

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

PRINTED: 10/01/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 09/30/2015
NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748		
(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 An onsite re-visit for the standard health survey was concluded on 09/30/15 and found the facility in compliance on 09/15/15 as alleged in their 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.

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26884, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185057	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 9/30/2015
Name of Facility SUNRISE MANOR NURSING HOME	Street Address, City, State, Zip Code 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0157</u> Reg. # <u>483.10(b)(11)</u> LSC _____	Correction Completed 09/15/2015	ID Prefix <u>F0166</u> Reg. # <u>483.10(f)(2)</u> LSC _____	Correction Completed 09/15/2015	ID Prefix <u>F0224</u> Reg. # <u>483.13(c)</u> LSC _____	Correction Completed 09/15/2015
ID Prefix <u>F0280</u> Reg. # <u>483.20(d)(3), 483.10(k)(2)</u> LSC _____	Correction Completed 09/15/2015	ID Prefix <u>F0282</u> Reg. # <u>483.20(k)(3)(II)</u> LSC _____	Correction Completed 09/15/2015	ID Prefix <u>F0323</u> Reg. # <u>483.25(h)</u> LSC _____	Correction Completed 09/15/2015
ID Prefix <u>F0371</u> Reg. # <u>483.35(l)</u> LSC _____	Correction Completed 09/15/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <u>SF-M</u> State Agency	Reviewed By <u>HT</u>	Date: <u>10/01/15</u>	Signature of Surveyor: <u>Ann Feller-Mann</u>	Date: <u>10-01-15</u>
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 8/6/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/20/2015
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NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748		
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F 000	<p>INITIAL COMMENTS</p> <p>An Abbreviated/Recertification/Extended Survey was conducted 07/21/15 through 08/06/15. Immediate Jeopardy was identified on 07/24/15 and determined to exist on 07/04/15 in the areas of 42 CFR 483.10 Resident Rights, F157 at Scope and Severity (S/S) of "J"; 42 CFR 483.13 Resident Behavior and Facility Practice, F224 at S/S of "J"; and, 42 CFR 483.20 Resident Assessment, F282 at S/S of "J". Substandard Quality of Care was identified at 42 CFR 483.13 Resident Behavior and Facility Practice. The facility was notified of the Immediate Jeopardy and Substandard Quality of Care on 07/24/15.</p> <p>On 07/04/15 at 2:30 AM, Resident #16, who required total assistance with transfers and toileting, was found alone in the bathroom, sitting on a bedside commode, yelling for help. The call light was wrapped around a support bar and could not be activated. The evening staff failed to communicate to the night staff the resident had been placed on the bedside commode at 9:15 PM on 07/03/15. The facility staff failed to conduct the scheduled routine checks on the resident and left the resident sitting in the bathroom alone with no method to call for help for greater than five (5) hours. When the resident was found, on 07/04/15 at approximately 2:30 AM, the resident complained of being cold and experienced pain and numbness in the hips/buttocks area. The resident had a diagnosis of Multiple Sclerosis and was totally dependent on staff for transfers and toileting needs.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 08/03/15, alleging the removal of Immediate Jeopardy on 07/29/15. The State</p>	F 000			

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

TITLE

(X6) DATE

Donna Bailey for Tom Kase

Interim Administrator

9/3/15

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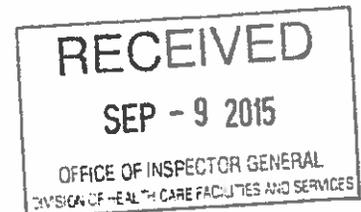
APPROVED
SEP - 9 2015
OFFICE OF INSPECTOR-IN-CHIEF
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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F 000	Continued From page 1 Survey Agency (SSA) validated the Immediate Jeopardy was removed on 07/29/15 as alleged prior to exit on 08/08/15, which lowered the Scope and Severity to a "D" at 42 CFR 483.10 Resident Rights (F157), 42 CFR 483.13 Resident Behavior and Facility Practice (F224), and 42 CFR 483.20 Resident Assessment (F282), while the facility develops and implements the Plan of Correction (POC), and the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes.	F 000	Sunrise Manor does not believe and does not admit that any deficiencies existed before, during or after the survey. The facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, Quality Assurance or self-critical examination privilege which the facility does not waive and reserves the right to assert in administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plans of correction as part of its ongoing efforts to provide quality of care to residents. F-157 Residents Affected: For Resident # 16, on 7/24/15, the Director of Nursing informed the responsible party for Resident #16 of the incident that occurred on 7/4/15	
F 157 SS=J	The Division of Health Care also investigated complaints KY23580 and KY23633 and found the allegations to be unsubstantiated. However, related deficiencies were cited. Additional deficiencies were cited during the Abbreviated/Recertification Survey with the highest scope and severity of a "F". 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge	F 157		

9/15/15

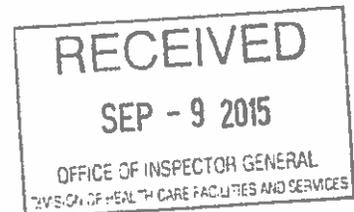


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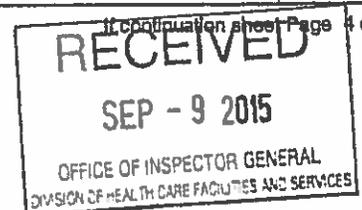
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F 157	<p>Continued From page 2</p> <p>the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to have an effective system in place to ensure the physician was notified regarding an incident that had the potential for requiring physician intervention for one (1) of the twenty-nine (29) sampled residents (Resident #16).</p> <p>On 07/04/15 at 2:30 AM, Resident #16, who required total assistance with transfers and toileting, was found alone in the bathroom, sitting on a bedside commode, yelling for help. The call light was wrapped around a support bar and could not be activated. The evening staff failed to communicate to the night staff the resident had been placed on the bedside commode at 9:15 PM on 07/03/15. The facility staff failed to conduct the scheduled routine checks on the resident and left</p>	F 157	<p>and what interventions had been put into place at the time of the incident. The attending physician was notified of the incident by the Director of Nursing on 7/25/15. On 7/25/15, the Director of Nursing conducted follow-up visit with Resident #16 and a follow-up call with Resident #16's Responsible Party. Both Resident #16 and the Responsible Party verbalized understanding and satisfaction with the outcome and interventions that were put in place.</p> <p><u>Residents Potentially Affected:</u> Residents of the facility have the potential to be affected by this deficient practice. Beginning July 25-27, 2015, all incident and accident reports since June 1, 2015 were audited to help identify any concerns of suspected abuse/neglect and for physician and responsible party notification. Several instances of non-notification were observed. At this time the physician and family were notified of these concerns. Beginning July 28, 2015 any residents' chart who had a change of condition is audited and reviewed in morning clinical meeting. One aspect of this audit/review is to help identify residents potentially affected by failure of the facility to notify physicians or responsible parties.</p>	



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F 157	<p>Continued From page 3</p> <p>the resident sitting in the bathroom alone with no method to call for help for greater than five (5) hours. When the resident was found, on 07/04/15 at approximately 2:30 AM, the resident complained of being cold and experienced pain and numbness in the hips/buttocks area. The resident had a diagnosis of Multiple Sclerosis and was totally dependent on staff for transfers and toileting needs. There was no documented evidence the resident's physician had been notified of the incident until 07/27/15, twenty-three (23) days after the incident occurred and surveyor intervention.</p> <p>The facility's failure to notify the physician of an incident that had the potential to require medical intervention has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 07/24/15 and determined to exist on 07/04/15.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 08/03/15, alleging the Immediate Jeopardy was removed on 07/29/15. The State Survey Agency validated the Immediate Jeopardy was removed on 07/29/15, as alleged, prior to exit on 08/06/15. The Scope and Severity was lowered to a "D" while the facility develops and implements the Plan of Correction (POC), and the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Change in Resident's Condition, revised October 2013, revealed the physician was to be notified of an accident or incident involving the resident. The notification was to be made within twenty-four</p>	F 157	<p>Systemic Measures:</p> <p>Nursing staff was educated by the SDC on 7/26 - 27/15 regarding the importance of notifying the physician and family of any incident that has the potential to require physician intervention. Beginning July 28, 2015, any changes of condition for our residents are being reviewed in daily morning clinical meeting, which are held Monday through Friday each morning and the record reviewed by our Nursing Administration team to assure that physician and family notification has occurred. If omissions are found, the Nursing Administration team will (1) Contact the Physician and/or the family to inform them of the change of condition and (2) Conduct re-education and/or disciplinary action with the staff member who did not contact the physician or family.</p>		



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F 157	<p>Continued From page 4</p> <p>(24) hours, except in medical emergencies, of a change occurring in the resident's medical/mental condition or status.</p> <p>Review of the facility's investigation, initiated on 07/04/15, revealed written statements were obtained from Certified Nursing Assistant (CNA) #2 and Licensed Practical Nurse (LPN) #1. Review of CNA #2's written statement, dated 07/04/15, revealed she was conducting a second routine check at 2:30 AM [on 07/04/15], when she heard the resident yelling behind the closed bathroom door. She found the resident sitting on the bedside commode with the call light wrapped around the support bar preventing the resident from activating the call light. Review of LPN #1's written statement, dated 07/04/15, revealed the aide reported Resident #16 was sitting on the bedside commode and believed the resident had been on the commode since 9:00 PM the previous shift [07/03/15]. The LPN documented the resident complained of hip pain and the resident's ankles were swollen; however, this was common if the resident was up too long. The resident requested pain medication. The nurse did not indicate she had notified the physician of the incident.</p> <p>During the Resident Council Group Meeting, conducted on 07/21/15 at 1:30 PM, Resident #16 revealed he/she had been left on the bedside commode for approximately five (5) hours and was unable to activate the call light.</p> <p>A private interview conducted with Resident #16, on 07/22/15 at 9:30 AM, revealed he/she had been placed on the bedside commode at approximately 9:15 PM on 07/03/15 to perform his/her nightly care and to use the bedside</p>	F 157	<p>Monitoring Measures:</p> <p>A Quality Assurance Performance Improvement meeting was held on July 26, 2015 at 3:15 pm with a physician who is covering for the Medical Director who was on vacation, the Administrator, Assistant Director of Nursing, a C.N.A./Central Supply Director, Admissions Director, Customer Experience Director, and Signature Care Consultant. One of the topics discussed included the importance of physician and/or family notification of changes of condition that might possibly require physician intervention. Beginning July 28, 2015 daily, Monday through Friday for 8 weeks, 10 charts will be audited for documentation to include notification of the physician and/or family for changes in condition of the resident that potentially could require physician intervention. Results of these and other audits will be brought to the monthly QAPI meeting for review times 6 months. At the 6-month point the QAPI Team will decide the frequency of ongoing audits.</p>		

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F 157	<p>Continued From page 5</p> <p>commode. When the resident tried to activate the call light for assistance from staff, the call light would not activate because it was wrapped around a support bar in the bathroom. The resident stated he/she had yelled out for help several times but nobody came. The resident stated when he/she was found, they were cold and shivering (resident was dressed in a gown), with pain to the hips/buttocks, and the entire body was numb. The resident stated he/she requested pain medication and a blanket after the incident.</p> <p>Review of Resident #16's clinical record revealed the facility admitted the resident on 01/19/12 with a re-admission on 04/30/13, with diagnoses of Multiple Sclerosis (MS), Hypertension, Thyroid Disorder, Osteoporosis, Right Shoulder Pain, Anxiety, Muscle Weakness, and Dysphagia.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 06/26/15, revealed the facility conducted a Brief Interview for Mental Status (BIMS) test with the resident scoring a fifteen (15) out of possible fifteen (15), meaning the resident was interviewable. The facility assessed the resident to require extensive assistance of two (2) persons for all transfers and toileting needs. The resident was non-ambulatory. The facility assessed the resident's balance to be unsteady and required staff assistance when moving on and off the toilet.</p> <p>Review of the comprehensive care plan, dated 03/20/15, revealed interventions to observe and report pain, numbness or tingling, edema, and general weakness related to the resident's MS, shoulder pain, and muscle spasms. The facility developed an intervention to report changes in pain location and type to the physician.</p>	F 157		

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F 157	<p>Continued From page 6</p> <p>Review of the Nurses' Notes, dated 07/07/15 at 2:30 AM, revealed Certified Nursing Assistant (CNA) #2 reported the resident was in the bathroom for a "lengthy" time. A skin assessment was conducted and pain medication was given for muscle aches. There was no documented evidence the resident's physician was notified.</p> <p>A telephone interview with LPN #1, on 07/23/15 at 1:40 PM and 08/04/15 at 4:05 PM, revealed she was the House Supervisor and working as a staff nurse (passing medications) on the night of 07/03/15 to earlier morning of 07/04/15. She stated between 1:30 AM and 2:00 AM, CNA #2 reported Resident #16 was found in the bathroom alone sitting on a bedside commode. The CNA told her the resident stated he/she had been on the bedside commode since 9:15-9:30 PM on 07/03/15. She said she assisted CNA #2 with transferring Resident #16 to bed and she performed a full body assessment. No injury was noted. She stated the resident complained of hip pain and the resident's ankles were swollen. She stated the resident requested a pain medication and she administered as requested. The LPN stated she had not notified the family or physician of the incident.</p> <p>Interview with the Social Worker, on 07/23/15 at 2:35 PM, revealed she was responsible for investigation of abuse/neglect and worked with the Administrator with oversight of the Complaint/Grievance Forms. She said with any incident such as the one involving Resident #16, a Complaint/Grievance Form should have been completed and the notification of the Physician and family would be documented on the form.</p>	F 157		

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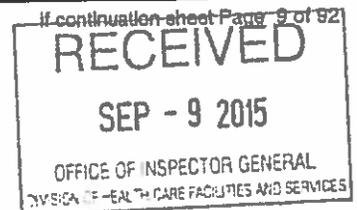
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F 157	<p>Continued From page 7</p> <p>However, she stated she had not investigated the incident because she was informed by the Administrator (previous/former) it had been taken care of. She was not aware the resident's physician had not been notified of the incident.</p> <p>Interview with the Director of Nursing, on 07/23/15 at 5:20 PM, revealed she found no documented evidence the resident's physician had been notified of the incident. No Complaint/Grievance Form was completed; therefore, the physician was not notified of the incident to determine if a change in treatment was needed. She stated this was an incident in which she would have notified the physician.</p> <p>Interview with Resident #16's physician, on 08/04/15 at 12:36 PM, revealed he learned of the incident on 07/27/15. He stated it was reported to him by the Director of Nursing after surveyor intervention. He was informed Resident #16, who was dependent on staff for transfers and toileting, was left on the bedside commode for greater than five (5) hours. He verified he had not been notified right after the incident and due to the resident's advanced MS, he would have wanted to be notified of the incident. He saw the resident on 07/07/15 and if he had been aware of the incident, he would have assessed the resident differently and asked more questions regarding pain.</p> <p>Review of the acceptable Allegation of Compliance (AOC), dated 07/29/15, revealed the facility took the following immediate actions:</p> <p>1. Resident #16 was removed from the bedside commode and transferred to the bed and assessed by Licensed Practical Nurse (LPN) #1</p>	F 157			

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

PRINTED: 08/20/2015
FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/06/2015	
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F 157	<p>Continued From page 8</p> <p>after the occurrence on 07/04/15. Swelling was noted to the Resident #16's ankles that dissipated by 3:15 AM. Resident #16 received pain medication (Norco) at 2:40 AM due to complaints of hip pain. Evaluations and assessments were continued through 07/07/15 with no new concerns.</p> <p>2. Certified Nursing Assistant (CNA) #2, who was assigned to Resident #16 on the night shift received a coaching and counseling session by LPN #1 and Registered Nurse (RN) #3. An investigation of the incident was initiated by LPN #1 and RN #3.</p> <p>3. Resident #16 was seen by a Orthopedic physician on 07/07/15 with orders for Physical Therapy and Occupational Therapy. Resident #16 was placed on case load from 07/09/15 through 07/24/15. No change of transfer status was identified.</p> <p>4. The resident's primary physician was notified of the occurrence involving Resident #16 being left on the bedside commode for an extended period of time on 07/24/15 by the Director of Nursing (DON). The Responsible party was notified on 07/24/15 by the DON.</p> <p>5. On 07/26/15, the Director of Program Development reviewed the personal files of CNA #2 and LPN #1, who were assigned to Resident #16 the night of the allegation, with no concerns pertaining to their abuse registry and back ground checks.</p> <p>6. Resident #16 was evaluated by the Customer Service Coordinator for the ability to use a call light on 07/25/15 and found it was difficult for</p>	F 157		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

