

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

PRINTED: 05/30/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/15/2014
NAME OF PROVIDER OR SUPPLIER MADONNA MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 000 INITIAL COMMENTS

A Recertification Survey was initiated on 05/13/14 and concluded on 05/15/14, with deficiencies cited at the highest Scope and Severity of an "E".

F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY
SS=D

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality

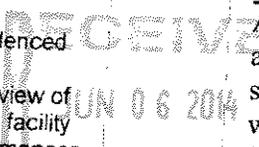
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and review of the facility's policy, it was determined the facility failed to promote care for residents in a manner and in an environment that maintained or enhanced each resident's dignity, for one (1) of fifteen (15) sampled residents. Resident #5 was observed to wait eighteen (18) minutes for his/her meal to be served while other residents at the table were eating.

The findings include:
Review of the facility's policy titled "Resident Bill of Rights", undated, revealed residents had the right to considerate and respectful care in full recognition of his/her dignity and individuality.
Review of Resident #5's medical record revealed the resident was admitted by the facility on 07/01/11 with diagnoses which included Hypertension, Depressive Disorder, and Anemia.
Review of the Quarterly Minimum Data Set

F 000 The completion and submission of this plan of correction does not constitute an admission that the facility agrees with the cited deficiencies as stated in the 2567. The facility is completing the plan of correction because it is required by state and federal law.
The facility alleges compliance as of 6/27/2014.

F 241

F 241 Dignity and Respect of Individuals
A Teaching Moment regarding the dignity and respect of residents was presented to staff by the Director of Nurses (DON) the week of May 19th (See Attachment # 6). Specific education was also provided in the teaching moment regarding the dignity of all residents during meal time. This education will also be part of the orientation process for all new staff.
Resident # 5 remains in the facility, continues to come to dining room for all meals and continues to have a good appetite. Staff who worked with resident # 5 on 5/14/14 was also given individual education reminding them of facility expectations to serve all residents at one table at or close to the same time. The staff included staff member #5, the MDS nurse and all other staff that worked on that household on 5/14/14.



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: Executive Director DATE: 6-6-14

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 241 Continued From page 1
(MDS) Assessment, dated 03/24/13, revealed the Brief Interview for Mental Status (BIMS) indicated Resident #5 was severely impaired for cognitive function.

Observation in the dining room, on 05/14/14 at 12:34 PM, revealed Resident #5 was seated at a table with three other residents who were served a bowl of soup, followed by the rest of their meal, by staff. Continued observation revealed Resident #5 sat in his/her Gerichair without anything to eat, and uttered the words, "Give me cup", and "Give me apples and bacon." Resident #5 was not served his/her meal until 12:52 PM, when Certified Nursing Assistant (CNA) #5 arrived to assist the resident with eating.

Interview with CNA #5, on 05/14/14 at 2:44 PM, revealed it was the process for staff to serve all residents at each table at the same time so that no one person was left without a plate. She gave an example stating, "If you gave a kid a piece of candy at a day care, it would be inappropriate not to give the other kid a piece of candy". She stated it was a dignity issue and/or abuse. She reported Resident #5 needed assistance with feeding and usually ate after other residents, when staff were available to help the resident. She further stated staff would normally leave the resident in front of the television during meals until they could assist with feeding him/her, but had forgotten to do so during this observation. Continued interview revealed Resident #5 should have been served at the same time as his/her table mates.

Interview with the MDS coordinator, on 05/15/14 at 3:21 PM, revealed she observed the meal on 05/15/14 at 12:34 PM, as she was assisting

F 241 The nurse management team and Director of Dining are monitoring meal service on all households. Observations include food temperatures, food satisfaction, and timeliness of service to residents at the same table. The audits are being done for at least one meal a day, five days a week for one month. Audits will be turned into the Director of Nurses and be reviewed by the facility Quality Assurance Committee to determine if further audits will be needed. The Quality Assurance Committee is made up of the Medical Director, Director of Nurses, Administrator, Pharmacist, Therapy Manager, Director of Dining, Facility

Manager, MDS Nurse, Assistant Director of Nursing and Social Worker.

