

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

Ky# 23250

PRINTED: 08/03/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185472</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>07/22/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>JOSEPH EDDIE BALLARD WESTERN KENTUCKY VETERANS CEN</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>926 VETERANS DRIVE</b> <b>HANSON, KY 42413</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	<b>INITIAL COMMENTS</b>  Based upon an Onsite Revisit conducted on 07/22/15 for Abbreviated Survey 06/04/15, the facility was determined to be in compliance on 07/09/15, as alleged in the acceptable PoC.	{F 000}			

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

TITLE

(X6) DATE

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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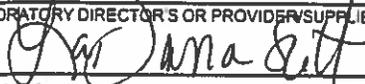
PRINTED: 06/18/2015  
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NAME OF PROVIDER OR SUPPLIER  JOSEPH EDDIE BALLARD WESTERN KENTUCKY VETERANS CEN	STREET ADDRESS, CITY, STATE, ZIP CODE 926 VETERANS DRIVE HANSON, KY 42413
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F 000	INITIAL COMMENTS  An Abbreviated Survey investigating complaint #KY00023250 was completed on 06/01/05 through 06/04/15. Complaint #KY00023250 was substantiated with deficiencies cited at the highest S/S of a "D".	F 000	F225 483.25 <i>Investigate/Report Allegations/Individuals</i>	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).  The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.  The results of all investigations must be reported to the administrator or his designated	F225	<u>What corrective action(s) will be accomplished for those residents found to be affected by the Deficient practice:</u>  Resident # 1 was assessed on (5/18/15) and #2 was assessed on (4/30/15) and both found to be free of injury. Both nurse aides # 1 and #2 were placed on leave pending the investigation to prevent further abuse.  <u>How you will identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken:</u>  In the event an allegation of abuse occurs the following tools/measures will be taken to ensure allegations of abuse are immediately reported and <u>interviews with other residents to whom the accused employee provides care or services are conducted. The Administrator and Assistant Administrator will be responsible to ensure all steps of an abuse allegation are followed.</u>  Allegation of Abuse/Neglect Checklist was revised on 6/22/15 by Administrator and will be used by the Administrator and/or Assistant Administrator <u>beginning 6/22/15</u> to ensure all steps in the facility's abuse policy are completed thoroughly.	6/25/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Administrator</i>	(X6) DATE 6/30/15
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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.

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F 225	Continued From page 1 representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.  This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, it was determined the facility failed to report allegations of abuse immediately and conduct interviews with other residents who received care from the alleged perpetrators for two (2) of four (4) sampled residents (Resident #1 and Resident #2) related to allegations of abuse. The findings include: Review of the facility's policy titled, "Reporting Abuse to Facility Management", dated February 2002, revealed it was the responsibility of each employee to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of an unknown origin to the administrator or his/her designee. Review of the facility's policy titled "Investigating Allegations of Physical Abuse", dated February 2002, revealed all reported incidents of physical abuse should be promptly and thoroughly investigated and when an investigation of physical abuse was conducted there should be a full body examination paying particular attention to the areas of the resident's complaint. Review of the facility's policy titled, "Prevention of Abuse, Neglect, and Misappropriation", dated 03/01/2010, revealed alleged violations of suspected abuse should be immediately reported to the Administrator or designee and any person having reasonable cause to suspect that an adult	F 225	(continued from Page 1) F225 482.25  <u>What measures will be put into place, or what systemic changes you will make to ensure that the deficient practice does not recur:</u>  All employees were re-educated by the Social Service Director and Administrator on the Abuse Policy and Procedures including: prevention, thoroughly investigating, promptly reporting to the Administrator and interviewing additional residents when an allegation is made. Completed 6/5/16  APRN, LPN #2, Unit Manager and OSA #1 were all in-serviced on 5/8/15 by the Social Service Director on the facility's Policy and Procedure on reporting abuse.  The PA#1 was educated on the facility abuse policy and procedure on 1/6/15 and 5/1/15 by the Social Service Director, and 6/4/15 by the Social Service Director and Administrator.  <u>The Allegation of Abuse/Neglect Checklist will be used by the Administrator or Assistant Administrator beginning 6/22/15 with all allegations of abuse to ensure ongoing compliance with all steps of the facility's abuse policy including reporting and interviewing other residents to whom the accused employee provided care or services.</u>		

