</p> <p>staff that was assigned to work on that hallway to determine if they had heard or witnessed anything. She stated the reason she did not interview the other staff that had the potential to witness or be aware of the incident was because they were not assigned to provide care to Resident #14.</p> <p>Telephone interview with CNA #3 on, 01/15/15 at 3:40 PM, revealed the Unit Manager questioned him regarding the care he provided Resident #14 and requested he write a statement. He stated he was not suspended or re-assigned to non-resident care activities and he left at his requested time of 10:00 PM.</p> <p>Interview with CNA #7 on, 01/15/15 at 6:30 PM, revealed the Unit Manager questioned her regarding the care she provided Resident #14 and requested she write a statement. She stated she was not suspended or re-assigned to non-resident care activities and she left right after completing her statement, sometime after 9:00 PM.</p> <p>Interview with the Administrator on, 01/15/15 at 2:00 PM, revealed he was informed of the allegation of abuse against Resident #14 on the evening of 01/13/14. He stated he had no concerns regarding the investigation or interviews conducted. He stated the allegation was made close to the end of shift and since both employees involved were leaving for the night he did not direct staff to suspend them or ensure they would not be called into work during the night. He stated he made his determination the next afternoon that the allegation was unsubstantiated and decided no other employee actions were necessary. He stated he believed</p>	F 226	<p>Hour assessments following the incident, notes from root cause analysis and staffing levels will be reviewed by the Administrator to ensure all documentation is completed and that the facilities investigative protocol was followed. The QAA determined that all aspects of an abuse investigation will be reviewed by the facility's Regional Clinical Quality Assurance Director or Regional Director of Operations within 24 hours of the alleged abuse and when the 5 day investigation is completed for future compliance of each investigation, identifying the root cause and completion of all documentation and that a thorough investigation was completed</p> <p><i>Monitoring</i></p> <p>The QAA determined that all aspects of an abuse investigation will be reviewed by the facility's Regional Clinical Quality Assurance Director or Regional Director of Operations within 24 hours of the alleged abuse and when the 5 day investigation is completed for future compliance of each investigation, identifying the root cause and completion of all documentation and that a thorough investigation was completed.</p> <p>This will validate that: any alleged abuse which would include: verbal, physical, mental, sexual, emotional, involuntary seclusion and neglect are being thoroughly investigated which consists of: reviewing the residents medical record to determine events leading up to the incident, interviewing the person reporting the incident, interviewing any witnesses to the incident, interviewing the resident (as medically appropriate), interview attending physician as needed, interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident, interview roommate, family members and visitors, interview other residents to whom the accused employee provides care or services, review all events leading up to incident, determine what residents were affected by the incident, other circumstances that may effected the incident, obtain witness reports in writing and obtained before leaving the building, inform Ombudsman, ensure during investigation the accused individuals NOT employed will be denied unsupervised access to the residents and suspended, keep resident and/or representative informed of progress, complete the "Resident Abuse Investigation Report Form" and report within the 5 days of investigation to OIG, local police department Ombudsman and any required state and local agency required by law.</p> <p>All abuse allegations and investigations will be reviewed at the Monthly QAA meetings for compliance and recommendations.</p>		



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F 226	Continued From page 13 the investigation into the allegation of abuse was investigated thoroughly, even though, all potential staff that could have witnessed or been aware of the incident were not interviewed.	F 226		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure resident sinks were in good repair to prevent potential injury from cuts and/or skin tears from rough edges where the porcelain finish was missing for three (3) of fourteen (14) sinks. (Room 301, 314, and 402) The findings include: The facility did not provide a policy on the maintenance and upkeep of resident equipment. Observation of fourteen (14) rooms to obtain water temperatures on 01/13/15 at 10:05 AM, revealed rooms 301, 314, and 402's sinks on the inside of the bowl nearest the resident had the porcelain missing with rough edges exposed. There were no residents present at the time of the observations. Interview with the Maintenance Director, on 01/14/15 at 9:45 AM, revealed the sinks had been in place since the building opened. These sinks	F 253	Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements. <i>Residents Affected</i> Resident #301, #314 and #402 sinks were repaired and open areas were sealed by the maintenance director on 1-17-15. <i>Identification of Other Residents</i> An audit was conducted 1/21/15 by the maintenance director which indicated that no other sinks were in need of repair. <i>Systemic Changes</i> A new system was developed and implemented to include housekeeping and maintenance to conduct a weekly room inspection. This maintenance/housekeeping directors will inspect each room once a week including the inspection of each sink basin to ensure no repairs are needed. Any needed repairs will be submitted through the facilities work order process.	2-16-15 per S. Longmire by PB 2-24-15

FEB 18 2015

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F 253	Continued From page 14 were slated to be replaced during renovation; however, there was no date certain for this remodel to occur. The Maintenance Director stated his only option at this point would be to fix any leaks as they occur. He further stated there was no plan in place to ensure the residents were not injured until the renovation; however, the Administrator may have knowledge of a plan. Interview with the Administrator, on 01/14/15 at 2:25 PM, revealed there had been no approval by the corporate office for the remodel and was not aware the porcelain was missing from the sinks. He stated there was no plan and the sinks would be replaced in the next three (3) weeks. However, there was no plan provided for the three (3) week period to ensure the residents were not injured. He further stated he was not sure if the sinks could be repaired and they would have to find another sink they could use or find another room for the resident.	F 253	<i>Monitoring</i> The weekly room inspections will be turned into the administrator for review and follow-up and the progress of the repairs and needed repairs will be reported and discussed in the daily Continuous Quality Improvement (CQI) meetings, (previously referred to as daily QA meeting). In addition, the results of the weekly rounds will be reported to the QAA meeting by the Administrator for review and compliance.		
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 review of the Resident Council Minutes, it was determined the facility failed to ensure air temperatures were comfortable for the residents in two (2) of two (2) shower rooms (A Unit and B Unit) and one (1) of one (1) dining rooms.	F 257	Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements. <i>Residents Affected</i> Specifically all residents on Unit A and B who prefer and are physically able to have showers, residents who sit in the hallways and residents who eat their meals in the dining room are affected.	2-16-15	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/15/2015
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F 257	<p>Continued From page 15</p> <p>The findings include:</p> <p>The facility did not provide a policy regarding the air temperature in the facility.</p> <p>Interview with the Resident Council, on 01/13/15 at 2:00 PM, revealed seven (7) residents attended the Quality of Life Group Interview and five (5) of the seven (7) stated concerns regarding the temperature of the shower rooms and dining room. They further stated they had voiced this concern at multiple Resident Council meetings.</p> <p>Review of the Resident Council minutes, dated 10/14/14, 11/12/14 and 12/10/14 revealed the council voiced a concern on 11/12/14 that it was cold in the dining room and hallways. Again, at the 12/10/14 meeting, the council voiced a concern that it was way too cold in the shower room.</p> <p>Observation of the B Unit shower room, on 01/13/15 at 3:00 PM, revealed the door was shut and no residents or staff were present. The thermometer attached to the wall of the shower room indicated the temperature was 68 degrees Fahrenheit (F). The A Unit shower room was in use at the time.</p> <p>Observation of the A Unit shower room, on 01/14/15 at 7:25 AM, revealed the shower room had been in use; however, when the staff was finished the thermometer mounted on the wall had a reading of 79 degrees (F). The B Unit shower room thermometer mounted on the wall had a reading of 72 degrees (F) with no indication the shower room had been used.</p>	F 257	<p><i>Identification of Other Residents</i> All patients on Unit A and B scheduled to take a shower on a given day; residents who sit in the hallways and residents who eat their meals in the dining room are affected.</p> <p>The both shower room air temperatures, hallway temperatures and the dining room temperatures are currently within acceptable temperature range of 71-81 degrees F.</p> <p>Air temperatures in both shower rooms, dining room and hallways throughout the facility are being monitoring daily by the maintenance director to ensure air temperatures are within normal range of 71-81 degrees F.</p> <p>Administrator initiated a resident council meeting was held on 2-5-15 by the social services director and activities director to ensure that resolutions and action items were reported to the group and followed-up with their concerns for the last 3 monthly resident council meetings.</p> <p><i>Systemic Changes</i> The maintenance director is checking air temperatures including both shower rooms, hallways and the dining room daily throughout the facility to ensure air temperatures are within normal range of 71-81 degrees F. The air temperatures are being logged on a daily audit sheet by the Maintenance Director; if the temperature is found to be below 71 degrees, the administrator will be notified immediate corrective action will be taken.</p> <p>The facility has implemented a new Grievance/Concern Program which consist of the following components: The Administrator has delegated the responsibility of grievance and/or complaint investigation to the social services department including resident council concerns, grievances or complaints. The social services department may obtain assistance from the department the grievance originated.</p> <p>Upon receipt of a grievance and/or complaint, the</p>		

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F 257	<p>Continued From page 16</p> <p>Observation of the main dining room, on 01/13/14 at 3:00 PM, revealed the wall mounted thermometer had a reading of 77 degrees (F) and further revealed the thermometer was covered to prevent anyone from changing the temperature; however, the cover was hanging down away from the thermometer to allow access. The temperature reading, on 01/14/15 at 7:32 AM, was 77 degrees (F) with the cover remaining open and allowing access to adjust the temperature.</p> <p>Interview, on 01/14/15 at 10:00 AM, with Resident #7, who was not in attendance at the Group meeting, revealed the shower room was too cold. The resident stated it was so cold it hurts and he/she shivers uncontrollably afterward. He/she stated the staff only provides a towel to wrap up in. The staff are told he/she wants the fastest shower ever, because he/she dreads shower day due to the cold temperature.</p> <p>Interview, on 01/14/15 at 10:50 AM, with Resident #1, who was not in attendance at the Group meeting, revealed the shower room water starts out warm, but cools too quickly. The shower room is too cold to get a shower. Resident #1 further stated he/she thought the staff was aware the shower room was too cold.</p> <p>Interview with the Maintenance Director, on 01/14/15 at 9:45 AM, revealed he had a vendor working on the HVAC. On 01/09/15, the B Unit did not have a damper and it was replaced. In addition, the heat pump was fixed for the B Unit shower. The Maintenance Director stated if the residents complained it was too cold, he would set the temperature higher, as long as it stayed in</p>	F 257	<p>social services department, with any assistance needed from the other departments, will investigate the allegations and submit a written report of such findings to the Administrator within five (5) working days of receiving the grievance and/or complaint.</p> <p>The Administrator will review the findings with the person investigating the complaint to determine what corrective actions, if any, need to be taken.</p> <p>The resident, resident council concerns, or person filing the grievance and/or complaint on behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. The Administrator, social service director or social service assistant will make such reports orally within (7) working days of the filing of the grievance or complaint with the facility.</p> <p>The Administrator, social service director or social service assistant will conduct a follow-up with the resident including resident council members, concerning the resolution of the grievance in (7) to (10) days after action plan was implemented to ensure corrective action was successful and grievance is resolved.</p> <p>Should the resident not be satisfied with the result of the investigation or if grievance/concern/complaint not resolved, a new grievance will be initiated by the social services department and a new action plan for resolution will be implemented.</p> <p>In addition all resident concerns/grievances will be discussed in the daily Continuous Quality Improvement meeting (CQI) previously referred to as the daily QA meetings.</p> <p>The grievance logs, resident council minutes and action plans will be submitted to the monthly QAA meetings to oversee that grievances are resolved.</p>		

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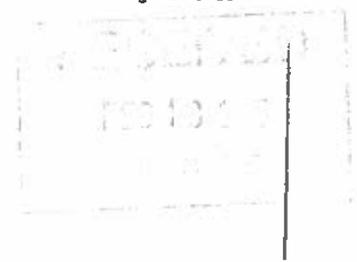
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F 279	<p>Continued From page 18</p> <p>Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure nursing staff developed a care plan for one (1) of twenty-one (21) sampled residents (Resident #8) to address the resident's contractures.</p> <p>The findings include:</p> <p>Review of the facility's policy Assessments and Care Plans, not dated, revealed the purpose was to identify the residents' needs and to assist the resident to attain the highest practical level of mental and physical function and well-being.</p> <p>Observation of Resident #8, on 01/13/15 at 12:10 PM and 12:30 PM, revealed the resident was up in a wheelchair with their eyes closed. The resident had a contracture of the left hand. There was no contracture prevention appliances in use for the contracture.</p> <p>Observation of Resident #8, on 01/13/15 at 1:45 PM, 2:26 PM and 3:08 PM, revealed the resident had no contracture prevention appliances in use for the hand contracture.</p> <p>Review of the clinical record for Resident #8, revealed the facility admitted the resident on 05/22/08 with diagnoses of Psychosis, Senile Dementia and Hypertension. The facility completed a quarterly Minimum Data Set (MDS) assessment on the resident on 12/16/14 which revealed the resident had a severe cognitive impairment, nonverbal and required total assistance of the nursing staff for all care needs. The resident was incontinent of bowel and bladder.</p>	F 279	<p>administrative team for contractures and any resident identified as having a contracture problem or a potential problem was referred to Occupational Therapy or Restorative Nursing for contracture management and a contracture management plan of care was developed; this was completed on 2/9/15.</p> <p>In addition, all resident's care plans were reviewed and revised as needed by the Interdisciplinary team (IDT) for appropriate care plan interventions including contracture prevention management; the care plan reviews and revisions were completed on 2/9/15.</p> <p>Systemic Changes On 2/9/15 a new procedure was developed for contracture management which includes that with each resident's quarterly or OBRA MDS assessment, the therapy department will screen the resident for actual or potential need for contracture management interventions and a plan of care will be developed according to the need identified.</p> <p>The administrator met with the therapy department and the DON to in-service the new procedure on 2/9/15.</p> <p>The MDS Coordinators are responsible to ensure that a contracture assessment was completed by the therapy department with each MDS quarterly or OBRA assessment completed and that a contracture prevention or actual problem is addressed in the comprehensive care plan.</p> <p>Each month the MDS Coordinators will give a list of MDS assessments to be completed to the QA Nurse for auditing of therapy screens and comprehensive care plans for contracture screening and management. The QA Nurse will submit findings of compliance to the monthly QAA meetings.</p> <p>Monitoring The MDS Coordinators are responsible to</p>		