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F 241	Continued From page 2 another resident at the same table as Resident #5. She reported she thought she heard the resident say something about wanting food, but could not be certain. She stated of the times she had observed meals, she had not noticed Resident #5 in front the television located on the unit, but rather seated at the table with his/her peers. She further stated the resident should not have waited so long to be served and fed while other residents at the table were eating. She added, "I would not have wanted to have waited." Interview with the Director of Nursing, on 05/15/14 at 5:03 PM, revealed it was her expectation for Resident #5 to be served at the same time the rest of the table was served. She stated it was unfair to the resident and she considered it a dignity issue. Interview with the Executive Director, on 05/15/14 at 5:23 PM, revealed it was his expectation for staff to feed Resident #5 along with the other residents at his/her table. He stated, "it was the right thing to do."			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	<u>F371 Food Procedure, store/prepare/Serve- Sanitary</u> A Nurse Meeting was held on May 19, 2014(See Attachment #1) by the Director of Nurses (DON). Nurse were re-educated on food storage and sanitation. The in-service included specific education regarding proper hand washing and the importance of proper glove usage. A dietary staff meeting was held on May 21, 2014 during the in-service the director of dining re-educated the staff on hand washing procedures. (See attachment 2) Proper storage of food, preparation, distribution and serving of food was also reviewed during this in-service. A Teaching Moment was also given to all staff reminding them on the importance of proper hand hygiene and sanity meal service (See attachment #3). STNA #1, 2, 3, and 4 along with the Sous Chef were individual re-educated on proper sanitary preparation, storage and distribution of food. All education was completed by DON and Director of Dining by June 2, 2014.	

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F 371 Continued From page 3
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and review of the facility's policy, it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. Observation of the evening meal preparation on 05/13/14 revealed the dietary staff and the staff of Household B and C did not wash or sanitize their hands between tasks. In addition, undated fudge bars were observed to be stored in the freezers on Household A and Household C.

The findings include:

Review of the facility's policy, "Hand Washing before preparing food" (no date), revealed gloves were to be worn for serving food, and utensils were to be used when touching food. Further review revealed staff were never to put gloves on without washing their hands first; therefore, anytime staff stopped to perform a different task, they were to repeat the steps of handwashing and applying new gloves. Additional review revealed to prevent cross-contamination, if staff touched their face or anything other than the food, even if wearing gloves, they were to remove the gloves, wash their hands and apply new gloves before resuming the handling of food.

Review of the facility notes titled, "Orientation Notes" (no date), revealed when serving food, staff must wear a hairnet, gloves and an apron. Continued review revealed hand washing was the best way to kill and stop the spread of bacteria.

1. Observation on Household B during the evening meal, on 05/13/14 at 5:10 PM, revealed State Registered Nurse Aide (SRNA) #1 was

F 371 The dietary staff continues to label food items with expiration dates. The Director of Dining is monitoring refrigerator, freezers and pantries three times a week for one month checking expiration dates and proper food storage See Attachment #7). The nurse management team and Director of Dining are monitoring meal service on all households. Observations include food temperatures, food satisfaction, and timeliness of service to residents at the same table. The audits are being done for at least one meal a day, five days a week for one month. Audits will be turned into the Director of Nurses and be reviewed by the

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F 371	<p>Continued From page 4</p> <p>breaking up lettuce and cutting tomatoes, and placing them in serving bowls with gloved hands. Continued observation revealed SRNA #1 obtained a packet of dressing with the same gloved hands and disbursed dressing from the packet onto four (4) servings of lettuce. Using the same gloved hand, she retrieved bread sticks from the warmer cart, opened the hinged lid on the steam table, and spooned out the food without washing her hands or changing her gloves. She repeated this process for the remainder of thirteen (13) residents seated in the dining room at the time. Further observation, on 05/13/14 at 5:29 PM, revealed SRNA #1 touched a chicken patty with the same gloved hand without utilizing the serving utensils.</p> <p>Interview with SRNA #1, on 05/13/14 at 5:35 PM, revealed she should have used tongs for taking the bread sticks out of the warming cart. Further interview revealed she could not ensure the dressing packets were clean when she handled them, and she should have washed her hands and changed her gloves prior to handling food.</p> <p>Interview with the Director of Dining, on 05/15/14 at 2:19 PM, revealed staff on the Households were to wear hair nets, gloves and aprons when serving food and were to always wash their hands after tasks. He stated you can never wash your hands too much. Further interview revealed staff should not have touched any food at all, even with gloves on, and should have used utensils to pick up the bread sticks and the chicken patty. He stated staff should not have been breaking lettuce or slicing tomatoes; it should have been done in the dietary department before the food was sent out to the Households</p>	F 371	<p>facility Quality Assurance Committee to determine if further audits will be needed. The Quality Assurance Committee is made up of the Medical Director, Director of Nurses, Administrator, Pharmacist, Therapy Manager, Director of Dining, Assistant Director of Nursing, Facility Manager, MDS Nurse, and Social Worker.</p> <p>Hand washing audits are also being conducted by the DON and or designee and the Director of Dining. At least four audits are done weekly for one month. Audits will also continue the second month at unscheduled times education will be provided immediately to any staff member noted for not following the guidelines found in F 371.</p> <p>All refrigerators and Freezers and pantries were check on May 16th and all undated items were removed and disposed of. Fudge bars now stay in the original box that they come in.</p> <p>Compliance date June 27, 2014</p>		