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F 225	<p>Continued From page 2</p> <p>has suffered abuse, neglect, or exploitation, shall report. The facility should have evidence that all alleged violations are investigated thoroughly. Review of the facility's policy titled "Abuse Investigation Protocol", last revised 05/13/15, revealed all reports of resident abuse, neglect, injuries of an unknown source, resident -to-resident abuse and resident-to-staff abuse should be promptly and thoroughly investigated by facility management. The individual conducting the investigation at a minimum should interview other residents to whom the accused employee provides care or service to determine if there are any complaints about the employee.</p> <p>1. Record review revealed the facility admitted Resident #1 on 03/13/15, with diagnoses which included Dementia, Parkinson's, Dysphagia, Gastrostomy, Dysphagia, Anxiety and Alzheimer Disease. Review of the Admission Minimum Data Set (MDS) assessment, dated 04/01/15, revealed the facility assessed that Resident #1 needed extensive assistance with activities of daily living. The facility assessed Resident #1 to not be interviewable due to his/her cognitive status.</p> <p>Review of an Incident Report and Investigation, dated 05/08/15, revealed Patient Aide (PA) #1 had reported to the Director of Nursing (DON) she observed Nurse Aide State Registered (NASR) #1 slap Resident #1 on his/her leg on 05/07/15. Further review of the investigation revealed no documented evidence the facility interviewed interviewable residents (Brief Interview of Mental Status {BIMS} score of eight {8} or above), who received care from NASR #1 to determine if there was any evidence of abuse. Interview with PA #1, on 06/02/15 at 1:58 PM, revealed she did not report her observation of NASR #1 slap Resident #1's leg during</p>	F 225	<p>(continued from page 2)</p> <p><u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance will be put into place:</u></p> <p>The Abuse Investigations and Reporting CQI tool was updated by Administrator on 6/22/15 to include monitoring staff knowledge on the abuse policy, specifically reporting <u>and interviewing</u>. The Abuse Investigation and Reporting Tool will be completed <u>weekly by Friday of each week X 2 months by Social Services</u> then quarterly ongoing <u>under the supervision of the Social Service Supervisor. All tools not meeting a set threshold will warrant an action plan and follow-up that may include but not limited to additional in-servicing, policy revision, and monitoring.</u></p>	

