

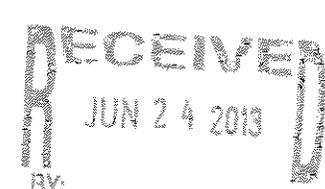
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185332	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/31/2013
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NAME OF PROVIDER OR SUPPLIER GRAND HAVEN NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 105 RODGERS PARK CYNTHIANA, KY 41031
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS A Recertification Survey was initiated on 05/29/13 and concluded on 05/31/13, with deficient practice cited at the highest scope and severity of an "E."	F 000		
F 160 SS=D	483.10(c)(8) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to convey funds within thirty (30) days for one (1) of five (5) discharged resident records reviewed (Deceased Resident #4). The findings include: Review of the facility's policy titled "Resident Trust", undated, revealed the facility shall provided a reliable and trustworthy system to protect the funds of all residents who prefer that the facility handle their personal monies. Further review revealed the facility shall assure that there is adequate control and protection of these funds and will provide a routine statement of monies deposited and monies that have been expended. Additional review of this policy revealed no documented evidence the facility had a procedure to close a resident's account.	F 160		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE administrator (X6) DATE 6-25-13

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

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F 160 Continued From page 1

Review of Deceased Resident #4's personal fund records revealed the resident expired on 12/01/12; however, the final conveyance of funds in the amount of \$978.84 was never completed and the account remained open, one hundred and eighty-one (181) days past the thirty (30) day time frame.

Interview with the Business Office Manager/Patient Accounts and Payroll, on 05/31/13 at 7:00 PM, revealed Deceased Resident #4 expired on 12/01/12. Further interview revealed she could not find evidence of a check disbursement and did not know if a check had in fact been disbursed to close the account.

Interview with the Director of Nursing, on 05/31/13 at 7:15 PM, revealed she was not familiar with the process but stated it should be completed per the facility's policy.

F 161 483.10(c)(7) SURETY BOND - SECURITY OF SS=E PERSONAL FUNDS

The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.

This REQUIREMENT is not met as evidenced by:

Based on interview, record review, and review of the facility's policy, it was determined the facility failed to assure the security of all personal funds of residents deposited with the facility. The facility failed to provide a surety bond in an amount

F 160

The facility's policy, "Resident Trust", has been reviewed and revised (6/18/13) to include proper direction upon discharge of a resident which includes returning the monies to the resident or responsible party within thirty (30) days. In the event of death, the funds will be dispersed to the executor of the estate within thirty (30) days.

The business office manager will meet with the Administrator monthly to review the proper conveyance of all resident funds.

Plans to Monitor Performance for Sustained Solutions

The Administrator will inform the Director of Operations of any monthly discrepancies in the conveyance of funds in order to assure compliance with F 160 and for recommendations.

F 161

F 161 483.10(c)(7) Surety Bond- Security of Personal Funds (E)

Corrective Action for Residents Found to Have Been Affected

No targeted residents were identified; however, all residents have the potential to be affected (see below).

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F 161 Continued From page 2
equal to or greater than the amount of resident funds in the resident funds account.

The findings include:

A review of the facility's surety bond (an agreement wherein the facility and the insurance company agree to compensate the residents for any loss of residents' funds that the facility holds, safeguard, manages, and accounts for), dated January 01, 2011, revealed the maximum amount insured to be ten thousand dollars (\$10,000.00).

Review of the monthly Resident Fund bank statements, revealed the account balance to be in excess of fifteen thousand dollars (\$15,000.00) at times during the statement period. Further review revealed, monthly statements to reflect monies in excess of ten thousand dollars (\$10,000.00) for the months of April 2013, March 2013, February 2013, January 2013, December 2012, November 2012, October 2012, September 2012, August 2012, and July 2012. Furthermore, for the months of December 2012 and January 2013, twenty one (21) out of thirty (30) days the account balance on each of these days was in excess of ten thousand dollars (\$10,000.00).

Interview with the Business Manager, on 05/31/13 at 7:00 PM, revealed she thought the ten thousand dollar (\$10,000.00) surety bond adequate.

Interview with the Administrator, on 05/31/13 at 7:20 PM, revealed she thought the surety bond was based on the quarterly average. No quarterly statements were provided as evidence of adequate amount of surety bond coverage.

F 161 **Identification of Other Residents Having the Potential to be affected by the Same Deficient Practice**
The facility's Chief Financial Officer secured an increase in surety bond coverage from ten thousand (\$10,000) to twenty-five thousand (\$25,000) with an effective date of June 1st 2013 to assure that the surety bond is well in excess of the highest historical balance.

Measures or Systemic Changes put into Place to Avoid Recurrence
The Administrator provided re-education on 6/18/13 to the business office manager on the role of the surety bond in assuring the security of all personal funds of residents deposited within the facility.

The facility's policy, "Resident Trust", has been reviewed and revised (6/18/13) to note that the facility maintains a surety bond to provide assurance of financial security for all resident monies deposited within the facility.

The business office manager will begin corresponding with the Administrator monthly to report on the resident trust balance to ensure that the balance remains under the limit of the surety bond.

Plans to Monitor Performance for Sustained Solutions

The Administrator will inform the Director of Operations of any monthly discrepancies in the amount of the surety bond in order to assure compliance with F 161 and for

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F 312 SS=E	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, the group interview, record review and review of the facility's policy, it was determined the facility failed to carry out activities of daily living (ADLs) as related to ensure resident received showers as scheduled for five (5) of thirteen (13) sampled residents (Residents #1, #3, #5, #6 and #11). The facility failed to ensure enough staff to assist residents with scheduled showers and answer call lights in a timely manner. Review of the State Registered Nursing Assistant (SRNA) Care Plan Records for the months of December 2012 through May 2013 revealed numerous instances in which showers were not given according to schedule. Interviews with both residents and staff revealed SRNA staff were rushed to provide care, and were unable to meet the care needs of residents on an ongoing basis.</p> <p>The findings include: Review of the facility's policy titled, "Staffing Policy and Procedure Direct Care", not dated, revealed the facility provided sufficient staff and sufficient hours of work to caregivers in order to assure that appropriate care was delivered to the</p>	F 312	<p>F 312 483.25(a)(3) ADL Care Provided For Dependent Residents (E)</p> <p>Corrective Action for Residents Found to Have Been Affected</p> <p>Individual Interviews were completed by the Administrator on 6-5-13 with Residents #1, #3, #5, #6, and #11 regarding their preferences for shower days and times. Any changes to the previous shower roster were corrected immediately. SRNAs were in-serviced on the facility's policies for ADL care and proper documentation of showers.</p> <p>Identification of Other Residents Having the Potential to be affected by the Same Deficient Practice</p> <p>All residents have the potential to be affected. The Administrator interviewed all residents and/or responsible parties when appropriate to ensure residents' preferences regarding ADLs, baths, and showers are being honored. Resident's care plans were updated as needed to reflect the resident's preferences.</p>	

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F 312 Continued From page 4
residents. The facility would provide direct care staff and support staff for the purpose of ensuring that care and services were provided that enhance the quality of life for each resident.

During the Group Interview, on 05/29/13 at 3:00 PM, which consisted of ten (10) interviewable residents, the residents expressed concern with the facility being short staffed. Residents shared occurrences in which staff failed to respond to call lights in a timely manner. Residents were adamant this was not the fault of the staff, as they expressed knowledge that staff were occupied caring for other residents. Residents shared they rarely received their showers as scheduled, and more often than not had to settle for a quick bed bath as staff was too rushed to provide showers.

1. Record review revealed the facility admitted Resident #1 on 03/25/04 with diagnoses which included Diabetes. Review of the Minimum Data Set (MDS) Assessment, dated 04/21/13 revealed the facility scored the resident as fourteen (14) out of fifteen (15) on the Brief Interview for Mental Status (BIMS) assessment, indicating the resident had no cognitive impairment. Continued review of the assessment revealed the facility assessed the resident as requiring assistance with bathing.

A review of the SRNA Care Plan Record for Resident #1 for the months of December 2012 through May 2013 revealed Resident #1 had showers scheduled two (2) times a week on second (2nd) shift. A review of services provided revealed Resident #1 received a shower a total of eight (8) times during the six (6) month review period, instead of the fifty-two (52) times

F 312 **Measures or Systemic Changes put into Place to Avoid Recurrence**
Interviews were completed by the Administrator on 6/5/13 with each resident and/or responsible party regarding their preferences for shower days and times. Any changes to the previous shower roster were corrected immediately. Resident's care plans were updated as needed to reflect the resident's preferences including residents who refuse showers.

The staff development coordinator completed in-servicing with all nursing staff beginning on 6/14/13 on the facility's policies for ADL care, proper completion of documentation of SRNA Care Plans, and procedures for monitoring care delivery.