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F 371	<p>Continued From page 5</p> <p>2. Observation of the evening meal service on Household C, on 05/13/14 at 5:00 PM, revealed SRNA #2 was assisting with serving the residents' food. SRNA #2 was observed to wipe her forehead with her gloved hand, and proceed to pick up three (3) meat patties with the same gloved hand in order to check the temperature of the meat. Further observation revealed SRNA #2 used a fork to serve the resident's spaghetti; however, she used her gloved hands to remove the spaghetti from the fork and place it on the residents' plates. Continued observation revealed SRNA #2 did not wash her hands or change her gloves throughout the meal service.</p> <p>Interview with SRNA #2 on Household C, on 05/13/14 at 5:59 PM, revealed staff should not touch food with their bare hands, in order to prevent cross contamination. SRNA #2 stated she had not been told not to pick up food with gloved hands. She further stated, however, one should not pick up food with gloved hands when any part of the body had been touched. Continued interview revealed she should have removed her gloves, washed her hands and applied new gloves when she wiped her forehead. In addition, she stated, she should have used utensils when handling the meat patties while checking the temperature. Further interview revealed CNA #2 did not have the proper serving utensil available for serving the residents' spaghetti. She stated the only utensil available to her was a fork.</p> <p>Further interview with the Dining Director, on 05/15/14 at 2:19 PM, revealed staff should use tongs, not a fork, to serve spaghetti. He stated staff should contact the kitchen and request additional utensils when they were needed. He</p>	F 371			

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F 371	<p>Continued From page 6</p> <p>further stated SRNA #2's handling of food during the evening meal service on 05/13/14 increased the potential for cross-contamination.</p> <p>3. Observation in the facility's kitchen, on 05/13/14 at 4:20 PM, revealed the Sous Chef lifted the hood of the trash can with gloved hands to throw something away. She proceeded to butter rolls, picking the rolls up to butter all sides of the bread, without washing her hands or changing her gloves. Further observation revealed the Sous Chef dropped a pan of meat patties on the floor. She picked the patties up off the floor and threw them away. The Sous Chef changed her gloves before proceeding to the next task, however, she did not wash her hands.</p> <p>Interview with the Sous Chef, on 05/15/14 at approximately 2:00 PM, revealed staff should wash their hands before preparing any food. She stated hands should be washed and re-gloved between all tasks. She further stated staff should not pick up any food item with their hands, but should use utensils. Continued interview revealed she should have washed her hands between tasks and before re-gloving.</p> <p>Review of the facility's policy titled "Food Dating Policy and Procedure", dated 06/01/12, revealed all food sent to the households was to be dated by dietary staff. In addition, the aides on the households were to keep track of all dates and expiration dates to maintain the quality and safety of the food. Continued review revealed staff were to date all foods except breads and other baked items that already had an expiration date for freshness. Additional review revealed the main kitchen had labels or black markers to be used for dating of food; staff were to submit a request</p>	F 371		
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F 371	Continued From page 7 for labels and markers as needed. 4. Observation, on 05/14/14 at 9:45 AM, revealed seven (7) undated fudge bars were stored in the unit freezer on Household C. Interview with SRNA #3, on 05/14/14 at 9:50 AM, on Household C, revealed the fudge bars should have been labeled with an expiration date. Observation on 05/14/14 at 9:55 AM, on Household A, revealed seven (7) undated fudge bars and one (1) Alaska ice cream bar was stored in the unit's freezer. Interview with SRNA #4, on 05/14/14 at 10:00 AM, on Household A, revealed the fudge bars should have been labeled with a sticker and an expiration date. Further interview with the Director of Dining, on 05/15/14 at 2:19 PM, revealed the kitchen staff should send food items to the households in dated plastic bags. He stated the fudge bars should have been left in the dated plastic bags while stored in the freezer so the expiration dates were visible. The Director of Dining reported if a resident were served out-dated food, it could be harmful to the resident; it could make them sick or even have the potential to kill a resident. In addition, he stated he instructed his staff, "when in doubt, throw it out." Interview with the Director of Nursing (DON), on 05/15/14 at approximately 5:03 PM, revealed it was her expectation for staff to wash their hands between tasks associated with meal preparation and service, in order to prevent cross-contamination.	F 371		
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F 387 483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT
SS=D