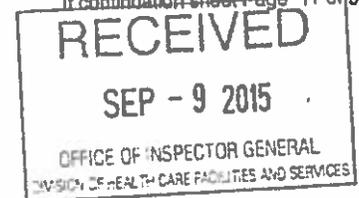
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F 157	<p>Continued From page 9</p> <p>him/her to use the current call light. Resident #16 received a new touch based call light on 07/25/15. The call light in the bathroom for Resident #16 was evaluated on 07/26/15 by the Regional Plant Operations Director and replaced by Technical Solutions on 07/28/15.</p> <p>7. All residents were assessed for any signs and symptoms of abuse and neglect. Residents with a Brief Interview of Mental Status (BIMS) score of greater than eight (8) were interviewed by the facility's Interim Administrator, DON, Minimum Data Set (MDS) Coordinator, Quality of Life Director and Medical Records for any abuse/neglect concerns starting 07/24/15 and concluding on 07/27/15. One concern from the initial audit was a concern regarding staffing. Residents who were identified to have a BIMS score of less than eight (8), were physically assessed by the Nursing Administration Team for any signs and symptoms of abuse/neglect, no new concerns were identified. Beginning 07/28/15, skin assessments would be completed each shift for ten (10) residents with a BIMS score of eight (8) or less then decreased to three times a week on 08/10/15 by the licensed nursing staff. An attempt to contact Residents' Responsible parties in regards to any abuse/neglect concerns began 07/24/15 and concluded on 07/27/15.</p> <p>8. The facility's Interim Administrator, DON, MDS Coordinator, Quality of Life Director, Medical Records and Central Supply were educated on 07/24/15 by the Signature Care Consultant on the abuse policy and procedure, to include but not limited to a thorough investigation, neglect, and reporting immediately. Department Administrative Managers were educated on 07/24/15. A total of</p>	F 157			

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

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OMB NO. 0938-0391

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F 157	Continued From page 10 seventeen (17) Department Head members were education on 07/24/15. Department Administrative Managers that did not receive the education could not return to work until abuse education was provided, and a post-test administered with a 100% score obtained. All were reviewed for compliance by the Signature Care Consultant. The facility does not utilize Agency Staff. The Interim Administrator and/or the DON was responsible for ensuring staff members were educated prior to returning to work. 9. Once the facility's Interim Administrator, DON, MDS Coordinator, Quality of Life Director, Medical Records and Central Supply were educated, then they were assigned to educate the staff on the facility's Abuse Policy, to include but not limited to, a thorough investigation, neglect and reporting immediately, on 07/24/15 and continued until 07/28/15. Staff that had not worked as of 07/28/15 would receive education prior to returning to work. Training was performed face to face in order to facilitate discussion and questions and included examples of items that would be considered as reportable. Staff members would not return to work until abuse education had been provided, post-test completed with a score of 100%. If the staff member did not achieve a score of a 100% on the post-test, the staff member would be re-educated on the Abuse Policy and Procedures and given the post-test again. The process would continue until the staff member achieved 100% on the post-test. Any staff member who was on vacation or Family Medical Leave would be provided the abuse/neglect education and given the post-test before allowed to return to work. with a score of 100% to be achieved on the	F 157		



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

PRINTED: 08/20/2015
FORM APPROVED
OMB NO. 0938-0391

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F 157	<p>Continued From page 11</p> <p>post-test. The Interim Administrator and the DON were responsible for ensuring this occurred.</p> <p>Every shift beginning on 07/28/15, ten (10) staff members on each shift would be given the post-test for abuse/neglect by the Interim Administrator, DON, Assistant Director of Nursing (ADON), Quality of Life Director and Plant Operations Director. A score of 100 % would be required, if less than 100 % the employee would be reinserviced and then given the post-test again until 100 % compliance was obtained.</p> <p>10. All new hires will receive abuse/neglect education during orientation and would be given a post-test to achieve a score of 100 %. If the new staff member did not achieve a score of 100 % on the post-test, the new staff member would have to be re-educated by the Staff Development Coordinator and DON and be given the post-test to achieve a score of 100 %. This process would continue until the new employee achieved a score of 100 % on the post-test. The Interim Administrator and DON would review the Post-tests given daily for any noted concerns. Any concerns would be addressed immediately.</p> <p>All new hires would complete six (6) modules of the CMS "Hand in Hand" training, during the general orientation period by the Staff Development Coordinator. The facility was in the process of all staff completing the CMS "Hand to Hand" training and one module would be assigned per month until all the modules are reviewed.</p> <p>11. Beginning on 07/24/15 and concluding on 07/28/15 100 % audit of all call lights in the facility were conducted, by the Interim Administrator,</p>	F 157		

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

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F 157	<p>Continued From page 12</p> <p>DON, MDS Coordinator, Quality of Life Director, Medical Records and or Central Supply, checking that the call lights were in working order and that the call lights were accessible for each resident and the resident had the ability to use the call light. The Initial call light audits were reviewed by the Signature Care Consultant daily from 07/24/15 through 07/28/15. There were two (2) call lights, Room 1502-B and 1602-B, which were identified as needing changed. Call light audits and education would remain ongoing, every shift from 07/28/15 until jeopardy was removed. The Call light audits would be reviewed by the Interim Administrator, DON and or regional staff daily.</p> <p>12. The facility's Performance Improvement Project (PIP) developed to monitor the corrective action through daily audits to ensure accessibility and function of call lights for residents was conducted by the Director of Program Development. The PIP would be reviewed two (2) times a week, then weekly times four (4) weeks by the interdisciplinary Care Team.</p> <p>13. On 07/24/15 the facility's Interim Administrator, DON, MDS Coordinator, Quality of Life Director, Medical Records, Unit Manager and/or Central Supply were assigned to visually observe where each resident in the facility was, if the resident's needs were being addressed, and if the residents felt safe. One hundred percent (100 %) of all current residents were observed and no concerns were identified. The facility's Interim Administrator, DON, MDS Coordinator, Quality of Life Director, Medical Records and/or Central Supply would audit this process to ensure compliance. Beginning 07/28/15, daily questionnaires will be completed each shift with ten (10) residents with a BIMS score of 8 or</p>	F 157		

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

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F 157	<p>Continued From page 13 above, by the DON, Interim Administrator, Quality of Life Director and Plant Operations Director asking the following questions: 1. Is everyone treated well? 2. Do you feel safe? 3. Do you have any concerns? These audits will decrease to three (3) times a week on 08/10/15.</p> <p>14. Visual observations of residents for safety and needs will be conducted every shift by nurses and CNAs at the change of shift. The staff would make visual observation of where each resident was in the facility, that the residents needs were being addressed and that the residents were safe. These rounds would be ongoing. The facility's Interim Administrator, DON, MDS Coordinator, Quality of Life Director, Medical Records and/or Central Supply would audit this process to ensure compliance. Ongoing education would be conducted with the staff regarding answering call lights timely, addressing resident needs, and making rounds at shift change. A rounding audit sheet would be filled out during walking rounds.</p> <p>15. Beginning on 07/24/15 and concluding on 07/27/15, 100 % of all current resident charts were reviewed for physician notification and any allegation of abuse or neglect since 06/01/15 by the Assistant Director of Nursing (ADON), Signature Care Consultant, Unit Manager and Customer Experience Coordinator.</p> <p>Beginning 07/28/15, ten (10) charts would be audited for documentation of allegations of abuse and neglect, physician and responsible party notification daily for two (2) weeks by the Interim Administrator and DON and then decreased to three times a week on 08/10/15. Any issues discovered at the time of the audits would be</p>	F 157			

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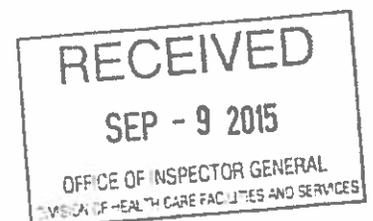
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F 157	<p>Continued From page 14</p> <p>brought to the attention of the Interim Administrator and DON. Audits would be reviewed by the Interim Administrator, DON, Signature Care Consultant or other regional staff members.</p> <p>16. Beginning on 07/24/15 and concluding on 07/27/15 100 % of current residents charts were audited by the Nursing Administration Staff and/or Signature Care Consultants for accuracy of care plans and CNA care plans, and assistive devices. Two variances were identified and corrected.</p> <p>17. All grievances since 01/01/15 were reviewed by the Interim Administrator, DON or Signature Care Consultant or Director of Program Development on 07/24/15 to determine if any items documented were an reportable event. All administrative staff were educated on the Grievance Process including how to fill out and complete a grievance and what was a grievance by the Director of Program Development on 07/27/15. The facility had identified thirteen concerns from the grievance audit that was reported to the Office of Inspector General as allegations of abuse. The current Social Services Director who handled the process was currently suspended and would be terminated. The Administrator resigned from the facility and her last day was 07/19/15.</p> <p>18. A Resident Council meeting was held on 07/25/15 by the Quality of Life Director and the Quality of Life Assistant, to discuss any abuse/neglect concerns and to provide education on whom to report any abuse/neglect concerns without fear of retribution.</p> <p>19. Beginning on 07/25/15 to 07/27/15 all</p>	F 157			

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

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F 157	<p>Continued From page 15</p> <p>Incident/accident reports since 07/01/15 had been reviewed by the DON and Signature Care Consultant to identify any concerns of suspected abuse/neglect and for physician and responsible party notification.</p> <p>20. On 07/24/15 the facility's Interim Administrator, DON, MDS Coordinators, Activities Director, Medical Records and Central Supply were educated on shift rounds, answering call lights, physician and responsible party notifications, by the Signature Care Consultant. These staff then educated the facility staff on shift rounds, answering call lights and physician notification. This was done face to face with staff interaction. A rounding audit sheet would be completed during the walking rounds. As of 07/27/15 the remaining ten (10) department heads had received their training. Staff members would not return to work until education had been provided. The facility employed 198 stakeholders and 128 employees had received education. 70 employees remained to receive training.</p> <p>21. A Quality Assurance Performance Improvement meetings was held, on 07/26/15 at 3:15 PM, with a physician representative, the Interim Administrator, a CNA, Central Supply Director, Customer Experience Coordinator, Assistant Director of Nursing, and the Signature Care Consultant. Topics that were discussed included call light response, appropriate call lights, rounding of Licensed Nurses, and CNAs checking on resident whereabouts, resident safety needs, following care plans, education provided, grievance process, abuse and neglect, reporting and investigating abuse and neglect, and physician and responsible party notification. Abuse/Neglect and Care Plan policies were</p>	F 157		



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

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F 157	<p>Continued From page 16 reviewed and there was no changes required to the policies.</p> <p>Results of the resident interviews, assessments and staff questionnaires would be reported to the QAPI committee weekly to determine the need for continued education or revision of the plan. Audits collected from staff members will be presented and discussed in the QAPI meeting. At that time, based on evaluation, the QAPI committee will determine at what frequency the resident interviews, assessments and staff questionnaires would need to continue. Concerns identified would be corrected immediately and reported to the Interim Administrator to ensure investigation of suspected abuse/neglect; the investigation was completed; the investigation and reporting guidelines were met; care plans were updated and followed; with physician and responsible party notifications made.</p> <p>A QAPI meeting will be held weekly until immediacy is removed, then decreased to every four (4) weeks, then monthly for recommendations and further follow up regarding the corrective actions of the AOC.</p> <p>22. Beginning 07/28/15 and continuing until the immediacy is removed, the resident change of condition would be reviewed daily in the morning clinical meeting to address any allegation of abuse and neglect, change of condition and that the physician and responsible party had been notified. The information for the clinical meeting would be gathered from but not limited to the twenty-four hour report sheet, Stop and Watch form, SBAR, resident orders, and verbal report from nurses. The information would be gathered</p>	F 157			

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

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F 157	<p>Continued From page 17 by the DON, Unit Manager, Medical Records, Customer Service Director and the Scheduling Coordinator.</p> <p>23. A nurse from the Regional Team or Corporate Office, Regional Vice President of Operations or Special Projects Administrator has been onsite daily since 07/24/15 providing training or assisting with the review of audits. They will continue weekly visits and or daily review by telephone until the Immediate Jeopardy had been removed and will decrease to every other week for four (4) weeks, then monthly. The nurses for the regional team or home office were assisting with investigations as needed, performing chart audits and providing oversight and consultation.</p> <p>Administrative oversight of the facility would be completed by the Special Projects Administrator, the Regional Vice President of Operations, or member of regional staff weekly on site and daily by telephone until removal of Immediate Jeopardy.</p> <p>24. The Interim Administrator and DON would review and discuss all abuse investigations daily to ensure the resident was protected; perpetrator was removed from resident care areas; that it was reported to the appropriate agencies timely; and, a thorough investigation was completed beginning 07/24/15 and continued until Immediate Jeopardy is removed. The Interim Administrator would maintain an abuse investigation log. The Interim Administrator and Corporate Staff will review each abuse allegation to ensure a thorough investigation had been completed, protection of the resident, and reported to the appropriate state agencies.</p>	F 157		

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

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F 157	<p>Continued From page 18</p> <p>25. During each care plan conference for each resident, any abuse/neglect concerns would be discussed along with any abuse/neglect education to include reporting, would be provided to the resident and or POA with supporting documentation noted starting 07/28/15.</p> <p>The State Survey Agency validated the implementation of the facility's acceptable AOC as follows:</p> <ol style="list-style-type: none"> 1. Review of the Nurses' Notes dated 07/04/15 at 2:30 AM, and interviews with CNA #1, on 07/23/15 at 3:20 PM and LPN #1, on 07/23/15 at 1:40 PM, revealed the resident was removed from the bedside commode and transferred to the bed where the resident was provided a blanket for warmth, skin assessment was performed, and pain medication was administered as requested. The Nurses' Notes from 07/04/15 through 07/07/15 revealed continued monitoring of the resident. 2. Review of the facility's investigation (initiated on 07/04/15) included a written coaching and counseling session with CNA #2. This was conducted by LPN #1 and signed as witnessed by RN #3. Written statements were obtained from CNA #2, LPN #1, and RN #3. 3. Review of the clinical record, Nurses' Notes dated 07/07/15, revealed the resident was seen by an Orthopedic physician. Interview with the DON, on 07/24/15 at 9:30 AM, revealed this appointment was already scheduled prior to the incident on 07/04/15. Review of therapy notes (07/09-24/15) revealed an evaluation of Resident #16 and services provided as stated in the AOC. 	F 157			

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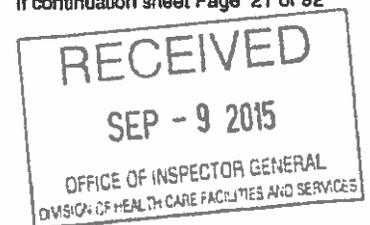
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F 157	<p>Continued From page 19</p> <p>Interview with the Physical Therapist, on 08/05/15 at 3:18 PM, revealed the resident remained a two-person assist and mechanical lift with all transfers.</p> <p>4. Interview with Resident #16's primary physician, on 08/04/15 at 12:36 PM, revealed he was notified of the incident on 07/27/15; however, he had been on vacation and the nursing facility had notified his office on 07/24/15. Interview with the DON, on 08/04/15 at 10:12 AM revealed she had notified the physician's office on 07/24/15.</p> <p>5. A review of the personnel files for CNA #2 and LPN #1 was conducted during the recertification survey as part of the 5-G Abuse task. No problems were identified. The SSA validated the abuse registry and background checks were conducted prior to hire with no findings.</p> <p>6. Observation of Resident #16's room, on 08/06/15 at 2:08 PM revealed the facility had provided a new soft touch call light. The call light in the resident's bathroom was replaced on 07/28/15.</p> <p>7. Review of the skin assessments revealed all residents in the facility received a skin assessment on 07/24/15 through 07/27/15 with no signs or symptoms of abuse/neglect found. Review of the skin assessments conducted by the facility revealed the facility continued to perform skin assessments on residents with a BIMS score of eight (8) or less. Review of the skin assessments conducted by the facility revealed the facility continued to perform skin assessments on residents with a BIMS score of eight (8) or less. Interviews on 08/04/15 with Resident #25 at 9:45 AM and Resident #29 at</p>	F 157		

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F 157	Continued From page 20 10:40 AM, revealed no concerns with abuse/neglect. 8. Review of the training records revealed on 07/24/15, the Corporate Care Consultant provided training on the facility's Abuse/Neglect Policy was provided to the Department Heads. This training included how to investigate an allegation of abuse/neglect and reporting requirements. The training also included physician notification, care plans, rounds, and call lights. Seventeen (17) Department Heads were present at the training including the Interim Administrator and Director of Nursing. Interview with the Corporate Consultant, on 08/06/15 at 3:46 PM, revealed she had provided training to all Department Heads on the Abuse/Neglect- Policy, investigating and reporting, call lights, grievances, and making visual rounds. Interview with the DON, on 08/06/15 at 1:36 PM, Quality of Life Director, on 08/06/15 at 10:00 AM, and Activity Director on 08/05/15 at 2:22 PM, Director of Program Development, on 08/05/15 at 4:08 PM, Customer Experience Director, on 08/05/15 at 4:33 PM, Maintenance Director, on 08/05/15 at 5:09 PM, and the Interim Administrator, on 08/06/15 at 2:36 PM, validated the training was provided on 07/24/15 and they had a good knowledge of how to investigate and report abuse. 9. Review of the training records revealed the facility staff was trained from 07/24/15 through 07/28/15, with as needed staff trained prior to working, on the Abuse/Neglect Policy. Post-tests were given regarding information presented on abuse/neglect with the staff scoring 100%. Training was validated through interviews with the Rehab (1-South) Unit Manager, on 08/06/15 at	F 157		