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F 225	<p>Continued From page 3</p> <p>incontinent care at the time of the incident on 05/07/15, she stated she reported it the next day to the Director of Nursing (DON). PA #1 stated she was educated on the reporting of abuse prior to providing patient care. Further interview with PA #1 revealed she did not report the incident immediately because it was her first day at work and she was uncomfortable.</p> <p>Interview with the DON, on 06/03/15 at 9:57 AM, revealed she expected staff to report any suspicions of abuse immediately. The DON stated PA #1 reported the alleged abuse to her on 05/08/15.</p> <p>Interview with the Administrator, on 06/02/15 at 4:00 PM and 5:00 PM, revealed abuse allegations should be reported immediately and PA #1 had not reported the allegation of abuse till 05/08/15, a day after the incident on 05/07/15.</p> <p>2. Record review revealed the facility admitted Resident #2 on 12/16/09 with diagnoses which included Impulse Control Disorder, Dementia, Status Post Cerebral Vascular Accident, Depression, Hard of Hearing, General Weakness, Anxiety, Manipulative Personality and Situational Depression. Review of the Quarterly MDS assessment, dated 03/21/15, revealed the facility assessed Resident #2's cognition as cognitively intact with a Brief Interview of Mental Status (BIMS) score of thirteen (13) which indicated the resident was interviewable. In addition, the resident needed extensive assistance with activities of daily living.</p> <p>Review of the Incident Report and Investigation, dated 04/30/15 at 4:05 PM, revealed Resident #2 had informed his/her Guardian that NASR #2 had grabbed his/her arm when attempting to retrieve tobacco from his/her pocket. Further interview revealed the Guardian reported to the Social Worker at approximately 4:00 PM. Further</p>	F 225		
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F 225	Continued From page 4 review of the investigation revealed there was no documented evidence the facility interviewed interviewable residents (BIMS score of eight {8} or above) who received care from NASR #2. Interview with Resident #2's Guardian, on 06/03/15 at 8:33 AM, revealed she had reported the allegation of abuse on 04/30/15 between 8:30 AM-9:00 AM to staff at the nursing station. The Guardian stated she spoke to the Advance Registered Nurse Practitioner (ARNP) at the desk about the allegation. Continued interview revealed the Guardian stated she had consulted with her supervisor and reported the allegation to the facility again at approximately 3:50 PM on 04/30/15 and had informed Adult Protective Services of the allegation. Interview with Office Support Assistant (OSA) #1, on 06/02/15 at 1:20 PM, revealed Resident #2's Guardian came to the nursing station on 04/30/15 around 10:00-10:30 AM, and reported Resident #2 had accused NASR #2 of grabbing his/her wrist. OSA #1 stated she did not report the incident because she thought someone else had reported it. Interview with the ARNP, on 06/02/15 at 3:52 PM, revealed Resident #2's Guardian came to the nursing station on the morning of 04/30/15 and reported an allegation involving NASR #2 and Resident #2. The ARNP stated she did not report the incident. However, she stated all allegations should be reported immediately to the supervisor. Interview with the Unit Manager, on 06/02/15 at 5:57 PM, revealed she was at the nursing station when Resident #2's Guardian reported NASR #2 grabbed Resident #2's arm but she did not look at it as an allegation of abuse and she did not report it. Interview with the Social Service Worker (SSW), on 06/02/15 at 1:33 PM, revealed Resident #2's	F 225			

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F 225	<p>Continued From page 5</p> <p>Guardian had notified her of the allegation of abuse on 04/30/15 around 4:00 PM via telephone. The SSW stated she immediately informed the Assistant Administrator of the allegation.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 06/02/15 at 6:00 PM, revealed other than Resident #1 and Resident #2, there were no additional interviews conducted related to the abuse allegations.</p> <p>Further review with the Unit Manager, on 06/02/15 at 5:57 PM, revealed in order to ensure the safety of residents during an allegation of abuse, interviewable residents should be interviewed. UM #1 further stated she did not know what the facility's policy said.</p> <p>Further interview with the DON, on 06/03/15 at 9:57 AM, revealed there were no additional interviews with alert and oriented residents during the investigation of either of the allegations of abuse involving Resident #1 or Resident #2.</p> <p>Interview with the Assistant Administrator, on 06/03/15 at 1:47 PM, revealed he did not see interviews done on the other residents during the investigations involving Resident #1 and Resident #2.</p> <p>Interview with the Administrator, on 06/02/15 at 4:00 PM and 5:00 PM; and, on 06/03/15 at 2:30 PM, revealed she did not know of the allegation of abuse involving Resident #2 until it was reported to her on 04/30/15 after 4:00 PM when the Guardian of Resident #2 called the facility and notified them again of the incident. The Administrator stated she should have been told of the allegation involving Resident #2 when the Guardian had reported it that morning at the nursing desk.</p> <p>Further interview with the Administrator, on 06/02/15 at 4:00 PM and 5:00 PM, and on</p>	F 225		