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F 279	Continued From page 19 Review of the comprehensive care plan for Resident #8, revealed the resident had a left hand contracture and a hand splint was ordered by the physician. When the splint was soiled a rolled washcloth or a soft carrot wrap was used. Review of the Nurse Aide Care Plan for Resident #8, revealed no information regarding the application of the splint, the washcloth or the carrot wrap for the resident's contractured left hand. Interview with Certified Nurse Aide (CNA) #5, on 01/13/15 at 3:09 PM, revealed she provided care for Resident #8. She stated the resident's splint was in the laundry and information regarding using a rolled wash cloth was not on the Nurse Aide Care Plan. She stated the nurse was responsible for updating the care plan and the splint was to prevent the contracture from getting worse. Interview with CNA #6, on 01/14/15 at 2:06 PM, revealed the CNA followed the Nurse Aide Care Plan and the nurses updated the plan as needed. Interview with Licensed Practical Nurse (LPN) #3, on 01/14/14 at 3:10 PM, revealed it was the responsibility of the nurse to ensure the Nurse Aide Care Plan was updated and accurate. She stated she was not sure how the care plan for Resident #8's contracture was missed.	F 279	ensure that a contracture assessment was completed by the therapy department with each MDS quarterly or OBRA assessment completed and that a contracture prevention or actual problem is addressed in the comprehensive care plan. Each month the MDS Coordinators will give a list of MDS assessments to be completed to the QA Nurse for auditing of therapy screens and comprehensive care plans for contracture screening and management. The QA Nurse will submit findings of compliance to the monthly QAA meetings.		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	F 280	Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it.	2-16-15	



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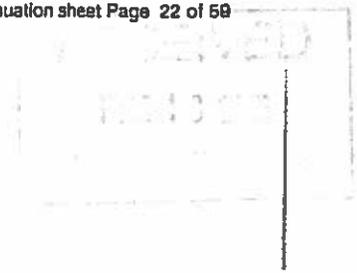
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F 280	<p>Continued From page 20</p> <p>participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to revise the care plan to meet the needs of the residents to prevent additional falls for two (2) of twenty-one (21) sampled residents after repeated falls. The facility failed to revise the care plan for Resident #15 with a history of falls and the resident sustained three (3) additional falls. In addition, the facility failed to revise Resident #9's care plan to address the need for appropriate footwear to prevent falls.</p> <p>The findings include:</p> <p>Review of the facility's policy Fall Management Program, not dated, revealed the facility would assess all residents to establish their risk for falls.</p>	F 280	<p>Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.</p> <p><i>Residents Affected</i> Resident #15's medical record, fall history and care plan was reviewed on 1-22-15 by the Interdisciplinary Team (IDT) and it was determined through the root cause analysis process on 1-22-15 to place resident #15 on a scheduled toileting program to increase the supervision during the late night and early morning hours. Also on 1-22-15 Resident #9 care plan was updated to address appropriate footwear as a fall preventive measure.</p> <p><i>Identification of Other Residents</i> All residents are required to have a comprehensive care plan and revision to that care plan according to current care needs, therefore all residents may be potentially affected. All resident's care plans were reviewed and revised as needed by the Interdisciplinary team (IDT) for appropriate care plan interventions including fall prevention measures; the care plan reviews and revisions were completed on 1-26-15.</p> <p><i>Systemic Changes</i> On 1-22-15 a new procedure was implemented to designate the MDS coordinators to update</p>		



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F 280	<p>Continued From page 21</p> <p>The facility would create a care plan for each resident at risk for a fall that would include appropriate interventions to minimize falls and injuries related to falls. The facility would track falls to establish patterns. The policy further stated when a fall occurred; the facility would complete an Incident/Accident Report and an Accident Circumstance Assessment (root cause analysis). The Director of Nursing (DON) would then review the incident investigation and incident report to determine appropriate interventions and documentation. The DON would submit the findings and recommendations to the Interdisciplinary Plan of Care Team (IDT) for revision or adoption of new interventions according to the root cause identified for the fall. The IDT would discuss the causative factors and would adjust interventions or add interventions to the care plan. The Policy further stated the DON or designee would keep an individual fall tracking system on each resident and monthly tracking and trending for all residents. The Quality Assurance Committee would review the tracking and trending of falls monthly and implement actions as a result of the findings.</p> <p>Review of the Incident Condition Protocol, not dated, revealed the facility must update the resident's care plan after each accident.</p> <p>Review of the facility's policy Updating Care Plans, not dated, revealed the Interdisciplinary Team (IDT) members updated the care plans during meetings when applicable. The policy also stated the nurses would place a copy of the physician orders on the comprehensive care plan and immediately update the Certified Nursing Assistant (CNA) care plan if the update applied to CNA care. The Minimum Data Set (MDS) nurse</p>	F 280	<p>and revise the comprehensive care plans and SRNA care plans to ensure that care plans are updated as each resident's care needs change. The care plans are being updated and revised daily with changes from the physician's orders, changes in condition, nutritional at risk meetings (NAR), wound meetings, daily CQI meetings, (previously referred to as QA meetings) and fall interventions after root cause analysis for the fall has been determined.</p> <p>The administrative nursing team was in-serviced regarding the new care plan update procedure on 1-22-15 by the Regional Clinical Director.</p> <p>The nursing staff was in-serviced on the new care plan revision procedure on 1-22-15 by the Director of Nursing.</p> <p>The Quality Assurance Nurse is auditing 5 resident care plans daily on each unit to ensure appropriate updates and revisions were completed.</p> <p>Monitoring The Quality Assurance Nurse is randomly auditing care plans daily to ensure appropriate updates and revisions were completed. The results of the QA audits will be reviewed in the daily CQI meetings (previously referred to as daily QA meetings).</p>		



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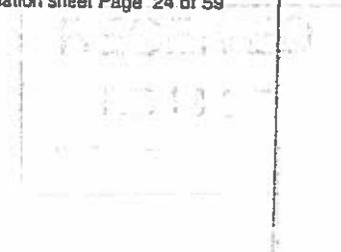
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F 280	<p>Continued From page 22</p> <p>would follow up with each physician's orders the next day and ensure the updates were appropriate.</p> <p>1. Review of the clinical record for Resident #15 revealed the facility admitted the resident on 08/16/06 with diagnoses of Alzheimer's, Abnormal Posture, Muscle Weakness, and Hypertension and a history of falls. He/she was receiving anti-depressant and anti-anxiety medications to treat symptoms of Depression and Anxiety.</p> <p>Review of Resident #15's quarterly Minimum Data Set (MDS) assessment, completed on 11/28/14, revealed he/she was ninety-three (93) years old, not steady on his/her feet and needed extensive assistance from staff to toilet, walk, and bathe. A Brief Interview for Mental Status (BIMS) exam was conducted during the assessment and the resident scored a zero (0) out of fifteen (15) indicating severe cognitive impairment. Additionally, Resident #15 exhibited wandering behaviors in the facility on a daily basis. He/she was not currently participating in a toileting program.</p> <p>Observation of Resident #15, on 01/15/15 at 10:40 AM, revealed the resident's bed had a concave mattress and the bed was in the lowest position. A fall mat was also on the floor at the resident's bedside.</p> <p>Review of an Accident Circumstance Assessment for Resident #15, dated 10/22/14, revealed Resident #15 fell on 10/22/14 at 3:45 AM. Nursing staff found the resident on the fall mat beside his/her bed. Staff documented Resident #15 was attempting to transfer himself/herself unassisted at the time of the fall. The resident</p>	F 280			

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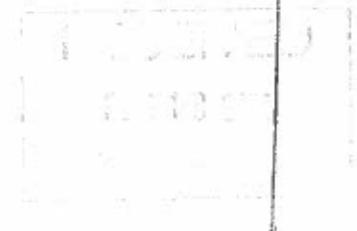
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F 280	<p>Continued From page 23</p> <p>was incontinent of urine at the time of the fall. The document stated the preventative measure added to prevent recurrence was to ensure the room was free of clutter.</p> <p>Review of the Condition Change Form attached to the Nurse's Notes for Resident #15, dated 10/22/14 at 3:45 AM, revealed staff heard the mattress alarm sounding, went to the resident's room, and found the resident lying on the floor mat next to his/her bed. Resident #15 obtained an abrasion to the right side of his/her head.</p> <p>Review of an Accident Circumstance Assessment for Resident #15, dated 11/07/14, revealed Resident #15 fell on 11/07/14 at 4:00 AM. Staff found the resident half on and half off the bed.</p> <p>Review of the Nurse's notes for Resident #15, dated 11/07/14 at 4:00 AM, revealed the resident obtained a red area to his/her left ear, shoulder, and outer part of the knee.</p> <p>Review of an Accident Circumstance Assessment for Resident #15, dated 01/12/15, revealed the resident fell on 01/12/15 at 4:20 AM. The nursing staff found the resident on the floor after the resident attempted to ambulate unassisted to the door. The resident was incontinent of urine at the time of the fall. The facility documented a referral to Occupational Therapy and Physical Therapy for a screening as a preventative measure.</p> <p>Review of the Nurse's notes for Resident #15, dated 01/12/15 at 4:20 AM, revealed staff found the resident on the floor on his/her right side. Resident #15 told the nurse that he/she was trying to walk.</p>	F 280			



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F 280	<p>Continued From page 24</p> <p>Review of the Care Plan for Resident #15, dated 09/29/14, revealed the facility identified the resident was at risk for falls and staff had put several interventions in place to reduce the risk of falls for the resident. The facility added interventions after each of the three above falls. The intervention after the fall on 10/21/14, dated 10/22/14, stated staff would ensure the resident's room was clutter free. The intervention after the fall on 11/07/14, dated 11/07/14 stated staff would complete neurological checks as indicated. The intervention after the fall on 01/12/15, dated 01/12/15, stated staff would refer the resident for a Physical Therapy (PT) evaluation.</p> <p>Interview with the Unit Manager (UM) of the A Unit, on 01/15/15 at 5:10 PM, revealed the UM added the intervention of a Physical Therapy (PT) evaluation to decrease falls risk for Resident #15 after the resident fell on 01/12/15. The UM stated she did not add any other interventions to decrease the risk of falls. The UM stated the Interdisciplinary Team (IDT) added an intervention to ensure the resident's room was clutter free after the resident's fall on 10/22/14. The UM stated the IDT added an intervention to complete neurological checks as indicated after the resident's fall on 11/07/14.</p> <p>Interview with the DON, on 01/15/15 at 6:00 PM, revealed the facility added interventions to Resident #15's care plan that did not reduce the risk of falls for Resident #15. The DON stated the facility used an Interdisciplinary Team (IDT) to identify the root cause of incidents, including falls. The IDT included the DON, the Unit Coordinator, and therapy. The morning after a resident had a fall, the IDT would bring that resident's chart and care plan to the IDT meeting. The IDT would</p>	F 280			



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F 280	<p>Continued From page 25</p> <p>review the incident, review the physician orders, and update the care plan. The facility had identified problems with completing the root cause analysis. The DON stated completing a root cause analysis was an important step in identifying risks and decreasing incidents. The DON stated the Interdisciplinary Team (IDT) added interventions to Resident #15's care plan to decrease falls. The intervention added after the fall on 10/22/14 was for staff to ensure the resident's room was clutter free. The intervention added after the fall on 11/07/14 was for nursing to complete neurological checks as indicated. The intervention after the fall on 01/15/15 was for the resident to complete a PT evaluation. The DON stated implementing those interventions did not reduce the risk of the resident falling out of the bed.</p> <p>Interview with the Administrator, on 01/15/15 at 2:00 PM, revealed the facility did not reduce the risk of falls for Resident #15. The Administrator reviewed each incident report and signed off on each one. As part of the morning IDT meeting, the Administrator pulled the charts to review nursing notes coincided with each incident report. The Administrator stated the facility had identified issues with conducting root cause analysis. The Administrator further stated conducting an effective root cause analysis would assist the facility to put effective interventions in place to prevent resident falls. He further stated the interventions put in place for Resident #15 would not prevent the resident from continuing to fall.</p> <p>2. Observation of Resident #9, on 01/13/15 at 11:23 AM, revealed the resident was sitting in his/her wheelchair in his/her room wearing</p>	F 280			