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F 157	<p>Continued From page 21</p> <p>9:25 AM, Social Services, on 08/05/15 at 1:45 PM, LPN #11, on 08/05/15 at 1:30 PM, LPN #12, on 08/05/15 at 1:36 PM, LPN #5 on 08/05/15 at 1:55 PM, and LPN #13, on 08/05/15 at 2:08 PM. Additional interviews were conducted with CNA # 10, on 08/05/15 at 1:42 PM, CNA #11 and #12 on 08/05/15 at 1:50 PM, CNA # 3 on 08/05/15 at 2:00 PM, CNA #25, on 08/05/15 at 2:02 PM, CNA # 14 on 08/05/15 at 2:05 PM, CNA #26 on 08/05/15 at 2:08 PM, CNA #6 on 08/05/15 at 2:10 PM, CNA # 7 and #24 on 08/05/15 at 2:15 PM, and CNA #8 on 08/05/15 at 3:05 PM. The staff had good knowledge of the definition of abuse/neglect and how to report. In addition, the nursing staff had been trained on communication rounds between shifts, conducting safety checks, call light accessibility, and the grievance process. Review revealed the facility continued to education on the Abuse/Neglect Policy with post-test given. Review of the results of the post-test revealed staff scored 100%.</p> <p>10. Review of the new hire list and comparison to the training documentation revealed the new employees would receive training on abuse/neglect with a Post-test required. All new hires must have a 100% pass rate. Interview with the Interim Administrator, on 08/06/15 at 2:36 PM, revealed newly hired employees will be required to complete the "Hand in Hand" modules (6), one per month. He stated there had been no new hires since 07/29/15. He said the Staff Development Coordinator would monitor the training. Review of the August 2015 schedule for new employee training revealed the Hand in Hand modules would be reviewed on August 10, 11, 12, 18, 19, and 20th.</p> <p>11. Observation during the extended survey</p>	F 157		

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F 157	<p>Continued From page 22</p> <p>revealed the residents' call lights were functional and within reach. Observation of the call light response time during the survey revealed the call lights were answered within five (5) minutes of activation. Review of the call light audits revealed the facility conduct a facility wide inspection of each resident's room, on 07/24/15, to determine if each call light was functional and within reach of the resident. The call light audits continued through the extended survey. The audits revealed two call lights were replaced and Resident #16's call light was replaced with a soft touch call light. Observation of Resident #16's bathroom, on 08/05/15 at 2:08 PM, revealed a soft touch call light and was within the resident's reach. Observation of the resident activating the new call light revealed the call light activated and staff responded within one minute. Interview with the resident during this observation revealed his/her needs were being met.</p> <p>12. The facility utilized a computer program (Abaqis) that monitors the corrective actions through daily audits. Members included the Interim Administrator, DON, ADON, Customer Service Director, and a CNA. Review of the Performance Improvement Project (PIP) revealed monitoring of call lights audits (daily the IDT team will discuss), care plan conference concerns, Abuse/Neglect Post-test, physician notification, daily charting audits, Hand in Handtraining, and Department Head rounds. Minutes from the PIP meetings were provided and reviewed. The facility met daily from 07/27/15 to 08/03/15. The PIP reviews were reviewed with Administrative Managers on 07/29/15. Interview with the Interim Administrator, on 08/06/05 at 2:36 PM, revealed the facility used PIP daily as this was another check for the audits.</p>	F 157			

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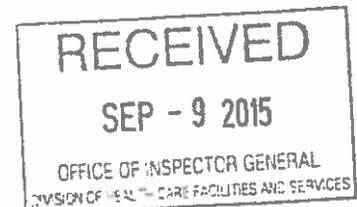
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F 157	Continued From page 23 13. Each resident was observed during the facility wide inspection of each resident's call light. Seventy-three (73) residents were interviewed and asked the following questions: (1) Is everyone treating you well? (2) Do you feel safe? (3) Do you have any concerns? No allegations of abuse/neglect were received. Other complaints were forward to the grievance process. Review of the daily questionnaires conducted (10) by the facility revealed the same questions were asked during the initial interviews with the residents conducted 07/24-27/15. No allegations of abuse/neglect were received. 14. Review of the daily assignment sheet for the nurse aides revealed the form had been revised to include a check off section that visual rounds had been conducted between the shifts. The nursing staff had been trained on the new process on 07/24/15-07/27/15. The shift reports were reviewed by the DON or Administrator. Observation, on 08/06/05 at 2:16 PM, revealed the nursing staff conducting the visual rounds on the 2-North Unit. Interviews with CNA # 10 on 08/05/15 at 1:42 PM, CNA #11 and #12 on 08/05/15 at 1:50 PM, CNA #3 on 08/05/15 at 2:00 PM, CNA #25 on 08/05/15 at 2:02 PM, CNA #14 on 08/05/15 at 2:05 PM, CNA #26 on 08/05/15 at 2:08 PM, CNA #6 on 08/05/15 at 2:10 PM, CNA #7 and #24, on 08/05/15 at 2:15 PM, and CNA #8 on 08/05/15 at 3:05 PM, revealed safety rounds were being conducted at the beginning and end of each working shift. Each resident must be seen on the rounds. 15. Review of the chart audits revealed the clinical record of each resident was reviewed. Clinical record review of the sampled residents	F 157		

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

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F 157	<p>Continued From page 24 during the extended survey revealed no issues with notification. The facility continued to conduct chart audits daily x two weeks.</p> <p>16. Review of the sampled residents for the extended survey revealed the comprehensive care plan and the nurse aide care plans had been revised to-reflect the resident's current status. No issues were found.</p> <p>17. Review of the training records revealed administrative staff had been trained on the facility's grievance process on 07/27/15 with re-education provided to the DON and Chaplain on 07/29/15. Interview with the DON, on 08/06/15 at 1:36 PM, revealed she had been trained on the grievance process a few weeks ago. She stated through the resident and family interviews, it generated several concerns that needed to be investigated. Some were reportable and others went through the grievance process. Interview with the Interim Administrator, on 08/06/15 at 2:36 PM, revealed the information from the resident and family interviews were taken to the Quality Assurance (QA) meetings. The facility reviewed their grievance log from June 1, 2015 to present and discovered some of the grievances had not been resolved. There was evidence the facility investigated those complaints and reported to the Office of Inspector General (OIG) as appropriate. The OIG investigated the complaints during the extended survey and found the allegations to be unsubstantiated.</p> <p>18. Review of the Resident Council Meeting minutes, held on 07/25/15, revealed no abuse/neglect allegations were received. The residents were provided education on how to report abuse/neglect.</p>	F 157			



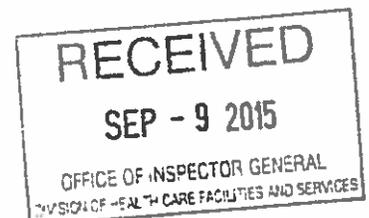
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F 157	<p>Continued From page 25</p> <p>19. Review of the event reports provided by the facility revealed the facility performed a clinical record audit from June 1, 2015 to present. The facility identified fourteen (14) incidents were physician notification was not completed. The physicians were notified of each resident's condition on 07/29/15 by the DON. Interview with the DON, on 08/06/15 at 1:36 PM, revealed a complete chart audit was conducted for all residents with the above findings. She stated all physician orders and change in status conditions were discussed in the daily clinical meetings to ensure notification was made.</p> <p>20. Review of the training records from 07/24/15 to 07/27/15 revealed staff was educated on shift rounds, answering call lights, and physician notification. Observation, on 08/06/05 at 2:16 PM, revealed the nursing staff conducting the visual rounds on the 2-North Unit. Observation during the extended survey revealed the residents' call lights were being answered.</p> <p>21. Review of the Quality Assurance Performance Improvement (QAPI) signature sheets revealed a meeting was held on 07/26/15 at 3:15 PM with the required members including a physician representative. The facility provided the minutes of the meeting that revealed the facility discussed the corrective action plans for immediate Jeopardy tags and the incident that triggered the Jeopardy. Additional QAPI meetings were held on 07/30/15 and 08/04/15. Interview with the Interim Administrator, on 08/06/15 at 2:36 PM, DON on 08/06/05 at 1:36 PM, and the Medical Director, on 08/04/15 at 12:36 PM, validated the QAPI meetings were held and what was discussed. The Interim Administrator stated results of the</p>	F 157		



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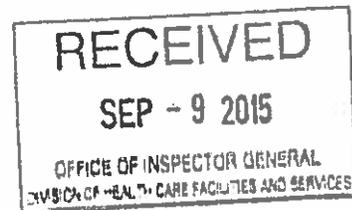
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F 157	<p>Continued From page 26</p> <p>residents' interview, assessments, and staff questionnaires were discussed. Audits collected from the staff member were reviewed and discussed. Any concerns identified would be corrected immediately the Administrator would ensure investigation of suspected abuse/neglect was completed; reported guidelines met; care plans revised and followed; and physician and responsible party notification was made.</p> <p>22. Interview with the DON, on 08/06/15 at 1:36 PM, revealed the morning clinical meetings were being held with discussion of physician orders, change in status conditions, any allegations of abuse/neglect, and physician notification. She stated she used a white board to monitor compliance, review twenty-four reports and other information forms.</p> <p>23. Interview with the Regional Corporate Nurse Consultant, on 08/06/15 at 3:45 PM and the Corporate Vice President of Operations, on 08/06/15 at 2:45 PM, revealed someone from the Regional Team would be there daily until Immediate Jeopardy was removed for support and guidance. The Corporate representative would be onsite weekly with daily telephone calls after the immediacy was removed and if all went well, reduce to every other week, then monthly for administrative oversight.</p> <p>24. Interview with the DON, on 08/06/15 at 1:36 PM, and the Interim Administrator, on 08/06/15 at 2:36 PM, revealed all allegations of abuse/neglect are investigated, residents are protected, and the allegations are reported to the state agencies. The Administrator maintained an Abuse Log. Review of the allegations of abuse/neglect reported to the OIG revealed the facility reported</p>	F 157			

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F 157	Continued From page 27 promptly. Several allegations were investigated during the extended survey with finding of unsubstantiated. Interview with DCBS representative, on 08/03/15 at 2:57 PM, revealed their agency received several reports of allegations of abuse from the facility and they would be investigating.	F 157		
F 166 SS=D	25. Review of seven (7) care plan conferences, dated 07/29/15, revealed each resident or resident's family was asked about abuse/neglect and provided information on how to report. 483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to provide prompt efforts to resolve grievances for one (1) of twenty-nine (29) sampled residents, Resident #16. The resident voiced a grievance regarding an incident that occurred on 07/04/15 when the resident was left on the bedside commode for greater than five (5) hours and the call light would not activate. The resident requested the findings of the investigation during a care plan conference on 07/22/15 and no results were provided. The findings include:	F 166	F-166 Residents Affected: For Resident # 16 a grievance report was completed by the Director of Nursing on 7/22/15. The Director of Nursing and Resident #16 discussed the incident that occurred on 7/4/15 and what interventions had been put into place at the time of the incident. On 7/25/15, the Director of Nursing conducted follow-up visit with Resident #16 and a follow-up call with Resident #16's Responsible Party. Both Resident #16 and the Responsible Party verbalized understanding and satisfaction with the outcome and interventions that were put in place.	9/15/15



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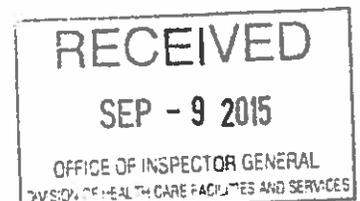
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F 166	<p>Continued From page 28</p> <p>Review of the Investigating a Resident Grievance or Complaint Policy, dated December 2010, revealed with each Grievance and Complaint Investigation Report, the Social Services Director, or designee, would investigate the allegation(s). The investigation and report would include, follow up/recommendation for corrective action, resolution and date resolution reported. The resident or person acting on behalf of the resident would be informed of the findings upon completion of the investigation, as well as any corrective actions.</p> <p>During the Resident Council Group Meeting, on 07/21/15 at 1:30 PM, Resident #16 voiced he/she was left in the bathroom alone on the bedside commode for over five (5) hours on 07/04/15. In addition, the resident stated the call light would not activate. The resident stated he/she had requested follow up and resolution of the investigation surrounding this event, but had not received any information from the facility. The resident was afraid this would happen again.</p> <p>Review of the Care Plan Meeting note, dated 07/23/15, by the Director of Nursing revealed Resident #16 and his/her sister voiced they would like to know the findings and resolution of the investigation regarding the incident on 07/04/15. Resident #16 wanted to know what the facility was doing to prevent a similar event from reoccurring.</p> <p>Review of the Administrative Investigation file revealed no Grievance and Complaint Report Form had been completed for the incident that occurred on 07/04/15 as indicated in the Social Service Progress Notes.</p>	F 166	<p><u>Residents Potentially Affected:</u> Residents of the facility have the potential to be affected by this deficient practice. An audit of all grievances since June 1, 2015 to include Resident Council Meeting Minutes (total of 54) were reviewed by the Administrator, DON, or Signature Care Consultant, or Director of Program Development on July 24, 2015 to determine if any items documented were a reportable event and resolution and follow-up were completed.</p> <p><u>Systemic Measures:</u> Administrative Staff were educated on the Grievance Process including how to fill out and complete a grievance and what constitutes a grievance by Director of Program Development on July 27, 2015. DON, CED, MDS Coordinators, ADONs, Unit Manager, Restorative Nurse Coordinator will inservice facility staff on how to fill out and complete a grievance and what constitutes a grievance.</p> <p><u>Monitoring Measures:</u> A Quality Assurance Performance Improvement meeting was held on July 26, 2015 at 3:15 pm with a physician who is covering for the</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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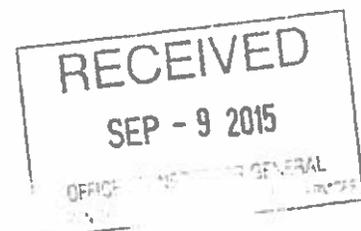
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F 166	<p>Continued From page 29</p> <p>Interview with the Activity Director, on 07/24/15 at 12:30 PM, stated she would normally document grievances expressed in the Resident Council Meeting on a Grievance/Complaint Investigation Report Form and then forward them to the Social Services Director. She stated she was not involved in the resolution of the grievance unless it involved her department. She stated the residents had complained during the Resident Council Meetings and no one had responded to their grievances. She stated the facility had a problem in the past with resolution of grievances and not following the facility policy. She stated the facility would verbally inform the resident of the findings and/or resolution, but did not follow up with formal documentation.</p> <p>Interview with the Director of Nursing, on 07/24/15 at 1:00 PM, revealed a Grievance/Complaint Investigation Report had not been completed because she was still looking into the event. The Director of Nursing stated she was not working the weekend of 07/04/15 and was informed by the Administrator the incident involving Resident #16 had been taken care of. She stated she reviewed the Administrator's investigation file and stated she was not aware it was incomplete until survey findings.</p> <p>Interview with the Social Services Director, on 07/24/15 at 1:10 PM, revealed she was the Abuse and Grievance Coordinator. She stated she recorded the grievances onto a log for tracking purposes. She stated when a grievance was received, she would discuss the problem at the morning administrative meeting and give the concern to the specific department the complaint was for. She stated they then would investigate and respond with actions to resolve the</p>	F 166	<p>Medical Director, who was on vacation, the Administrator, Assistant Director of Nursing, a C.N.A./Central Supply Director, Admissions Director, Customer Experience Director, and Signature Care Consultant. Topics discussed included the grievance process. Grievance Performance Improvement Plan was reviewed daily starting July 29, 2015 by members of the QAPI team and is now being reviewed Monday through Friday. QAPI meeting was held weekly beginning July 26, 2015 for 4 weeks and move to monthly thereafter. Grievances will be reviewed and assigned to the appropriate Department Head by Customer Experience Director for follow-up in the daily Stand-Up Meeting Monday through Friday until they are resolved. The Administrator will audit 50% of the grievances weekly for 8 weeks then monthly times 6 months to ensure resolution, follow-up with residents/responsible parties, and for completion. Findings of the above stated audits will be reviewed by the QAPI committee monthly for 6 months for further recommendations and follow-up as indicated.</p>		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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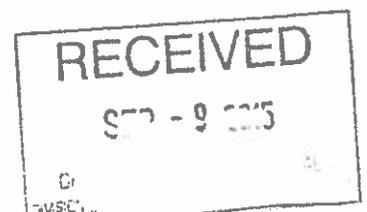
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F 224	Continued From page 59 well, reduce to every other week, then monthly for administrative oversight. 24. Interview with the DON, on 08/06/15 at 1:36 PM, and the Interim Administrator, on 08/06/15 at 2:36 PM, revealed all allegations of abuse/neglect are investigated, residents are protected, and the allegations are reported to the state agencies. The Administrator maintained an Abuse Log. Review of the allegations of abuse/neglect reported to the OIG revealed the facility reported promptly. Several allegations were investigated during the extended survey with finding of unsubstantiated. Interview with DCBS representative, on 08/03/15 at 2:57 PM, revealed their agency received several reports of allegations of abuse from the facility and they would be investigating. 25. Review of seven (7) care plan conferences, dated 07/29/15, revealed each resident or resident's family was asked about abuse/neglect and provided information on how to report.	F 224	F-280 Residents Affected: Resident #20's record was reviewed and updated on August 26, 2015 by the Interdisciplinary Team. The Interdisciplinary Team discussed the care needs of Resident #20 with relation to the Fall Risk assessment and interventions were added to the care plan to reflect the resident's fall care regimen. Residents Potentially Affected: Residents with a Fall Risk Assessment score of 10 or greater have the potential to be affected by this cited practice. Care plans for residents with a Fall Risk Assessment Score of 10 or greater were reviewed by Interdisciplinary Team to ensure that the care plans identified the care needs of the resident and their fall risk care regimen by September 15 2015. Systemic Measures: In-service education was completed by the DON and Customer Experience Director for facility nursing staff on July 22, 2015 regarding appropriately identifying resident's care needs on the care plan and ensuring the implementation of care plan	9/15/15
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in	F 280		