The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.

A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.

This REQUIREMENT is not met as evidenced by:

Based on interview and review of the resident's medical record, it was determined the facility failed to ensure the initial physician visit was completed by the physician for one (1) of fifteen (15) sampled residents. Resident #8's initial history and physical was completed by the Nurse Practitioner.

The findings include:

A policy related to physician visits was not provided by the facility; however, interview with the Director of Nursing (DON), on 05/15/14 at 2:40 PM and 3:48 PM, revealed it was the facility's policy for the physician to visit each resident upon admission.

Review of the medical record revealed Resident #8 was admitted by the facility on 07/15/13, and re-admitted on 08/08/13, with diagnoses which included Vascular Dementia, Hypertension, Dementia with Behavior Disturbances, and Depressive Disorder.

Review of the Quarterly Minimum Data Set

F 387

F387 Frequency & Timeliness of Physician Visit

Dr. Rafael Fleites (Medical Director) made rounds at facility on May 16, 2014. All charts were reviewed with Dr. Fleites, the Director of Nurses, and the Executive Director. All charts were reviewed for updates of needed History & Physicals as well as Physician progress notes. A Physician visit Policy has been adopted (see attachment 4). The policy was approved by facility Quality Assurance Committee on June 6, 2014. The Quality Assurance Committee is made up of the Medical Director, Director of Nurses, Administrator, Pharmacist, Therapy Manager, Director of Dining, Assistant Director of Nursing, Facility Manager, MDS Nurse, and Social Worker. The policy was also sent to all physicians who utilize a nurse practitioner. This policy is also part of

the credentialing packet for any new physicians.

Resident # 8 remains in the facility and had a new History & Physical completed on June 6, 2014 by the resident's physician.

A physician log has been created to track Physician visits. (See attachment 5) Medical Records personal have been retrained on the use of the log and the importance of compliance for physician visits. This education was provided on May 16, 2014.

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F 387 Continued From page 9
(MDS) Assessment, dated 03/01/14, revealed Resident #8 was assessed to have a Brief Interview for Mental Status (BIMS) score of thirteen (13), which indicated the resident was cognitively intact.

Review of Resident #8's History and Physical revealed the resident's initial exam was completed by the Advanced Registered Nurse Practitioner (ARNP) on 08/09/13, the day after admission.

Continued interview with the Director of Nursing (DON) revealed the attending physician was required and expected to examine each resident for the admission "Medical History and Physical Examination". She stated after the initial examination, the physician could alternate visits with the ARNP. Further interview revealed Resident #8 should not have been seen by the ARNP for the initial history and physical. She stated the resident was seen by the ARNP and there was no documented evidence the resident was seen by the physician.

F 388 483.40(c)(3)-(4) PERSONAL VISITS BY SS=E PHYSICIAN, ALTERNATE PA/NP

Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.

At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section.

F 387 Medical Records will review each resident chart at least once monthly to monitor for physician visit compliance of History & Physicals (H&P) and progress note requirements.

If a resident is due for an H&P or progress note from the physician, medical records, will update the log and will call the physician to alert him/her of the need to make a visit. If a resident does not get seen in a timely manner (10 days of when due from the last visit), then the Medical Director will be notified of the need to see the individual resident.

Medical Records will review all charts monthly for physician visits. The Director of Nursing or designee will audit 3 charts per month, for compliance and report findings to the quality assurance committee. The Quality Assurance Committee is made up of the Medical Director, Director of Nurses, Administrator, Pharmacist, Therapy Manager, Director of Dining, Assistant Director of Nursing, Facility Manager, MDS Nurse, and Social Worker.