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F 312	Continued From page 5 scheduled. Interview with Resident #1, on 05/30/13 at 5:00 PM, revealed the resident would rather have a shower each time it was scheduled but further stated I know they are short staffed sometimes and have to assist him/her with a bed bath instead of a full shower. 2. Record review revealed the facility admitted Resident #3 on 09/26/06 with diagnoses which included diabetes and Depression. Review of the Annual MDS Assessment, dated 04/17/13 revealed the facility assess the resident as having a BIMS score of fifteen (15) out of fifteen (15) indicating the resident was cognitively intact and as requiring assistance with e bathing. A review of the SRNA Care Plan Record for Resident #3 for the months of December 2012 through May 2013 revealed Resident #3 had showers scheduled three times a week on second (2nd) shift. A review of services provided revealed Resident #3 received forty-nine (49) of the seventy-eight (78) showers scheduled during the six month review period. Interview with Resident #3, on 05/31/13 at 11:30 AM, revealed hts/her needs were not being met and this was his/her home. Resident #3 stated he/she was supposed to get a shower two (2) times a week and when there was only two (2) staff on each hall, he/she was not given an option of a shower, just bed baths. He She stated this happened about three (3) times a month. The resident stated he/she was told by staff the reason for bed baths, was because there was not enough help.	F 312	Plans to Monitor Performance for Sustained Solutions All nurse aid care plan documentation will be reviewed prior to end of shift for completion and accuracy with reference to shower/bathing schedule. SRNA care plans will be audited twice weekly for completion and accuracy by the Director or Assistant Director of Nursing. Residents will be interviewed quarterly by the Social Services Director until compliance has been sustained to ensure individual preferences are honored regarding bath and shower schedule. Any further issues in this area will be put through the CQI process. Care plans will be audited monthly prior to change over by the Director or Assistant Director of Nursing with audit results submitted for review to the Quality Assurance Committee. The facility will follow the recommendations of the Quality Assurance Committee.	6/26/2013	

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F 312	Continued From page 6 3. Record review revealed the facility admitted Resident #5 on 10/14/09 with diagnoses which included Osteoporosis, Parkinson's Disease and Congeslve Heart Failure. Review of the Quarterly MDS Assessment, dated 03/20/13, revealed the facility assessed the resident with a BIMS score of twelve (12) out of fifteen (15) indicating the resident had moderately impaired cognition. Further review revealed the facility the resident as requiring assistance with bathing and lolleting. A review of the SRNA Care Plan Record for Resident #5 for the months of December 2012 through May 2013 revealed Resident #5 had showers scheduled three times a week on second (2nd) shift. A review of services provided revealed Resident #5 received forty-one (41) of the fifty-two (52) showers scheduled during the six month review period, with a period of thirleen (13) days without a shower during the month of December 2012. Interview with Resident #5, on 05/30/13 at 4:40 PM, revealed staff took a while to answer the call belt. Resident #5 further stated when I turned the call betl on, on 05/29/13 (time unknown) he/she had an accident in the bed because staff did not get to him/her in time and he/she had to wait and thls made him/her feel awful. The Resident further staled he/she would rather have a shower than a bed bath on his/her scheduled days. 4. Record review revealed the facility admitted Resident #6 on 08/24/10 with diagnoses which included Dementia, Dlabetes and Peripheral Vascular Disease. Review of the Quarterly MDS	F 312			

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F 312	<p>Continued From page 7</p> <p>Assessment, dated 02/15/13 revealed the facility assessed the resident as having severe cognitive impairment and requiring extensive assistance with bathing.</p> <p>A review of the SRNA Care Plan Record for Resident #6 for the months of December 2012 through May 2013 revealed Resident #6 had showers scheduled two (2) times a week on second (2nd) shift. A review of services provided revealed Resident #6 received twenty-eight (28) of the fifty-two (52) showers scheduled during the six month review period, with a period of sixteen (16) days without a shower from the end of April 2013 through the beginning of May 2013.</p> <p>5. Record review revealed the facility admitted Resident #11 on 01/18/13. Review of the Quarterly MDS Assessment revealed the facility assessed the resident as being moderately impaired in cognition and requiring assistance with bathing.</p> <p>A review of the SRNA Care Plan Record for Resident #11 for the months of December 2012 through May 2013 revealed Resident #11 had showers scheduled two times a week on second (2nd) shift. A review of services provided revealed Resident #11 received forty-five (45) of fifty-two (52) showers scheduled during the six month review period.</p> <p>Interview with Resident #11, on 05/31/13 at 11:45 AM, revealed he/she was scheduled for a shower two (2) times a week and about every other week he/she did not get a shower and was told by staff that it was because there was not enough staff. He/She stated it made him/her feel "bad" and</p>	F 312		

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F 312	<p>Continued From page 8</p> <p>"lousy" when he/she didn't get a shower.</p> <p>An interview with SRNA #5, on 05/30/13 at 10:56 AM, revealed she tried to treat residents the way she would want to be treated in their position. She shared she could not provide showers because there wasn't enough staff, and that residents were fortunate to get bed baths. SRNA #5 stated she felt it wrong not to be able to give resident's their showers, and that aides were rushed and not able to provide quality care, describing her tasks as running into a resident room, bathing them, dressing them, then rushing to the next resident. SRNA #5 stated she felt it neglectful to have to treat residents like a job instead of a person. SRNA #5 stated aides had tried to talk to the Director of Nursing (DON) and residents had spoken with the DON about some nurses not helping out.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 05/30/13 at 11:37 AM, revealed it was everybody's job to answer call lights. LPN #1 acknowledged there had been times when residents had been incontinent because aides hadn't been able to get to them. She stated at one time they seemed to be having a lot of call ins, and when they were short staffed resident care suffered.</p> <p>Interview with SRNA #7, on 05/30/13 at 3:15 PM, revealed when she was initially employed at the facility there was more individual attention paid to residents. She expressed the quality of care residents received suffered when working short-staffed and that she had been working shifts short-staffed quite a bit. She stated there are lots of times that residents only get bed baths</p>	F 312		
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F 312	<p>Continued From page 9</p> <p>Instead of showers because there was not enough staff.</p> <p>Interview with SRNA #8, on 05/30/13 at 3:43 PM, revealed she had worked all three shifts, and the facility was often short-staffed on second shift. SRNA #8 stated showers did not get done, and sometimes there was not time for even bed baths depending on how short staffed they were working. SRNA #8 went on to reveal when staff expressed concerns about staffing, they feel their concerns were not addressed.</p> <p>Interview with SRNA #12, on 05/31/12 at 10:59 AM, revealed, if nobody called in on weekends, residents who were scheduled showers got them. If someone called in, they had to provide bed baths instead, and residents were "pretty understanding" of this. SRNA #12 stated aides could not get to residents if they were bathing or showering someone else, or toileting someone else.</p> <p>Interview with SRNA #14 on 05/31/12 at 11:50 AM revealed she works short-staffed quite a bit. She stated she could not get to call lights when she was giving baths, and that there were residents that require multiple bathroom breaks per eight hour shift, and there wasn't enough help.</p> <p>Interview with SRNA #15, on 05/31/12 at 2:21 PM, revealed nurses did not answer call lights, and instead would go to find aides, even the aides were giving baths, if call lights were going off. SRNA #15 stated she had finished bathing residents to find two (2) or three (3) call lights going off. SRNA #15 stated she brought this to the attention of the DON a month or two ago, but</p>	F 312		

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F 312	<p>Continued From page 10</p> <p>she can't tell that anything had changed.</p> <p>An interview with the DON, on 05/30/13 at 2:45 PM, revealed occasionally staff and residents came to her with concerns, although no one expressed to her a concern about staffing. She stated staffing concerns came up in resident council, and were addressed in a meeting with the Administrator and Conservator. The DON stated on average they received more than one call in a week, and when there was a call in, staff made calls to fill the vacancy. The DON stated the facility had been doing audits on call lights since December 2012, and that although aides had told her some nurses didn't respond to call lights, she had discussed this with nurses and made observations of nurses answering call lights.</p> <p>Interview with the ADON on 05/31/13 at 4:01 PM revealed all staff are responsible for answering call lights, with the expectation being they are answered within three to four minutes. The ADON revealed she was told some nursing staff weren't responding to call lights, although staff audits hadn't supported this. Regarding showers, the ADON stated they were expected to be given unless a resident declined to have one given. The ADON expressed on second shift, if they were short staffed after attempting to replace staff that had called in, they "made due".</p> <p>An interview with the Administrator, on 05/31/13 at 5:50 PM, revealed no one had come to her with a problem regarding staffing, and she was unaware of the allegation nursing staff was not responding to call lights. She further stated she was not aware residents were not receiving their</p>	F 312		
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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: 185332	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/31/2013
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F 312	Continued From page 11 showers as scheduled.	F 312			
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview, the group interview, record review and review of the facility's policy, it was determined the facility failed to maintain sufficient staff to attain or maintain the highest practicable physical, mental, and psychosocial well-being for five (5) of thirteen (13) sampled residents (Residents #1, #3, #5, #6 and #11). The facility failed to ensure enough staff to assist residents with scheduled showers and answer call lights in	F 353	F 353 483.30(a) Sufficient 24-hr Nursing Staff per Care Plans (E) Corrective Action for Residents Found to Have Been Affected The facility interviewed resident #1, #3, #5, #6, and #11 for the purpose of assuring that sufficient staff exists to meet the needs of each resident. Each resident voiced that they are satisfied with staffing and their care. Care is provided timely and according to the Comprehensive Care Plan.		