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

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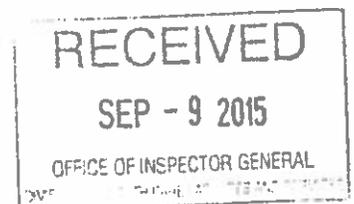
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F 280	<p>Continued From page 60</p> <p>disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, facility policy and procedure review, and review of SBAR (Situation, Background, Assessment, Request) Communication Form, it was determined the facility failed to investigate the fall of one (1) of twenty-nine (29) sampled residents, Resident #20. On 06/11/15, Resident #20 sustained a fall with no new interventions put in place after the fall; thereby, leaving the resident at risk of falls from transfers to the toilet.</p> <p>The findings include:</p> <p>Review of the Care Plans-Comprehensive policy provided by the facility, revised October 2013, revealed the Care Planning/Interdisciplinary Team was responsible for the review and updating of care plans when the desired outcome was not met.</p> <p>Review of the Falls Policy, review date of 06/01/15, revealed the care plan would be reviewed following each fall, staff would begin an investigation, the Interdisciplinary Team (IDT) would determine the root cause of a fall if possible, and then the care plan would be</p>	F 280	<p>interventions. Care plans will be reviewed and updated in the Clinical Meeting, which are held Monday through Friday each morning, for residents who have a change in their fall risk. The Director of Nursing will audit 10% of resident's care plans weekly for 8 weeks then monthly times 6 months to ensure the care plan appropriately reflects the resident's Fall Risk.</p> <p>Monitoring Measures: Findings of the above stated audits will be reviewed by the QAPI committee monthly for 6 months for frequency of ongoing audits or further recommendations and follow-up as indicated.</p>	



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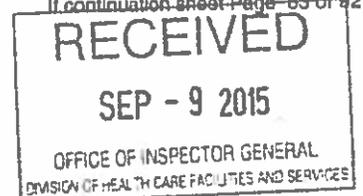
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F 280	<p>Continued From page 61 updated.</p> <p>Review of the clinical record for Resident #20 revealed the facility admitted the resident on 10/29/14 with diagnoses of Heart Failure, Hypertension, Peripheral Vascular Disease, End-Stage Renal Disease (ESRD), Diabetes Mellitus, and Bilateral Below Knee Amputation (BKA) with Prothesis.</p> <p>Review of the Annual Minimum Data Set (MDS) assessment, dated 04/15/15, revealed the facility assessed Resident #20 as requiring the extensive to total assist of two (2) persons with transfers.</p> <p>Review of the Comprehensive Care Plan, dated 04/17/15, revealed the staff was to assist the resident daily as needed with transfers and locomotion to desired locations.</p> <p>Review of the facility's Fall Risk Assessment Evaluation, dated 04/17/15, revealed Resident #20 scored eighteen (18) which meant the resident was at risk for falls.</p> <p>Review of the SBAR Communication Form, dated 06/11/15, revealed Resident #20 lost his/her balance and fell forward when attempting to transfer from the wheelchair to the toilet without assistance.</p> <p>Review of the Care Plan Conference Summary for Resident #20, dated 06/17/15, revealed the resident's last fall was on 06/11/15; however, there was no evidence that interventions for falls were discussed or the care plan updated during</p>	F 280			



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

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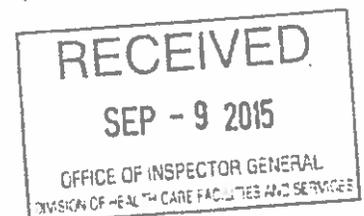
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F 280	Continued From page 62 the Care Plan Conference. Interview with RN #1, on 07/23/15 at 3:17 PM, revealed she filled out the SBAR Communication Form and notified the Floor Manager. RN #1 stated she reported incidents to the Floor Manager and expected the Floor Manager to input an intervention onto the resident's care plan. Interview with the Director of Nursing (DON), on 07/23/15 at 2:45 PM, revealed at the time of the fall the staff who identified the fall should have notified the Nursing Supervisor on-call so an immediate care plan intervention could have been implemented based on the root cause of the fall. The DON reviewed Resident #20's chart and could not identify any care plan interventions put in place related to the fall described by the SBAR Communication Form, dated 06/11/15.	F 280	F-282 <u>Residents Affected:</u> For resident #16, the resident's Care Plan and CNA Care Plan were reviewed for Care Plan accuracy. Revisions made at that time included installation and use of an air touch sensor pad for the call light. Therapy had no new recommendations regarding toileting positioning, change of transfer status or additional changes to resident's plan of care. <u>Residents Potentially Affected:</u> Residents of the facility have the potential to be affected by the cited deficient practice. To assist in identifying other residents who could have the potential to be affected by the deficient practice, a 100% audit of resident charts as well as a 100% audit of resident Care Plans and CNA Care Plans began on July 24, 2015 and concluded on July 28, 2015 by the Nursing Administration Staff, Signature Care Consultant, ADON, DON, MDS Coordinators, Unit Manager. The audits were to determine the current accuracy of the Care Plans and included a review of any assistive devices necessary to meet resident needs. Any variances were corrected at the time discovered.	9/15/15
F 282 SS=J	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 policy review, it was determined the facility failed to have an effective system in place to ensure the staff followed the resident's care plan for one (1) of twenty-nine (29) sampled residents, Resident #16. The facility staff failed to implement the care plan interventions to keep the call light within easy reach, assist with activities of daily living,	F 282		



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

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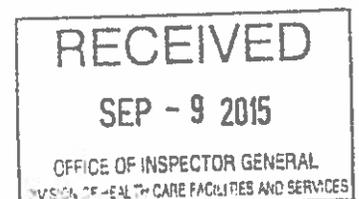
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F 166	Continued From page 30 grievance. She stated she strived for a seventy-two (72) hour response time, but stated it did not always occur. She stated she had not completed a grievance form for Resident #16's complaint because she was not present during the event and was informed by the Administrator, everything was taken care of. She stated Resident #16's sister had called her on 07/06/15 and left her a message asking if she was aware of the incident. The Social Services Director was informed the Administrator had spoken with the resident and everything was okay. The Social Services Director asked the Administrator a second time if she needed to complete an investigation and was informed the Administrator had conducted an investigation and everything was fine. Interview with the Corporate Nurse Consultant, on 07/24/15 at 10:00 AM, revealed she was unaware of the incident involving Resident #16 prior to the survey. She stated the event that occurred on 07/04/15 was the type of event she normally would be informed of along with having completed reports in the Event Manager Program and Grievance/Complaint Investigation Reports. She stated the Event Manager Program helped establish investigative protocols and resolutions for the facility. The Nurse Consultant stated she was present in the facility on 07/07/15 through 07/09/15, but assistance or guidance was not requested in regards to the 07/04/15 incident with Resident #16.	F 166		
F 224 SS=J	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit	F 224	F-224 Residents Affected: For resident #16, when the resident was found on the commode, she was assisted to bed and made comfortable by the CNA and LPN assigned to her that shift. The LPN completed an evaluation after she was placed in bed. No areas of redness were noted. The resident complained of left hip pain and swelling in her left ankle and was given medication to address the pain. At 3:15am, the LPN assigned to resident #16's care, completed a follow-up evaluation and no swelling was noted to the ankle. Resident reported pain relief from the medication administered.	9/15/15



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 224	<p>Continued From page 31</p> <p>mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility's policies and investigation, it was determined the facility failed to ensure residents were free from neglect for one (1) of twenty-nine (29) sampled residents, Resident #16. The facility failed to have an effective system in place to ensure the necessary care and services related to transfers and toileting needs were provided as needed or requested.</p> <p>On 07/04/15 at 2:30 AM, Resident #16, who required total assistance with transfers and toileting, was found alone in the bathroom, sitting on a bedside commode, yelling for help. The call light was wrapped around a support bar and could not be activated. The evening staff failed to communicate to the night staff the resident had been placed on the bedside commode at 9:15 PM on 07/03/15. The facility staff failed to conduct the scheduled routine checks on the resident and left the resident sitting in the bathroom alone with no method to call for help for greater than five (5) hours. When the resident was found, on 07/04/15 at approximately 2:30 AM, the resident complained of being cold and experienced pain and numbness in the hips/buttocks area. The resident had a diagnosis of Multiple Sclerosis and was totally dependent on staff for transfers and toileting needs.</p>	F 224	<p>Resident #16 was evaluated by the nurse assigned at the following times: July 4, 2015 at 3:15am, 4:30am, 3:00pm and 3:15pm. July 5, 2015, 2:00pm, 10:40pm July 6, 2015, 7:00am, 9:30am, 10:25pm. July 7, 2015, 6:00am, 1:00pm. During all evaluations, resident #16 had no redness or other concerns. The CNA assigned to resident #16 received a coaching and counseling on July 4, 2015. Resident #16 was seen by a physician on July 7, 2015 and wrote orders for PT & OT evaluations to be performed. The resident was on case load from July 9 to July 24, 2015. Therapy had no new recommendations regarding toileting positioning, change of transfer status or additional changes to resident's plan of care. Call Light: On July 26, 2015, the Regional Plant Operations Director evaluated the call light in resident #16's bathroom. On July 28, 2015, Technical Solutions will be at Sunrise Manor to run wiring from the bedside box to the bathroom and install an air touch sensor pad in resident 16's bathroom.</p>		



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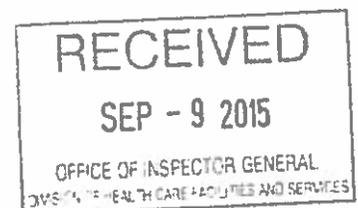
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F 224	<p>Continued From page 32</p> <p>The facility's failure to have an effective system to ensure residents were protected from neglect has caused or was likely to cause serious injury, harm, impairment or death. The Immediate Jeopardy was identified on 07/24/15, and was determined to exist on 07/04/15. The facility was notified of the Immediate Jeopardy on 07/24/15.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 08/03/15, alleging the Immediate Jeopardy was removed on 07/29/15. The State Survey Agency validated the Immediate Jeopardy was removed on 07/29/15, as alleged, prior to exit on 08/06/15. The Scope and Severity was lowered to a "D" while the facility develops and implements the Plan of Correction (POC), and the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>Review of the Abuse/Neglect Policy, revised March 2013, revealed abuse and neglect were prohibited. However, the policy did not define neglect.</p> <p>Review of the Routine Resident Checks Policy, revised October 2013, revealed staff would make routine resident checks at least every two hours to help maintain resident safety and well-being, making sure residents needs were being met, and identify any changes in the resident's condition. Any concerns were to be reported to the nurse and the nurse was to document on the Event Reporting Sheet which was forward to the Social Worker and the Administrator for follow-up.</p> <p>Review of the Safety and Supervision of Resident Policy, reviewed on 06/01/15, revealed staff</p>	F 224	<p>Residents Potentially Affected:</p> <p>Residents of the facility have the potential to be affected by the cited deficient practice. An assessment was conducted for all residents of the facility in regard to abuse/neglect. In order to identify other residents of the facility who might potentially be affected, all residents with a BIMs score greater than eight (8) were interviewed by: The Interim Administrator, DON, ADON, MDS Coordinators, SDC, Director of Dietary, Business Office Manager, Quality of Life Director, Marketing/Admissions Director, Medical Records, and/or Central Supply. One (1) concern related to staffing was voiced.</p> <p>Residents with a BIMs score less than eight (8) were physically assessed by the Nursing Administration Team for any physical signs and symptoms of abuse/neglect. No new concerns were identified.</p> <p>Call lights: To assist in identifying other residents of the facility with potential issues related to call light use, beginning on July 24, 2015 and concluding on July 28, 2015, a 100% initial audit of all call lights in the facility was conducted by the facility Interim Administrator, DON, ADON, MDS Coordinators,</p>	
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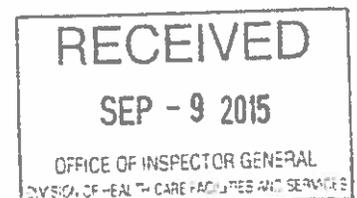
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/06/2015
NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748		
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F 224	<p>Continued From page 33</p> <p>would perform routine resident checks. Routine checks by nursing staff involved entering the resident's room and/or identifying the resident's location on the unit to determine if the resident's needs were met, identify any change in the resident's condition, identify whether the resident had any concerns and see if the resident was sleeping, needed toileting assistance, etc.</p> <p>Review of the facility's investigative file, initiated on 07/04/15, revealed written statements were obtained from Certified Nursing Assistant (CNA) #2 and Licensed Practical Nurse (LPN) #1. Review of CNA #2's written statement, dated 07/04/15, revealed she was conducting a second routine check at 2:30 AM, when she heard the resident yelling behind the closed bathroom door. She found the resident sitting on the bedside commode with the call light wrapped around the support bar preventing the resident from activating the call light. Review of LPN #1's written statement, dated 07/04/15, revealed the aide reported Resident #16 was sitting on the bedside commode and believed the resident had been on the commode since 9:00 PM the previous shift. The LPN documented the resident complained of hip pain and the resident's ankles were swollen; however, this was common if the resident was up too long. The resident requested pain medication. The nurse did not indicate she had notified the physician of the incident.</p> <p>During the Group Resident Council meeting, on 07/21/15 at 1:30 PM, Resident #16 stated he/she had been left alone on the bedside commode in the bathroom for approximately five (5) hours. The event had been reported; however, the resident felt as if nothing had been done because he/she was not given findings or resolution of the</p>	F 224	<p>SDC, Director of Dietary, Business Office Manager, Quality of Life Director Chaplain, Marketing/Admissions Director, Medical Records and Central Supply. Call lights were checked to assure that the call light was in working order, is accessible for each resident, the resident has the ability to use the call light.</p> <p><u>Systemic Measures:</u> In-service education on the Abuse Policy and Procedure, to include but not limited to, thorough investigation, neglect and immediate reporting of incidents was completed on July 24, 2015 by the Signature Care Consultant. The audience was the facility Interim Administrator, DON, ADON, MDS Coordinators, SDC, Director of Dietary, Business Office Manager, Quality of Life Director, Marketing/Admissions Director, Medical Records and Central Supply. Department Managers: A total of 17 Dept. Managers were educated on July 24, 2015. This training was performed face-to-face in order to facilitate discussion, questions and included: Examples of items that would be considered reportable such as staff being mean to residents, residents being left on the commode for long periods of</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 224	<p>Continued From page 34</p> <p>voiced complaint. The resident was afraid the incident would happen again.</p> <p>Further interview with Resident #16, on 07/22/15 at 9:30 AM, revealed he/she had been placed on the bedside commode at approximately 9:15 PM on 07/03/15 to perform his/her nightly care and to use the bedside commode. The resident stated this would normally take about 45 minutes to an hour. When the resident tried to activate the call light for assistance from staff, the call light would not activate because it was wrapped around the support bar. The resident said he/she yelled out for help, but nobody could hear him/her. The resident stated it was a very long time before staff found him/her in the bathroom. The resident stated they were cold and shivering (resident was dressed in gown), with pain to the hips/buttocks, and the entire body was numb when the staff found them. The resident stated he/she was afraid this could happen again because the resident was dependent on staff for all transfers on and off the bedside commode with a mechanical lift.</p> <p>Review of Resident #16's clinical record revealed the facility admitted the resident on 01/19/12 with a re-admission on 04/30/13, with diagnoses of Multiple Sclerosis (MS), Hypertension, Thyroid Disorder, Osteoporosis, Right Shoulder Pain, Anxiety, Muscle Weakness, and Dysphagia.</p> <p>Review of Resident #16's quarterly Minimum Data Set (MDS) assessment, dated on 06/26/15 revealed a Brief Interview for Mental Status (BIMS) test was conducted with a score of fifteen (15) out of possible fifteen (15), meaning the resident was interviewable. The facility assessed the resident to require extensive assistance of</p>	F 224	<p>time, injuries of unknown origin, withholding belongings, verbal or physical resident to resident altercations, taking residents' belongings or exploitation. Dept. Managers could not return to work until abuse education was provided a post test administered with a 100% score. If any Dept. Manager scored less than 100%, they were immediately re-educated and the post-test re-administered. All post tests were reviewed by a Signature Care Consultant.</p> <p>On July 24, 2015, once the facility Interim Administrator, DON, ADON, MDS Coordinators, SDC, Director of Dietary, Business Office Manager, Quality of Life Director, Marketing/Admissions Director, Medical Records and Central Supply were educated, they were reassigned to educate the rest of the staff on the abuse Policy and Procedure, to include but not limited to, thorough investigation, neglect and immediate reporting of incidents. Training continued through July 28, 2015. Any staff member who has not worked since July 28, 2015 will receive the same education presented to the Department Manager group before being allowed to return to work. Post-Tests must be completed and</p>		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 224	<p>Continued From page 35</p> <p>two (2) persons for bed mobility, transfers, dressing, hygiene and toilet use. The resident's balance was assessed to be unsteady and the resident required assistance during transition on and off the toilet. The facility assessed the resident to have limited range of motion and impairment to his/her bilateral upper and lower extremities.</p> <p>Review of the Activity of Daily Living (ADL) self-care deficit care plan, dated 03/20/15, revealed an intervention to keep the call light within easy reach. Review of the at risk for developing skin breakdown care plan, dated 03/20/15, revealed an intervention to assist the resident with reposition/shift weight to relieve pressure as needed to promote comfort. In addition, the staff was to assist the resident with toileting and hygiene needs.</p> <p>Review of Nurses' Notes, dated 07/04/15 at 2:30 AM, revealed CNA #2 reported to LPN #1 that Resident #16 was found in the bathroom alone on a bedside commode. The nurse performed a skin assessment that revealed edema in the resident's ankles, and the resident requested pain medication for muscle aches.</p> <p>Interview with CNA #1, on 07/23/15 at 2:52 PM, revealed she had placed Resident #16 on the bedside commode at approximately 9:15 PM, placed the call light within reach, and closed the bathroom door. The aide stated the resident's nightly routine took about an hour and it normally started earlier than 9:15 PM. She stated she checked on the resident at 9:30 PM, but the resident had not completed the tasks so she left the resident on the bedside commode. She stated she informed the aide from the night shift</p>	F 224	<p>score 100%. If any staff member scores less than 100%, they will be immediately re-educated and the post-test re-administered until 100% score is achieved. All new hires will receive during general orientation, the abuse/neglect education and will be given a post-test requiring a 100% score. If any newly-hired staff member scores less than 100%, they will be immediately re-educated by the Staff Development Coordinator, DON or ADON and the post-test re-administered until 100% score is achieved. All new hires will also complete the 6 modules of the CMS "Hand-in-Hand" training during the general orientation period. This will be administered by the Staff Development Coordinator. The facility is in the process of having all staff complete the CMS "Hand-in-Hand" training. This training has been ongoing since 2013.</p> <p>Resident Observation: On July 24, 2015, the facility Interim Administrator, DON, ADON, MDS Coordinators, SDC, Director of Dietary, Business Office Manager, Quality of Life Director, Marketing/Admissions Director, Medical Records and Central Supply were assigned to visually observe where each resident was in the facility, that each resident's</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 224	<p>Continued From page 36</p> <p>the resident was on the bedside commode before she left her shift at 10:00 PM.</p> <p>Interview with CNA #2, on 07/23/15 at 3:20 PM, revealed she received shift report from CNA #1, but could not recall if she received report on Resident #16's status. CNA #2 stated she had conducted a resident check/safety round at approximately 10:15 PM to 10:30 PM and noticed Resident #16's privacy curtain was pulled around the bed and the bathroom door was closed. She stated she did not look behind the privacy curtain or open the bathroom door to visualize the resident. The CNA stated it was a busy night with admissions and she was responsible for twenty-six (26) residents on the Rehab Unit. When conducting a second round at approximately 1:30 AM to 2:00 AM the CNA entered Resident #16's room and heard the resident yelling from the bathroom. She opened the bathroom door and found Resident #16 on the bedside commode and the call light cord was wrapped around a support bar. The resident told the aide he/she had been calling out trying to get someone's attention without success. CNA #2 reported the incident to LPN #1 and they transferred Resident #16 from the bedside commode to the bed using a mechanical lift.</p> <p>Interview with LPN #1, on 07/23/15 at 1:40 PM, revealed she was working as the House Supervisor and passing medications on the night of 07/03-04/15. The nurse stated around 2:30 AM, CNA #2 reported Resident #16 was found in the bathroom on the bedside commode and stated she had been there for awhile. LPN #1 assisted CNA #2 with transferring Resident #16 from the bedside commode to bed, performed a full body assessment and gave him/her a pain</p>	F 224	<p>needs were being addressed and that the resident was safe. 100% of residents were observed and no concerns identified. The facility CNAs and Nurses were assigned to visually observe where each resident was in the facility, that each resident's needs were being addressed and that the resident was safe at the beginning of every shift.</p> <p>Monitoring Measures: Hand-in-Hand training will be supervised and tracked by the Staff Development Director and the DON. Call Lights: A facility PIP (Performance Improvement Project) was developed by the Director of Program Development, to monitor the corrective action through daily audits to ensure accessibility and function of call lights for residents. The PIP will be reviewed daily times 2 weeks, then Mon – Fri times 4 weeks by the Interdisciplinary Care Team and will be reported to the Quality Assurance Performance Improvement Committee on July 30, 2015. Following this meeting the frequency will move to weekly time 8 weeks, then monthly times 6 months, with revisions as needed. Resident Observation: The facility CNAs and Nurses were assigned to</p>		