Compliance date June 27, 2014

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER MADONNA MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017	
(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 388 Continued From page 10

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F388 Personal visits by physician, alternate PA/NP

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, it was determined the facility failed to ensure the Advanced Registered Nurse Practitioner (ARNP) alternated resident visits with the Physician, for seven (7) of fifteen (15) sampled residents (Residents #1, #2, #3, #5, #8, #9, and #11).

The findings include:

A facility policy related to physician visits was not provided; however, the Director of Nursing (DON) stated, on 05/15/14 at 2:40 PM, it was expected the Physician could alternate monthly visits with the ARNP after the initial examination.

1. Review of the clinical record revealed Resident #1 was admitted by the facility on 08/22/11 with diagnoses which included Hypertension, Coronary Artery Disease, Anemia, Osteoporosis, Anxiety, Bipolar Disorder, and Psychosis.

Review of the History and Physical dated 12/16/13 revealed it was signed by the Physician. Continued review revealed all subsequent monthly and PRN (as needed) medical service visits between 01/02/14 and 05/02/14 were performed and signed by the ARNP.

2. Medical record review revealed Resident #3 was admitted by the facility on 09/17/13 with diagnoses which included Pressure Ulcer Stage IV, Chronic Pain Syndrome, Anxiety, Hyperlipidemia, Esophageal Reflux.

Dr. Rafael Fleites (Medical Director) made rounds at facility on May 16, 2014. Resident #1 remains in the facility and was seen by the physician on 6/6/2014 and a new H& P was completed by physician on 6/6/14 date.

Resident #2 remains in the facility and was seen by the physician on 5/16/2014. The Physician completed a progress note, as well on 5/16/14 for resident #2.

Resident # 3 remains in facility and was seen by the physician on 5/16/2014. A new H& P was completed by the physician on 6/6/2014.

Resident # 5 remains in facility and was seen by the physician on for an updated progress note 5/16/14.

Resident # 8 remains in facility and was seen by the physician on 5/16/2014. A new H& P was completed by the physician on 6/6/2014.

Resident # 9 remains in the facility and was seen by the physician on 5/16/2014.

Resident # 11 remains in the facility and was seen by the physician on 6/6/14 for a new H&P.

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F 388 Continued From page 11
Hypertension, Diabetes, Neurogenic Bladder, Osteoarthritis.

Continued record review revealed the initial History and Physical was performed and signed by the Physician and the ARNP on 9/18/13. Subsequently, a Medical Progress Note was signed by the Physician on 12/11/13. Additional review revealed all other monthly and PRN medical service visits between 11/04/13 and 05/08/14 were performed and signed by the ARNP.

3. Review of Resident #5's medical record revealed the resident was admitted by the facility on 07/01/11 with diagnoses which included Hypertension, Depressive Disorder, Anemia, and Macular Degeneration. Continued review revealed the most recent examination conducted by the Physician was dated 12/16/13. All subsequent monthly and PRN medical service visits were performed and signed by the ARNP.

Interview with the DON, on 05/15/15 at approximately 5:15 PM, revealed Resident #5 was previously seen by Physician #12; however, Physician #12 had requested all her residents be transferred to the medical director (Physician #9). The DON stated the resident should have been seen by Physician #9 after the transfer of services.

4. Review of Resident #8's medical record revealed the resident was admitted by the facility on 07/15/13, and re-admitted on 08/08/14, with diagnoses which included Hypertension, Dementia with Behavior Disturbances, and Depressive Disorder.

F 388

A physician log has been created to track Physician visits. (See attachment 5) Medical Records personal have been retrained on the use of the log and the importance of compliance for physician visits. This education was provided on May 16, 2014. Medical Records will review each resident chart at least once monthly to monitor for physician visit compliance of History & Physicals (H&P) and progress note requirements. If a resident is due for an H&P or progress note from the physician, medical records, will update the log and will call the physician to alert him/her of the need to make a visit. If a resident does not get seen in a timely manner (10 days of when due

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Review of Resident #8's admission History and Physical, dated 08/09/13, revealed it was completed and signed by the ARNP. Continued review of the medical record revealed the ARNP continued to make monthly and PRN medical service visits through 05/14/14. Further review revealed no documented evidence the Physician had seen the resident since admission.

5. Review of the medical record for Resident #11 revealed the resident was admitted by the facility on 01/03/14 with diagnoses which included Diabetes and Muscle Weakness. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 03/30/14, revealed the resident was cognitively impaired.