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F 353	<p>Continued From page 12</p> <p>a timely manner. Review of the State Registered Nursing Assistant (SRNA) Care Plan Records for the months of December 2012 through May 2013 revealed numerous instances in which showers were not given according to schedule. Interviews with both residents and staff revealed SRNA staff were rushed to provide care, and were unable to meet the care needs of residents on an ongoing basis.</p> <p>(Refer to F-312)</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Staffing Policy and Procedure Direct Care", not dated, revealed the facility provided sufficient staff and sufficient hours of work to caregivers in order to assure that appropriate care was delivered to the residents. The facility would provide direct care staff and support staff for the purpose of ensuring that care and services were provided that enhance the quality of life for each resident.</p> <p>During the Group Interview, on 05/29/13 at 3:00 PM, which consisted of ten (10) interviewable residents, the residents expressed concern with the facility being short staffed. Residents shared occurrences in which staff failed to respond to call lights in a timely manner. Residents were adamant this was not the fault of the staff, as they expressed knowledge that staff were occupied caring for other residents. Residents shared they rarely received their showers as scheduled, and more often than not had to settle for a quick bed bath as staff was too rushed to provide showers.</p> <p>1. Record review revealed the facility admitted</p>	F 353	<p>Identification of Other Residents Having the Potential to be affected by the Same Deficient Practice</p> <p>All residents have the potential to be affected.</p> <p>The facility conducted interviews of all residents to determine if staffing was adequate to meet the care needs of the resident. If the Resident was non-communicative, the responsible party for each resident was contacted for the interview. All Resident and/or responsible party interviews were reviewed to determine that the staffing required was evident to meet the needs of the residents. Interviews indicated that care is being provided timely and according to the Comprehensive Care Plan.</p> <p>Staff education was provided on 6/21/13 by the Director of Nursing to all nursing staff regarding providing care in a timely manner to meet the needs of residents in accordance with the resident plan of care.</p>	

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F 353 Continued From page 13

Resident #1 on 03/25/04 with diagnoses which included Diabetes. Review of the Minimum Data Set (MDS) Assessment, dated 04/21/13 revealed the facility scored the resident as fourteen (14) out of fifteen (15) on the Brief Interview for Mental Status (BIMS) assessment, indicating the resident had no cognitive impairment. Continued review of the assessment revealed the facility assessed the resident as requiring assistance with bathing.

A review of the SRNA Care Plan Record for Resident #1 for the months of December 2012 through May 2013 revealed Resident #1 had showers scheduled two (2) times a week on second (2nd) shift. A review of services provided revealed Resident #1 received a shower a total of eight (8) times during the six (6) month review period, instead of the fifty-two (52) times scheduled.

Interview with Resident #1, on 05/30/13 at 5:00 PM, revealed the resident would rather have a shower each time it was scheduled but further stated I know they are short staffed sometimes and have to assist him/her with a bed bath instead of a full shower.

2. Record review revealed the facility admitted Resident #3 on 09/26/06 with diagnoses which included diabetes and Depression. Review of the Annual MDS Assessment, dated 04/17/13 revealed the facility assess the resident as having a BIMS score of fifteen (15) out of fifteen (15) indicating the resident was cognitively intact and as requiring assistance with e bathing.

A review of the SRNA Care Plan Record for

F 353

Measures or Systemic Changes put Into Place to Avoid Recurrence

The Administrator developed a ten point questionnaire to be used for Resident/Responsible Party interviews to determine that sufficient staff existed to meet the needs of each Resident. Interviews were conducted by the Director of Nursing, Assistant Director of Nursing, Social Services Director and two MDS nursing personnel. Any identified concerns were addressed immediately. These interviews will be conducted for the next two months to determine that sufficient staffing is sustained to meet the needs of the residents.

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F 353	<p>Continued From page 14</p> <p>Resident #3 for the months of December 2012 through May 2013 revealed Resident #3 had showers scheduled three times a week on second (2nd) shift. A review of services provided revealed Resident #3 received forty-nine (49) of the seventy-eight (78) showers scheduled during the six month review period.</p> <p>Interview with Resident #3, on 05/31/13 at 11:30 AM, revealed his/her needs were not being met and this was his/her home. Resident #3 stated he/she was supposed to get a shower two (2) times a week and when there was only two (2) staff on each hall, he/she was not given an option of a shower, just bed baths. He She stated this happened about three (3) times a month. The resident stated he/she was told by staff the reason for bed baths, was because there was not enough help.</p> <p>3. Record review revealed the facility admitted Resident #5 on 10/14/09 with diagnoses which included Osteoporosis, Parkinson's Disease and Congestive Heart Failure. Review of the Quarterly MDS Assessment, dated 03/20/13, revealed the facility assessed the resident with a BIMS score of twelve (12) out of fifteen (15) indicating the resident had moderately impaired cognition. Further review revealed the facility the resident as requiring assistance with bathing and toileting.</p> <p>A review of the SRNA Care Plan Record for Resident #5 for the months of December 2012 through May 2013 revealed Resident #5 had showers scheduled three times a week on second (2nd) shift. A review of services provided revealed Resident #5 received forty-one (41) of</p>	F 353	<p>The Administrator, Director and Assistant Director of Nursing reviewed the staffing patterns of the facility in conjunction with the completed resident Interviews and the Comprehensive Care Plans to determine that the staffing required to meet the needs of the residents is scheduled and is in place.</p> <p>The Director and Assistant Director of Nursing reviews the daily staffing and reports to the Administrator to assure that staffing is adequate to meet the needs of each resident.</p> <p>Staff education was provided by the Director of Nursing on 6/21/13 to all nursing staff regarding providing care in a timely manner to meet the needs of residents in accordance with the resident plan of care.</p> <p>The Director and Assistant Director of Nursing are reviewing 24 hour report and staffing assignments to ensure staffing is available and assigned to meet the residents' needs. Any requests for changes in staffing are to go directly to the Director of Nursing.</p>

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F 353	Continued From page 15 the fifty-two (52) showers scheduled during the six month review period, with a period of thirteen (13) days without a shower during the month of December 2012. Interview with Resident #5, on 05/30/13 at 4:40 PM, revealed staff took a while to answer the call bell. Resident #5 further stated when I turned the call bell on, on 05/29/13 (time unknown) he/she had an accident in the bed because staff did not get to him/her in time and he/she had to wait and this made him/her feel awful. The Resident further stated he/she would rather have a shower than a bed bath on his/her scheduled days. 4. Record review revealed the facility admitted Resident #6 on 08/24/10 with diagnoses which included Dementia, Diabetes and Peripheral Vascular Disease. Review of the Quarterly MDS Assessment, dated 02/15/13 revealed the facility assessed the resident as having severe cognitive impairment and requiring extensive assistance with bathing. A review of the SRNA Care Plan Record for Resident #6 for the months of December 2012 through May 2013 revealed Resident #6 had showers scheduled two (2) times a week on second (2nd) shift. A review of services provided revealed Resident #6 received twenty-eight (28) of the fifty-two (52) showers scheduled during the six month review period, with a period of sixteen (16) days without a shower from the end of April 2013 through the beginning of May 2013. 5. Record review revealed the facility admitted Resident #11 on 01/18/13. Review of the Quarterly MDS Assessment revealed the facility	F 353	Charge nurses review the nursing department staffing schedules, assignments and needs of the residents daily to ensure that adequate staff are in place to provide care in a timely manner for each resident in accordance with their individual plan of care. Staff education has been given by the Director of Nursing on 6/21/13 to charge nurses regarding supervision and delegation of duties to provide timely care to meet the needs of residents in accordance with the individual plan of care. The staffing patterns are reviewed at the daily Continuous Quality Improvement (CQI) meetings to assure that staffing is provided to meet the needs of each resident.		

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F 353	<p>Continued From page 16</p> <p>assessed the resident as being moderately impaired in cognition and requiring assistance with bathing.</p> <p>A review of the SRNA Care Plan Record for Resident #11 for the months of December 2012 through May 2013 revealed Resident #11 had showers scheduled two times a week on second (2nd) shift. A review of services provided revealed Resident #11 received forty-five (45) of fifty-two (52) showers scheduled during the six month review period.</p> <p>Interview with Resident #11, on 05/31/13 at 11:45 AM, revealed he/she was scheduled for a shower two (2) times a week and about every other week he/she did not get a shower and was told by staff that it was because there was not enough staff. He/She stated it made him/her feel "bad" and "lousy" when he/she didn't get a shower.</p> <p>An interview with SRNA #4, on 05/30/13 at 10:28 AM, revealed for the past "four or five months", she hadn't been able to get her work done "the way I would like to". She went on to elaborate that she was always rushing and unable to spend any quality time with residents. She went on to express residents didn't feel like they were getting the attention they deserved. SRNA #4 went on to reveal residents informed her they had to wait twenty (20) to thirty (30) minutes for staff to answer call lights, and that this was a daily occurrence. SRNA #4 stated that it was an aides job to visit with residents who did not come out of their rooms, but they didn't have time to do it. SRNA #4 also shared some nurses did not answer call lights.</p>	F 353	<p>Plans to Monitor Performance for Sustained Solutions</p> <p>Residents attending the monthly resident council meeting will be interviewed to determine if staffing is sufficient to meet resident's needs in a timely manner.</p> <p>Residents and/or responsible party (if appropriate) will be interviewed quarterly by the Social Services director until compliance has been sustained to determine if staffing is sufficient to meet the individual needs of the resident. Any further issues in this area will be put through the CQI process.</p> <p>Results of CQI staffing patterns and Resident/Responsible Party Interviews will be reviewed by QA committee monthly to ensure that sufficient staff is available to meet residents' needs. The facility will follow the recommendations of the QA committee.</p> <div style="border: 1px solid black; width: fit-content; margin: 10px auto; padding: 5px;">6-26-2013</div>