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F 224	<p>Continued From page 37</p> <p>medication as requested for pain to the hips and buttocks. LPN #1 stated the Rehab Unit had admissions and it was a busy night. The nurse stated she was not aware CNA #2 had not conducted the routine checks according to the facility's policy. She stated she was too busy and assumed the safety checks had been completed. The nurse stated there was only one nurse and one CNA scheduled for the Rehab Unit to care for twenty-six (26) residents.</p> <p>Interview with the Director of Nursing (DON), on 07/24/15 at 9:30 AM and 1:00 PM, in regards to the event involving Resident #16, revealed she was out of town during the weekend of 07/04/15. Upon her return to the facility, she was informed the investigation of the incident had been completed by the Administrator (previous/former). She stated she was told it was a communication problem between the shifts and CNA #2 had not conducted the routine resident checks according to the facility's policy. In addition, the resident's call light had been wrapped around the support bar and would not activate. She stated re-education was provided to the staff; however, review of the training sheets revealed only the night shift working at the time of the incident received the education. The DON stated she was responsible for ensuring staff nurses were monitoring CNAs for completing routine resident checks and she monitored this by reviewing assignment sheets and manager reports.</p> <p>Further interview with the DON, on 08/04/15 at 10:12 AM, revealed the facility's investigation had not considered staffing to be a contributing factor; however, she revealed the night of the incident, there was only one nurse and one aide on the Rehab Unit and North Unit. She stated the normal</p>	F 224	<p>visually observe where each resident was in the facility, that each resident's needs were being addressed and that the resident was safe at the beginning of every shift. These observations will continue and be audited by the facility Interim Administrator, DON, ADON, MDS Coordinators, SDC, Director of Dietary, Business Office Manager, Quality of Life Director, Marketing/Admissions Director, Medical Records and Central Supply</p> <p>Findings of the above stated audits will be reviewed by the QAPI committee monthly for 6 months for further recommendations and follow-up as indicated.</p>	

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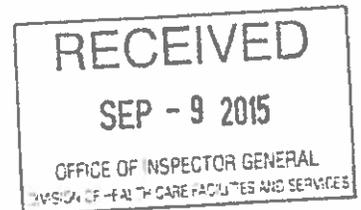
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F 224	<p>Continued From page 38</p> <p>staffing pattern would be for two (2) aides on each unit. There was a float CNA to assist. She stated the floating aide did not have a specific assignment, and they were to check with the nurse and aide to determine where the help was needed. The DON stated there had been frequent call-ins during the time of the incident and the facility had used this staffing schedule for awhile. She stated the float CNA was supposed to assist the scheduled aide in performing tasks.</p> <p>Review of the staffing schedule for 07/03/15 and 07/04/15, revealed one nurse and one aide with a float CNA was scheduled for the 1-South (Rehab) Unit and the 1-North Unit. Review of the daily census for those dates revealed there were twenty-six (26) residents on the 1-South Unit and thirty-five (35) residents on the 1-North Unit.</p> <p>Interview with CNA #15 (the float aide working on 07/04/15), on 08/04/15 at 4:19 PM, revealed when she started her shift she was told to work on the 1-North Unit because there were more residents (35) with higher acuity needs. There was only one aide on that unit also. She stated she went to the Rehab Unit (1-South), where Resident #16 resided, around 2:30 AM to relieve CNA #2 for her break. When she came onto the unit, she said Resident #16 had already been found sitting on the bedside commode. She observed LPN #1 and CNA #2 transfer the resident from the bedside commode to the bed. The resident complained of being cold, bottom numb, and kept repeating he/she couldn't use the call light because it was wrapped tightly around the support bar. She stated the resident was very upset. She validated she had not assisted CNA #2 on the Rehab Unit until after the incident with Resident #16. She was not aware the resident</p>	F 224		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 224	<p>Continued From page 39</p> <p>was on the bedside commode and had not conducted any resident or environmental checks for that unit.</p> <p>Interview with the Social Services Director (SSD), on 07/23/15 at 2:35 PM, revealed she was the Abuse Coordinator for the facility and was responsible for coordinating abuse/neglect complaints and grievances. The SSD stated the sister of Resident #16 had left her a voice message informing her about the incident of 07/04/15. The SSD stated she had spoken with the Administrator on Monday (07/06/15) following the incident and was told everything was taken care of. Resident #16 came to the SSD later that day and was telling her about the incident. The SSD stated she had spoken with the Administrator a second time and asked if there was anything, such as interviews, she needed to perform in regards to an investigation surrounding the event involving Resident #16 on 07/04/15. The former Administrator told her "No", "it had been taken care of."</p> <p>Observation, on 07/22/15 at 2:30 PM, of an re-enacting of the location of the call light, revealed there were two (2) call lights in the resident's bathroom. One call light was located on the wall by the toilet and the other was located on the wall of the shower. The call light was draped over the shower head to the support bar and then around the wall to the sink and hooked over the faucet with a loop handle. Resident #16 wrapped the call light cord around the support bar to demonstrate how the call light was placed on 07/04/15. When the resident pulled the call light cord, it would not activate the call system to call for help.</p>	F 224		



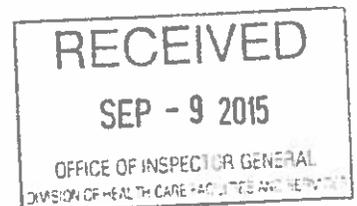
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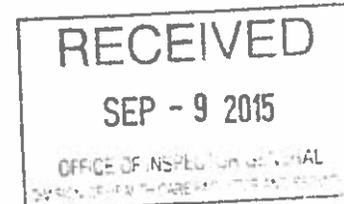
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F 224	<p>Continued From page 40</p> <p>Review of the acceptable Allegation of Compliance (AOC), dated 07/29/15, revealed the facility took the following immediate actions:</p> <ol style="list-style-type: none"> 1. Resident #16 was removed from the bedside commode and transferred to the bed and assessed by Licensed Practical Nurse (LPN) #1 after the occurrence on 07/04/15. Swelling was noted to the Resident #16's ankles that dissipated by 3:15 AM. Resident #16 received pain medication (Norco) at 2:40 AM due to complaints of hip pain. Evaluations and assessments were continued through 07/07/15 with no new concerns. 2. Certified Nursing Assistant (CNA) #2, who was assigned to Resident #16 on the night shift received a coaching and counseling session by LPN #1 and Registered Nurse (RN) #3. An investigation of the incident was initiated by LPN #1 and RN #3. 3. Resident #16 was seen by a Orthopedic physician on 07/07/15 with orders for Physical Therapy and Occupational Therapy. Resident #16 was placed on case load from 07/09/15 through 07/24/15. No change of transfer status was identified. 4. The resident's primary physician was notified of the occurrence involving Resident #16 being left on the bedside commode for an extended period of time on 07/24/15 by the Director of Nursing (DON). The Responsible party was notified on 07/24/15 by the DON. 5. On 07/26/15, the Director of Program 	F 224		



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

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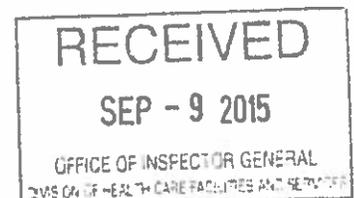
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F 224	<p>Continued From page 41</p> <p>Development reviewed the personal files of CNA #2 and LPN #1, who were assigned to Resident #16 the night of the allegation, with no concerns pertaining to their abuse registry and back ground checks.</p> <p>6. Resident #16 was evaluated by the Customer Service Coordinator for the ability to use a call light on 07/25/15 and found it was difficult for him/her to use the current call light. Resident #16 received a new touch based call light on 07/25/15. The call light in the bathroom for Resident #16 was evaluated on 07/26/15 by the Regional Plant Operations Director and replaced by Technical Solutions on 07/28/15.</p> <p>7. All residents were assessed for any signs and symptoms of abuse and neglect. Residents with a Brief Interview of Mental Status (BIMS) score of greater than eight (8) were interviewed by the facility's Interim Administrator, DON, Minimum Data Set (MDS) Coordinator, Quality of Life Director and Medical Records for any abuse/neglect concerns starting 07/24/15 and concluding on 07/27/15. One concern from the initial audit was a concern regarding staffing. Residents who were identified to have a BIMS score of less than eight (8), were physically assessed by the Nursing Administration Team for any signs and symptoms of abuse/neglect, no new concerns were identified. Beginning 07/28/15, skin assessments would be completed each shift for ten (10) residents with a BIMS score of eight (8) or less then decreased to three times a week on 08/10/15 by the licensed nursing staff. An attempt to contact Residents' Responsible parties in regards to any abuse/neglect concerns began 07/24/15 and concluded on 07/27/15.</p>	F 224		



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

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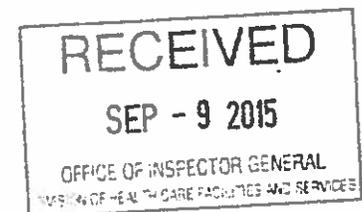
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F 224	<p>Continued From page 42</p> <p>8. The facility's Interim Administrator, DON, MDS Coordinator, Quality of Life Director, Medical Records and Central Supply were educated on 07/24/15 by the Signature Care Consultant on the abuse policy and procedure, to include but not limited to a thorough investigation, neglect, and reporting immediately. Department Administrative Managers were educated on 07/24/15. A total of seventeen (17) Department Head members were education on 07/24/15. Department Administrative Managers that did not receive the education could not return to work until abuse education was provided, and a post-test administered with a 100% score obtained. All were reviewed for compliance by the Signature Care Consultant. The facility does not utilize Agency Staff. The Interim Administrator and/or the DON was responsible for ensuring staff members were educated prior to returning to work.</p> <p>9. Once the facility's Interim Administrator, DON, MDS Coordinator, Quality of Life Director, Medical Records and Central Supply were educated, then they were assigned to educate the staff on the facility's Abuse Policy, to include but not limited to, a thorough investigation, neglect and reporting immediately, on 07/24/15 and continued until 07/28/15. Staff that had not worked as of 07/28/15 would receive education prior to returning to work. Training was performed face to face in order to facilitate discussion and questions and included examples of items that would be considered as reportable. Staff members would not return to work until abuse education had been provided, post-test completed with a score of 100 %. If the staff member did not achieve a score of a 100 % on</p>	F 224		



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

PRINTED: 08/20/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/06/2015
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F 224	<p>Continued From page 43</p> <p>the post-test, the staff member would be re-educated on the Abuse Policy and Procedures and given the post-test again. The process would continue until the staff member achieved 100 % on the post-test. Any staff member who was on vacation or Family Medical Leave would be provided the abuse/neglect education and given the post-test before allowed to return to work with a score of 100 % to be achieved on the post-test. The Interim Administrator and the DON were responsible for ensuring this occurred.</p> <p>Every shift beginning on 07/28/15, ten (10) staff members on each shift would be given the post-test for abuse/neglect by the Interim Administrator, DON, Assistant Director of Nursing (ADON), Quality of Life Director and Plant Operations Director. A score of 100 % would be required, if less than 100 % the employee would be reinserviced and then given the post-test again until 100 % compliance was obtained.</p> <p>10. All new hires will receive abuse/neglect education during orientation and would be given a post-test to achieve a score of 100 %. If the new staff member did not achieve a score of 100 % on the post-test, the new staff member would have to be re-educated by the Staff Development Coordinator and DON and be given the post-test to achieve a score of 100 %. This process would continue until the new employee achieved a score of 100 % on the post-test. The Interim Administrator and DON would review the Post-tests given daily for any noted concerns. Any concerns would be addressed immediately.</p> <p>All new hires would complete six (6) modules of the CMS "Hand In Hand" training, during the general orientation period by the Staff</p>	F 224		



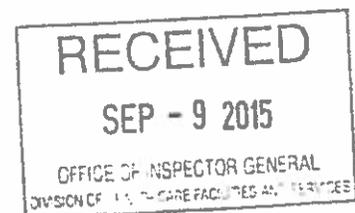
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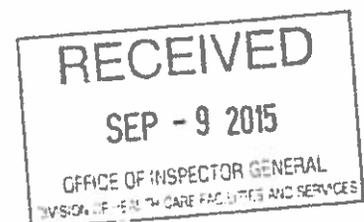
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F 224	<p>Continued From page 44</p> <p>Development Coordinator. The facility was in the process of all staff completing the CMS "Hand to Hand" training and one module would be assigned per month until all the modules are reviewed.</p> <p>11. Beginning on 07/24/15 and concluding on 07/28/15 100 % audit of all call lights in the facility were conducted, by the Interim Administrator, DON, MDS Coordinator, Quality of Life Director, Medical Records and or Central Supply, checking that the call lights were in working order and that the call lights were accessible for each resident and the resident had the ability to use the call light. The initial call light audits were reviewed by the Signature Care Consultant daily from 07/24/15 through 07/28/15. There were two (2) call lights, Room 1502-B and 1602-B, which were identified as needing changed. Call light audits and education would remain ongoing, every shift from 07/28/15 until jeopardy was removed. The Call light audits would be reviewed by the Interim Administrator, DON and or regional staff daily.</p> <p>12. The facility's Performance Improvement Project (PIP) developed to monitor the corrective action through daily audits to ensure accessibility and function of call lights for residents was conducted by the Director of Program Development. The PIP would be reviewed two (2) times a week, then weekly times four (4) weeks by the interdisciplinary Care Team.</p> <p>13. On 07/24/15 the facility's Interim Administrator, DON, MDS Coordinator, Quality of Life Director, Medical Records, Unit Manager and/or Central Supply were assigned to visually observe where each resident in the facility was, if the resident's needs were being addressed, and if</p>	F 224		