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F 225	Continued From page 6 06/03/15 at 2:30 PM, revealed they did not do interviews with any other residents during the investigations involving Resident #1 and Resident #2, and that probably would have been best practice. The Administrator stated she did feel the investigations were thorough and they did follow their policy.	F 225	F 226 483.13 <i>Develop/Implement Abuse/Neglect, etc. Policies</i>	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review it was determined the facility staff failed to implement the facility's policy on reporting alleged abuse allegations immediately and failed to conduct interviews with other residents who received care from the alleged perpetrator for two (2) of four (4) sampled residents (Resident #1 and Resident #2), per facility policy. The findings include: Review of facility policy titled, "Reporting Abuse to Facility Management", dated February 2002, revealed it was the responsibility of each employee to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of an unknown origin to the administrator or his/her designee. Review of the facility's policy titled, "Investigating Allegations of Physical Abuse", dated February 2002, revealed	F 226	What corrective action(s) will be accomplished for those residents found to be affected by the Deficient practice:  Resident # 1 was assessed on (5/18/15) and #2 was assessed on (4/30/15) and both found to be free of injury. Both nurse aides # 1 and #2 were placed on leave pending the investigation to prevent further <u>abuse and re-educated on reporting immediately to ensure resident safety.</u>  <u>APRN, LPN #2, Unit Manager and OSA #1 were all in-serviced on 5/8/15 by the Social Service Director on the facility's Policy and Procedure on reporting abuse and then again on 6/4/15 &amp; 6/5/15 by the Social Service Director and Administrator.</u>  <u>The PA#1 was educated on the facility abuse policy and procedure (including reporting) on 1/6/15 and 5/1/15 by the Social Service Director, and 6/4/15 by the Social Service Director and Administrator.</u>  All employees were re-educated by the Social Service Director and Administrator on the Abuse Policy and Procedures including: <u>Immediately</u> reporting to the Administrator and interviewing additional residents when an allegation is made. Completed 6/5/16	7/2/15

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F 226	<p>Continued From page 7</p> <p>all reported incidents of physical abuse should be promptly.</p> <p>Review of facility's policy titled, "Prevention of Abuse, Neglect, and Misappropriation", dated 03/01/2010, revealed alleged violations of suspected abuse should be immediately reported to the Administrator or designee immediately and any person having reasonable cause to suspect that an adult has suffered abuse, neglect, or exploitation, shall report. The facility should have evidence that all alleged violations are investigated thoroughly.</p> <p>Review of facility policy titled "Abuse Investigation Protocol", last revised 05/13/15, revealed all reports of resident abuse, neglect, injuries of an unknown source, resident -to-resident abuse and resident-to-staff abuse should be promptly and thoroughly investigated by facility management. The individual conducting the investigation at a minimum should interview other residents to whom the accused employee provides care or service to determine if there are any complaints about the employee.</p> <p>1. Record review revealed the facility admitted Resident #1 on 03/13/15 with diagnoses which included Dementia, Parkinson's, Dysphagia, Gastrostomy status, Difficulty Walking, Dysphagia, Anxiety, Lack of Coordination, and Alzheimer Disease.</p> <p>Review of an Incident Report and Investigation, dated 05/08/15, and interviews with Patient Aide (PA) #1, on 06/02/15 at 1:58 PM; the Director of Nursing (DON) on 06/03/15 at 1:58 PM; the Unit Manager, on 06/02/15 at 5:57 PM; the Assistant DON, on 06/03/15 at 12:55 PM; and, the Assistant Administrator, on 06/03/15 at 1:47 PM, revealed PA #1 had reported to the Director of Nursing (DON) she observed Nurse Aide State Registered (NASR) #1 slap Resident #1 on the</p>	F 226	<p>(continued from Page 7 of 16) F 226 483.13</p> <p><u>How you will identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken;</u></p> <p><u>To aide in identifying residents having the potential to be affected by the deficient practice of the staff not reporting abuse, Quality of Life/Resident Interviews will be conducted quarterly under the supervision of the Social Service Director. The audit tool was revised by the Administrator on 6/29/15 to include interviewing residents on types of abuse and reporting</u></p> <p><u>What measures will be put into place, or what systemic changes you will make to ensure that the deficient practice does not recur;</u></p> <p><u>Facility's Abuse Policies were reviewed, and condensed into one policy ADM 6070 by the Administrator on 6/24/15 to improve clarity of the abuse policy. Each department will receive quarterly in-service education on the Abuse Policy ADM 6070 to ensure ongoing knowledge of the policy and steps to take if abuse is suspected under the supervision of the Staff Development Coordinator. Will start 3<sup>rd</sup> quarter in August, 2015.</u></p>	