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F 353	<p>Continued From page 17</p> <p>An interview with SRNA #5, on 05/30/13 at 10:58 AM, revealed she tried to treat residents the way she would want to be treated in their position, "like they're family". She shared she could not provide showers because there was not enough staff, and that residents were fortunate to get bed baths. SRNA #5 stated she felt it wrong not to be able to give resident's their showers, and that aides were rushed and not able to provide quality care, describing her tasks as running into a resident room, bathing them, dressing them, then rushing to the next resident. SRNA #5 stated she felt it neglectful to have to treat residents like a job instead of a person, "but we do the best we can". SRNA #5 stated aides had tried to talk to the Director of Nursing (DON) and residents had spoken with the DON, about some nurses not helping out.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 05/30/13 at 11:37 AM, revealed it was everybody's job to answer call lights, and she responded to call lights. LPN #1 acknowledged there had been times when residents had been incontinent because aides hadn't been able to get to them. She stated at one time they seemed to be having a lot of call lns, and when they are short staffed resident care may suffer.</p> <p>Interview with SRNA #7, on 05/30/13 at 3:15 PM, revealed when she was initially employed at the facility there was more individual attention paid to residents. She expressed the quality of care residents receive suffered when working short-staffed, and that she had been working shifts short-staffed quite a bit.</p> <p>Interview with SRNA #8, on 05/30/13 at 3:43 PM,</p>	F 353		
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F 353	<p>Continued From page 18</p> <p>revealed she had worked all three shifts, and the facility was often short-staffed on second shift. SRNA #8 stated she has had residents cry when they urinated on themselves because aides haven't been able to get to them in time, and nurses did not always help. She stated showers did not get done, and sometimes there wasn't time for even bed baths depending on how short staffed they were working.</p> <p>Interview with SRNA #9, on 05/30/13 at 4:38 PM, revealed "two people [aides] can't do the job on third shift," and when there are fewer than four aides on second shift, residents don't always get their smoke breaks on time, on occasions having to wait 20 to 25 minutes past scheduled time. SRNA #9 stated it doesn't happen often, but there had been times when she wasn't able to get to residents in time before they had a bowel or bladder accident, and that residents were sometimes upset because we weren't there when they needed us.</p> <p>Interview with SRNA #12, on 05/31/12 at 10:59 AM, revealed if nobody called in on weekends, residents who were scheduled showers got them. If someone called in, they had to provide bed baths instead, and residents were "pretty understanding" of this. SRNA #12 stated call lights were more a concern on st shift, and there had been quite a few times when residents had had an incontinent episode while waiting on staff to respond to call lights. SRNA #12 stated aides could not get to residents if they were bathing or showering someone else, or toileting someone else.</p> <p>Interview with SRNA #14, on 05/31/12 at 11:50</p>	F 353			

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F 353	<p>Continued From page 19</p> <p>AM, revealed she worked short-staffed quite a bit. She stated she could not get to call lights when she was giving baths, and that there were residents that required fourteen or fifteen bathroom breaks per eight hour shift, and there was not enough help.</p> <p>Interview with SRNA #15, on 05/31/12 at 2:21 PM, revealed nurses did not answer call lights, and instead would go to find aides, even if giving baths, if call lights were going off. SRNA #15 stated she has finished bathing residents to find two or three call lights going off. SRNA #15 stated she brought this to the attention of the DON a month or two ago, but she could not tell that anything had changed. SRNA #15 stated there had been times when residents had bowel or bladder accidents while waiting on staff to respond to call lights, and she did not think it was acceptable, and residents weren't happy about it.</p> <p>An interview with the DON, on 05/30/13 at 2:45 PM, revealed occasionally staff and residents came to her with concerns, although no one expressed to her a concern about staffing. She stated staffing concerns came up in resident council and were addressed in a meeting with the Administrator and Conservator. The DON stated on average they received more than one call in a week, and when there was a call in, staff made calls to fill the vacancy. The DON stated the facility had been doing audits on call lights since December 2012, and that although aides had told her some nurses didn't respond to call lights, she had discussed this with nurses and made observations of nurses answering call lights.</p> <p>Interview with the ADON, on 05/31/13 at 4:01 PM,</p>	F 353			

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F 353	Continued From page 20 revealed all staff was responsible for answering call lights, with the expectation being they would be answered within three to four minutes. The ADON revealed she was told some nursing staff weren't responding to call lights, although staff audits hadn't supported this. The ADON revealed she didn't believe the presence of management staff when present affected the results of audits, and felt audits conducted by nursing staff were valid. The ADON revealed if nurses weren't answering call lights, she wasn't aware of it. Regarding showers, the ADON stated they were expected to be given unless a resident declined to have one given. The ADON expressed on second shift, if they were short staffed after attempting to replace staff that had called in, they "made due". An interview with the Administrator, on 05/31/13 at 5:50 PM, revealed no one had come to her with a problem regarding staffing, and she was unaware of the allegation nursing staff was not responding to call lights. The Administrator, in light of this allegation, stated she still felt it appropriate for nurses to do audits. She revealed the facility call light audits had not revealed any problems.	F 353			

Office of Inspector General

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NAME OF PROVIDER OR SUPPLIER GRAND HAVEN NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 105 RODGERS PARK CYNTHIANA, KY 41031
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(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETE DATE
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N 000 INITIAL COMMENTS
A Re-licensure Survey was initiated on 05/29/13 and concluded on 05/31/13 with deficiencies cited.

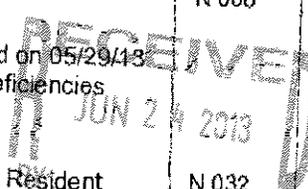
N 032 902 KAR 20:300-3(3)(e) Section 3. Resident Rights
(3) Protection of resident funds.
(e) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility shall convey promptly the resident's funds, and a final accounting of those funds, to the individual administering the resident's estate.

This requirement is not met as evidenced by:
Based on interview, record review, and review of the facility's policy, it was determined the facility failed to convey funds within thirty (30) days for one (1) of five (5) discharged resident records reviewed (Deceased Resident #4).

The findings include:

Review of the facility's policy titled "Resident Trust", undated, revealed the facility shall provided a reliable and trustworthy system to protect the funds of all residents who prefer that the facility handle their personal monies. Further review revealed the facility shall assure that there is adequate control and protection of these funds and will provide a routine statement of monies deposited and monies that have been expended. Additional review of this policy revealed no documented evidence the facility had a procedure to close a resident's account.

Review of Deceased Resident #4's personal fund records revealed the resident expired on



N 000 Preparation and execution of this plan of Correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared 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 deficiencies below is not an admission that the alleged facts occurred as presented in the statements.

N032 902 KAR 20:300-3(3)(e) Section 3. Resident Rights

Corrective Action for Residents Found to Have Been Affected
On 6/4/2013 the Business Office Manager dispersed the funds to the Estate of Resident #4 as noted in F 160.

Identification of Other Residents Having the Potential to be affected by the Same Deficient Practice
On 6/18/2013 a review of all residents related to the conveyance of all personal funds was completed by the business office manager.

[Signature]
administrator
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
STATE FORM 6899

Measures or Systemic Changes put into Place to Avoid Recurrence
On 6/18/2013 the Administrator provided additional education to the business office manager on proper conveyance of funds upon the death of a resident.
6) DATE 6-24-13
sheet 1 of 20

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N 032	Continued From page 1 12/01/12; however, the final conveyance of funds in the amount of \$978.84 was never completed and the account remained open, one hundred and eighty-one (181) days past the thirty (30) day time frame. Interview with the Business Office Manager/Patient Accounts and Payroll, on 05/31/13 at 7:00 PM, revealed Deceased Resident #4 expired on 12/01/12. Further interview revealed she could not find evidence of a check disbursement and did not know if a check had in fact been disbursed to close the account. Interview with the Director of Nursing, on 05/31/13 at 7:15 PM, revealed she was not familiar with the process but stated it should be completed per the facility's policy.	N 032	The facility's policy, "Resident Trust", has been reviewed and revised (6/18/13) to include proper direction upon discharge of a resident which includes returning the monies to the resident or responsible party within thirty (30) days. In the event of death, the funds will be dispersed to the executor of the estate within thirty (30) days. The business office manager will meet with the Administrator monthly to review the proper conveyance of all resident funds. Plans to Monitor Performance for Sustained Solutions The Administrator will inform the Director of Operations of any monthly discrepancies in the conveyance of funds in order to assure compliance with F 160 and for recommendations.	
N 033	902 KAR 20:300-3(3)(f) Section 3. Resident Rights (3) Protection of resident funds. (f) Assurance of financial security. The facility shall purchase a surety bond, or provide self-insurance to assure the security of all personal funds of residents deposited with the facility. This requirement is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to assure the security of all personal funds of residents deposited with the facility. The facility failed to provide a surety bond in an amount equal to or greater than the amount of resident funds in the resident funds account. The findings include:	N 033	<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 10px auto;">6-26-2013</div> N 033 902 KAR 20:300-3(3)(f) Section 3. Resident Rights Corrective Action for Residents Found to Have Been Affected No targeted residents were identified; however, all residents have the potential to be affected (see below).	