Continued review of the medical record revealed Resident #11's initial History and Physical was conducted by Physician #9 and the ARNP on 01/06/14. Further review revealed all subsequent monthly and PRN medical service visits were performed by the ARNP. There was no documented evidence Resident #11 was seen by the Physician after the initial visit on 01/06/14.

Interview with Resident #11, on 05/14/14 at 11:32 AM, revealed he/she had "hardly" seen the physician. The resident stated his/her daughter would made arrangements to have the resident sent out of the facility to see a doctor at the local hospital.

6. Medical record review revealed Resident #2 was admitted by the facility on 10/05/13 with diagnoses which included Hypertension, Gastroesophageal Reflux Disease, Osteoporosis, Senile Dementia, Anxiety, Depressive Disorder, and Chronic Airway Obstruction. Continued

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from the last visit), then the Medical Director will be notified of the need to see the individual resident.

Medical Records will review all charts monthly for physician visits. The Director of Nursing or designee will audit 3 charts per month, for compliance and report findings to the quality assurance committee. A Physician visit Policy has been adopted (see attachment 4). The policy was approved by the facilities Quality Assurance Committee on June 6, 2014. The Quality Assurance Committee is made up of the Medical Director, Director of Nurses, Administrator, Pharmacist, Therapy Manager, Director of Dining, Assistant Director of Nursing, Facility Manager, MDS Nurse, and Social Worker. A copy of the policy was sent to all physicians who see residents at the facility. This policy is also part of the credentialing process for future facility physicians.

Compliance June 27, 2014.

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F 388 Continued From page 13 F 388

record review revealed the Physician signed the initial History and Physical on 10/07/14. Further review revealed all subsequent monthly and PRN Physician Progress Notes were completed by the ARNP, with no documented evidence Resident #2 was seen by the Physician after the initial examination on 10/07/14.

7. Review of the clinical record revealed Resident #9 was admitted by the facility on 12/19/13 with diagnoses which included Morbid Obesity, Acute Diastolic Heart Failure, Hypertension, Gastroesophageal Reflux Disease, and Diabetes Type II. Review of the BIMS dated 03/31/14 revealed Resident #9 scored a fifteen (15), which indicated the resident had no cognitive impairment. Further record review revealed Physician #1 cosigned the initial "Medical History and Physical Examination", with the ARNP, on 12/20/13. Continued review revealed all subsequent medical service visits were conducted and signed by the ARNP. There was no documented evidence Resident #9 was seen by the Physician after the initial visit on 12/20/13.

Interview with Resident #9, on 05/14/14 at 10:00 AM, revealed the resident did not believe he/she had ever been examined by Physician #1. Further interview revealed Resident #9 stated he/she was always examined by the ARNP.

Interview with the DON, on 05/15/14 at 2:40 PM, revealed the attending physician was required and expected to examine each resident on the first visit for the "Medical History and Physical Examination", and could alternate monthly visits with the ARNP thereafter. Further interview

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F 388	Continued From page 14 revealed that Physician #1 should have alternated medical service visits to Residents #1, #2, #3, #5, #8, #9, and #11 with ARNP #1.	F 388
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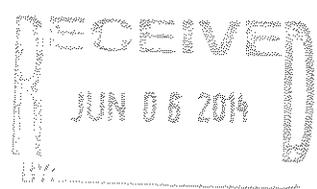
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K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 02 PLAN APPROVAL: 04/06/2010 SURVEY UNDER: 2000 New FACILITY TYPE: SNF/NF TYPE OF STRUCTURES: One (1) story, Type V (111) SMOKE COMPARTMENTS: Four (4) smoke compartments. FIRE BARRIER: The non-certified facility and the Skilled Nursing Facility were separated by a two-hour fire barrier. FIRE ALARM: Complete automatic fire alarm system with heat and smoke detectors. SPRINKLER SYSTEM: Complete automatic (wet and dry) sprinkler system. The dry sprinkler system covers the exterior canopies. GENERATOR: Type II generator, fuel source is diesel. A standard Life Safety Code survey was conducted on 05/14/14. Madonna Manor was found to be in compliance with Title 42, Code of Federal Regulations, 483.70 (a) et. seq. (Life Safety from Fire). Requirements for Participation in Medicare and Medicaid.	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Executive Director	(X6) DATE 6-1-14
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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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