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F 226	<p>Continued From page 8</p> <p>leg on 05/07/15 around 10:00 AM. However, the incident occurred on 05/07/15, but the PA failed to report the incident immediately per facility policy; the allegation was not reported until 05/08/15 (the next day). In addition, the facility failed to conduct a complete investigation with interviews with interviewable residents who were assessed to have a Brief Interview of Mental Status (BIMS) score of eight {8} or above to determine if there was any evidence of abuse per the facility's policy.</p> <p>2. Record review revealed the facility admitted Resident #2 on 12/16/09 with diagnoses which included Impulse Control Disorder, Dementia, Status Post Cerebral Vascular Accident, Depression, Hard of Hearing, General Weakness, Anxiety, Manipulative Personality, Situational Depression, and Polio.</p> <p>Review of the Incident Report and Investigation, dated 04/30/15 at 4:05 PM, and interviews with Resident #2's Guardian, on 06/03/15 at 8:33 AM; Office Support Assistant (OSA) #1, on 06/02/15 at 1:20 PM; the Advance Registered Nurse Practitioner, on 06/02/15 at 3:52 PM; the Social Service Worker (SSW), on 06/02/15 at 1:33 PM; Licensed Practical Nurse (LPN) #2, on 06/02/15 at 6:00 PM; the Unit Manager, on 06/02/15 at 5:57 PM; the Assistant DON, on 06/03/15 at 12:55 PM; and, the Assistant Administrator, on 06/03/15 at 1:47 PM revealed Resident #2 had informed his/her Guardian that Nurse Aide State Registered (NASR) #2 had grabbed his/her arm when attempting to retrieve tobacco from his/her pocket. The staff at the nursing station failed to report the allegation to the Administrator, as required per the facility's policy. The Guardian called and reported the incident again to the Social Worker at approximately 4:00 PM and the incident was reported to Administration at that</p>	F 226	<p><u><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance will be put into place:</b></u></p> <p>The Abuse Investigations and Reporting CQI tool was updated by Administrator on 6/22/15 to include monitoring staff knowledge on the abuse policy, specifically reporting. The Abuse Investigation and Reporting Tool will be completed <u><b>weekly by Friday of each week X 2 months by Social Services</b></u> then quarterly ongoing <u><b>under the supervision of the Social Service Supervisor.</b></u></p> <p><u><b>The Social Service Director will ensure CQI tool: "Quality of Life/Resident Interview" is conducted quarterly. The audit tool was revised by the Administrator on 6/29/15 to include interviewing residents who have potential to be affected by abuse.</b></u></p>	
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NAME OF PROVIDER OR SUPPLIER  JOSEPH EDDIE BALLARD WESTERN KENTUCKY VETERANS CEN	STREET ADDRESS, CITY, STATE, ZIP CODE 926 VETERANS DRIVE HANSON, KY 42413
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F 226	Continued From page 9 time. In addition, the facility failed to conduct a complete investigation of the allegation to include interviews with interviewable residents (BIMS score of eight (8) or above) to determine if there was any evidence of abuse per the facility's policy. Interview with the DON, on 06/03/15 at 9:57 AM, revealed staff should have reported the allegations of abuse immediately per facility policy. The DON stated there were no additional interviews conducted with alert and oriented residents during the investigation of either of the allegations of abuse involving Resident #1 or Resident #2 to ensure a complete investigation was conducted per facility policy. Interview with the Administrator, on 06/02/15 at 4:00 PM and 5:00 PM; and, on 06/03/15 at 2:30 PM, revealed staff should have reported the allegations of abuse immediately. The Administrator stated they did not do any interviews with other residents during the investigations involving Resident #1 and Resident #2, and that probably would have been best practice.	F 226		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, it was determined the facility failed to provide care in accordance with one (1) of four	F 282	F282 483.20 Services by <u>Qualified Persons/Per Care Plan</u>  What corrective action(s) will be accomplished for those residents found to be affected by the Deficient practice:  The care plan for Resident #1 was reviewed and revised to include additional interventions to be used for displayed behaviors. Nurse aide #1 and #4 were educated <u>by the Unit Managers, Staff Development Coordinator, Assistant Director of Nursing and Director of Nursing under the supervision of the Director of Nursing</u> on the importance of knowing what is on the NASR care plan prior to performing care and implementing the care <u>as planned. Completed by: 7/2/15</u>	7/3/15