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N 033	Continued From page 2 A review of the facility's surety bond (an agreement wherein the facility and the insurance company agree to compensate the residents for any loss of residents' funds that the facility holds, safeguard, manages, and accounts for), dated January 01, 2011, revealed the maximum amount insured to be ten thousand dollars (\$10,000.00). Review of the monthly Resident Fund bank statements, revealed the account balance to be in excess of fifteen thousand dollars (\$15,000.00) at times during the statement period. Further review revealed, monthly statements to reflect monies in excess of ten thousand dollars (\$10,000.00) for the months of April 2013, March 2013, February 2013, January 2013, December 2012, November 2012, October 2012, September 2012, August 2012, and July 2012. Furthermore, for the months of December 2012 and January 2013, twenty one (21) out of thirty (30) days the account balance on each of these days was in excess of ten thousand dollars (\$10,000.00). Interview with the Business Manager, on 05/31/13 at 7:00 PM, revealed she thought the ten thousand dollar (\$10,000.00) surety bond adequate. Interview with the Administrator, on 05/31/13 at 7:20 PM, revealed she thought the surety bond was based on the quarterly average. No quarterly statements were provided as evidence of adequate amount of surety bond coverage.	N 033	Identification of Other Residents Having the Potential to be affected by the Same Deficient Practice The facility's Chief Financial Officer secured an increase in surety bond coverage from ten thousand (\$10,000) to twenty-five thousand (\$25,000) with an effective date of June 1 st 2013 to assure that the surety bond is well in excess of the highest historical balance. Measures or Systemic Changes put into Place to Avoid Recurrence The Administrator provided re-education on 6/18/13 to the business office manager on the role of the surety bond in assuring the security of all personal funds of residents deposited within the facility. The facility's policy, "Resident Trust", has been reviewed and revised (6/18/13) to note that the facility maintains a surety bond to provide assurance of financial security for all resident monies deposited within the facility.	
N 207	902 KAR 20:300-8(1)(c) Section 8. Quality of Care (1) Activities of dally living. Based on the comprehensive assessment of a resident, the facility shall ensure:	N 207	The business office manager will begin corresponding with the Administrator monthly to report on the resident trust balance to ensure that the balance remains under the limit of the surety bond.	

The Administrator will inform the Director of Operations of any monthly discrepancies in the amount of the surety bond in order to assure compliance with F 161 and for

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N 207	Continued From page 3 (c) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This requirement is not met as evidenced by: Based on interview, the group interview, record review and review of the facility's policy, it was determined the facility failed to carry out activities of daily living (ADLs) as related to ensure resident received showers as scheduled for five (5) of thirteen (13) sampled residents (Residents #1, #3, #5, #6 and #11). The facility failed to ensure enough staff to assist residents with scheduled showers and answer call lights in a timely manner. Review of the State Registered Nursing Assistant (SRNA) Care Plan Records for the months of December 2012 through May 2013 revealed numerous instances in which showers were not given according to schedule. Interviews with both residents and staff revealed SRNA staff were rushed to provide care, and were unable to meet the care needs of residents on an ongoing basis. The findings include: Review of the facility's policy titled, "Staffing Policy and Procedure Direct Care", not dated, revealed the facility provided sufficient staff and sufficient hours of work to caregivers in order to assure that appropriate care was delivered to the residents. The facility would provide direct care staff and support staff for the purpose of ensuring that care and services were provided that enhance the quality of life for each resident. During the Group Interview, on 05/29/13 at 3:00 PM, which consisted of ten (10) interviewable residents, the residents expressed concern with the facility being short staffed. Residents shared	N 207	<u>N 207 902 KAR 20:300-8(1)(c)</u> <u>Section 8. Quality of Care</u> <u>Corrective Action for Residents Found to Have Been Affected</u> Individual Interviews were completed by the Administrator on 6-5-13 with Residents #1, #3, #5, #6, and #11 regarding their preferences for shower days and times. Any changes to the previous shower roster were corrected immediately. SRNAs were in-serviced on the facility's policies for ADL care and proper documentation of showers. <u>Identification of Other Residents Having the Potential to be affected by the Same Deficient Practice</u> All residents have the potential to be affected. The Administrator interviewed all residents and/or responsible parties when appropriate to ensure residents' preferences regarding ADLs, baths, and showers are being honored. Resident's care plans were updated as needed to reflect the resident's preferences. <u>Measures or Systemic Changes put into Place to Avoid Recurrence</u> Interviews were completed by the Administrator on 6/5/13 with each resident and/or responsible party regarding their preferences for shower days and times. Any changes to the previous shower roster were corrected immediately. Resident's care plans were updated as needed to reflect the resident's preferences including residents who refuse showers.	

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	<p>Continued From page 4</p> <p>occurrences in which staff failed to respond to call lights in a timely manner. Residents were adamant this was not the fault of the staff, as they expressed knowledge that staff were occupied caring for other residents. Residents shared they rarely received their showers as scheduled, and more often than not had to settle for a quick bed bath as staff was too rushed to provide showers.</p> <p>1. Record review revealed the facility admitted Resident #1 on 03/25/04 with diagnoses which included Diabetes. Review of the Minimum Data Set (MDS) Assessment, dated 04/21/13 revealed the facility scored the resident as fourteen (14) out of fifteen (15) on the Brief Interview for Mental Status (BIMS) assessment, indicating the resident had no cognitive impairment. Continued review of the assessment revealed the facility assessed the resident as requiring assistance with bathing.</p> <p>A review of the SRNA Care Plan Record for Resident #1 for the months of December 2012 through May 2013 revealed Resident #1 had showers scheduled two (2) times a week on second (2nd) shift. A review of services provided revealed Resident #1 received a shower a total of eight (8) times during the six (6) month review period, instead of the fifty-two (52) times scheduled.</p> <p>Interview with Resident #1, on 05/30/13 at 5:00 PM, revealed the resident would rather have a shower each time it was scheduled but further stated I know they are short staffed sometimes and have to assist him/her with a bed bath instead of a full shower.</p> <p>2. Record review revealed the facility admitted Resident #3 on 09/26/06 with diagnoses which</p>		<p>The staff development coordinator completed in-servicing with all nursing staff beginning on 6/14/13 on the facility's policies for ADL care, proper completion of documentation of SRNA Care Plans, and procedures for monitoring care delivery.</p> <p>Plans to Monitor Performance for Sustained Solutions</p> <p>All nurse aid care plan documentation will be reviewed prior to end of shift for completion and accuracy with reference to shower/bathing schedule. SRNA care plans will be audited twice weekly for completion and accuracy by the Director or Assistant Director of Nursing.</p> <p>Residents will be interviewed quarterly by the Social Services Director until compliance has been sustained to ensure individual preferences are honored regarding bath and shower schedule. Any further issues in this area will be put through the CQI process.</p> <p>Care plans will be audited monthly prior to change over by the Director or Assistant Director of Nursing with audit results submitted for review to the Quality Assurance Committee. The facility will follow the recommendations of the Quality Assurance Committee.</p>	

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N 207	<p>Continued From page 5</p> <p>Included diabetes and Depression. Review of the Annual MDS Assessment, dated 04/17/13 revealed the facility assess the resident as having a BIMS score of fifteen (15) out of fifteen (15) indicating the resident was cognitively intact and as requiring assistance with e bathing.</p> <p>A review of the SRNA Care Plan Record for Resident #3 for the months of December 2012 through May 2013 revealed Resident #3 had showers scheduled three times a week on second (2nd) shift. A review of services provided revealed Resident #3 received forty-nine (49) of the seventy-eight (78) showers scheduled during the six month review period.</p> <p>Interview with Resident #3, on 05/31/13 at 11:30 AM, revealed his/her needs were not being met and this was his/her home. Resident #3 stated he/she was supposed to get a shower two (2) times a week and when there was only two (2) staff on each hall, he/she was not given an option of a shower, just bed baths. He She stated this happened about three (3) times a month. The resident stated he/she was told by staff the reason for bed baths, was because there was not enough help.</p> <p>3. Record review revealed the facility admitted Resident #5 on 10/14/09 with diagnoses which included Osteoporosis, Parkinson's Disease and Congestive Heart Failure. Review of the Quarterly MDS Assessment, dated 03/20/13, revealed the facility assessed the resident with a BIMS score of twelve (12) out of fifteen (15) indicating the resident had moderately impaired cognition. Further review revealed the facility the resident as requiring assistance with bathing and toileting.</p>	N 207		
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N 207	Continued From page 6 A review of the SRNA Care Plan Record for Resident #5 for the months of December 2012 through May 2013 revealed Resident #5 had showers scheduled three times a week on second (2nd) shift. A review of services provided revealed Resident #5 received forty-one (41) of the fifty-two (52) showers scheduled during the six month review period, with a period of thirteen (13) days without a shower during the month of December 2012. Interview with Resident #5, on 05/30/13 at 4:40 PM, revealed staff took a while to answer the call bell. Resident #5 further stated when I turned the call bell on, on 05/29/13 (time unknown) he/she had an accident in the bed because staff did not get to him/her in time and he/she had to wait and this made him/her feel awful. The Resident further stated he/she would rather have a shower than a bed bath on his/her scheduled days. 4. Record review revealed the facility admitted Resident #6 on 08/24/10 with diagnoses which included Dementia, Diabetes and Peripheral Vascular Disease. Review of the Quarterly MDS Assessment, dated 02/15/13 revealed the facility assessed the resident as having severe cognitive impairment and requiring extensive assistance with bathing. A review of the SRNA Care Plan Record for Resident #6 for the months of December 2012 through May 2013 revealed Resident #6 had showers scheduled two (2) times a week on second (2nd) shift. A review of services provided revealed Resident #6 received twenty-eight (28) of the fifty-two (52) showers scheduled during the six month review period, with a period of sixteen (16) days without a shower from the end of April 2013 through the beginning of May 2013.	N 207		