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

PRINTED: 08/20/2015
FORM APPROVED
OMB NO. 0938-0391

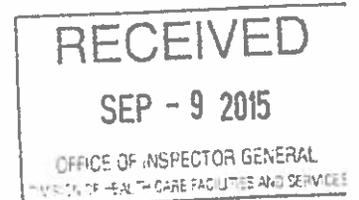
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F 224	Continued From page 45 the residents felt safe. One hundred percent (100 %) of all current residents were observed and no concerns were identified. The facility's Interim Administrator, DON, MDS Coordinator, Quality of Life Director, Medical Records and/or Central Supply would audit this process to ensure compliance. Beginning 07/28/15, daily questionnaires will be completed each shift with ten (10) residents with a BIMS score of 8 or above, by the DON, Interim Administrator, Quality of Life Director and Plant Operations Director asking the following questions: 1. Is everyone treated well? 2. Do you feel safe? 3. Do you have any concerns? These audits will decrease to three (3) times a week on 08/10/15. 14. Visual observations of residents for safety and needs will be conducted every shift by nurses and CNAs at the change of shift. The staff would make visual observation of where each resident was in the facility, that the residents needs were being addressed and that the residents were safe. These rounds would be ongoing. The facility's Interim Administrator, DON, MDS Coordinator, Quality of Life Director, Medical Records and/or Central Supply would audit this process to ensure compliance. Ongoing education would be conducted with the staff regarding answering call lights timely, addressing resident needs, and making rounds at shift change. A rounding audit sheet would be filled out during walking rounds. 15. Beginning on 07/24/15 and concluding on 07/27/15, 100 % of all current resident charts were reviewed for physician notification and any allegation of abuse or neglect since 06/01/15 by the Assistant Director of Nursing (ADON), Signature Care Consultant, Unit Manager and	F 224			



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

PRINTED: 08/20/2015
FORM APPROVED
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F 224	<p>Continued From page 46 Customer Experience Coordinator.</p> <p>Beginning 07/28/15, ten (10) charts would be audited for documentation of allegations of abuse and neglect, physician and responsible party notification daily for two (2) weeks by the Interim Administrator and DON and then decreased to three times a week on 08/10/15. Any issues discovered at the time of the audits would be brought to the attention of the Interim Administrator and DON. Audits would be reviewed by the Interim Administrator, DON, Signature Care Consultant or other regional staff members.</p> <p>16. Beginning on 07/24/15 and concluding on 07/27/15 100 % of current residents charts were audited by the Nursing Administration Staff and/or Signature Care Consultants for accuracy of care plans and CNA care plans, and assistive devices. Two variances were identified and corrected.</p> <p>17. All grievances since 01/01/15 were reviewed by the Interim Administrator, DON or Signature Care Consultant or Director of Program Development on 07/24/15 to determine if any items documented were an reportable event. All administrative staff were educated on the Grievance Process including how to fill out and complete a grievance and what was a grievance by the Director of Program Development on 07/27/15. The facility had identified thirteen concerns from the grievance audit that was reported to the Office of Inspector General as allegations of abuse. The current Social Services Director who handled the process was currently suspended and would be terminated. The Administrator resigned from the facility and her last day was 07/19/15.</p>	F 224			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

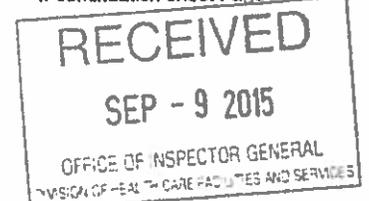
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F 224	Continued From page 47 18. A Resident Council meeting was held on 07/25/15 by the Quality of Life Director and the Quality of Life Assistant, to discuss any abuse/neglect concerns and to provide education on whom to report any abuse/neglect concerns without fear of retribution. 19. Beginning on 07/25/15 to 07/27/15 all incident/accident reports since 07/01/15 had been reviewed by the DON and Signature Care Consultant to identify any concerns of suspected abuse/neglect and for physician and responsible party notification. 20. On 07/24/15 the facility's Interim Administrator, DON, MDS Coordinators, Activities Director, Medical Records and Central Supply were educated on shift rounds, answering call lights, physician and responsible party notifications, by the Signature Care Consultant. These staff then educated the facility staff on shift rounds, answering call lights and physician notification. This was done face to face with staff interaction. A rounding audit sheet would be completed during the walking rounds. As of 07/27/15 the remaining ten (10) department heads had received their training. Staff members would not return to work until education had been provided. The facility employed 198 stakeholders and 128 employees had received education. 70 employees remained to receive training. 21. A Quality Assurance Performance Improvement meetings was held, on 07/26/15 at 3:15 PM, with a physician representative, the Interim Administrator, a CNA, Central Supply Director, Customer Experience Coordinator, Assistant Director of Nursing, and the Signature	F 224			

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

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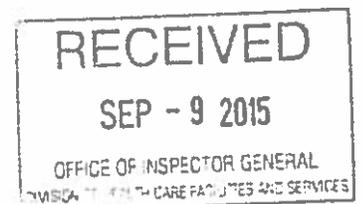
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F 224	<p>Continued From page 48</p> <p>Care Consultant. Topics that were discussed included call light response, appropriate call lights, rounding of Licensed Nurses, and CNAs checking on resident whereabouts, resident safety needs, following care plans, education provided, grievance process, abuse and neglect, reporting and investigating abuse and neglect, and physician and responsible party notification. Abuse/Neglect and Care Plan policies were reviewed and there was no changes required to the policies.</p> <p>Results of the resident interviews, assessments and staff questionnaires would be reported to the QAPI committee weekly to determine the need for continued education or revision of the plan. Audits collected from staff members will be presented and discussed in the QAPI meeting. At that time, based on evaluation, the QAPI committee will determine at what frequency the resident interviews, assessments and staff questionnaires would need to continue. Concerns identified would be corrected immediately and reported to the Interim Administrator to ensure investigation of suspected abuse/neglect; the investigation was completed; the investigation and reporting guidelines were met; care plans were updated and followed; with physician and responsible party notifications made.</p> <p>A QAPI meeting will be held weekly until immediacy is removed, then decreased to every four (4) weeks, then monthly for recommendations and further follow up regarding the corrective actions of the AOC.</p> <p>22. Beginning 07/28/15 and continuing until the immediacy is removed, the resident change of</p>	F 224			



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

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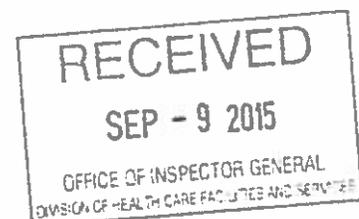
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F 224	<p>Continued From page 49</p> <p>condition would be reviewed daily in the morning clinical meeting to address any allegation of abuse and neglect, change of condition and that the physician and responsible party had been notified. The information for the clinical meeting would be gathered from but not limited to the twenty-four hour report sheet, Stop and Watch form, SBAR, resident orders, and verbal report from nurses. The information would be gathered by the DON, Unit Manager, Medical Records, Customer Service Director and the Scheduling Coordinator.</p> <p>23. A nurse from the Regional Team or Corporate Office, Regional Vice President of Operations or Special Projects Administrator has been onsite daily since 07/24/15 providing training or assisting with the review of audits. They will continue weekly visits and or daily review by telephone until the Immediate Jeopardy had been removed and will decrease to every other week for four (4) weeks, then monthly. The nurses for the regional team or home office were assisting with investigations as needed, performing chart audits and providing oversight and consultation.</p> <p>Administrative oversight of the facility would be completed by the Special Projects Administrator, the Regional Vice President of Operations, or member of regional staff weekly on site and daily by telephone until removal of Immediate Jeopardy.</p> <p>24. The Interim Administrator and DON would review and discuss all abuse investigations daily to ensure the resident was protected; perpetrator was removed from resident care areas; that it was reported to the appropriate agencies timely; and, a thorough investigation was completed</p>	F 224			



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

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F 224	<p>Continued From page 50 beginning 07/24/15 and continued until Immediate Jeopardy is removed. The Interim Administrator would maintain an abuse investigation log. The Interim Administrator and Corporate Staff will review each abuse allegation to ensure a thorough investigation had been completed, protection of the resident, and reported to the appropriate state agencies.</p> <p>25. During each care plan conference for each resident, any abuse/neglect concerns would be discussed along with any abuse/neglect education to include reporting, would be provided to the resident and or POA with supporting documentation noted starting 07/28/15.</p> <p>The State Survey Agency validated the implementation of the facility's acceptable AOC as follows:</p> <p>1. Review of the Nurses' Notes dated 07/04/15 at 2:30 AM, and interviews with CNA #1, on 07/23/15 at 3:20 PM and LPN #1, on 07/23/15 at 1:40 PM, revealed the resident was removed from the bedside commode and transferred to the bed where the resident was provided a blanket for warmth, skin assessment was performed, and pain medication was administered as requested. The Nurses' Notes from 07/04/15 through 07/07/15 revealed continued monitoring of the resident.</p> <p>2. Review of the facility's investigation (initiated on 07/04/15) included a written coaching and counseling session with CNA #2. This was conducted by LPN #1 and signed as witnessed by</p>	F 224		



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

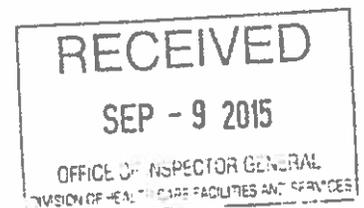
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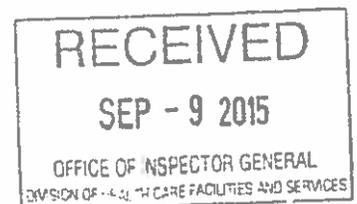
F 224	<p>Continued From page 51</p> <p>RN #3. Written statements were obtained from CNA #2, LPN #1, and RN #3.</p> <p>3. Review of the clinical record, Nurses' Notes dated 07/07/15, revealed the resident was seen by an Orthopedic physician. Interview with the DON, on 07/24/15 at 9:30 AM, revealed this appointment was already scheduled prior to the incident on 07/04/15. Review of therapy notes (07/09-24/15) revealed an evaluation of Resident #16 and services provided as stated in the AOC. Interview with the Physical Therapist, on 08/05/15 at 3:18 PM, revealed the resident remained a two-person assist and mechanical lift with all transfers.</p> <p>4. Interview with Resident #16's primary physician, on 08/04/15 at 12:36 PM, revealed he was notified of the incident on 07/27/15; however, he had been on vacation and the nursing facility had notified his office on 07/24/15. Interview with the DON, on 08/04/15 at 10:12 AM revealed she had notified the physician's office on 07/24/15.</p> <p>5. A review of the personnel files for CNA #2 and LPN #1 was conducted during the recertification survey as part of the 5-G Abuse task. No problems were identified. The SSA validated the abuse registry and background checks were conducted prior to hire with no findings.</p> <p>6. Observation of Resident #16's room, on 08/06/15 at 2:08 PM revealed the facility had provided a new soft touch call light. The call light in the resident's bathroom was replaced on 07/28/15.</p> <p>7. Review of the skin assessments revealed all residents in the facility received a skin</p>	F 224		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 224	Continued From page 52 assessment on 07/24/15 through 07/27/15 with no signs or symptoms of abuse/neglect found. Review of the skin assessments conducted by the facility revealed the facility continued to perform skin assessments on residents with a BIMS score of eight (8) or less. Review of the skin assessments conducted by the facility revealed the facility continued to perform skin assessments on residents with a BIMS score of eight (8) or less. Interviews on 08/04/15 with Resident #25 at 9:45 AM and Resident #29 at 10:40 AM, revealed no concerns with abuse/neglect. 8. Review of the training records revealed on 07/24/15, the Corporate Care Consultant provided training on the facility's Abuse/Neglect Policy was provided to the Department Heads. This training included how to investigate an allegation of abuse/neglect and reporting requirements. The training also included physician notification, care plans, rounds, and call lights. Seventeen (17) Department Heads were present at the training including the Interim Administrator and Director of Nursing. Interview with the Corporate Consultant, on 08/06/15 at 3:46 PM, revealed she had provided training to all Department Heads on the Abuse/Neglect- Policy, investigating and reporting, call lights, grievances, and making visual rounds. Interview with the DON, on 08/06/15 at 1:36 PM, Quality of Life Director, on 08/06/15 at 10:00 AM, and Activity Director on 08/05/15 at 2:22 PM, Director of Program Development, on 08/05/15 at 4:08 PM, Customer Experience Director, on 08/05/15 at 4:33 PM, Maintenance Director, on 08/05/15 at 5:09 PM, and the Interim Administrator, on 08/06/15 at 2:36 PM, validated the training was provided on	F 224			



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

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F 224	<p>Continued From page 53</p> <p>07/24/15 and they had a good knowledge of how to investigate and report abuse.</p> <p>9. Review of the training records revealed the facility staff was trained from 07/24/15 through 07/28/15, with as needed staff trained prior to working, on the Abuse/Neglect Policy. Post-tests were given regarding information presented on abuse/neglect with the staff scoring 100%. Training was validated through interviews with the Rehab (1-South) Unit Manager, on 08/06/15 at 9:25 AM, Social Services, on 08/05/15 at 1:45 PM, LPN #11, on 08/05/15 at 1:30 PM, LPN #12, on 08/05/15 at 1:36 PM, LPN #5 on 08/05/15 at 1:55 PM, and LPN #13, on 08/05/15 at 2:08 PM. Additional interviews were conducted with CNA # 10, on 08/05/15 at 1:42 PM, CNA #11 and #12 on 08/05/15 at 1:50 PM, CNA # 3 on 08/05/15 at 2:00 PM, CNA #25, on 08/05/15 at 2:02 PM, CNA # 14 on 08/05/15 at 2:05 PM, CNA #26 on 08/05/15 at 2:08 PM, CNA #6 on 08/05/15 at 2:10 PM, CNA # 7 and #24 on 08/05/15 at 2:15 PM, and CNA #8 on 08/05/15 at 3:05 PM. The staff had good knowledge of the definition of abuse/neglect and how to report. In addition, the nursing staff had been trained on communication rounds between shifts, conducting safety checks, call light accessibility, and the grievance process. Review revealed the facility continued to education on the Abuse/Neglect Policy with post-test given. Review of the results of the post-test revealed staff scored 100%.</p> <p>10. Review of the new hire list and comparison to the training documentation revealed the new employees would receive training on abuse/neglect with a Post-test required. All new hires must have a 100% pass rate. Interview with the Interim Administrator, on 08/06/15 at 2:36 PM,</p>	F 224		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/06/2015
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F 224	<p>Continued From page 54</p> <p>revealed newly hired employees will be required to complete the "Hand in Hand" modules (6), one per month. He stated there had been no new hires since 07/29/15. He said the Staff Development Coordinator would monitor the training. Review of the August 2015 schedule for new employee training revealed the Hand in Hand modules would be reviewed on August 10, 11, 12, 18, 19, and 20th.</p> <p>11. Observation during the extended survey revealed the residents' call lights were functional and within reach. Observation of the call light response time during the survey revealed the call lights were answered within five (5) minutes of activation. Review of the call light audits revealed the facility conduct a facility wide inspection of each resident's room, on 07/24/15, to determine if each call light was functional and within reach of the resident. The call light audits continued through the extended survey. The audits revealed two call lights were replaced and Resident #16's call light was replaced with a soft touch call light. Observation of Resident #16's bathroom, on 08/05/15 at 2:08 PM, revealed a soft touch call light and was within the resident's reach. Observation of the resident activating the new call light revealed the call light activated and staff responded within one minute. Interview with the resident during this observation revealed his/her needs were being met.</p> <p>12. The facility utilized a computer program (Abaqis) that monitors the corrective actions through daily audits. Members included the Interim Administrator, DON, ADON, Customer Service Director, and a CNA. Review of the Performance Improvement Project (PIP) revealed monitoring of call lights audits (daily the IDT team</p>	F 224		
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F 224	<p>Continued From page 55</p> <p>will discuss), care plan conference concerns, Abuse/Neglect Post-test, physician notification, daily charting audits, Hand in Hand training, and Department Head rounds. Minutes from the PIP meetings were provided and reviewed. The facility met daily from 07/27/15 to 08/03/15. The PIP reviews were reviewed with Administrative Managers on 07/29/15. Interview with the Interim Administrator, on 08/06/05 at 2:36 PM, revealed the facility used PIP daily as this was another check for the audits.</p> <p>13. Each resident was observed during the facility wide inspection of each resident's call light. Seventy-three (73) residents were interviewed and asked the following questions: (1) Is everyone treating you well? (2) Do you feel safe? (3) Do you have any concerns? No allegations of abuse/neglect were received. Other complaints were forward to the grievance process. Review of the daily questionnaires conducted (10) by the facility revealed the same questions were asked during the initial interviews with the residents conducted 07/24-27/15. No allegations of abuse/neglect were received.</p> <p>14. Review of the daily assignment sheet for the nurse aides revealed the form had been revised to include a check off section that visual rounds had been conducted between the shifts. The nursing staff had been trained on the new process on 07/24/15-07/27/15. The shift reports were reviewed by the DON or Administrator. Observation, on 08/06/05 at 2:16 PM, revealed the nursing staff conducting the visual rounds on the 2-North Unit. Interviews with CNA # 10 on 08/05/15 at 1:42 PM, CNA #11 and #12 on 08/05/15 at 1:50 PM, CNA #3 on 08/05/15 at 2:00 PM, CNA #25 on 08/05/15 at 2:02 PM, CNA</p>	F 224		