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F 282

Continued From page 10  
(4) sampled residents' (Resident #1) care plans. The Nurse Aides State Registered failed to implement Resident #1's care plan to apply a warm blanket during an episode of agitation, combativeness, and rejection of care, and leave and reapproach the resident in fifteen (15) minute intervals.  
The findings include:  
Review of the facility's policy titled, "Care Plans", last revised 05/06/15, revealed the comprehensive care plan should include measurable objectives to meet the individual resident's medical, nursing, mental and psychological needs; incorporate problem areas and risk factors; reflect treatment goals, and recognize standards of practice for problem areas and conditions; and when goals are not achieved the care plan should be updated with new goals and objectives.  
Record review revealed the facility admitted Resident #1 on 03/13/15 with diagnoses which included Dementia, Parkinson's, Difficulty Walking, Dysphagia, Anxiety, Lack of Coordination, and Alzheimer Disease. Review of the Admission Minimum Data Set (MDS) assessment, dated 04/01/15, revealed the facility determined Resident #1 needed extensive assistance with activities of daily living and was unable to be interviewed due to cognitive status. Review of Resident #1's Comprehensive Care Plan, last revised 05/01/15, revealed the resident was on psychotropic medications. The resident had behaviors of hitting, cursing, yelling out, kicking staff, swinging arms towards staff, periods of rejection of care in staff attempts to provide personal care with interventions for staff to attempt to redirect the resident's thoughts to a pleasant topic such as family and music; to apply a warm blanket during periods of agitation,

F 282

F282 (continued from page 10 of 16)  
To ensure care is provided in accordance with resident care plans and nurse aides have time to review the care plans and receive report at the beginning of their shift during shift change, meal routines have been moved by 15 minutes effective 6/29/15.  
  
Nurse Aides are being in-serviced by the Unit Managers, Staff Development Coordinator, Assistant Director of Nursing and Director of Nursing under the supervision of the Director of Nursing on the requirement to read the Care plans, implement interventions according to the care plan and receiving/giving report from one shift to another. Complete date: 7/2/15  
  
How you will identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken;  
  
To prevent future failure to provide care in accordance with the care plan, all Nurse Aides will take the Nurse Aide care plan binders and do walking rounds with the off going shifts to ensure they are aware of the interventions to use for care and redirection of resident behaviors, moods and/or psychosocial needs. Walking rounds with binders to begin 7/2/15 under the supervision of each unit manager.

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F 282	<p>Continued From page 11</p> <p>combativeness, and rejection of care; and, if the resident refuses or rejects care to reapproach in fifteen (15) minutes times three (3). Interview with Patient Aide (PA) #1, on 06/02/15 at 1:58 PM, revealed while providing incontinent care, Resident #1 was trying to kick staff during care and NASR #1 slapped Resident #1's leg with the back of her hand telling him/her to stop. Interview with NASR #1, on 06/03/15 at 11:10 AM; and, on 06/04/15 at 5:08 PM, revealed Resident #1 was told not to kick, or hit during incontinent care, and they were not aware of what the interventions on the care plan were when the resident became combative during care. NASR#1 revealed she should be aware of the care plan interventions in order to provide the appropriate care for that resident.</p> <p>Further interview (Post Survey) with NASR #1, on 06/17/15 at 1:18 PM, revealed there were NASR care plans in a binder on the unit and she had access to the binder at all times. NASR #1 stated they have to chart in the binder and she looks at the binder at the end of the shift when she charts. She stated that was the only opportunity she had to look at the book because she "hits the floor running" when she arrives at work every day.</p> <p>Interview with NASR #4, on 06/04/15 at 3:38 PM, revealed she provided care to Resident #1 with NASR #1. She stated she was not aware of what the care plan interventions were related to Resident #1's behaviors during care, she just knew the resident was combative.</p> <p>Interview (Post Survey) with the Director of Nursing (DON), on 06/17/15 at 1:33 PM, revealed she expected the staff to read the NASR care plans daily prior to going to the floor to care for the residents to see if there had been any changes in addition to receiving report. The DON</p>	F 282	<p>F 282 (continued from page 11 of 16)</p> <p><u>MDS Coordinators, Social Services and RD's will ensure the NASR Care plans are revised as information about the resident and the residents' condition occurs. The Unit Manger and Charge Nurse will serve as "back ups" to the MDS Coordinators. There are 2 Social Service employees and 2 RD's that will be each others' back-up for updating NASR care plans</u></p> <p><u>The above disciplines will obtain the information regarding resident changes from information such as: morning report, Event Reports, 24 hour report, charge reports, resident care meetings, assessment outcomes and physicians orders and will update the care plans as needed.</u></p> <p><u>What measures will be put into place, or what systemic changes you will make to ensure that the deficient practice does not recur:</u></p> <p>All NASR care plans are being updated with a new behavior section so interventions can be easily spotted. Social Services will place interventions in the behavior section by <u>7/1/15</u> to more easily assist with redirecting residents with behavior, mood and/or psychosocial needs.</p> <p>All Nurse Aides are being educated by the <u>by the Unit Managers, Staff Development Coordinator, Assistant Director of Nursing and Director of Nursing under the supervision of the Director of Nursing</u> on the importance of receiving/giving report to oncoming/off going shift; implementing the interventions care planned for the residents specifically, behavior interventions; revision of meal times to allow time for report and review of care plans; Nurse aide care plan form revisions and performing walking rounds. <u>7/2/15</u></p>	