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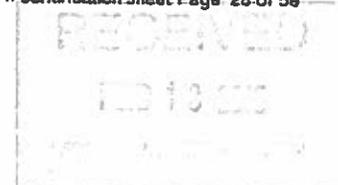
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F 280	<p>Continued From page 26</p> <p>regular socks and no shoes on his/her feet. The resident had a clip alarm to his/her wheelchair. The resident's bed was in a low position with a fall mat on the floor.</p> <p>Review of the clinical record for Resident #9 revealed the facility admitted the resident on 12/01/03 with diagnoses of Femur Fracture, Osteoporosis, Chronic Pain, Restless Leg Syndrome, Macular Degeneration, Osteoarthritis, and Dementia and a history of falls. The resident was receiving anti-depressant medications to treat symptoms of Depression.</p> <p>Review of Resident #9's quarterly Minimum Data Set (MDS) assessment, completed on 12/09/14, revealed he/she was ninety-three (93) years old, not steady on his/her feet and needed extensive assistance from staff to toilet, walk, and bathe. A Brief Interview for Mental Status (BIMS) was conducted during the assessment and the resident scored an eight (8) out of fifteen (15) indicating moderate cognitive impairment.</p> <p>Review of the care plan for Resident #9, dated 06/13/14, revealed the resident was at risk for falls and had a history of falls. Interventions to reduce the risk of falls included the staff would ensure the resident was wearing appropriate footwear when ambulating or mobile in his/her wheelchair.</p> <p>Review of the Nurse Aide Care Plan for Resident #9, dated December 2014, revealed the nursing staff had not addressed footwear on this form.</p> <p>Review of the Incident/Accident Report for Resident #9, dated 12/28/14, revealed the resident fell on 12/28/14 at 11:30 AM. The</p>	F 280			



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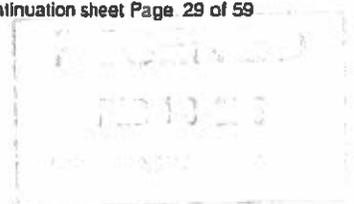
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F 280	<p>Continued From page 27</p> <p>resident was attempting to transfer unassisted from the wheelchair to the bed in his/her room when he/she fell. No injuries were noted on the accident report. Staff left the accident circumstance assessment portion of the report blank, which would have indicated the circumstances and preventative measures that were in place at the time of the fall. The accident circumstance assessment portion also included an area to describe preventative measures added to prevent recurrence of the fall.</p> <p>Interview with Certified Nursing Assistant (CNA) #8, on 01/14/15 at 2:10 PM, revealed the CNA was unaware of any footwear requirements for Resident #9. The CNA stated the resident usually wore shoes, but would sometimes refuse to wear them. The CNA further stated when a resident was supposed to wear something specific for safety the nurse would have put that information on the Nurse Aide Care Plan in the resident's closet.</p> <p>Interview with Licensed Practical Nurse (LPN) #8, on 01/14/15 at 2:15 PM, revealed the nursing care plan stated the resident would wear appropriate footwear when ambulating or mobilizing in his/her wheelchair. The LPN defined appropriate footwear as shoes. She stated the nurse who added the intervention to the nursing care plan would have been responsible for also putting the intervention on the Nurse Aid Care Plan. The LPN stated Resident #9 would sometimes refuse to wear shoes. The LPN further revealed the process for making changes to the nursing care plans and the Nurse Aid Care Plans. LPN #8 stated any nurse was able to make changes to the care plan. She stated that when a nurse added an</p>	F 280			



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F 280	<p>Continued From page 28</p> <p>intervention to the care plan, that nurse would have written an order. The nurse who wrote the order would then fax a copy for physician approval, place a copy in the nurse's notes, and update the nursing care plan. Then the nurse would have updated the Nurse Aid Care Plan in red ink. The nurses maintained the Nurse Aid Care Plans, located in each of the residents' rooms on the inside of the residents' closet doors. The nurse also placed a green paper on the door of the resident's closet to inform the CNA's that they had made changes to the resident's care plan.</p> <p>Interview with the Unit Manager, on 01/14/15 at 2:35 PM, revealed Resident #9 should have been wearing non-skid socks, shoes with backs on them, or slippers with a sole per his/her care plan. The Unit Manager further stated appropriate footwear was important to ensure safety for the resident when the resident transferred or mobilized. The Unit Manager further stated it was important for the Nurse Aid Care Plan to have the footwear information on it so the CNA's would know what was appropriate for the resident when they provided assistance. If the CNA's did not put appropriate footwear on Resident #9, the resident could fall. The Unit Manager stated a breakdown in the system for updating care plans was responsible for the Nursing Care Plan not having addressed appropriate footwear for Resident #9. The Unit Manager stated the process by which any nurse would update a Nurse Aid Care Plan after the nurse identified a need for appropriate footwear through an assessment, the nurse would then write an order. The nurse would fax the order to the pharmacy for physician approval and update the nursing care plan. The nurse would immediately update the Nurse Aid Care</p>	F 280		



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F 280	<p>Continued From page 29</p> <p>Plan in the resident's room. The nurse would send a copy of the order to the MDS nurse, who would check the care plan and Nurse Aid Care Plan daily to ensure the nurse had made the updates correctly.</p> <p>Interview with MDS Nurse, on 01/14/15 at 3:45 PM, revealed the MDS nurses checked the physician orders and updated care plans and Nurse Aid Care Plans daily. The MDS nurses updated the original electronic care plan and then physically checked the nursing care plans to ensure the interventions match the order. The MDS nurse also physically checked the Nurse Aid Care Plans to ensure necessary information was on it. The MDS nurse stated that the Nurse Aid Care Plans should not have too much information on it, just what the CNA needed to know to provide necessary care. The MDS nurse stated if a resident's care plan indicated the resident should wear non-skid socks, specifically; the non-skid socks would have been on the Nurse Aid Care Plan. However, she would not have placed the intervention on Resident #9's care plan to wear appropriate footwear on the Nurse Aid Care Plan because it was a generic intervention. All of the residents who were at risk for falls had this same intervention. The MDS Nurse further stated that all residents should have shoes in their room and shoes are part of a resident's outfit. The MDS nurse stated her definition of appropriate footwear was shoes or non-skid socks. The MDS nurse further stated that not all socks are non-skid.</p> <p>Interview with the DON, on 01/15/15 at 6:00 PM, revealed nursing should include the intervention of appropriate footwear when ambulating or mobilizing in the wheelchair on the Nurse Aid</p>	F 280			

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F 280	Continued From page 30 Care Plan. The DON stated that Nurses are responsible for updating the Nurse Aid Care Plans. The DON defined appropriate footwear as shoes or non-skid socks.	F 280			
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, record review and review of the facility policies, it was determined the facility failed to ensure nursing staff followed the care plans for three (3) of twenty-one (21) sampled residents (Residents #7, 12, and 16). The facility failed to respond to Resident #7's call light timely to assist with toileting as care planned. The facility failed to provide supervision for Resident #12 when in the bathroom as care planned. The facility failed to ensure Resident #16's alarms were attached and was not left unsupervised in the bathroom as care planned. The findings include: Review of the facility's policy Assessments and Care Plans, not dated, revealed the purpose was to identify the residents' needs and to assist the resident to attain the highest practical level of mental and physical function and well-being. 1. Review of the clinical record for Resident #7	F 282	Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements. <i>Residents Affected</i> Resident #7 and Resident #9 care plans were reviewed and revised by the Interdisciplinary team (IDT) to ensure appropriate interventions are included in the comprehensive and SRNA care plan which were completed on 1/22/15. The comprehensive care plan and the SRNA care plans were compared to the resident and the resident's room and wheelchair to ensure that all interventions were in place. <i>Identification of Other Residents</i> All residents have a potential to be affected. An audit of all resident's care plan interventions were compared to the resident, resident's room and wheelchair to ensure that the appropriate interventions were in place by the nursing administrative team; this audit was completed on 1/23/15. The Nursing staff were in-serviced on following	2-16-15	



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F 282	<p>Continued From page 31</p> <p>revealed the facility admitted the resident on 10/15/14 with diagnoses of Falls, Clostridium Difficile (Infection in the bowel causing infectious diarrhea), Generalized Muscle Weakness and an Abnormal Gait.</p> <p>Review of Resident #7's Nursing Care Plan for falls, dated 10/29/14, revealed the resident needed a prompt response to all requests for assistance and the resident used an electronic bed alarm. The staff was to ensure the device was in place as needed.</p> <p>Review of Resident #7's Nurse Aide Care Plan sheet, containing no reference date, revealed there was no written direction for nursing assistants to provide a prompt response to all requests for assistance or to ensure the resident used the electronic bed alarm device or that it was in place and functioning.</p> <p>Review of the Care Plan Update sheet, dated 12/04/14 and timed at 4:00 PM, revealed the resident was experiencing loose stool. Nursing interventions put in place were to; place resident in contact isolation; collect a stool specimen and send it to the lab for culture to determine if the stool was infected with Clostridium difficile.</p> <p>Review of a laboratory report, dated 12/04/14 at 5:01 PM and faxed to the facility on 12/04/14 at 5:38 PM, revealed Resident #7 was positive for Clostridium difficile.</p> <p>Review of Resident #7's medical record revealed nursing documented Resident #7 sustained a fall on 12/04/14 at 6:30 PM when attempting to transfer from the bed to the bedside commode. Nursing documented the residents call light was on and a nursing assistant heard the resident</p>	F 282	<p>care plans and the procedure of reviewing the care plans prior to providing care by the Director of Nursing on 1-22-15.</p> <p><i>Systemic Changes</i> The facility conducted an in-service which was completed on 1-26-15 for the nursing department on following care plans including fall prevention measures by the Director of Nursing.</p> <p>A new system was implemented on 1-26-15 to have the Unit Coordinators conduct a daily round on each unit, which will include observing and recording SRNA compliance with following care plan interventions. Upon identifying a needed correction of not following a care plan intervention, an immediate one on one in-service will be conducted to correct any problem.</p> <p>The QA nurse will additionally conduct a daily audit consisting of 5 rooms on both units to ensure care plan interventions are being implemented including fall prevention measures.</p> <p><i>Monitoring</i> The unit coordinators and the QA nurse will submit the daily care plan intervention compliance rounds to the daily QA meeting for review. The findings of these rounds will additionally be submitted to the facility monthly QA meetings for review and for recommendations.</p>		



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F 282	<p>Continued From page 32</p> <p>holler out. The nursing assistant entered the room and found the resident on the floor. It was noted in the facility's fall investigation notes that Resident #7's sensor pad was not alarming; however, there was no explanation or findings regarding why it was not alarming.</p> <p>Further review of the nursing documentation revealed Resident #7 was found lying on the floor with a skin tear to the left outer elbow and a laceration to the left eyebrow, along with bruising to the back of the left hand. The resident reported hitting their head during the fall. The physician was called and ordered the resident transferred to the emergency room for evaluation and treatment. The resident returned to the facility with a diagnosis of acute cervical strain and laceration to the eyebrow.</p> <p>Interview with Resident #7, on 01/14/15 at 1:00 PM, revealed on 12/04/14 the resident fell while trying to transfer self to the bedside commode. Resident #7 was experiencing frequent diarrhea and had turned the call light on for assistance; however, the staff did not answer the light timely so the resident decided to transfer alone in order to not have an accident in the bed.</p> <p>Interview with CNA # 2, on 01/14/15 at 1:55 PM, revealed she was not aware of Resident #7's nursing intervention to provide prompt response to all requests for assistance. She stated she was aware of Resident #7's history of frequent diarrhea; however, she was never directed to increase her rounds or supervision regarding Resident #7's toileting needs. She stated the facility policy was to toilet residents every two hours and upon request. She stated it was hard to answer all lights timely when they were</p>	F 282			



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F 282	<p>Continued From page 33 assisting residents in other rooms.</p> <p>Interview with the Director of Nursing, on 01/15/15 at 4:40 PM, revealed the nursing care plan interventions to be performed by nurse aides were placed on the Nurse Aide Care Plan sheet by nursing staff. She stated not all nursing interventions on the resident's nursing care plan would be placed on the nurse aide care plan sheet. She stated because nursing aides received education in school regarding the expectation to answer call lights promptly, this information did not need to be placed on the nurse aide care plan sheet, even though Resident #7 was experiencing frequent diarrhea from an infection.</p> <p>2. Review of the clinical record for Resident #12 revealed the facility admitted the resident on 11/01/14 with diagnoses of Schizophrenia, Frequent Falls and a Gait Abnormality. Review of Resident #12's Nursing Care Plan, dated 11/12/14, revealed the resident was at risk for injury from falls related to being unaware of safety needs, psychoactive drug use, gait/balance problems and history of falls. Nursing interventions put in place was for a safety alarm to be placed on the resident's bed and wheelchair and for the resident not to be left unattended while showering or toileting. Further review of the Psychiatric Physician documentation, dated 12/03/14, revealed the resident was evaluated for delusional behavior due to thinking the call light was conveying information to the resident.</p> <p>Observation during the initial tour, on 01/13/15 at 9:15 AM, revealed staff was not aware of Resident #12's location. Further observation revealed staff found Resident #12 in the</p>	F 282			