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	<p>Continued From page 7</p> <p>5. Record review revealed the facility admitted Resident #11 on 01/18/13. Review of the Quarterly MDS Assessment revealed the facility assessed the resident as being moderately impaired in cognition and requiring assistance with bathing.</p> <p>A review of the SRNA Care Plan Record for Resident #11 for the months of December 2012 through May 2013 revealed Resident #11 had showers scheduled two times a week on second (2nd) shift. A review of services provided revealed Resident #11 received forty-five (45) of fifty-two (52) showers scheduled during the six month review period.</p> <p>Interview with Resident #11, on 05/31/13 at 11:45 AM, revealed he/she was scheduled for a shower two (2) times a week and about every other week he/she did not get a shower and was told by staff that it was because there was not enough staff. He/She stated it made him/her feel "bad" and "lousy" when he/she didn't get a shower.</p> <p>An Interview with SRNA #5, on 05/30/13 at 10:56 AM, revealed she tried to treat residents the way she would want to be treated in their position. She shared she could not provide showers because there wasn't enough staff, and that residents were fortunate to get bed baths. SRNA #5 stated she felt it wrong not to be able to give resident's their showers, and that aides were rushed and not able to provide quality care, describing her tasks as running into a resident room, bathing them, dressing them, then rushing to the next resident. SRNA #5 stated she felt it neglectful to have to treat residents like a job instead of a person. SRNA #5 stated aides had tried to talk to the Director of Nursing (DON) and</p>			

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N 207	Continued From page 8 residents had spoken with the DON about some nurses not helping out. Interview with Licensed Practical Nurse (LPN) #1, on 05/30/13 at 11:37 AM, revealed it was everybody's job to answer call lights. LPN #1 acknowledged there had been times when residents had been incontinent because aides hadn't been able to get to them. She stated at one time they seemed to be having a lot of call ins, and when they were short staffed resident care suffered. Interview with SRNA #7, on 05/30/13 at 3:15 PM, revealed when she was initially employed at the facility there was more individual attention paid to residents. She expressed the quality of care residents received suffered when working short-staffed and that she had been working shifts short-staffed quite a bit. She stated there are lots of times that residents only get bed baths instead of showers because there was not enough staff. Interview with SRNA #8, on 05/30/13 at 3:43 PM, revealed she had worked all three shifts, and the facility was often short-staffed on second shift. SRNA #8 stated showers did not get done, and sometimes there was not time for even bed baths depending on how short staffed they were working. SRNA #8 went on to reveal when staff expressed concerns about staffing, they feel their concerns were not addressed. Interview with SRNA #12, on 05/31/12 at 10:59 AM, revealed, if nobody called in on weekends, residents who were scheduled showers got them. If someone called in, they had to provide bed baths instead, and residents were "pretty understanding" of this. SRNA #12 stated aides.	N 207		

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N 207	<p>Continued From page 9</p> <p>could not get to residents if they were bathing or showering someone else, or toileting someone else.</p> <p>Interview with SRNA #14 on 05/31/12 at 11:50 AM revealed she works short-staffed quite a bit. She stated she could not get to call lights when she was giving baths, and that there were residents that require multiple bathroom breaks per eight hour shift, and there wasn't enough help.</p> <p>Interview with SRNA #15, on 05/31/12 at 2:21 PM, revealed nurses did not answer call lights, and instead would go to find aides, even the aides were giving baths, if call lights were going off. SRNA #15 stated she had finished bathing residents to find two (2) or three (3) call lights going off. SRNA #15 stated she brought this to the attention of the DON a month or two ago, but she can't tell that anything had changed.</p> <p>An interview with the DON, on 05/30/13 at 2:45 PM, revealed occasionally staff and residents came to her with concerns, although no one expressed to her a concern about staffing. She stated staffing concerns came up in resident council, and were addressed in a meeting with the Administrator and Conservator. The DON stated on average they received more than one call in a week, and when there was a call in, staff made calls to fill the vacancy. The DON stated the facility had been doing audits on call lights since December 2012, and that although aides had told her some nurses didn't respond to call lights, she had discussed this with nurses and made observations of nurses answering call lights.</p> <p>Interview with the ADON on 05/31/13 at 4:01 PM revealed all staff are responsible for answering</p>	N 207		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 207	Continued From page 10 call lights, with the expectation being they are answered within three to four minutes. The ADON revealed she was told some nursing staff weren't responding to call lights, although staff audits hadn't supported this. Regarding showers, the ADON stated they were expected to be given unless a resident declined to have one given. The ADON expressed on second shift, if they were short staffed after attempting to replace staff that had called in, they "made due". An interview with the Administrator, on 05/31/13 at 5:50 PM, revealed no one had come to her with a problem regarding staffing, and she was unaware of the allegation nursing staff was not responding to call lights. She further stated she was not aware residents were not receiving their showers as scheduled.	N 207		
N 239	902 KAR 20:300-9 Section 9. Nursing Services The facility shall have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. This requirement is not met as evidenced by: Based on interview, the group interview, record review and review of the facility's policy, it was determined the facility failed to maintain sufficient staff to attain or maintain the highest practicable physical, mental, and psychosocial well-being for five (5) of thirteen (13) sampled residents (Residents #1, #3, #5, #6 and #11). The facility failed to ensure enough staff to assist residents with scheduled showers and answer call lights in a timely manner. Review of the State Registered Nursing Assistant (SRNA) Care Plan Records for	N 239	N 239 902 KAR 20:300-9 Section 9. Nursing Services Corrective Action for Residents Found to Have Been Affected The facility interviewed resident #1, #3, #5, #6, and #11 for the purpose of assuring that sufficient staff exists to meet the needs of each resident. Each resident voiced that they are satisfied with staffing and their care. Care is provided timely and according to the Comprehensive Care Plan.	

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N 239	<p>Continued From page 11</p> <p>the months of December 2012 through May 2013 revealed numerous instances in which showers were not given according to schedule. Interviews with both residents and staff revealed SRNA staff were rushed to provide care, and were unable to meet the care needs of residents on an ongoing basis.</p> <p>(Refer to F-312)</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Staffing Policy and Procedure Direct Care", not dated, revealed the facility provided sufficient staff and sufficient hours of work to caregivers in order to assure that appropriate care was delivered to the residents. The facility would provide direct care staff and support staff for the purpose of ensuring that care and services were provided that enhance the quality of life for each resident.</p> <p>During the Group Interview, on 05/29/13 at 3:00 PM, which consisted of ten (10) interviewable residents, the residents expressed concern with the facility being short staffed. Residents shared occurrences in which staff failed to respond to call lights in a timely manner. Residents were adamant this was not the fault of the staff, as they expressed knowledge that staff were occupied caring for other residents. Residents shared they rarely received their showers as scheduled, and more often than not had to settle for a quick bed bath as staff was too rushed to provide showers.</p> <p>1. Record review revealed the facility admitted Resident #1 on 03/25/04 with diagnoses which included Diabetes. Review of the Minimum Data Set (MDS) Assessment, dated 04/21/13 revealed the facility scored the resident as fourteen (14)</p>	N 239	<p>Identification of Other Residents Having the Potential to be affected by the Same Deficient Practice</p> <p>All residents have the potential to be affected.</p> <p>The facility conducted interviews of all residents to determine if staffing was adequate to meet the care needs of the resident. If the Resident was non-communicative, the responsible party for each resident was contacted for the interview. All Resident and/or responsible party Interviews were reviewed to determine that the staffing required was evident to meet the needs of the residents. Interviews indicated that care is being provided timely and according to the Comprehensive Care Plan.</p> <p>Staff education was provided on 6/21/13 by the Director of Nursing to all nursing staff regarding providing care in a timely manner to meet the needs of residents in accordance with the resident plan of care.</p>	

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N 239	Continued From page 12 out of fifteen (15) on the Brief Interview for Mental Status (BIMS) assessment, indicating the resident had no cognitive impairment. Continued review of the assessment revealed the facility assessed the resident as requiring assistance with bathing. A review of the SRNA Care Plan Record for Resident #1 for the months of December 2012 through May 2013 revealed Resident #1 had showers scheduled two (2) times a week on second (2nd) shift. A review of services provided revealed Resident #1 received a shower a total of eight (8) times during the six (6) month review period, instead of the fifty-two (52) times scheduled. Interview with Resident #1, on 05/30/13 at 5:00 PM, revealed the resident would rather have a shower each time it was scheduled but further stated I know they are short staffed sometimes and have to assist him/her with a bed bath instead of a full shower. 2. Record review revealed the facility admitted Resident #3 on 09/26/06 with diagnoses which included diabetes and Depression. Review of the Annual MDS Assessment, dated 04/17/13 revealed the facility assess the resident as having a BIMS score of fifteen (15) out of fifteen (15) indicating the resident was cognitively intact and as requiring assistance with e bathing. A review of the SRNA Care Plan Record for Resident #3 for the months of December 2012 through May 2013 revealed Resident #3 had showers scheduled three times a week on second (2nd) shift. A review of services provided revealed Resident #3 received forty-nine (49) of the seventy-eight (78) showers scheduled during	N 239	Measures or Systemic Changes put into Place to Avoid Recurrence The Administrator developed a ten point questionnaire to be used for Resident/Responsible Party interviews to determine that sufficient staff existed to meet the needs of each Resident. Interviews were conducted by the Director of Nursing, Assistant Director of Nursing, Social Services Director and two MDS nursing personnel. Any identified concerns were addressed immediately. These interviews will be conducted for the next two months to determine that sufficient staffing is sustained to meet the needs of the residents. The Administrator, Director and Assistant Director of Nursing reviewed the staffing patterns of the facility in conjunction with the completed resident interviews and the Comprehensive Care Plans to determine that the staffing required to meet the needs of the residents is scheduled and is in place.	