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F 282	Continued From page 12 stated there were interventions on Resident #1's care plan that addressed what to do if the resident became combative with care and she expected them to follow the care plan.	F 282	F 282 (continued from page 12) <u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance will be put into place:</u> The NASR Care Plan Compliance CQI tool was updated by Administrator on 6/25/15 to include monitoring for walking rounds with the care plan binders. The NASR Care Plan Compliance Tool will be completed <u>weekly by Friday X 2 months</u> then quarterly ongoing <u>under the supervision of the QA nurse.</u>	
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES- RESTORE EATING SKILLS  Based on the comprehensive assessment of a resident, the facility must ensure that --  (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident 's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and  (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to provide appropriate treatment and services for a Percutaneous Endoscopic Gastrostomy (PEG) tube (feeding tube) for one (1) of four sampled (4) residents (Resident #1). Observation revealed Resident #1's PEG tubing and connector was on	F 322	F322 483.25 NG Treatments/Services-Restore Eating Skills  <u>What corrective action(s) will be accomplished for those residents found to be affected by the Deficient practice:</u>  The feeding tubing and product of Resident #1 was thrown away and replaced on 6/1/15 due to contamination.  <u>How you will identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken:</u>  To prevent future episode s of failure to provide appropriate treatments and services for a (PEG) tube, PEG tube policies were updated to reflect appropriate infection control measures to take when tubing is contaminated. Policies were updated by Director of Nursing 6/23/15 and process will be monitored through CQI by the QA nurse.	7/9/15