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/15/2015
NAME OF PROVIDER OR SUPPLIER PROVIDENCE RICHWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031		
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F 282	<p>Continued From page 34</p> <p>bathroom alone with the wheelchair sitting in the middle of the bedroom with no wheelchair alarm sounding or in place.</p> <p>Interview with Resident #12, on 01/14/15 at 8:25 AM, revealed the resident did not like to use the call light or to bother the staff when he/she needed assistance because the staff was busy.</p> <p>Interview with CNA #2, on 01/14/15 at 1:45 PM, revealed she was assigned to care for Resident #12 on 01/13/15 and on that morning she had gotten the resident dressed and transferred into the wheelchair. She stated she did not pay attention to the fact the wheelchair was not the resident's wheelchair but the facility's transportation wheelchair. She also did not remember to place a wheelchair alarm on the patient because she was in rush to get the residents ready for breakfast. She stated the resident had gone out of the facility on 01/12/15 for a doctor's appointment and they had put Resident #12 in the facility's wheelchair and left Resident #12's wheelchair by the back door. She stated when the resident returned to the facility they forgot to put the resident back into the resident's own wheelchair. She stated it was not until they looked for Resident #12's location did they identify the resident was not in the correct wheelchair and that the wheelchair alarm was not in place. She stated there was a Nurse Aide Care Plan sheet on the back of every resident's closet door and this document directed her in the care of each resident. She stated she could not recall what was on Resident #12's sheet without referencing it and stated she had not referenced the sheet the morning of 01/13/15 prior to providing care to Resident #12.</p>	F 282			

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F 282	<p>Continued From page 35</p> <p>Interview with the Director of Nursing, on 01/15/15 at 4:40PM, revealed she was not aware Resident #12 was in the bathroom unassisted and in the facility's wheelchair without an alarm on 01/13/14. She stated the Nurse Aide Care Plan sheet had resident care needs listed and provided direction to the staff and should be followed.</p> <p>3. Review of the clinical record for Resident #16 revealed the facility admitted the resident on 01/02/15 for strengthening and rehabilitation therapy after an exacerbation of Chronic Obstructive Pulmonary Disease (COPD). Additional diagnoses included Coronary Artery Disease, Diabetes, Hyperlipidemia, Hypertension, Myalgia, Myositis, and a history of Methacillin Resistant Staphylococcus (MRSA) infection.</p> <p>Review of Resident #16's Admission Minimum Data Set (MDS) Assessment, dated 01/09/15, revealed falls were a triggered care area related to generalized muscle weakness, difficulty walking, gait and balance issues, and a personal history of a fall at home prior to admission.</p> <p>Review of Resident #16's falls care plan, revealed interventions that included a clip alarm to his/her wheelchair, a sensor alarm to his/her bed, a concave mattress with a fall mat at his/her bedside.</p> <p>Review of an Incident/Accident Report, dated 01/06/15, revealed on 01/06/15 at 6:00 AM, Resident #16 slid off the side of his/her bed and was found on the floor by staff. At that time, the safety interventions added to the resident's care plan included a sensor pad to the bed and tab</p>	F 282			



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F 282	<p>Continued From page 36 alarm to the wheelchair.</p> <p>Review of an Incident/Accident Report, dated 01/09/15, revealed Resident #16 again slid off his/her bed on 01/09/15 at 12:30 AM, and was discovered on the floor next to his/her bed.</p> <p>Review of the Interdisciplinary Team Review of the Fall that occurred on 01/09/15, revealed the interventions added after the fall on 01/09/15 included placing a concave mattress on the resident's bed, adding a floor mat to the bedside, and continuing the use of the bed sensor alarm and clip alarm for seven (7) more days.</p> <p>Observation, on 01/15/15 at 10:35 AM, revealed Resident #16 was seated in his/her room in a wheelchair, a tab alarm was affixed to the back of the wheelchair, but the part of the alarm that was supposed to be clipped to the resident's clothing was observed dangling at the side of the resident's wheelchair.</p> <p>Observation, on 01/15/15 at 1:23 PM, revealed Resident #16 was seated in a wheelchair in his/her room near the overbed table. The tab alarm was observed at the back of the wheelchair, but the clip was not attached to the resident's clothing, and was still dangling at the side of the wheelchair.</p> <p>Interview, on 01/15/15 at 3:30 PM, with the Unit Manager (UM) for the B Unit, revealed she thought the two (2) falls Resident #16 had on 01/06/15 and 01/09/15 were similar in nature as both times the resident slid from his/her bed. She stated sensor and chair alarms were the care interventions added after the initial fall with a plan to re-evaluate the need for the alarms within three</p>	F 282			



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F 282	Continued From page 37 (3) days, but when Resident #16 had the second fall on 01/09/15, it was determined the alarms should remain for another seven (7) days, with re-evaluation at that time. The UM stated direct care staff assigned to a hallway should make rounds at a minimum of every two (2) hours throughout their shifts, but depending on a resident's status/condition, more frequent rounds might be necessary. Continued interview with the UM revealed any direct care staff who assisted residents with showers, transfers, etc., should ensure the clip/tab alarms were put back in place and were functioning so the staff would be alerted when a resident needed assistance and to ensure the resident remained safe. Interview, on 01/15/15 at 8:00 PM, with the DON, revealed Certified Nursing Assistants (CNAs) and Licensed Nurses assigned to the facility's units were responsible to ensure that tab/sensor alarms and any safety devices for the prevention of falls and injury were in place and functioning at all times. The DON stated she monitored for care plan compliance through visual inspection as she made rounds on all the nursing units. The DON stated she was not aware of a specific audit tool in use at the facility to assess CNAs and Nurses for compliance with resident care, but resident care needs were reviewed during weekly standards of care meetings and via a stop and watch method for observation of direct care staff as they provided care to the residents.	F 282			
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	F 323	Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of reaction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last	2/16/15	



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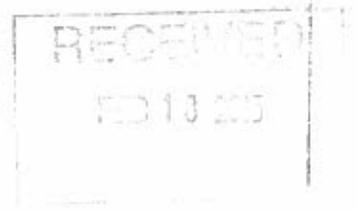
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F 323	<p>Continued From page 38</p> <p>adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility fall program, it was determined the facility failed to investigate falls to determine a root cause for three (3) of twenty-one (21) sampled residents. (Residents #7, #9, and #15). In addition, the facility failed to ensure the resident's wheelchair arm pads were repaired or replaced to prevent potential skin tears for seven (7) of seventy-eight (78) wheelchairs in Rooms 209, 308, 404, 503, 506, 509, and 606.</p> <p>The findings include:</p> <p>Review of the facility's policy Fall Management Program, not dated, revealed residents assessed to be at risk for falling would have appropriate interventions in place and their individual care plan would have a plan of care for their risks for falls. When a fall occurred, immediate action would be taken in accordance with the Incident Condition Protocol which included completing an Incident/Accident report; an Accident Circumstances Assessment (root cause analysis); neuro checks if indicated; interventions to prevent falls; Falls check list; and, notification to the DON or designee. The Director of Nursing would review the incident investigation and the incident report for appropriate interventions and documentation. The findings and recommendations would be submitted to the Interdisciplinary Team (IDT) Plan of Care</p>	F 323	<p>completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.</p> <p><i>Residents Affected</i> Resident #7, #9, #15, #16 and # 18 care plans were reviewed by the Interdisciplinary Team (IDT). The review included assistive devices, and fall prevention measures to reduce fall/injury; the reviews were completed on 1/22/2015.</p> <p><i>Identification of Other Residents</i> All the residents have a potential to be affected. The Nurse management/IDT reviewed and audited all the residents care plans for appropriate problems and interventions which included assistive devices and fall prevention measures. The audit and care plan reviews was completed on 1-26-15.</p> <p><i>Systemic Changes</i> The Regional Clinical Director completed an administrative/ nurse management staff training on 1-22-15 regarding conducting fall investigations and root cause analysis to ensure appropriate interventions are being implemented. The facility has implemented a new incident report, a new post fall investigation worksheet which includes a root cause analysis section to be completed to best determine an appropriate fall prevention measure. The facilities fall prevention program has been revised to include conducting a post fall investigation and determining the root cause of the fall and implementing the appropriate intervention after completion. The DON and nurse management team in-serviced the nursing staff regarding root cause</p>	

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F 323	<p>Continued From page 39</p> <p>meetings for revision or adoption of interventions according to the root cause analysis identified for the fall. On the first business day following a fall, the IDT would meet and discuss causative factors, interventions, and other relevant information and review findings of the incident from the DON's investigation. The care plan would be adjusted and additional interventions made as appropriate for the patient at this time.</p> <p>1. Review of the clinical record for Resident #7 revealed the facility admitted the resident on 10/15/14 with diagnoses of Falls, Clostridium Difficile (infection in the bowel causing infectious diarrhea), Generalized Muscle Weakness and an Abnormal Gait.</p> <p>Review of Resident #7's Quarterly Minimum Data Set (MDS) assessment, completed on 11/12/14, revealed he/she was not steady on his/her feet and needed extensive assistance from staff to toilet, transfer and walk. A Brief Interview for Mental Status (BIMS) was conducted during the assessment and the resident scored an eight (8) out of fifteen (15) indicating cognitively intact.</p> <p>Review of Resident #7's Nursing Care Plan for falls, dated 10/29/14, stated the resident needed a prompt response to all requests for assistance and the resident used a electronic bed alarm. The staff were to ensure the device was in place as needed.</p> <p>Review of Resident #7's Nurse Aide Care Plan sheet, not dated, revealed Resident #7 required the assistance of one to ambulate and transfer. The Nurse Aide Care Plan also indicated the resident required a sensor pad to the bed to alert staff when rising. The document also revealed a</p>	F 323	<p>analysis, introduction to new incident report and post fall investigation worksheets, and new falls risk policy and procedure; date of completion was 1/28/2015</p> <p>A new incident report and with an attached investigation worksheet was implemented to be utilized after each incident to determine a root cause analysis and appropriate interventions. These completed incident and investigation worksheets will be submitted to the DON daily.</p> <p>A new system was implemented on 1-26-15 to have the Unit Coordinators conduct a daily round on each unit, which will include observing and recording SRNA compliance with following care plan interventions. Upon identifying a needed correction of not following a care plan intervention, an immediate one on one in-service will be conducted to correct any problem.</p> <p>The QA nurse will additionally conduct a daily audit of 5 rooms on both units to ensure care plan interventions are being implemented including fall prevention measures.</p> <p><i>Monitoring</i></p> <p>The unit coordinators and the QA nurse will submit the daily care plan intervention compliance rounds to the daily QA meeting for review; and the IDT will review each fall/incident report and the root cause determination to ensure appropriate interventions were implemented and that care plans were updated to reflect root cause and appropriate interventions implemented.</p> <p>The findings of these rounds and root cause analysis for the incidents will be submitted to the facility monthly QA meetings for review and for recommendations.</p>	



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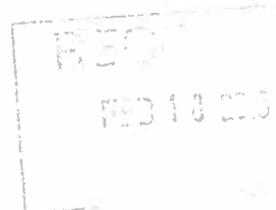
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F 323	<p>Continued From page 40</p> <p>hand written notation which was not dated, under Safety that stated to not leave the resident unattended while toileting or showering.</p> <p>Review of Care Plan Update sheet, dated 12/04/14 and timed at 4:00 PM, revealed the resident was experiencing loose stools. Nursing interventions put in place were; place resident in contact isolation; collect a stool specimen; and, send to the lab for culture to determine if the resident was infected with Clostridium difficile. Review of the laboratory report, dated 12/04/14 at 5:01 PM and faxed to facility on 12/04/14 at 5:38 PM, revealed Resident #7 was positive for Clostridium difficile.</p> <p>Review of Resident #7's clinical record revealed nursing documented Resident #7 sustained a fall on 12/04/14 at 6:30 PM attempting to transfer from the bed to the bedside commode. Nursing documented the resident's call light was on and the nursing assistant heard the resident holler out, entered the room and found the resident on the floor. It was noted in the facility's fall investigation notes the resident's sensor pad was not alarming; however, there was no explanation or findings regarding the functioning status of the alarm.</p> <p>Further review of the nursing notes revealed Resident #7 was found lying on the floor on their left side, with a skin tear to the left outer elbow and a laceration to the left eyebrow, along with bruising to the back of the left hand. The resident reported hitting their head during the fall. The physician was called and ordered the resident to be transferred to the emergency room for evaluation and treatment related to the fall and laceration. The resident returned to the facility</p>	F 323			



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F 323	<p>Continued From page 41 with a diagnosis of Acute Cervical Strain and a laceration to the eyebrow.</p> <p>Interview with CNA #2, on 01/14/15 at 1:55 PM, revealed she was not aware of Resident #7's nursing intervention to provide a prompt response to all requests for assistance. She stated she was aware of Resident #7's history of frequent diarrhea; however, she was never directed to increase her rounds or supervision regarding Resident #7's toileting needs.</p> <p>Interview with the Director of Nursing (DON), on 01/14/15 at 4:40 PM, revealed the nursing care plan interventions provided by nurse aides were placed on the Nurse Aide Care Plan sheet by the nursing staff. She stated not all nursing interventions on the resident's nursing care plan would be placed on the nurse aide care plan sheet. She stated because nursing aides received education in school regarding the expectation to answer call lights promptly and they understood this expectation; information regarding this did not need to be placed on the nurse aide care plan sheet even though Resident #7 was experiencing frequent episodes of diarrhea.</p> <p>Continued interview with the DON revealed she had not received training in root cause analysis; however, no actions had been put in place for her to receive training as of 01/14/15. She stated due to Resident #7 not waiting for assistance it was determined this was the root cause of the fall. She stated the intervention put in place to reduce the chance of another fall for Resident #7 was to move the bedside commode away from the resident's bed when staff was not in the room. She stated an investigation to determine the</p>	F 323			