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N 239	<p>Continued From page 13</p> <p>the six month review period.</p> <p>Interview with Resident #3, on 05/31/13 at 11:30 AM, revealed his/her needs were not being met and this was his/her home. Resident #3 stated he/she was supposed to get a shower two (2) times a week and when there was only two (2) staff on each hall, he/she was not given an option of a shower, just bed baths. He She stated this happened about three (3) times a month. The resident stated he/she was told by staff the reason for bed baths, was because there was not enough help.</p> <p>3. Record review revealed the facility admitted Resident #5 on 10/14/09 with diagnoses which included Osteoporosis, Parkinson's Disease and Congestive Heart Failure. Review of the Quarterly MDS Assessment, dated 03/20/13, revealed the facility assessed the resident with a BIMS score of twelve (12) out of fifteen (15) indicating the resident had moderately impaired cognition. Further review revealed the facility the resident as requiring assistance with bathing and toileting.</p> <p>A review of the SRNA Care Plan Record for Resident #5 for the months of December 2012 through May 2013 revealed Resident #5 had showers scheduled three times a week on second (2nd) shift. A review of services provided revealed Resident #5 received forty-one (41) of the fifty-two (52) showers scheduled during the six month review period, with a period of thirteen (13) days without a shower during the month of December 2012.</p> <p>Interview with Resident #5, on 05/30/13 at 4:40 PM, revealed staff took a while to answer the call bell. Resident #5 further stated when I turned the</p>	N 239	<p>The Director and Assistant Director of Nursing reviews the daily staffing and reports to the Administrator to assure that staffing is adequate to meet the needs of each resident.</p> <p>Staff education was provided by the Director of Nursing on 6/21/13 to all nursing staff regarding providing care in a timely manner to meet the needs of residents in accordance with the resident plan of care.</p> <p>The Director and Assistant Director of Nursing are reviewing 24 hour report and staffing assignments to ensure staffing is available and assigned to meet the residents' needs. Any requests for changes in staffing are to go directly to the Director of Nursing.</p>	

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N 239	Continued From page 14 call bell on, on 05/29/13 (time unknown) he/she had an accident in the bed because staff did not get to him/her in time and he/she had to wait and this made him/her feel awful. The Resident further stated he/she would rather have a shower than a bed bath on his/her scheduled days. 4. Record review revealed the facility admitted Resident #6 on 08/24/10 with diagnoses which included Dementia, Diabetes and Peripheral Vascular Disease. Review of the Quarterly MDS Assessment, dated 02/15/13 revealed the facility assessed the resident as having severe cognitive impairment and requiring extensive assistance with bathing. A review of the SRNA Care Plan Record for Resident #6 for the months of December 2012 through May 2013 revealed Resident #6 had showers scheduled two (2) times a week on second (2nd) shift. A review of services provided revealed Resident #6 received twenty-eight (28) of the fifty-two (52) showers scheduled during the six month review period, with a period of sixteen (16) days without a shower from the end of April 2013 through the beginning of May 2013. 5. Record review revealed the facility admitted Resident #11 on 01/18/13. Review of the Quarterly MDS Assessment revealed the facility assessed the resident as being moderately impaired in cognition and requiring assistance with bathing. A review of the SRNA Care Plan Record for Resident #11 for the months of December 2012 through May 2013 revealed Resident #11 had showers scheduled two times a week on second (2nd) shift. A review of services provided revealed Resident #11 received forty-five (45) of	N 239	Charge nurses review the nursing department staffing schedules, assignments and needs of the residents daily to ensure that adequate staff are in place to provide care in a timely manner for each resident in accordance with their individual plan of care. Staff education has been given by the Director of Nursing on 6/21/13 to charge nurses regarding supervision and delegation of duties to provide timely care to meet the needs of residents in accordance with the individual plan of care. The staffing patterns are reviewed at the daily Continuous Quality Improvement (CQI) meetings to assure that staffing is provided to meet the needs of each resident.	

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N 239	Continued From page 15 fifty-two (52) showers scheduled during the six month review period. Interview with Resident #11, on 05/31/13 at 11:45 AM, revealed he/she was scheduled for a shower two (2) times a week and about every other week he/she did not get a shower and was told by staff that it was because there was not enough staff. He/She stated it made him/her feel "bad" and "lousy" when he/she didn't get a shower. An interview with SRNA #4, on 05/30/13 at 10:28 AM, revealed for the past "four or five months", she hadn't been able to get her work done "the way I would like to". She went on to elaborate that she was always rushing and unable to spend any quality time with residents. She went on to express residents didn't feel like they were getting the attention they deserved. SRNA #4 went on to reveal residents informed her they had to wait twenty (20) to thirty (30) minutes for staff to answer call lights, and that this was a daily occurrence. SRNA #4 stated that it was an aides job to visit with residents who did not come out of their rooms, but they didn't have time to do it. SRNA #4 also shared some nurses did not answer call lights. An interview with SRNA #5, on 05/30/13 at 10:56 AM, revealed she tried to treat residents the way she would want to be treated in their position, "like they're family". She shared she could not provide showers because there was not enough staff, and that residents were fortunate to get bed baths. SRNA #5 stated she felt it wrong not to be able to give resident's their showers, and that aides were rushed and not able to provide quality care, describing her tasks as running into a resident room, bathing them, dressing them, then rushing to the next resident. SRNA #5 stated she	N 239	Plans to Monitor Performance for Sustained Solutions Residents attending the monthly resident council meeting will be interviewed to determine if staffing is sufficient to meet resident's needs in a timely manner. Residents and/or responsible party (if appropriate) will be interviewed quarterly by the Social Services director until compliance has been sustained to determine if staffing is sufficient to meet the individual needs of the resident. Any further issues in this area will be put through the CQI process. Results of CQI staffing patterns and Resident/Responsible Party Interviews will be reviewed by QA committee monthly to ensure that sufficient staff is available to meet residents' needs. The facility will follow the recommendations of the QA committee.	6/26/2013

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N 239	<p>Continued From page 16</p> <p>felt it neglectful to have to treat residents like a job instead of a person, "but we do the best we can". SRNA #5 stated aides had tried to talk to the Director of Nursing (DON) and residents had spoken with the DON, about some nurses not helping out.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 05/30/13 at 11:37 AM, revealed it was everybody's job to answer call lights, and she responded to call lights. LPN #1 acknowledged there had been times when residents had been incontinent because aides hadn't been able to get to them. She stated at one time they seemed to be having a lot of call ins, and when they are short staffed resident care may suffer.</p> <p>Interview with SRNA #7, on 05/30/13 at 3:15 PM, revealed when she was initially employed at the facility there was more individual attention paid to residents. She expressed the quality of care residents receive suffered when working short-staffed, and that she had been working shifts short-staffed quite a bit.</p> <p>Interview with SRNA #8, on 05/30/13 at 3:43 PM, revealed she had worked all three shifts, and the facility was often short-staffed on second shift. SRNA #8 stated she has had residents cry when they urinated on themselves because aides haven't been able to get to them in time, and nurses did not always help. She stated showers did not get done, and sometimes there wasn't time for even bed baths depending on how short staffed they were working.</p> <p>Interview with SRNA #9, on 05/30/13 at 4:38 PM, revealed "two people [aides] can't do the job on third shift," and when there are fewer than four aides on second shift, residents don't always get</p>	N 239		

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N 239	Continued From page 17 their smoke breaks on time, on occasions having to wait 20 to 25 minutes past scheduled time. SRNA #9 stated it doesn't happen often, but there had been times when she wasn't able to get to residents in time before they had a bowel or bladder accident, and that residents were sometimes upset because we weren't there when they needed us. Interview with SRNA #12, on 05/31/12 at 10:59 AM, revealed if nobody called in on weekends, residents who were scheduled showers got them. If someone called in, they had to provide bed baths instead, and residents were "pretty understanding" of this. SRNA #12 stated call lights were more a concern on st shift, and there had been quite a few times when residents had had an incontinent episode while waiting on staff to respond to call lights. SRNA #12 stated aides could not get to residents if they were bathing or showering someone else, or toileting someone else. Interview with SRNA #14, on 05/31/12 at 11:50 AM, revealed she worked short-staffed quite a bit. She stated she could not get to call lights when she was giving baths, and that there were residents that required fourteen or fifteen bathroom breaks per eight hour shift, and there was not enough help. Interview with SRNA #15, on 05/31/12 at 2:21 PM, revealed nurses did not answer call lights, and instead would go to find aides, even if giving baths, if call lights were going off. SRNA #15 stated she has finished bathing residents to find two or three call lights going off. SRNA #15 stated she brought this to the attention of the DON a month or two ago, but she could not tell that anything had changed. SRNA #15 stated	N 239		

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N 239	<p>Continued From page 18</p> <p>there had been times when residents had bowel or bladder accidents while waiting on staff to respond to call lights, and she did not think it was acceptable, and residents weren't happy about it.</p> <p>An interview with the DON, on 05/30/13 at 2:45 PM, revealed occasionally staff and residents came to her with concerns, although no one expressed to her a concern about staffing. She stated staffing concerns came up in resident council and were addressed in a meeting with the Administrator and Conservator. The DON stated on average they received more than one call in a week, and when there was a call in, staff made calls to fill the vacancy. The DON stated the facility had been doing audits on call lights since December 2012, and that although aides had told her some nurses didn't respond to call lights, she had discussed this with nurses and made observations of nurses answering call lights.</p> <p>Interview with the ADON, on 05/31/13 at 4:01 PM, revealed all staff was responsible for answering call lights, with the expectation being they would be answered within three to four minutes. The ADON revealed she was told some nursing staff weren't responding to call lights, although staff audits hadn't supported this. The ADON revealed she didn't believe the presence of management staff when present affected the results of audits, and felt audits conducted by nursing staff were valid. The ADON revealed if nurses weren't answering call lights, she wasn't aware of it. Regarding showers, the ADON stated they were expected to be given unless a resident declined to have one given. The ADON expressed on second shift, if they were short staffed after attempting to replace staff that had called in, they "made due".</p>	N 239			