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F 322	<p>Continued From page 13</p> <p>the floor and the staff failed to change the feeding and tubing prior to reconnecting the tubing. The findings include:</p> <p>Interview with the Administrator, on 06/03/15 at 4:10 PM, revealed there was no policy related to infection control with PEG-tubes (feeding tube). Record review revealed the facility admitted Resident #1 on 03/13/15 with diagnoses which included End Stage Dementia and Gastrostomy. Review of the Admission Minimum Data Set (MDS) assessment, dated 04/01/15, revealed the facility determined Resident #1 needed extensive assistance with activities of daily living and was unable to be interviewed due to his/her cognitive status.</p> <p>Observation of Resident #1, on 06/01/15 at 3:45 PM, revealed the PEG tube and connector were in a small puddle of Jevity 1.5 (tube feeding), on the floor in the television room and was not connected to the resident's abdominal tubing. Further observation at 3:46 PM, revealed Licensed Practical Nurse (LPN) #1 picked up the PEG tube and connector from the floor and placed it over the feeding pump. LPN #1 then obtained an alcohol pad and wiped the PEG-tube connector and the abdominal connector and reconnected the tube.</p> <p>Interview with LPN #1, on 06/01/15 at 3:48 PM, revealed she had used her nursing judgment to clean the tubing connector. She further stated the facility had not provided her any inservicing about how to do it.</p> <p>Interview with the Unit Manager, on 06/01/15 at 4:04 PM, revealed she did not expect alcohol pads to be utilized to clean the connections to the tube feeding. UM #1 stated the bottle of Jevity 1.5 and the connecting tubing should have been thrown away and replaced because of the risk of infection and contamination. She stated the</p>	F 322	<p>F 322 (continued from page 1</p> <p><u><i>The OA Nurse and Staff Development Coordinator will perform a tube feeding competency skills check off on all licensed nurses to ensure they are knowledgeable of the policy, procedures and proper technique of a feeding tube. To be completed by the OA Nurse and Staff Development by 7/8/15.</i></u></p> <p><u><i>What measures will be put into place, or what systemic changes you will make to ensure that the deficient practice does not recur:</i></u></p> <p>To prevent contamination on any other residents with a feeding tube, the facility policies pertaining to any feeding system with tubing were updated by the Director of Nursing on 6/23/15. The policies include infection control measures to take when tubing comes in contact with a contaminated surface.</p> <p>All nursing staff were in-serviced on tubing, contamination and procedures to take if tubing is contaminated by the Infection Control Nurse and Staff Development Coordinator. Completed 6/5/15.</p> <p><u><i>The OA Nurse and Staff Development Coordinator will perform a tube feeding competency skills check off on all licensed nurses to ensure they are knowledgeable of the policy, procedures and proper technique of a feeding tube. To be completed by the OA Nurse and Staff Development by 7/8/15.</i></u></p>	
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F 322	Continued From page 14 tubing should not be used once it had touched the floor. Interview with Registered Nurse (RN) #1 (Charge Nurse for whole facility), on 06/01/15 at 4:10 PM, revealed she expected staff to change the tubing and bottle of feeding if the tubing was found on the floor. RN #1 stated she would not expect a nurse to use alcohol pads to wipe the connecting ends and reconnect them because they would not know how long it had been on the floor. RN #1 further stated she was not aware of any inservicing on infection control for peg tubes. Interview with the Infection Control Nurse (ICN) #1, on 06/01/15 at 4:25 PM, revealed the staff would need to change the tubing and feeding if they found it disconnected and on the floor. She stated there was the potential to introduce contaminants to the system anytime there was a break in the system. Interview with Staff Development Coordinator (SDC), on 06/02/15 at 3:08 PM, revealed she expected the tubing and the bottle of nutrition supplement to be changed if it was on the floor for an undetermined amount of time. The SDC stated if there was a puddle on the floor the whole thing needed to be changed because it had been there a while, and using alcohol to clean the connectors and reattach them may not introduce bacteria but she would not want to take the chance. Interview with Assistant Director of Nursing (ADON), on 06/03/15 at 12:55 PM, revealed she did not expect staff to utilize alcohol pads to wipe the connecting ends of the tubing and reconnect them back together after they had touched the floor, because anything that touched the floor was considered contaminated. Interview with the Director of Nursing (DON), on 06/03/15 at 9:57 AM, revealed if tubing was found	F 322	F322 (continued from page 14)  <u>All nursing staff will receive annual tube feeding competency skills check-offs by the Staff Development Coordinator on policy, procedures and proper technique of a feeding tube.</u>  <u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance will be put into place:</u>  The infection Control General CQI Tool and Special Procedure Review CQI tool were updated by Administrator on 6/23/15 to include an observation of making sure tubing is properly handled and if contaminated, replaced. <u>The tools will be completed monthly X2 by the last Friday of the month by the QA nurse then quarterly ongoing. (The Staff Development Coordinator will be the back-up for the QA Nurse).</u>		

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F 322	Continued From page 15 on the floor she would not expect alcohol swabs to be used to wipe the connectors and reconnect them; she would expect the tubing to be changed. Interview on 06/03/15 at 1:47 PM with Assistant Administrator (AA) revealed he would expect the tubing to be replaced if it had been found on the floor. Further interview revealed the best practice would not be to clean the connections with an alcohol pad and reconnect them because there could be bacteria.	F 322		