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F 323	<p>Continued From page 42</p> <p>reason the sensor pad was not alarming or if there was an issue with staff not answering call lights timely was not completed. She stated after the determination was made that the resident's fall was due to not waiting for staff assistance, no direction was given to staff to increase supervision or provide closer monitoring of Resident #7, even though, the resident had frequent toileting needs due to diarrhea.</p> <p>2. Review of the clinical record for Resident #15 revealed the facility admitted the resident on 08/16/06 with diagnoses of Alzheimer's, Abnormal Posture, Muscle Weakness, and Hypertension and a history of falls. He/she was receiving anti-depressant and anti-anxiety medications to treat symptoms of Depression and Anxiety.</p> <p>Review of Resident #15's quarterly Minimum Data Set (MDS) assessment, completed on 11/28/14, revealed he/she was ninety-three (93) years old, not steady on his/her feet and needed extensive assistance from staff to toilet, walk, and bathe. A Brief Interview for Mental Status (BIMS) was conducted during the assessment and the resident scored a zero (0) out of fifteen (15) indicating severe cognitive impairment. Additionally, Resident #15 exhibited wandering behaviors in the facility on a daily basis. He/she was not currently participating in a toileting program.</p> <p>Observation of Resident #15, on 01/15/15 at 10:40 AM, revealed the resident's bed had a concave mattress and the bed was in the lowest position. A fall mat was also on the floor at the resident's bedside.</p>	F 323			



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F 323	<p>Continued From page 43</p> <p>Review of an Accident Circumstance Assessment for Resident #15, dated 10/22/14, revealed Resident #15 fell on 10/22/14 at 3:45 AM. The nursing staff found the resident on the fall mat beside his/her bed. The staff documented Resident #15 was attempting to transfer unassisted at the time of the fall and the resident was incontinent of urine at the time of the fall. The assessment stated the preventative measure added to prevent recurrence was to ensure the room was free of clutter.</p> <p>Review of the Condition Change Form attached to the Nurse's Notes for Resident #15, dated 10/22/14 at 3:45 AM, revealed the staff heard the mattress alarm sounding, went to the resident's room, and found the resident lying on the floor mat next to his/her bed. Resident #15 obtained an abrasion to the right side of his/her head.</p> <p>Review of an Accident Circumstance Assessment for Resident #15, dated 11/07/14, revealed Resident #15 fell on 11/07/14 at 4:00 AM. The staff found the resident half on and half off the bed.</p> <p>Review of the nurse's notes for Resident #15, dated 11/07/14 at 4:00 AM, revealed the resident obtained a red area to the left ear, shoulder, and outer part of knee.</p> <p>Review of an Accident Circumstance Assessment for Resident #15, dated 01/12/15, revealed the resident fell on 01/12/15 at 4:20 AM. The nursing staff found the resident on the floor after the resident attempted to ambulate unassisted to the door. The resident was incontinent of urine at the time of the fall. The facility documented a referral</p>	F 323		

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F 323	<p>Continued From page 44</p> <p>to Occupational Therapy and Physical Therapy for a screening of the resident as a preventative measure.</p> <p>Review of the nurse's notes for Resident #15, dated 01/12/15 at 4:20 AM, revealed the staff found the resident on the floor on their right side. Resident #15 told the nurse that he/she was trying to walk.</p> <p>Review of the Care Plan for Resident #15, dated 09/29/14, revealed the facility identified the resident as at risk for falls and interventions of safety alarm; staff assistance with wheelchair mobility; concave mattress; staff assistance with toileting and hygiene; activities to promote exercises; fall mat on floor; staff assistance with transfers; anti roll backs on the wheelchair; staff assistance with ambulation; and, non-skid socks in place to reduce risk of falls for the resident. The facility added interventions after each of the three (3) above falls. The intervention after the fall on 10/21/14, dated 10/22/14, stated staff would ensure resident's room was clutter free. The intervention after the fall on 11/07/14, dated 11/07/14 stated staff would complete neurological checks as indicated. The intervention after the fall on 01/12/15, dated 01/12/15, stated staff would refer resident for a Physical Therapy (PT) evaluation.</p> <p>Interview with the Unit Manager of the A Unit, on 01/15/15 at 5:10 PM, revealed the Unit Manager added the intervention of a Physical Therapy (PT) evaluation to decrease fall risk for Resident #15 after the resident fell on 01/12/15. The Unit Manager stated she did not add any other interventions to decrease risk of falls. The Unit Manager stated the Interdisciplinary Team (IDT)</p>	F 323			



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F 323	<p>Continued From page 45</p> <p>added an intervention to ensure the resident's room was clutter free after the resident's fall on 10/22/14. The Unit Manager stated the IDT added an intervention to complete neurological checks as indicated after the resident's fall on 11/07/14.</p> <p>Interview with the DON, on 01/15/15 at 6:00 PM, revealed the facility added interventions to Resident #15's care plan that did not reduce the risk of falls for the resident. The intervention added after the fall on 10/22/14 was for staff to ensure the resident's room was clutter free. The intervention added after the fall on 11/07/14 was for nursing to complete neurological checks as indicated. The intervention after the fall on 01/15/15 was for the resident to complete a PT evaluation. The DON revealed implementing these interventions did not reduce the risk of the resident falling out of the bed.</p> <p>3. Observation of Resident #9, on 01/13/15 at 11:23 AM, revealed the resident was sitting in his/her wheel chair in his/her room wearing regular socks and no shoes on his/her feet. The resident had a clip alarm to his/her wheelchair. The resident's bed was in a low position with a fall mat at the bedside.</p> <p>Review of the clinical record for Resident #9 revealed the facility admitted the resident on 12/01/03 with diagnoses of Femur Fracture, Osteoporosis, Chronic Pain, Restless Leg Syndrome, Macular Degeneration, Osteoarthritis, and Dementia and a history of falls. He/she was receiving anti-depressant medications to treat symptoms of Depression.</p> <p>Review of Resident #9's quarterly Minimum Data</p>	F 323		



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F 323	<p>Continued From page 46</p> <p>Set (MDS) assessment, completed on 12/09/14, revealed he/she was ninety-three (93) years old, not steady on his/her feet and needed extensive assistance from staff to toilet, walk, and bathe. A Brief Interview for Mental Status (BIMS) was conducted during the assessment and the resident scored an eight (8) out of fifteen (15) indicating moderate cognitive impairment.</p> <p>Review of the care plan for Resident #9, dated 08/13/14, revealed the resident was at risk for falls with a history of falls. Interventions to reduce the risk of falls included the staff ensuring the resident was wearing appropriate footwear when ambulating or mobilizing in the wheelchair. Other interventions included the resident would have a tab alarm to the wheelchair and staff would not leave the resident unsupervised on the toilet or when showering.</p> <p>Review of the Nurse Aide Care Plan for Resident #9, dated December 2014, revealed the nursing staff had not addressed footwear on this form.</p> <p>Review of the Incident/Accident Report for Resident #9, dated 12/28/14, revealed the resident fell on 12/28/14 at 11:30 AM. The resident was attempting to transfer from the wheelchair to the bed when the fall occurred. Staff left the accident circumstance assessment portion of the report blank. The accident circumstance assessment portion of the report was the area for staff to report the circumstances and preventative measures that were in place at the time of the fall. The accident circumstance assessment portion also included an area to describe preventative measures added to prevent recurrence of the fall.</p>	F 323			



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F 323	<p>Continued From page 47</p> <p>Interview with CNA #8, on 01/14/15 at 2:10 PM, revealed normally the resident wore socks, but refused sometimes. The CNA stated she did not know if the resident wore non-skid socks.</p> <p>Interview with the DON, on 01/15/15 at 6:00 PM, revealed the the facility used an Interdisciplinary Team (IDT) to identify the root cause of incidents, including falls. The IDT included the DON, the Unit Coordinator, and therapy. The day after a resident falls, the IDT would bring that resident's chart and care plan to the IDT meeting. The IDT would review the incident, the physician orders, and update the care plan. The facility had identified problems with completing root cause analysis. The DON stated completing a root cause analysis was an important step in identifying risks and decreasing incidents.</p> <p>Interview with the Administrator, on 01/15/15 at 2:00 PM, revealed the Administrator reviewed each incident report and signed off on each one. As part of the morning IDT meeting, the Administrator pulled the charts to review nursing notes coinciding with each incident report.</p> <p>4. Review of the facility's Maintenance Service policy, not dated, revealed Maintenance service would be provided to all areas of the building, grounds and equipment. Continued review of the Policy Interpretation and Implementation revealed resident equipment such as wheelchairs were not listed as a function by Maintenance. However, the last item listed stated others that may become necessary or appropriate.</p> <p>Review of the facility's procedure, not identified with a title and not dated, revealed any wheelchair needing a repair would be identified and a work</p>	F 323			



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F 323	<p>Continued From page 48</p> <p>order for maintenance would be completed. Random audits would be completed by Maintenance each month for equipment repairs which included wheelchairs. Additionally, during daily rounds, the Administrative staff would also identify any equipment which included wheelchair repairs and would complete a work order for maintenance and/or would submit work orders during the morning QA meetings.</p> <p>Review of the list of residents with wheelchairs, provided by the facility on 01/14/15, revealed there were seventy-eight (78) residents designated by a check mark as using a wheelchair.</p> <p>Observation of these wheelchairs, on 01/14/15 at 11:30 AM, revealed arm pads were cracked, and peeling away exposing the lining to wheelchairs in rooms 209, 308, 404, 503, 506 and 509. The wheelchair in room 606 had a missing arm pad on the left side of the chair.</p> <p>Review of tickets (work orders), dated 12/15/14, 12/17/14, 01/02/15, 01/05/15, 01/06/15, 01/07/15 x3, 01/08/15, 01/09/15, 01/10/15, and 01/12/15 x2, revealed these work orders had repair requests; however, none identified the wheelchairs as listed above, as requiring arm pads that needed to be replaced. Review of a ticket, dated 12/30/15, revealed the wheelchair in 506-2 needed to be lowered; however, it did not mention the wheelchair that had the missing arm pad and required a replacement.</p> <p>Review of the facility's Plan of Action, dated 11/06/14, revealed the Maintenance Department was aware of needed wheelchair arm repairs. Follow up, dated 11/13/14, revealed the arm rest</p>	F 323		



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F 323	<p>Continued From page 49</p> <p>were being ordered and repaired as they are available. Follow up, dated 12/10/14, revealed there had been some wheelchair arm rest delivered to the facility and repairs had been made to some of the wheelchairs, and Maintenance would continue to order armrests and make repairs when they arrived at the facility. However, the plan of action did not identify, specify or give direction, for a preventive measure to be put in place to protect the resident's skin while the ordering of arm pads was taking place.</p> <p>Interview with the Maintenance Director, on 01/14/15 at 9:45 AM, revealed he went through the rooms and checked the wheelchairs to identify any needed repairs, if the wheelchair was in the room. If the wheelchair was not in the room during this check, it did not get checked and he would try to do a spot check for those. If the resident brought repairs to his attention, he would fix them. In addition, there were work orders that could be completed by staff in paper form or they could send a text message to his phone. If it was in paper form he would write a note on it when completed and save the ticket. If it was a message he would send a message to that person's phone when the work was completed. The Maintenance Director stated he had not received any work orders in paper form or by phone message in a while.</p> <p>Interview with the Administrator, on 01/14/15 at 2:25 PM, revealed resident equipment was audited by a supply manager and discussed in the 9:00 AM meeting. They also discussed with therapy if any recommendations were forthcoming, such as, a different wheelchair was needed. The Administrator stated Maintenance ensured wheelchair arm pads were in good</p>	F 323			



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F 323	Continued From page 50 repair. He further stated he made rounds to check on resident equipment every day to find needed repairs. He stated he last trained the staff on work orders eight (8) weeks ago; however, there had been no work orders since, to identify any needed repairs.	F 323			
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356	Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements. <i>Residents Affected</i> Potentially all residents who reside here at Providence Richwood <i>Identification of Other Residents</i> Potentially all residents who reside here at Providence Richwood <i>Systemic Changes</i> On 1-21-15 the staffing nurse was inserviced on the requirements for posting the nursing staff information. Information is being posted including the facility name,	2-16-15	



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F 356	Continued From page 51 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the staffing level posted for the facility included the total number of hours for each nursing and non-nursing position, including the current census for the day for two (2) of two (2) units. A Unit and B Unit on 01/13/15 and 01/14/15. The findings include: The facility did not provide a policy regarding the posting of the staffing levels. Observation, on 01/13/15 at 12:13 PM and 1:13 PM, of the posted staffing levels on the A Unit and B Unit, revealed the posting did not specify the current census for the day nor did it indicate the total number of hours for each level of staff, Registered Nurse (RN), Licensed Practical Nurse (LPN) or the Certified Nursing Assistants (CNA). Observation, on 01/14/15 at 7:35 AM and 7:38 AM, on the A Unit and B Unit, revealed the posted staffing level did not specify the current census for the day nor the total number of hours for each RN, LPN or CNA for the day. Interview with the Staffing/Restorative LPN, on 01/14/15 at 10:20 AM, revealed staffing levels were posted each day at each nurses station and one copy was kept in her office. The copy in her office was changed through out the day to reflect any changes in the census and staffing and then maintained in her office. The copy posted at the	F 356	the current date, the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift including Registered nurses and licensed practical nurses or licensed vocational nurse (as defined under State law), certified aids and the resident census. The posted nursing staff information will be posted for each unit and as a whole building. <i>Monitoring</i> The staffing nurse will submit the daily posted information in the daily QA meeting for review. The findings of these forms will additionally be submitted to the facility monthly QA meetings for review and for recommendations.		