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N 239	Continued From page 10 An interview with the Administrator, on 05/31/13 at 5:50 PM, revealed no one had come to her with a problem regarding staffing, and she was unaware of the allegation nursing staff was not responding to call lights. The Administrator, in light of this allegation, stated she still felt it appropriate for nurses to do audits. She revealed the facility call light audits had not revealed any problems.	N 239		

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

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OMB NO. 0938-0391

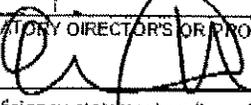
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185332	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/29/2013
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NAME OF PROVIDER OR SUPPLIER GRAND HAVEN NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 106 RODGERS PARK CYNTHIANA, KY 41031
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Plan approval: 1979</p> <p>Facility type: SNF/NF</p> <p>Type of structure: One story, Type V (unprotected)</p> <p>Smoke Compartment: Four (4)</p> <p>Fire Alarm: Complete fire alarm with smoke detectors installed in corridors, single station smoke detectors installed in resident rooms 102, 103, 106, 107, 109, 203, 204, 209, and 210</p> <p>New panel installed 2005.</p> <p>Sprinkler System: Complete sprinkler system (dry). New dry pipe valve installed 11/15/11</p> <p>Generator: Type 2 generator powered by natural gas</p> <p>A Standard Life Safety Code Survey was conducted on 05/29/13. Grand Haven Nursing Facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was forty-nine (49). The facility is licensed for fifty four (54) beds.</p> <p>The Highest Scope and Severity deficiency was</p>	K 000	<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 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 deficiencies below is not an admission that the alleged facts occurred as presented in the statements.</p>	
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RECEIVED
JUN 24 2013
BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE administrator	(X6) DATE 6-24-13
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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.

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: 185332	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/29/2013
NAME OF PROVIDER OR SUPPLIER GRAND HAVEN NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 105 RODGERS PARK CYNTHIANA, KY 41031	
(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
K 000	Continued From page 1 an "F" level.	K 000	<u>K 018 (E) Fully Latching Doors</u>	
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridor doors would resist the passage of smoke. The deficiency had the potential to affect three (3) doors, six (6) residents, staff, and visitors. The findings include: Observation, on 05/29/13 between 9:00 AM and 12:00 PM, revealed resident room doors 105,	K 018	Corrective Action for Residents Found to Have Been Affected On 5/29/2013 the resident room doors 105, 202, and 212 were addressed by the maintenance technician and have fully latching doors. Identification of Other Residents Having the Potential to be affected by the Same Deficient Practice All residents have the potential to be affected by the same deficient practice and on 5/29/13, the Administrator completed rounds throughout the facility to identify any other doors that were cited in K 018. No other doors were identified to have non latching doors. Measures or Systemic Changes put into Place to Avoid Recurrence Monthly facility-wide rounds will be completed by the maintenance technician to monitor resident room doors to ensure that they fully latch when closed. Any identified issues will be corrected immediately. Documentation will be provided to the Administrator and the Safety Committee.	

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

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K 018	<p>Continued From page 2</p> <p>202, and 212 would not latch when shut. Resident room doors must latch to resist the passage of smoke. The observation was confirmed with the Maintenance Director.</p> <p>Interview, on 02/05/13 at 1:00 PM, with the Maintenance Director revealed he was not aware the resident room doors, located in the corridor, would not latch. This was confirmed with the Administrator.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass</p>	K 018	<p>Plans to Monitor Performance for Sustained Solutions</p> <p>Results of the monthly audits for properly latching doors are monitored by the Administrator and reviewed by the Safety Committee that meets monthly. The Safety Committee will make recommendations and provide follow-up for proper door latching.</p> <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 10px auto;">6/26/2013</div> <p>K 025 (F) Smoking Penetrations</p> <p>Corrective Action for Residents Found to Have Been Affected</p> <p>On 5/29/2013 the three (3) of four (4) smoking compartments identified in K 025 were addressed by the maintenance technician and the smoking compartments were sealed per regulatory guidance provided in K 025. Since all residents have the potential to be affected please see below for the identification of all residents.</p>
K 025 SS=F		K 025	

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K 025 Continued From page 3
panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure smoke barriers were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, all residents, staff and visitors. The facility is licensed for fifty-four (54) beds and the census was forty-nine (49) on the day of the survey.

The findings include:

Observation, on 05/29/13 at 11:15 AM, revealed smoke barrier at 200 Hall had penetrations (three (3) one inch in diameter) not sealed around conduit piping and data wires penetrated the walls. Also 100 Hall smoke barrier had (two (2) one inch) penetrations around conduit and data wires not sealed also five(5) to six(6) large voids around truss lumber penetrating through the smoke barrier was not sealed to resist the passage of smoke.

Interview, on 05/29/13 at 11:40 AM, with the Maintenance Director revealed he was unaware of the penetrations.

K 025 **Identification of Other Residents Having the Potential to be affected by the Same Deficient Practice**
On 6/8/1013 the facility's contracted fire safety vendor completed a review of all smoke barriers to identify the potential of smoke barrier penetrations. On 6/10/2013 the administrator obtained an outside contractor to audit all smoke barriers to identify any smoking penetrations and to educate the maintenance technician on the proper monitoring and recognition of smoke barrier penetrations. On 6/14/2013 the maintenance technician identified and repaired any penetrations that were not sealed around conduit piping, data wires and around trusses.

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K 025 Continued From page 4
Interview, on 5/29/13 at 12:10 PM, with the Administrator revealed she thought the smoke barriers were in compliance after the work from last year.

Reference: NFPA 101 (2000 edition)
8.2.4.4.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as follows:

(1) The space between the penetrating item and the smoke partition shall meet one of the following conditions:

- a. It shall be filled with a material that is capable of limiting the transfer of smoke.
- b. It shall be protected by an approved device that is designed for the specific purpose.

(2) Where the penetrating item uses a sleeve to penetrate the smoke partition, the sleeve shall be solidly set in the smoke partition, and the space between the item and the sleeve shall meet one of the following conditions:

- a. It shall be filled with a material that is capable of limiting the transfer of smoke.
- b. It shall be protected by an approved device that is designed for the specific purpose.

(3) Where designs take transmission of vibrations into consideration,

K 025 **Measures or Systemic Changes put into Place to Avoid Recurrence**
The Maintenance technician will shadow each contracted technician to identify any newly created smoking penetrations during maintenance of building. All Interrupted penetrations made will be corrected immediately.

Maintenance technician will complete documented environmental rounds on a weekly basis and provide the results to the Administrator and the Safety Committee. The environmental rounds include monitoring of smoking penetrations to ensure that they are properly sealed.

Plans to Monitor Performance for Sustained Solutions
Results of the weekly audits for smoke barrier penetrations are monitored by the Administrator and reviewed by the Safety Committee that meets monthly. The Safety Committee will make recommendations and provide follow-up for and smoke barrier penetrations.

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K 025 K 027 SS=F	<p>Continued From page 5 any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke partitions. b. It shall be made by an approved device that is designed for the specific purpose.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 3/4-inch thick solid bonded wood core. Non-rated protective plaes that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain smoke barrier doors to resist the passage of smoke, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of four (4) smoke barriers, all residents, staff and visitors. The facility is licensed for fifty-four (54) beds and the census the day of the survey was Forty-nine (49).</p> <p>The findings Include:</p> <p>Observation, on 05/29/13 at 9:43 AM, revealed the doors located in the smoke barriers located in 100 Hall did not completely close to resist the</p>	K 025 K 027	<p>K 027 (F) Smoke Barrier Doors</p> <p>Corrective Action for Residents Found to Have Been Affected On 6/10/2013 the facility hired a maintenance consultant who asslsted the maintenance technician in both identifying and correcting any citations related to K 027. The smoke barrier doors on the 100 Hall are closing properly to prevent the passage of smoke. Since all residents have the potential to be affected please see below for the identification of all residents.</p> <p>Identification of Other Residents Having the Potential to be affected by the Same Deficlent Practice On 6/10/2013 all smoke barrier doors were reviewed for proper closure to prevent the passage of smoke.</p>

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K 027 Continued From page 6 passage of smoke.

Interview, on 05/29/13 at 9:43 AM, with the Maintenance Director, revealed he didn't know why the doors would not close completely but would correct the problem.

Reference: NFPA 101 (2000 edition)
8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.

Centers for Medicare and Medicaid Services survey and certification letter: 7-18

K 027 **Measures or Systemic Changes put into Place to Avoid Recurrence**
On 6/18/2013 smoke barrier doors were added to the documented environmental rounds. These observations will be made using the rounds checklist and will continue on a weekly basis. Any identified issues will be repaired immediately.

Plans to Monitor Performance for Sustained Solutions
The results of the documented rounds will be provided to the Administrator and the monthly safety committee for review, recommendations and follow-up.

6/26/2013