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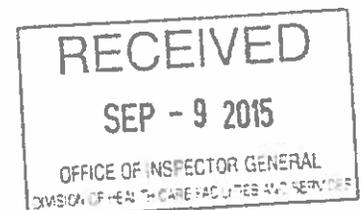
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F 224	<p>Continued From page 56</p> <p>#14 on 08/05/15 at 2:05 PM, CNA #26 on 08/05/15 at 2:08 PM, CNA #6 on 08/05/15 at 2:10 PM, CNA #7 and #24, on 08/05/15 at 2:15 PM, and CNA #8 on 08/05/15 at 3:05 PM, revealed safety rounds were being conducted at the beginning and end of each working shift. Each resident must be seen on the rounds.</p> <p>15. Review of the chart audits revealed the clinical record of each resident was reviewed. Clinical record review of the sampled residents during the extended survey revealed no issues with notification. The facility continued to conduct chart audits daily x two weeks.</p> <p>16. Review of the sampled residents for the extended survey revealed the comprehensive care plan and the nurse aide care plans had been revised to reflect the resident's current status. No issues were found.</p> <p>17. Review of the training records revealed administrative staff had been trained on the facility's grievance process on 07/27/15 with re-education provided to the DON and Chaplain on 07/29/15. Interview with the DON, on 08/06/15 at 1:36 PM, revealed she had been trained on the grievance process a few weeks ago. She stated through the resident and family interviews, it generated several concerns that needed to be investigated. Some were reportable and others went through the grievance process. Interview with the Interim Administrator, on 08/06/15 at 2:36 PM, revealed the information from the resident and family interviews were taken to the Quality Assurance (QA) meetings. The facility reviewed their grievance log from June 1, 2015 to present and discovered some of the grievances had not been resolved. There was evidence the facility</p>	F 224		



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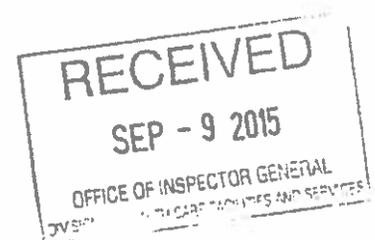
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F 224	<p>Continued From page 57</p> <p>investigated those complaints and reported to the Office of Inspector General (OIG) as appropriate. The OIG investigated the complaints during the extended survey and found the allegations to be unsubstantiated.</p> <p>18. Review of the Resident Council Meeting minutes, held on 07/25/15, revealed no abuse/neglect allegations were received. The residents were provided education on how to report abuse/neglect.</p> <p>19. Review of the event reports provided by the facility revealed the facility performed a clinical record audit from June 1, 2015 to present. The facility identified fourteen (14) incidents where physician notification was not completed. The physicians were notified of each resident's condition on 07/29/15 by the DON. Interview with the DON, on 08/06/15 at 1:36 PM, revealed a complete chart audit was conducted for all residents with the above findings. She stated all physician orders and change in status conditions were discussed in the daily clinical meetings to ensure notification was made.</p> <p>20. Review of the training records from 07/24/15 to 07/27/15 revealed staff was educated on shift rounds, answering call lights, and physician notification. Observation, on 08/06/15 at 2:16 PM, revealed the nursing staff conducting the visual rounds on the 2-North Unit. Observation during the extended survey revealed the residents' call lights were being answered.</p> <p>21. Review of the Quality Assurance Performance Improvement (QAPI) signature sheets revealed a meeting was held on 07/26/15 at 3:15 PM with the required members including a physician</p>	F 224			

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F 224	<p>Continued From page 58</p> <p>representative. The facility provided the minutes of the meeting that revealed the facility discussed the corrective action plans for Immediate Jeopardy tags and the incident that triggered the Jeopardy. Additional QAPI meetings were held on 07/30/15 and 08/04/15. Interview with the Interim Administrator, on 08/06/15 at 2:36 PM, DON on 08/06/05 at 1:36 PM, and the Medical Director, on 08/04/15 at 12:36 PM, validated the QAPI meetings were held and what was discussed. The Interim Administrator stated results of the residents' interview, assessments, and staff questionnaires were discussed. Audits collected from the staff member were reviewed and discussed. Any concerns identified would be corrected immediately the Administrator would ensure investigation of suspected abuse/neglect was completed; reported guidelines met; care plans revised and followed; and physician and responsible party notification was made.</p> <p>22. Interview with the DON, on 08/06/15 at 1:36 PM, revealed the morning clinical meetings were being held with discussion of physician orders, change in status conditions, any allegations of abuse/neglect, and physician notification. She stated she used a white board to monitor compliance, review twenty-four reports and other information forms.</p> <p>23. Interview with the Regional Corporate Nurse Consultant, on 08/06/15 at 3:45 PM and the Corporate Vice President of Operations, on 08/06/15 at 2:45 PM, revealed someone from the Regional Team would be there daily until Immediate Jeopardy was removed for support and guidance. The Corporate representative would be onsite weekly with daily telephone calls after the immediacy was removed and if all went</p>	F 224			



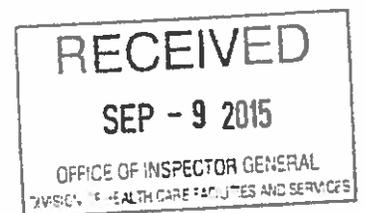
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F 282	<p>Continued From page 63</p> <p>assist regularly and as needed to reposition/shift weight to relieve pressure and promote comfort, report changes in pain location/type to MD and assist with transfers.</p> <p>On 07/04/15 at 2:30 AM, Resident #16, who required total assistance with transfers and toileting, was found alone in the bathroom, sitting on a bedside commode, yelling for help. The call light was wrapped around a support bar and could not be activated. The evening staff failed to communicate to the night staff the resident had been placed on the bedside commode at 9:15 PM on 07/03/15. The facility staff failed to conduct the scheduled routine checks on the resident and left the resident sitting in the bathroom alone with no method to call for help for greater than five (5) hours. When the resident was found, on 07/04/15 at approximately 2:30 AM, the resident complained of being cold and experienced pain and numbness in the hips/buttocks area. The resident had a diagnosis of Multiple Sclerosis and was totally dependent on staff for transfers and toileting needs. (Refer to F224)</p> <p>The facility's failure to have an effective system to ensure care plan interventions were implemented has caused or is likely to cause serious injury, harm, impairment or death to residents. Immediate Jeopardy was identified on 07/24/15 and was determined to exist on 07/04/15.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 08/03/15, alleging the Immediate Jeopardy was removed on 07/29/15. The State Survey Agency validated the Immediate Jeopardy was removed on 07/29/15, as alleged, prior to exit on 08/06/15. The Scope and Severity was lowered to a "D" while the facility develops and</p>	F 282	<p>Systemic Measures: In-service education on use, accuracy and revision of Care Plans was conducted on July 27 and 28, 2015. Care Plan Audits began on July 24, 2015 and concluded on July 28, 2015 by the Nursing Administration Staff, Signature Care Consultant, ADON, DON, MDS Coordinators, Unit Manager. The audits were to determine the current accuracy of the Care Plans and included a review of any assistive devices necessary to meet resident needs. Any variances were corrected at the time discovered. An ongoing, random-sampling Care Plan Audit is being conducted daily by the above-mentioned staff as well.</p> <p>Monitoring Measures: Care Plan Audits are being conducted during Morning Clinical Meeting which are held Monday through Friday each morning . Any changes or corrections are facilitated at that interdisciplinary meeting. A Quality Assurance Performance Improvement meeting was held on July 26, 2015 at 3:15pm with a physician who was covering for the Medical Director who was on vacation, the Administrator, Asst. Director of Nursing, A CNA,</p>	



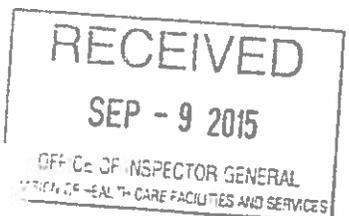
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F 282	<p>Continued From page 64 implements the Plan of Correction (POC), and the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>Review of the Comprehensive Care Plan Policy, revised October 2010, revealed care plan interventions were designed for consideration between the resident's problem areas and their causes.</p> <p>Review of the clinical record for Resident #18 revealed the facility admitted the resident on 01/19/12 with a re-admission on 04/30/13 with diagnoses of Multiple Sclerosis (MS), Hypertension, Thyroid Disorder, Osteoporosis, Right Shoulder Pain, Anxiety, Muscle Weakness, and Dysphagia.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 06/26/15, revealed the facility conducted a Brief Interview for Mental Status (BIMS) test with the resident scoring a fifteen (15) out of a possible fifteen (15), meaning the resident was interviewable. The facility assessed the resident to require extensive assistance of two (2) persons for all transfers and toileting needs. The resident was non-ambulatory. The facility assessed the resident's balance to be unsteady and required staff assistance when moving on and off the toilet.</p> <p>Review of the comprehensive care plan for pain, dated 03/20/15, revealed interventions to observe and report pain, numbness or tingling, edema, and general weakness related to the diagnosis of MS, shoulder pain, and muscle spasms. The facility developed an intervention to report</p>	F 282	<p>Central Supply Director, Admissions Director, Customer Experience Director and Signature Care Consultant. One topic discussed in this meeting was following the resident care plans in regard to provision of services. Results from the ongoing random-sampling Care Plan audits mentioned in our Systemic Measures will be reviewed at our monthly Quality Assurance Performance Improvement Committee Meeting times 6 months. If, during these meetings it is determined that the audits should continue, the Committee may extend this period of review.</p>	



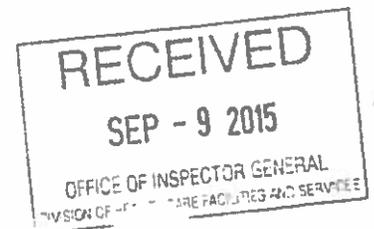
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F 282	<p>Continued From page 65</p> <p>changes in pain location and type to the physician. Other interventions included provide comfort measures such as repositioning.</p> <p>Review of the Activity of Daily Living (ADL) self-care deficit care plan, dated 03/20/15, revealed an intervention to keep call light within easy reach. Review of the at risk for developing skin breakdown care plan, dated 03/20/15, revealed an intervention to assist the resident with reposition/shift weight to relieve pressure as needed to promote comfort. In addition, the staff was to assist the resident with toileting and hygiene needs.</p> <p>Review of the Certified Nursing Assistant (CNA) Care Plan, dated July 2015, revealed the resident was non-ambulatory and required two (2) staff assist for transfers with a stand-up lift, incontinent check and change every 2 hours and PRN, and total assist for Activities of Daily Living (ADL).</p> <p>Interview with Resident #16, on 07/22/15 at 9:30 AM, revealed he/she had been placed on the bedside commode at approximately 9:15 PM on 07/03/15 to perform his/her nightly care and to use the bedside commode, which would normally take about forty-five (45) minutes to an hour. When the resident tried to activate the call light for assistance from staff, it would not activate because the cord was wrapped around a support bar preventing it from working. The resident said he/she yelled out for help, but nobody could hear him/her. The resident stated it was a very long time before staff found him/her in the bathroom. The resident described how they felt after sitting a while in the bathroom and said they were cold and shivering (resident was dressed in gown), with pain to the hips/buttocks, and the entire body</p>	F 282		



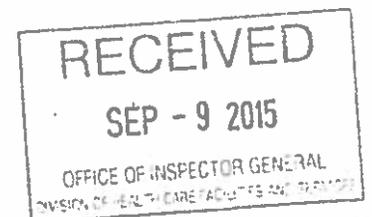
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F 282	<p>Continued From page 66</p> <p>was numb when the staff found them. The resident stated he/she was afraid this could happen again because the resident was dependent on staff for all transfers on and off the bedside commode with a mechanical lift.</p> <p>Interview with CNA #1, on 07/23/15 at 2:52 PM, revealed she had placed Resident #16 on the bedside commode at approximately 9:15 PM, placed the call light within reach, and closed the bathroom door. The aide stated the resident's nightly routine took about an hour and it normally started earlier than 9:15 PM. She stated the resident was dependent on staff for all transfers.</p> <p>Interview with CNA #2, on 07/23/15 at 3:20 PM, revealed CNA #2 stated she had conducted a resident check/safety round approximately 10:15 PM to 10:30 PM and noticed Resident #16's privacy curtain was pulled around the bed and the bathroom door was closed. She stated she did not look behind the privacy curtain or open the bathroom door to visualize the resident. At approximately 1:30 AM to 2:00 AM the CNA entered Resident #16's room and heard the resident yelling from the bathroom. She opened the bathroom door and found Resident #16 on the bedside commode and the call light cord was wrapped around a support bar, pulled tight and could not be activated. The resident told the aide he/she had been calling out trying to get someone's attention without success.</p> <p>Interview with LPN #1, on 07/23/15 at 1:40 PM, revealed she was working as the House Supervisor and passing medications on the night of 07/03-04/15. The nurse stated around 2:30 AM, CNA #2 reported Resident #16 was found in the bathroom on the bedside commode and</p>	F 282		



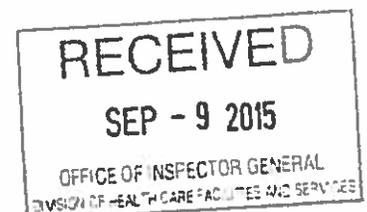
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PRINTED: 08/20/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/06/2015
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NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
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F 282	<p>Continued From page 67</p> <p>stated she had been there for awhile. LPN #1 assisted CNA #2 with transferring Resident #16 from the bedside commode to bed, performed a full body assessment and gave him/her a pain medication as requested for pain to the hips and buttocks. The nurse stated she was not aware CNA #2 had not conducted the routine checks according to the care plan and facility policy. She stated she was too busy and assumed the safety checks had been completed. The nurse stated the resident was unable to remove self from the bedside commode and had to wait the extended time for staff to assist him/her with transfers and reposition. She had not notified the resident's physician of the incident and the need for the resident to be medicated for pain.</p> <p>Interview with the Director of Nursing (DON), on 07/24/15 at 9:30 AM and 1:00 PM, in regards to the event involving Resident #16, revealed she had been told it was a communication problem between the shifts and CNA #2 had not conducted the routine resident check according to the care plan and the facility's policy. In addition, the resident's call light had been wrapped around the support bar so tight it would not activate.</p> <p>Review of the acceptable Allegation of Compliance (AOC), dated 07/29/15, revealed the facility took the following immediate actions:</p> <p>1. Resident #16 was removed from the bedside commode and transferred to the bed and assessed by Licensed Practical Nurse (LPN) #1 after the occurrence on 07/04/15. Swelling was noted to the Resident #16's ankles that dissipated by 3:15 AM. Resident #16 received pain</p>	F 282		



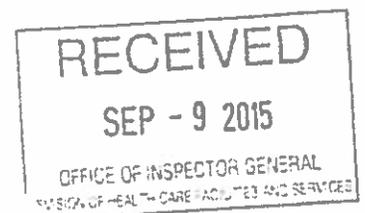
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F 282	<p>Continued From page 68</p> <p>medication (Norco) at 2:40 AM due to complaints of hip pain. Evaluations and assessments were continued through 07/07/15 with no new concerns.</p> <p>2. Certified Nursing Assistant (CNA) #2, who was assigned to Resident #16 on the night shift received a coaching and counseling session by LPN #1 and Registered Nurse (RN) #3. An investigation of the incident was initiated by LPN #1 and RN #3.</p> <p>3. Resident #16 was seen by a Orthopedic physician on 07/07/15 with orders for Physical Therapy and Occupational Therapy. Resident #16 was placed on case load from 07/09/15 through 07/24/15. No change of transfer status was identified.</p> <p>4. The resident's primary physician was notified of the occurrence involving Resident #16 being left on the bedside commode for an extended period of time on 07/24/15 by the Director of Nursing (DON). The Responsible party was notified on 07/24/15 by the DON.</p> <p>5. On 07/26/15, the Director of Program Development reviewed the personal files of CNA #2 and LPN #1, who were assigned to Resident #16 the night of the allegation, with no concerns pertaining to their abuse registry and back ground checks.</p> <p>6. Resident #16 was evaluated by the Customer Service Coordinator for the ability to use a call light on 07/25/15 and found it was difficult for him/her to use the current call light. Resident #16 received a new touch based call light on 07/25/15. The call light in the bathroom for</p>	F 282		