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F 356	Continued From page 52 nursing stations were never totaled or changed. The LPN further stated she posted the staffing level for the next day before she left for the day. So the night shift posting would actually reflect the next day. Additionally, the LPN stated she had not been trained in that facet of her job duties; however, that was the way it was done prior to her taking over. Interview with the Interim Director of Nurses (DON), on 01/14/15 at 1:35 PM, revealed she was not certain if the Staffing/Restorative LPN had been trained in that job duty and the LPN was the only staff person responsible for that task.	F 356			
F 490 SS=D	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's policy, it was determined the Administrator failed to administer the facility in a manner that ensured the safety of all residents after an allegation of abuse was received for one (1) of twenty-one (21) sampled residents. (Resident #14) Refer to F225 and F226. This is a repeat deficiency from the Immediate Jeopardy survey on 10/30/14. The findings include:	F 490	Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements. <i>Residents Affected</i> Resident #14 was observed and assessed on 1-14-15, 1-15-15 and 1-16-15 by charge nurse and the social services director completed a psychosocial evaluation on 1-16-15 since the incident and no new areas of concern have been identified. The nurse completing the physical assessment on resident #14 after the abuse allegation was given one on one training by the Administrator to ensure all documents are fully completed on	2/16/15	



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F 490	Continued From page 53 Review of the facility's Abuse Investigation Tool, not dated, revealed the individual conducting the investigation would, at a minimum, review the resident medical record to determine events leading up to the incident; interview the person(s) reporting the incident; interview any witnesses to the incident; interview the resident; interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; interview the resident's roommate, family members, and visitors; interview other residents to whom the accused employee provided care or services; review all events leading up to the alleged incident; determine any patterns with geography; staffing levels at the time of incident; determine what residents were affected by the incident; employees during the investigation may be suspended or reassigned to nonresident care duties; and, each interview would be conducted separately and in a private location. Interview with Unit Manager (UM) #2, on 01/15/15 at 3:00 PM, revealed she called both CNA #3 and CNA #7 to the nurses' station separately, questioned them regarding the care they had provided, and requested they write a statement. She stated CNA #3, who matched the description, was scheduled to leave at 10:00 PM that evening and CNA #7 at 9:00 PM. She stated CNA #7 wrote her statement and then left for the evening; however, she did not inform the aide that she would be re-assigned to non-resident care activities if she returned to work prior to the completion of the investigation or that she was suspended. The UM stated CNA #3 remained at the nurses' station, while he completed his written statement, and was not immediately removed	F 490	1-16-15. The abuse investigation was re-opened on 2-4-15 and was completed on 2-9-15 to include interviewing of all staff working on that unit the night of the complaint; no new findings identified. On 2-9-15 all interviewable residents on that unit have been questioned by the social services director for any concerns with any staff members; no further concerns identified. <i>Identification of Other Residents</i> All residents receiving care at our facility are potentially affected; any alleged abuse which would include: verbal, physical, mental, sexual, emotional, involuntary seclusion and neglect are being thoroughly investigated which consists of: reviewing the residents medical record to determine events leading up to the incident, interviewing the person reporting the incident, interviewing any witnesses to the incident, interviewing the resident (as medically appropriate), interview attending physician as needed, interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident, interview roommate, family members and visitors, interview other residents to whom the accused employee provides care or services, review all events leading up to incident, determine what residents were affected by the incident, other circumstances that may effected the incident, obtain witness reports in writing and obtained before leaving the building, inform Ombudsman, ensure during investigation the accused individuals NOT employed will be denied unsupervised access to the residents, keep resident and/or representative informed of progress, complete the "Resident Abuse Investigation Report Form" and report within the 5 days of investigation to OIG, local police department Ombudsman and any required state and local agency required by law.		



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F 490	<p>Continued From page 54</p> <p>from the resident care area. She stated CNA #3 left at his scheduled time and she did not inform him he was suspended or would be re-assigned if he returned to work prior to the conclusion of the investigation.</p> <p>Interview with the UM, on 01/15/15, revealed she did not continue her investigation into the allegation of abuse until she returned to work on 01/14/15. She stated she only interviewed the staff that was assigned to work on that hallway to determine if they had heard or witnessed anything. She stated the reason she did not interview the other staff that had the potential to witness or be aware of the incident was because they were not assigned to provide care to Resident #14.</p> <p>Interview with the Director of Nursing, on 01/15/15 at 1:57 PM, revealed she believed the abuse investigation for Resident #14 was thorough and complete; however, the nurse should have documented a head to toe nursing assessment instead of just a skin assessment.</p> <p>Interview with the Administrator, on 01/15/15 at 2:00 PM, revealed he was informed of the allegation of abuse against Resident #14 on the evening of 01/13/14. He stated he had no concerns regarding the investigation or interviews conducted. He stated the allegation was made close to the end of the shift and since both employees involved were leaving for the night he did not direct staff to suspend them or ensure they would not be called into work during the night. He stated he made his determination the next afternoon that the allegation was unsubstantiated and decided no other employee actions were necessary. He stated he believed</p>	F 490	<p>The facilities abuse policy was updated by the Administrator on 2/13/15 to suspend accused employees immediately to ensure accused employees are removed from any chance of resident care. The phrase "reassign accused employees to nonresident care duties" was omitted from the facility's policy. The administrator in-serviced the department heads of the revision to the abuse policy on 2-13-15. An in-service on abuse prevention, screening, training and investigating was conducted for all staff on 1/22/15 by the Administrator and Director of Nursing.</p> <p>A Quality Assurance and Assessment (QAA) Committee meeting was held 2/5/15 with the interim Director of Nursing, the Medical Director, QA Nurse, Dietary Manager, Infection Control Nurse and Social Services Director all of which were present to discuss the outcome of the survey and cited deficiencies and recommendations for plans of correction were initiated.</p> <p>Systemic Changes On 1-21-15 the QAA Committee reviewed the prior POC of 10-30-14 and determined that the facilities abuse investigation protocol needed to be revised to include a section for initiation of a Root-Cause-Analysis determination. The QAA in addition determined that all nursing management and other department heads needed additional training and education on conducting a thorough abuse investigations; and ascertain that all documentation is accurate and complete.</p> <p>The QAA in addition determined that all aspects of an abuse investigation will be reviewed by the facility's Regional Clinical Quality Assurance Director or Regional Director of Operations within 24 hours of the alleged abuse and when the 5 day investigation is completed for future compliance of each investigation, identifying the root cause and</p>		



completion of all documentation and that a thorough investigation was completed.

The facilities abuse policy was updated by the Administrator on 2/13/15 to suspend accused employees immediately to ensure accused employees are removed from any chance of resident care. The phrase "reassign accused employees to nonresident care duties" was omitted from the facility's policy. The administrator in-serviced the department heads of the revision to the abuse policy.

The facilities in-servicing education included the following:

The Regional Director for Clinical Services conducted an Abuse in-service training with the Administrator and the Nursing Administrative team which included: DON, ADON, QA Nurse, IC Nurse and Unit Managers on recognizing, determining root cause analysis and investigating abuse allegations for all management staff on 1/22/15.

The in-service also included: The primary purposes of the Quality Assessment and Assurance Plan which is to provide a means to identify and resolve present and potential negative outcomes related to resident care and safety; to reinforce and build upon effective systems of services and positive care measures; to provide a structure and process to correct identified quality deficiencies; to establish and implement plans to correct deficiencies, and to monitor the effects of these action plans on resident outcome; to help departments, consultants, and ancillary services that provide direct or indirect care to residents to communicate effectively, and to delineate lines of authority, responsibility, and accountability; to provide a means to centralize and coordinate comprehensive Quality Assessment and Assurance activities in order to meet the needs of the residents and the facility; and to establish a system and process to maintain documentation relative to the Quality Assessment and Assurance Program, as a basis for demonstrating that there is an effective ongoing program.

The DON and the Administrator conducted an in-service on 1-22-15 through 1-26-15 with *all nursing staff* by the Director of Nursing on completing incident report, and conducting a head-to-toe physical assessment with completed documentation on all alleged abuse allegations. An in-service on abuse prevention, screening, training and investigating was conducted for *all staff* on 1/22/15 by the Administrator and Director of Nursing.

The Administrator conducted an in-service training with the *Social Service Director* on conducting investigations for abuse and grievances on 1-22-15.

In addition, the facility has implemented a new Grievance/Concern Program which consist of the following components:

The Administrator has delegated the responsibility of grievance and/or complaint investigation to the social services department

FD 1302

including resident council concerns, grievances or complaints. The social services department may obtain assistance from the department the grievance originated.

Upon receipt of a grievance and/or complaint, the social services department, with any assistance needed from the other departments, will investigate the allegations and submit a written report of such findings to the Administrator within five (5) working days of receiving the grievance and/or complaint.

The Administrator will review the findings with the person investigating the complaint to determine what corrective actions, if any, need to be taken.

The resident, resident council concerns, or person filing the grievance and/or complaint on behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. The Administrator, or his or her designee, will make such reports orally within (7) working days of the filing of the grievance or complaint with the facility.

The social services director or designee will conduct a follow-up with the resident including resident council members, concerning the resolution of the grievance in (7) to (10) days after action plan was implemented to ensure corrective action was successful and grievance is resolved.

Should the resident not be satisfied with the result of the investigation or if grievance/concern/complaint not resolved, a new grievance will be initiated by the social services department and a new action plan for resolution will be implemented.

In addition all resident concerns/grievances will be discussed in the daily Continuous Quality Improvement (CQI) meetings previously referred to as QA meetings and the grievance logs, resident council minutes and action plans will be submitted to the monthly Quality Assurance and Assessment (QAA) meetings to oversee that grievances are resolved.

In-service training on the new Grievance Program was conducted with the Administrator, Social Services Director and the Facilities Department Managers on 2-9-15 by the Regional Director of Clinical Services.

Monitoring

All investigative documents including the Long-Term Care Facility-Self Reported Incident Form, the Abuse Investigation Tool form, and the Resident Abuse Investigation Report Form, all the written statements from accused employees before leaving the building, interviews of persons reporting the incident, interviews of any witnesses, interview of staff members, interviews with resident's roommates, family members and visitors, timeline of event, interviews with other residents, 72-hour assessments following the

incident, notes from root cause analysis and staffing levels will be reviewed by the Administrator to ensure all documentation is completed and that the facilities investigative protocol was followed.

The QAA in addition determined that all aspects of an abuse investigation will be reviewed by the facility's Regional Clinical Quality Assurance Director or Regional Director of Operations within 24 hours of the alleged abuse and when the 5 day investigation is completed for future compliance of each investigation, identifying the root cause and completion of all documentation and that a thorough investigation was completed.

This will validate that: any alleged abuse which would include: verbal, physical, mental, sexual, emotional, involuntary seclusion and neglect are being thoroughly investigated which consists of: reviewing the residents medical record to determine events leading up to the incident, interviewing the person reporting the incident, interviewing any witnesses to the incident, interviewing the resident (as medically appropriate), interview attending physician as needed, interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident, interview roommate, family members and visitors, interview other residents to whom the accused employee provides care or services, review all events leading up to incident, determine what residents were affected by the incident, other circumstances that may effected the incident, obtain witness reports in writing and obtained before leaving the building, inform Ombudsman, ensure during investigation the accused individuals NOT employed will be denied unsupervised access to the residents and suspended, keep resident and/or representative informed of progress, complete the "Resident Abuse Investigation Report Form" and report within the 5 days of investigation to OIG, local police department Ombudsman and any required state and local agency required by law. Furthermore, all abuse investigations and grievances/concerns are being submitted to the monthly QAA meetings for review and recommendations.



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2015
NAME OF PROVIDER OR SUPPLIER PROVIDENCE RICHWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031	
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F 490	Continued From page 55 the investigation into the allegation of abuse was investigated thoroughly, even though, all potential staff that could have witnessed or been aware of the Incident were not interviewed.	F 490		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary, and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy and facility plan of	F 520	Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements. <i>Residents Affected</i> Resident #14 was observed and assessed on 1-14-15, 1-15-15 and 1-16-15 by charge nurse and the social services director completed a psychosocial evaluation on 1-16-15 since the incident and no new areas of concern have been identified. The nurse completing the physical assessment on resident #14 after the abuse allegation was given one on one training by the Administrator to ensure all documents are fully completed on 1-16-15. The abuse investigation was re-opened on 2-4-15 and was completed on 2-9-15 to include interviewing of all staff working on that unit the night of the complaint; no new findings identified. On 2-9-15 all interviewable residents on that unit have been questioned by the social services director for any concerns with any staff members; no further concerns identified. <i>Identification of Other Residents</i> All residents are potentially affected by this deficiency. A Quality Assurance and Assessment (QAA) Committee meeting was held 2/5/15 with the interim Director of Nursing, the Medical Director, QA Nurse, Dietary Manager, Infection Control Nurse and Social Services Director to discuss the outcome of the survey and cited deficiencies and recommendations for plans	2-16-15

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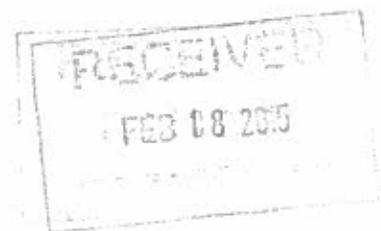
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F 520	<p>Continued From page 56</p> <p>correction, it was determined the facility's Quality Assurance (QA) Committee failed to develop and implement appropriate plans of action to ensure identified quality deficiencies during an abbreviated survey completed on 10/30/14 remained corrected.</p> <p>The facility failed to promptly remove the alleged perpetrators from the resident care area and not allow them to return until the allegation was determine to be substantiated or not, failed to complete nursing assessment of the potential victim for harm and no documentation, all potential staff witnesses were not interviewed, failed to follow their policy regarding interviewing and protecting residents from further potential abuse for one (1) of twenty-one (21) sampled residents (Resident #14) and one (1) of one (1) unsampled residents (Unsample Resident A). Refer to F225 and F226. This is a repeat deficiency from the Immediate Jeopardy survey on 10/30/14.</p> <p>The findings include:</p> <p>Review of facility's policy Abuse Investigation Tool, not dated, revealed employees during the investigation may be suspended or reassigned to nonresident care duties.</p> <p>Facility plan of correction revealed the facility administrator will be ultimately responsible for compliance with stated plans. The facility will ensure protection of residents during abuse investigations.</p> <p>Record review of the Resident Abuse</p>	F 520	<p>of correction were initiated.</p> <p>All residents receiving care at our facility are potentially affected; any alleged abuse which would include: verbal, physical, mental, sexual, emotional, involuntary seclusion and neglect are being thoroughly investigated which consists of: reviewing the residents medical record to determine events leading up to the incident, interviewing the person reporting the incident, interviewing any witnesses to the incident, interviewing the resident (as medically appropriate), interview attending physician as needed, interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident, interview roommate, family members and visitors, interview other residents to whom the accused employee provides care or services, review all events leading up to incident, determine what residents were affected by the incident, other circumstances that may effected the incident, obtain witness reports in writing and obtained before leaving the building, inform Ombudsman, ensure during investigation the accused individuals NOT employed will be denied unsupervised access to the residents, accuser will be suspended, keep resident and/or representative informed of progress, complete the "Resident Abuse Investigation Report Form" and report within the 5 days of investigation to OIG, local police department Ombudsman and any required state and local agency required by law.</p> <p>An in-service on abuse prevention, screening, training and investigating was conducted for all staff on 1/22/15 by the Administrator and Director of Nursing. The facilities abuse policy was updated by the Administrator on 2/13/15 to suspend accused employees immediately to ensure accused employees are removed from any chance of resident care. The phrase "reassign accused employees to nonresident care duties" was omitted from the facility's policy. The administrator in-serviced the department heads of the revision to the abuse policy on 2-13-15.</p> <p><i>Systemic Changes</i> On 1-21-15 the QAA Committee reviewed the prior POC of 10-30-14 and determined that the facilities abuse investigation protocol needed to be revised to include a section for initiation of a Root-Cause-Analysis determination. The QAA in addition determined that all nursing</p>	

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F 520	<p>Continued From page 57</p> <p>Investigation Report Form for Resident #14, dated 01/13/15, revealed there was no completed physical assessment for possible injury.</p> <p>Review of the Nursing Assessment form for Resident #14, dated 01/13/15, revealed the nurse took no vital signs, did not assess the resident for pain, and only completed the skin assessment portion of the assessment.</p> <p>Interview with the Administrator, on 01/15/15 at 2:00 PM, revealed he was informed of the allegation of abuse against Resident #14 on the evening of 01/13/14 and had no concerns regarding the nursing assessment documentation; although it was not complete. He stated the allegation was made close to the end of shift and since both employees involved were leaving for the night he instructed staff to send them home. The Administrator stated he did not direct staff to suspend them or ensure they would not be called into work during the night. The Administrator stated he completed the interview with Unsamped Resident A and asked him/her how his/her care was, if he/she had any problems, and how his/her night was. Administrator stated he did not ask specific questions about the alleged abuse to Resident #14. He stated he made his determination on 01/14/15 that the allegation was unsubstantiated and decided no other employee actions were necessary. He stated he believed the investigation into the allegation of abuse was investigated thoroughly, even though, all potential staff that could have witnessed or been aware of the incident were not interviewed.</p> <p>Further interview with the Administrator, on 01/15/15 at 2:00 PM, revealed the facility followed</p>	F 520	<p>management and other department heads needed additional training and education on conducting a thorough abuse investigations; and ascertain that all documentation is accurate and complete.</p> <p>The QAA in addition determined that all aspects of an abuse investigation will be reviewed by the facility's Regional Clinical Quality Assurance Director or Regional Director of Operations within 24 hours of the alleged abuse and when the 5 day investigation is completed for future compliance of each investigation, identifying the root cause and completion of all documentation and that a thorough investigation was completed.</p> <p>The facilities abuse policy was updated by the Administrator on 2/13/15 to suspend accused employees immediately to ensure accused employees are removed from any chance of resident care. The phrase "reassign accused employees to nonresident care duties" was omitted from the facility's policy. The administrator in-serviced the department heads of the revision to the abuse policy.</p> <p>The facilities in-servicing education included the following: The Regional Director for Clinical Services conducted an Abuse in-service training with the Administrator and the Nursing Administrative team which included: DON, ADON, QA Nurse, IC Nurse and Unit Managers on recognizing, determining root cause analysis and investigating abuse allegations for all management staff on 1/22/15.</p> <p>The in-service also included: The primary purposes of the Quality Assessment and Assurance Plan which is to provide a means to identify and resolve present and potential negative outcomes related to resident care and safety; to reinforce and build upon effective systems of services and positive care measures; to provide a structure and process to correct identified quality deficiencies; to establish and implement plans to correct deficiencies, and to monitor the effects of these action plans on resident outcome; to help departments, consultants, and ancillary services that provide direct or indirect care to residents to communicate effectively, and to delineate lines of authority, responsibility, and accountability; to provide a means to centralize and coordinate comprehensive Quality Assessment and Assurance activities in order to meet the needs of the residents and the facility; and to establish a system and process</p>		



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F 520	Continued From page 58 the Plan of Correction from the Abbreviated Survey, conducted 10/30/14. The Administrator confirmed the facility discussed the Allegation of Compliance and Plan of Correction in the committee meetings.	F 520	to maintain documentation relative to the Quality Assessment and Assurance Program, as a basis for demonstrating that there is an effective ongoing program. The DON and the Administrator conducted an in-service on 1-22-15 through 1-26-15 with <i>all nursing staff</i> by the Director of Nursing on completing incident report, and conducting a head-to-toe physical assessment with completed documentation on all alleged abuse allegations. An in-service on abuse prevention, screening, training and investigating was conducted for <i>all staff</i> on 1/22/15 by the Administrator and Director of Nursing. The Administrator conducted an in-service training with the <i>Social Service Director</i> on conducting investigations for abuse and grievances on 1-22-15. In addition, the facility has implemented a new Grievance/Concern Program which consist of the following components: The Administrator has delegated the responsibility of grievance and/or complaint investigation to the social services department including resident council concerns, grievances or complaints. The social services department may obtain assistance from the department the grievance originated. Upon receipt of a grievance and/or complaint, the social services department, with any assistance needed from the other departments, will investigate the allegations and submit a written report of such findings to the Administrator within five (5) working days of receiving the grievance and/or complaint. The Administrator will review the findings with the person investigating the complaint to determine what corrective actions, if any, need to be taken. The resident, resident council concerns, or person filing the grievance and/or complaint on behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. The Administrator, or his or her designee, will make such reports orally within (7) working days of the filing of the grievance or complaint with the facility. The social services director or designee will conduct a follow-up with the resident including resident council members, concerning the resolution of the grievance in (7) to (10) days after action plan was implemented to ensure corrective action was successful and grievance is resolved. Should the resident not be satisfied with the result of		



the investigation or if grievance/concern/complaint not resolved, a new grievance will be initiated by the social services department and a new action plan for resolution will be implemented.

In addition all resident concerns/grievances will be discussed in the daily Continuous Quality Improvement (CQI) meetings previously referred to as QA meetings and the grievance logs, resident council minutes and action plans will be submitted to the monthly Quality Assurance and Assessment (QAA) meetings to oversee that grievances are resolved.

In-service training on the new Grievance Program was conducted with the Administrator, Social Services Director and the Facilities Department Managers on 2-9-15 by the Regional Director of Clinical Services.

Monitoring

All investigative documents including the Long-Term Care Facility-Self Reported Incident Form, the Abuse Investigation Tool form, and the Resident Abuse Investigation Report Form, all the written statements from accused employees before leaving the building, interviews of persons reporting the incident, interviews of any witnesses, interview of staff members, interviews with resident's roommates, family members and visitors, timeline of event, interviews with other residents, 72-Hour assessments following the incident, notes from root cause analysis and staffing levels will be reviewed by the Administrator to ensure all documentation is completed and that the facilities investigative protocol was followed.

The QAA in addition determined that all aspects of an abuse investigation will be reviewed by the facility's Regional Clinical Quality Assurance Director or Regional Director of Operations within 24 hours of the alleged abuse and when the 5 day investigation is completed for future compliance of each investigation, identifying the root cause and completion of all documentation and that a thorough investigation was completed.

This will validate that: any alleged abuse which would include: verbal, physical, mental, sexual, emotional, involuntary seclusion and neglect are being thoroughly investigated which consists of: reviewing the residents medical record to determine events leading up to the incident, interviewing the person reporting the incident, interviewing any witnesses to the incident, interviewing the resident (as medically appropriate), interview attending physician as needed, interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident, interview roommate, family members and visitors, interview other residents to whom the accused employee provides care or services, review all events leading up to incident, determine what residents were affected by the incident, other circumstances that may effected the incident, obtain witness reports in writing and obtained before leaving the building, inform Ombudsman, ensure during investigation the accused individuals NOT employed will be denied unsupervised access to the residents and suspended, keep resident and/or representative informed of progress, complete the "Resident Abuse Investigation Report Form" and report within the 5 days of investigation to OIG, local police department Ombudsman and any required state and local agency required by law.

Furthermore, all abuse investigations and grievances/concerns are being submitted to the monthly QAA meetings for review and recommendations.

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1997, 2000</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (111)</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II, 90 KW generator. Fuel source is Natural Gas.</p> <p>A Recertification Life Safety Code Survey was conducted on 01/13/15. The facility was found not in compliance with the Requirements for Participation in Medicare and Medicaid. The facility has one-hundred and twenty (120) certified beds and the census was one-hundred and one (101) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000			

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

TITLE

X Administrator

(X6) DATE

X 2/18/15

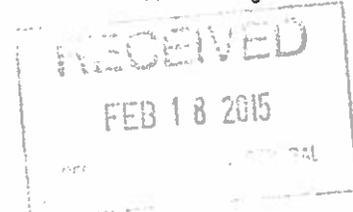
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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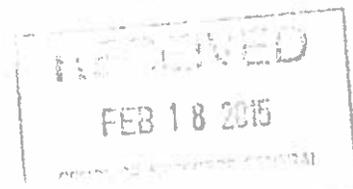
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K 000	Continued From page 1	K 000		
K 029 SS=E	<p>Deficiencies were cited with the highest deficiency identified at F level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect four (4) of five (5) smoke compartments, residents, staff and visitors. The facility has one-hundred and twenty (120) certified beds and the census was one-hundred and one (101) on the day of the survey.</p> <p>The findings include:</p> <p>1. Observation, on 01/13/15 at 9:07 AM, with the</p>	K 029	<p>Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.</p> <p>Residents Affected No specific residents were identified as being affected by the lack of door closures on hazardous material storage rooms. Spring-loaded hinges were immediately ordered and installed on unit A Janitor closet, hall 400 janitor closet, unit A clean utility closet, unit B utility closet and unit B janitor closet on 1-27-15 by the maintenance director. All combustibles were removed from the non-smoke tight room where the walls did not reach the ceiling 1-14-15.</p> <p>Identification of Other Residents All residents have the potential to be affected by this alleged deficient practice. All the doors in the building have been checked for the need for spring loaded hinges.</p>	1-28-15



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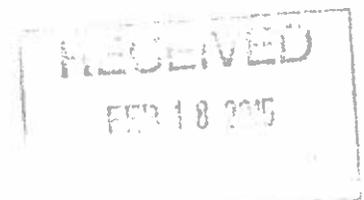
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B WING _____		(X3) DATE SURVEY COMPLETED 01/13/2015
NAME OF PROVIDER OR SUPPLIER PROVIDENCE RICHWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 RICHWOOD WAY LA GRANGE, KY 40031		
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K 029	<p>Continued From page 2</p> <p>Director of Maintenance and the facility's Dietician revealed a Storage Room located within the Dining Room was being used to store combustible boxes containing food. The Storage Room was also used as the Dietician's Office space. The room did not have full height walls, was not smoke tight, and the door was not equipped with a self-closing device.</p> <p>Interview, on 01/13/15 at 9:09 AM, with the Director of Maintenance and the facility's Dietician revealed they were not aware the room did not meet the requirements for storage of combustible material as required by code.</p> <p>2. Observation, on 01/13/15 at 10:47 AM, with the Director of Maintenance revealed the door to the Janitor's Closet, located within the Unit A Nurses Station, was not equipped with a self-closing device</p> <p>Interview, on 01/13/15 at 10:49 AM, with the Director of Maintenance revealed he was not aware the door to the Janitor's Closet, storing hazardous cleaning solutions, was required to be equipped with a self-closing device.</p> <p>3. Observation, on 01/13/15 at 10:55 AM, with the Director of Maintenance revealed the door to a Storage Room located in the 300 Hall, was not equipped with a self-closing device. The room was previously used as an office and had recently been converted to a Storage Room containing combustible materials.</p> <p>Interview, on 01/13/15 at 10:57 AM, with the Director of Maintenance revealed he was not aware if the room was used as storage it must be equipped with a self-closing device.</p>	K 029	<p>Systemic Changes</p> <p>The Maintenance Director installed spring-loaded hinges on all doors leading to non-compliant storage areas on unit A Janitor closet, hall 400 janitor closet, unit A clean utility closet, unit B utility closet and unit B janitor closet on 1-27-15 by the maintenance director. 1-27-15.</p> <p>All combustibles were removed from the non-smoke tight room where the walls did not reach the ceiling 1-14-15.</p> <p>This area of concern has been added to the monthly maintenance rounding form to monitor all doors for need of spring loaded hinges and to ensure no combustibles are added to the non-smoke tight room where the walls don't reach the ceiling.</p> <p>Monitoring</p> <p>The Maintenance Director will conduct a monthly audit on all doors throughout the facility for the need of spring loaded hinges. Will also add to the monthly audit a check to make sure no combustibles are added to the non-smoke tight room where the walls don't reach the ceiling.</p> <p>The findings will be reviewed during the monthly QAA meeting to ensure compliance.</p>		



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K 029	<p>Continued From page 3</p> <p>4. Observation, on 01/13/15 at 11:11 AM, with the Director of Maintenance revealed the door to the Janitor's Closet, located within the 400 Hall, was not equipped with a self-closing device</p> <p>Interview, on 01/13/15 at 11:13 AM, with the Director of Maintenance revealed he was not aware of the requirement the door to the Janitor's Closet, storing hazardous cleaning solutions, was required to be equipped with a self-closing device.</p> <p>5. Observation, on 01/13/15 at 11:28 AM, with the Director of Maintenance revealed the door to the Clean Utility Room, located within the Unit B Nurses Station, was not equipped with a self-closing device</p> <p>Interview, on 01/13/15 at 11:30 AM, with the Director of Maintenance revealed he was not aware the door to the Clean Utility Room, was required to be equipped with a self-closing device.</p> <p>6. Observation, on 01/13/15 at 11:34 AM, with the Director of Maintenance revealed the door to the Janitor's Closet, located within the Unit B Nurses Station, was not equipped with a self-closing device</p> <p>Interview, on 01/13/15 at 11:36 AM, with the Director of Maintenance revealed he was not aware the door to the Janitor's Closet, storing hazardous cleaning solutions, was required to be equipped with a self-closing device.</p>	K 029		



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K 029	Continued From page 4 The census of one-hundred and one (101) was verified by the Administrator, on 10/13/15. The findings were acknowledged by the Administrator and verified by the Director of Maintenance at the exit interview on 01/13/15. Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or	K 029			

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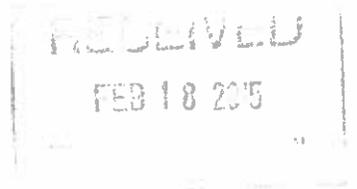
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K 029	Continued From page 5 field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure fifteen (15) second delayed egress signage was maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, approximately sixty (60) residents, staff and visitors. The facility has one-hundred and twenty (120) certified beds and the census was one-hundred and one (101) on the day of the survey. The findings include: 1. Observation, on 01/13/15 at 10:31 AM, with the Director of Maintenance revealed the fifteen (15) second delayed egress signage displayed on the exit door from the 200 Hall had been faded and was not readily identifiable.	K 038	Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements. <i>Residents Affected</i> No specific residents were identified as being affected by the delayed egress door signs. New signs were ordered and placed on the doors immediately on 1-13-15 by the maintenance director. <i>Identification of Other Residents</i> All residents have the potential to be affected. New door signs were ordered and placed on the doors immediately on 1-13-15 by the maintenance director.	1/14/15



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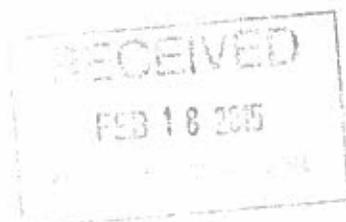
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K 038	<p>Continued From page 6</p> <p>Interview, on 01/13/15 at 10:33 AM, with the Director of Maintenance revealed he was not aware the fifteen (15) second delayed egress signage was not readily identifiable as required by code.</p> <p>2. Observation, on 01/13/15 at 11:04 AM, with the Director of Maintenance revealed the fifteen (15) second delayed egress signage displayed on the exit doors from the 300 Hall had been faded and was not readily identifiable.</p> <p>Interview, on 01/13/15 at 11:06 AM, with the Director of Maintenance revealed he was not aware the fifteen (15) second delayed egress signage was not readily identifiable as required by code.</p> <p>The census of one-hundred and one (101) was verified by the Administrator on 01/13/15. The findings were acknowledged by the Administrator and verified by the Director of Maintenance at the exit interview on 01/13/15.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through</p>	K 038	<p>Systemic Changes</p> <p>The Maintenance Director removed the old signs and replaced with new signs that have a contrasting background. The Maintenance Director will conduct a monthly audit on all exits and delayed egress signs and report findings to the Administrator.</p> <p>Monitoring</p> <p>The Maintenance Director will conduct a monthly audit on all exits and delayed egress signs and will submit findings to the administrator. The findings will be reviewed during the monthly QAA meeting to ensure compliance.</p>	



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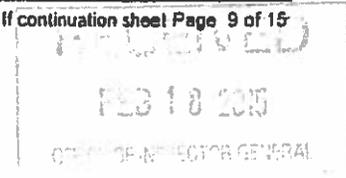
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K 038	Continued From page 7 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) *On the door adjacent to the release device, there	K 038		



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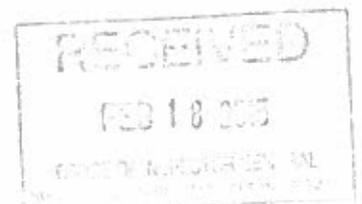
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K 038	Continued From page 8 shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS 7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO. 7.5.2.2* Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit. Mirrors shall not be placed on exit doors. Mirrors shall not be placed in or adjacent to any exit in such a manner as to confuse the direction of exit. Exception: Curtains shall be permitted across means of egress openings in tent walls if the following criteria are met: (a) They are distinctly marked in contrast to the tent wall so as to be recognizable as means of egress. (b) They are installed across an opening that is at least 6 ft (1.8 m)	K 038			



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K 050	Continued From page 10 Review of the facility's fire drills, on 01/13/15 at 3:03 PM, with the Director of Maintenance revealed the facility had no evidence of fire drills being conducted during the first, second and third shifts in the second quarter of 2014. Fire drills are required to be conducted, at a minimum of one (1) per shift, per quarter of each year. Interview, on 01/13/15 at 3:05 PM, with the Director of Maintenance revealed the facility did not have a full time Maintenance Director during that time period. The census of one-hundred and one (101) was verified by the Administrator on 01/13/15. The findings were acknowledged by the Administrator and verified by the Director of Maintenance at the exit interview on 01/13/15. Reference: NFPA 101 Life Safety Code (2000 Edition) 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050	<i>Monitoring</i> All drills will be documented and stored in "Fire Drill Logs" binder located in Maintenance Office. The fire drill log will be reviewed during the monthly QAA meeting to ensure compliance.		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on interview and review of the facility's	K 062	Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or	1/28/15	



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K 062	<p>Continued From page 11</p> <p>automatic sprinkler system, it was determined the facility failed to maintain the sprinkler system in accordance with the National Fire Protection Association (NFPA) Standards. The deficiency had the potential to affect each of the five (5) smoke compartments, residents, staff and visitors. The facility has one-hundred and twenty (120) certified beds and the census was one-hundred and one (101) on the day of the survey.</p> <p>The findings include:</p> <p>Review of the automatic sprinkler system, on 01/13/15 at 2:43 PM, with the Director of Maintenance revealed the facility failed to provide evidence that a quarterly inspection had been conducted during the fourth quarter of 2014.</p> <p>Interview, on 01/13/15 at 2:45 PM, with the Director of Maintenance revealed he was not aware the quarterly inspection of the automatic sprinkler system had not been conducted during the fourth quarter of 2014. The third quarterly inspection of 2014 was conducted on 07/07/14 and the first quarterly inspection of 2015 was conducted on 01/06/15.</p> <p>The census of one-hundred and one (101) was verified by the Administrator on 01/13/15. The findings were acknowledged by the Administrator and verified by the Director of Maintenance at the exit interview on 01/13/15.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and</p>	K 062	<p>challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.</p> <p><i>Residents Affected</i> No specific residents were identified as being affected by the deficiency in quarterly inspections on the fire sprinkler system.</p> <p><i>Identification of Other Residents</i> All residents have the potential to be affected. The sprinkler system was checked on 1/6/15 by Midwest Sprinkler Corporation.</p> <p><i>Systemic Changes</i> All inspections for the year have been scheduled with Midwest Sprinkler Corporation in advanced.</p> <p><i>Monitoring</i> The inspections will be noted on a calendar in the "Fire Sprinkler Inspections" binder located in the Maintenance Office. The Maintenance Director will confirm the inspections during the monthly QAA meeting as they occur.</p>



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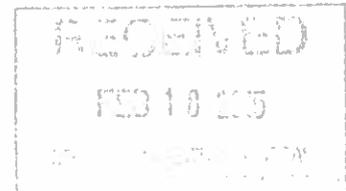
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K 062	Continued From page 12 maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9. Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years	K 062		



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/13/2015	
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K 062	Continued From page 13 thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10 Table 9-1 Summary of Valves, Valve Components, and Trim Inspection, Testing, and Maintenance Component Activity Frequency Reference Control Valves Sealed Inspection Weekly 9-3.3.1 Locked Inspection Monthly 9-3.3.1 Exception No. 1 Tamper switches Inspection Monthly 9-3.3.1 Exception No. 1 Alarm Valves Exterior Inspection Monthly 9-4.1.1 Interior Inspection 5 years 9-4.1.2 Strainers, filters, orifices Inspection 5 years 9-4.1.2 Check Valves Interior Inspection 5 years 9-4.2.1 Preaction/Deluge Valves Enclosure (during cold weather) Inspection Daily/weekly 9-4.3.1 Exterior Inspection Monthly 9-4.3.1.2 Interior Inspection Annually/5 years 9-4.3.1.3 Strainers, filters, orifices Inspection 5 years 9-4.3.1.4 Dry Pipe Valves/Quick-Opening Devices Enclosure (during cold weather) Inspection Daily/weekly 9-4.4.1.1 Exterior Inspection Monthly 9-4.4.1.3	K 062		



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K 062	Continued From page 14 Interior Inspection Annually 9-4.4.1.4 Strainers, filters, orifices Inspection 5 years 9-4.4.1.5 Pressure Reducing and Relief Valves Sprinkler systems Inspection Quarterly 9-5.1.1 Hose connections Inspection Quarterly 9-5.2.1 Hose racks Inspection Quarterly 9-5.3.1 Fire pumps Casing relief valves Inspection Weekly 9-5.5.1, 9-5.5.1.1 Pressure relief valves Inspection Weekly 9-5.5.2, 9-5.5.2.1 Backflow Prevention Assemblies Reduced pressure Inspection Weekly/monthly 9-6.1 Reduced pressure detectors Inspection Weekly/monthly 9-6.1 Fire Department Connections Inspection Quarterly 9-7.1 Main Drains Test Annually 9-2.6, 9-3.4.2 Waterflow Alarms Test Quarterly 9-2.7 Control Valves Position Test Annually 9-3.4.1 Operation Test Annually 9-3.4.1 Supervisory Test Semiannually 9-3.4.3 Preaction/Deluge Valves Priming water Test Quarterly 9-4.3.2.1 Low air pressure alarms Test Quarterly 9-4.3.2.10 Full flow Test Annually 9-4.3.2.2 Dry Pipe Valves/Quick-Opening Devices Priming water Test Quarterly 9-4.4.2.1 Low air pressure alarm Test Quarterly 9-4.4.2.6 Quick-opening devices Test Quarterly 9-4.4.2.4 Trip test Test Annually 9-4.4.2.2 Full flow trip test Test 3 years 9-4.4.2.2.1	K 062			