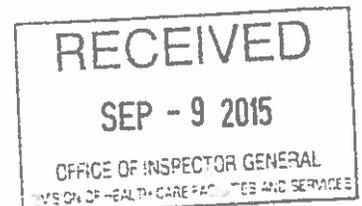
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F 282	<p>Continued From page 69</p> <p>Resident #16 was evaluated on 07/26/15 by the Regional Plant Operations Director and replaced by Technical Solutions on 07/28/15.</p> <p>7. All residents were assessed for any signs and symptoms of abuse and neglect. Residents with a Brief Interview of Mental Status (BIMS) score of greater than eight (8) were interviewed by the facility's Interim Administrator, DON, Minimum Data Set (MDS) Coordinator, Quality of Life Director and Medical Records for any abuse/neglect concerns starting 07/24/15 and concluding on 07/27/15. One concern from the initial audit was a concern regarding staffing. Residents who were identified to have a BIMS score of less than eight (8), were physically assessed by the Nursing Administration Team for any signs and symptoms of abuse/neglect, no new concerns were identified. Beginning 07/28/15, skin assessments would be completed each shift for ten (10) residents with a BIMS score of eight (8) or less then decreased to three times a week on 08/10/15 by the licensed nursing staff. An attempt to contact Residents' Responsible parties in regards to any abuse/neglect concerns began 07/24/15 and concluded on 07/27/15.</p> <p>8. The facility's Interim Administrator, DON, MDS Coordinator, Quality of Life Director, Medical Records and Central Supply were educated on 07/24/15 by the Signature Care Consultant on the abuse policy and procedure, to include but not limited to a thorough investigation, neglect, and reporting immediately. Department Administrative Managers were educated on 07/24/15. A total of seventeen (17) Department Head members were education on 07/24/15. Department Administrative Managers that did not receive the</p>	F 282		



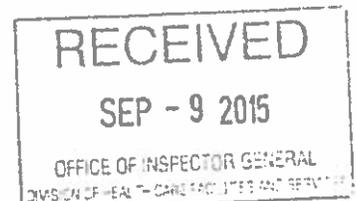
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F 282	<p>Continued From page 70</p> <p>education could not return to work until abuse education was provided, and a post-test administered with a 100% score obtained. All were reviewed for compliance by the Signature Care Consultant. The facility does not utilize Agency Staff. The Interim Administrator and/or the DON was responsible for ensuring staff members were educated prior to returning to work.</p> <p>9. Once the facility's Interim Administrator, DON, MDS Coordinator, Quality of Life Director, Medical Records and Central Supply were educated, then they were assigned to educate the staff on the facility's Abuse Policy, to include but not limited to, a thorough investigation, neglect and reporting immediately, on 07/24/15 and continued until 07/28/15. Staff that had not worked as of 07/28/15 would receive education prior to returning to work. Training was performed face to face in order to facilitate discussion and questions and included examples of items that would be considered as reportable. Staff members would not return to work until abuse education had been provided, post-test completed with a score of 100%. If the staff member did not achieve a score of a 100% on the post-test, the staff member would be re-educated on the Abuse Policy and Procedures and given the post-test again. The process would continue until the staff member achieved 100% on the post-test. Any staff member who was on vacation or Family Medical Leave would be provided the abuse/neglect education and given the post-test before allowed to return to work with a score of 100% to be achieved on the post-test. The Interim Administrator and the DON were responsible for ensuring this occurred.</p>	F 282		



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F 282	<p>Continued From page 71</p> <p>Every shift beginning on 07/28/15, ten (10) staff members on each shift would be given the post-test for abuse/neglect by the Interim Administrator, DON, Assistant Director of Nursing (ADON), Quality of Life Director and Plant Operations Director. A score of 100 % would be required, if less than 100 % the employee would be reinserviced and then given the post-test again until 100 % compliance was obtained.</p> <p>10. All new hires will receive abuse/neglect education during orientation and would be given a post-test to achieve a score of 100 %. If the new staff member did not achieve a score of 100 % on the post-test, the new staff member would have to be re-educated by the Staff Development Coordinator and DON and be given the post-test to achieve a score of 100 %. This process would continue until the new employee achieved a score of 100 % on the post-test. The Interim Administrator and DON would review the Post-tests given daily for any noted concerns. Any concerns would be addressed immediately.</p> <p>All new hires would complete six (6) modules of the CMS "Hand in Hand" training, during the general orientation period by the Staff Development Coordinator. The facility was in the process of all staff completing the CMS "Hand to Hand" training and one module would be assigned per month until all the modules are reviewed.</p> <p>11. Beginning on 07/24/15 and concluding on 07/28/15 100 % audit of all call lights in the facility were conducted, by the Interim Administrator, DON, MDS Coordinator, Quality of Life Director, Medical Records and or Central Supply, checking that the call lights were in working order and that</p>	F 282		

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F 282	<p>Continued From page 72</p> <p>the call lights were accessible for each resident and the resident had the ability to use the call light. The initial call light audits were reviewed by the Signature Care Consultant daily from 07/24/15 through 07/28/15. There were two (2) call lights, Room 1502-B and 1602-B, which were identified as needing changed. Call light audits and education would remain ongoing, every shift from 07/28/15 until jeopardy was removed. The Call light audits would be reviewed by the Interim Administrator, DON and or regional staff daily.</p> <p>12. The facility's Performance Improvement Project (PIP) developed to monitor the corrective action through daily audits to ensure accessibility and function of call lights for residents was conducted by the Director of Program Development. The PIP would be reviewed two (2) times a week, then weekly times four (4) weeks by the Interdisciplinary Care Team.</p> <p>13. On 07/24/15 the facility's Interim Administrator, DON, MDS Coordinator, Quality of Life Director, Medical Records, Unit Manager and/or Central Supply were assigned to visually observe where each resident in the facility was, if the resident's needs were being addressed, and if the residents felt safe. One hundred percent (100 %) of all current residents were observed and no concerns were identified. The facility's Interim Administrator, DON, MDS Coordinator, Quality of Life Director, Medical Records and/or Central Supply would audit this process to ensure compliance. Beginning 07/28/15, daily questionnaires will be completed each shift with ten (10) residents with a BIMS score of 8 or above, by the DON, Interim Administrator, Quality of Life Director and Plant Operations Director asking the following questions: 1. Is everyone</p>	F 282		
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F 282	<p>Continued From page 73</p> <p>treated well? 2. Do you feel safe? 3. Do you have any concerns? These audits will decrease to three (3) times a week on 08/10/15.</p> <p>14. Visual observations of residents for safety and needs will be conducted every shift by nurses and CNAs at the change of shift. The staff would make visual observation of where each resident was in the facility, that the residents needs were being addressed and that the residents were safe. These rounds would be ongoing. The facility's Interim Administrator, DON, MDS Coordinator, Quality of Life Director, Medical Records and/or Central Supply would audit this process to ensure compliance. Ongoing education would be conducted with the staff regarding answering call lights timely, addressing resident needs, and making rounds at shift change. A rounding audit sheet would be filled out during walking rounds.</p> <p>15. Beginning on 07/24/15 and concluding on 07/27/15, 100 % of all current resident charts were reviewed for physician notification and any allegation of abuse or neglect since 06/01/15 by the Assistant Director of Nursing (ADON), Signature Care Consultant, Unit Manager and Customer Experience Coordinator.</p> <p>Beginning 07/28/15, ten (10) charts would be audited for documentation of allegations of abuse and neglect, physician and responsible party notification daily for two (2) weeks by the Interim Administrator and DON and then decreased to three times a week on 08/10/15. Any issues discovered at the time of the audits would be brought to the attention of the Interim Administrator and DON. Audits would be reviewed by the Interim Administrator, DON,</p>	F 282		

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F 282	<p>Continued From page 74</p> <p>Signature Care Consultant or other regional staff members.</p> <p>16. Beginning on 07/24/15 and concluding on 07/27/15 100 % of current residents charts were audited by the Nursing Administration Staff and/or Signature Care Consultants for accuracy of care plans and CNA care plans, and asslitive devices. Two variances were identified and corrected.</p> <p>17. All grievances since 01/01/15 were reviewed by the Interim Adminlstrator, DON or Signature Care Consultant or Director of Program Development on 07/24/15 to determine if any items documented were an reportable event. All administrative staff were educated on the Grievance Process including how to fill out and complete a grievance and what was a grievance by the Director of Program Development on 07/27/15. The facility had identified thirteen concerns from the grievance audit that was reported to the Office of Inspector General as allegations of abuse. The current Social Services Director who handled the process was currently suspended and would be terminated. The Administrator resigned from the facility and her last day was 07/19/15.</p> <p>18. A Resident Council meeting was held on 07/25/15 by the Quality of Life Director and the Quality of Life Assistant, to discuss any abuse/neglect concerns and to provide education on whom to report any abuse/neglect concerns without fear of retribution.</p> <p>19. Beginning on 07/25/15 to 07/27/15 all incident/accident reports since 07/01/15 had been reviewed by the DON and Signature Care Consultant to identify any concerns of suspected</p>	F 282		
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F 282	<p>Continued From page 75 abuse/neglect and for physician and responsible party notification.</p> <p>20. On 07/24/15 the facility's Interim Administrator, DON, MDS Coordinators, Activities Director, Medical Records and Central Supply were educated on shift rounds, answering call lights, physician and responsible party notifications, by the Signature Care Consultant. These staff then educated the facility staff on shift rounds, answering call lights and physician notification. This was done face to face with staff interaction. A rounding audit sheet would be completed during the walking rounds. As of 07/27/15 the remaining ten (10) department heads had received their training. Staff members would not return to work until education had been provided. The facility employed 198 stakeholders and 128 employees had received education. 70 employees remained to receive training.</p> <p>21. A Quality Assurance Performance Improvement meetings was held, on 07/26/15 at 3:15 PM, with a physician representative, the Interim Administrator, a CNA, Central Supply Director, Customer Experience Coordinator, Assistant Director of Nursing, and the Signature Care Consultant. Topics that were discussed included call light response, appropriate call lights, rounding of Licensed Nurses, and CNAs checking on resident whereabouts, resident safety needs, following care plans, education provided, grievance process, abuse and neglect, reporting and investigating abuse and neglect, and physician and responsible party notification. Abuse/Neglect and Care Plan policies were reviewed and there was no changes required to the policies.</p>	F 282		

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F 282	<p>Continued From page 76</p> <p>Results of the resident interviews, assessments and staff questionnaires would be reported to the QAPI committee weekly to determine the need for continued education or revision of the plan. Audits collected from staff members will be presented and discussed in the QAPI meeting. At that time, based on evaluation, the QAPI committee will determine at what frequency the resident interviews, assessments and staff questionnaires would need to continue. Concerns identified would be corrected immediately and reported to the Interim Administrator to ensure investigation of suspected abuse/neglect; the investigation was completed; the investigation and reporting guidelines were met; care plans were updated and followed; with physician and responsible party notifications made.</p> <p>A QAPI meeting will be held weekly until immediacy is removed, then decreased to every four (4) weeks, then monthly for recommendations and further follow up regarding the corrective actions of the AOC.</p> <p>22. Beginning 07/28/15 and continuing until the immediacy is removed, the resident change of condition would be reviewed daily in the morning clinical meeting to address any allegation of abuse and neglect, change of condition and that the physician and responsible party had been notified. The information for the clinical meeting would be gathered from but not limited to the twenty-four hour report sheet, Stop and Watch form, SBAR, resident orders, and verbal report from nurses. The information would be gathered by the DON, Unit Manager, Medical Records, Customer Service Director and the Scheduling Coordinator.</p>	F 282		
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F 282	Continued From page 77 23. A nurse from the Regional Team or Corporate Office, Regional Vice President of Operations or Special Projects Administrator has been onsite daily since 07/24/15 providing training or assisting with the review of audits. They will continue weekly visits and or daily review by telephone until the Immediate Jeopardy had been removed and will decrease to every other week for four (4) weeks, then monthly. The nurses for the regional team or home office were assisting with investigations as needed, performing chart audits and providing oversight and consultation. Administrative oversight of the facility would be completed by the Special Projects Administrator, the Regional Vice President of Operations, or member of regional staff weekly on site and daily by telephone until removal of Immediate Jeopardy. 24. The Interim Administrator and DON would review and discuss all abuse investigations daily to ensure the resident was protected; perpetrator was removed from resident care areas; that it was reported to the appropriate agencies timely; and, a thorough investigation was completed beginning 07/24/15 and continued until Immediate Jeopardy is removed. The Interim Administrator would maintain an abuse investigation log. The Interim Administrator and Corporate Staff will review each abuse allegation to ensure a thorough investigation had been completed, protection of the resident, and reported to the appropriate state agencies. 25. During each care plan conference for each resident, any abuse/neglect concerns would be discussed along with any abuse/neglect	F 282			

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F 282	<p>Continued From page 78</p> <p>education to include reporting, would be provided to the resident and or POA with supporting documentation noted starting 07/28/15.</p> <p>The State Survey Agency validated the implementation of the facility's acceptable AOC as follows:</p> <ol style="list-style-type: none"> 1. Review of the Nurses' Notes dated 07/04/15 at 2:30 AM, and interviews with CNA #1, on 07/23/15 at 3:20 PM and LPN #1, on 07/23/15 at 1:40 PM, revealed the resident was removed from the bedside commode and transferred to the bed where the resident was provided a blanket for warmth, skin assessment was performed, and pain medication was administered as requested. The Nurses' Notes from 07/04/15 through 07/07/15 revealed continued monitoring of the resident. 2. Review of the facility's investigation (initiated on 07/04/15) included a written coaching and counselling session with CNA #2. This was conducted by LPN #1 and signed as witnessed by RN #3. Written statements were obtained from CNA #2, LPN #1, and RN #3. 3. Review of the clinical record, Nurses' Notes dated 07/07/15, revealed the resident was seen by an Orthopedic physician. Interview with the DON, on 07/24/15 at 9:30 AM, revealed this appointment was already scheduled prior to the incident on 07/04/15. Review of therapy notes (07/09-24/15) revealed an evaluation of Resident #16 and services provided as stated in the AOC. Interview with the Physical Therapist, on 08/05/15 	F 282		

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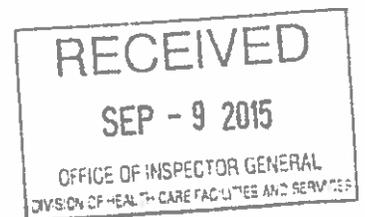
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F 282	<p>Continued From page 79</p> <p>at 3:18 PM, revealed the resident remained a two-person assist and mechanical lift with all transfers.</p> <p>4. Interview with Resident #16's primary physician, on 08/04/15 at 12:36 PM, revealed he was notified of the incident on 07/27/15; however, he had been on vacation and the nursing facility had notified his office on 07/24/15. Interview with the DON, on 08/04/15 at 10:12 AM revealed she had notified the physician's office on 07/24/15.</p> <p>5. A review of the personnel files for CNA #2 and LPN #1 was conducted during the recertification survey as part of the 5-G Abuse task. No problems were identified. The SSA validated the abuse registry and background checks were conducted prior to hire with no findings.</p> <p>6. Observation of Resident #16's room, on 08/06/15 at 2:08 PM revealed the facility had provided a new soft touch call light. The call light in the resident's bathroom was replaced on 07/28/15.</p> <p>7. Review of the skin assessments revealed all residents in the facility received a skin assessment on 07/24/15 through 07/27/15 with no signs or symptoms of abuse/neglect found. Review of the skin assessments conducted by the facility revealed the facility continued to perform skin assessments on residents with a BIMS score of eight (8) or less. Review of the skin assessments conducted by the facility revealed the facility continued to perform skin assessments on residents with a BIMS score of eight (8) or less. Interviews on 08/04/15 with Resident #25 at 9:45 AM and Resident #29 at 10:40 AM, revealed no concerns with</p>	F 282		

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F 282	Continued From page 80 abuse/neglect. 8. Review of the training records revealed on 07/24/15, the Corporate Care Consultant provided training on the facility's Abuse/Neglect Policy was provided to the Department Heads. This training included how to investigate an allegation of abuse/neglect and reporting requirements. The training also included physician notification, care plans, rounds, and call lights. Seventeen (17) Department Heads were present at the training including the Interim Administrator and Director of Nursing. Interview with the Corporate Consultant, on 08/06/15 at 3:46 PM, revealed she had provided training to all Department Heads on the Abuse/Neglect- Policy, investigating and reporting, call lights, grievances, and making visual rounds. Interview with the DON, on 08/06/15 at 1:36 PM, Quality of Life Director, on 08/06/15 at 10:00 AM, and Activity Director on 08/05/15 at 2:22 PM, Director of Program Development, on 08/05/15 at 4:08 PM, Customer Experience Director, on 08/05/15 at 4:33 PM, Maintenance Director, on 08/05/15 at 5:09 PM, and the Interim Administrator, on 08/06/15 at 2:36 PM, validated the training was provided on 07/24/15 and they had a good knowledge of how to investigate and report abuse. 9. Review of the training records revealed the facility staff was trained from 07/24/15 through 07/28/15, with as needed staff trained prior to working, on the Abuse/Neglect Policy. Post-tests were given regarding information presented on abuse/neglect with the staff scoring 100%. Training was validated through interviews with the Rehab (1-South) Unit Manager, on 08/06/15 at 9:25 AM, Social Services, on 08/05/15 at 1:45	F 282		



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F 282	<p>Continued From page 81</p> <p>PM, LPN #11, on 08/05/15 at 1:30 PM, LPN #12, on 08/05/15 at 1:36 PM, LPN #5 on 08/05/15 at 1:55 PM, and LPN #13, on 08/05/15 at 2:08 PM. Additional Interviews were conducted with CNA # 10, on 08/05/15 at 1:42 PM, CNA #11 and #12 on 08/05/15 at 1:50 PM, CNA # 3 on 08/05/15 at 2:00 PM, CNA #25, on 08/05/15 at 2:02 PM, CNA # 14 on 08/05/15 at 2:05 PM, CNA #26 on 08/05/15 at 2:08 PM, CNA #6 on 08/05/15 at 2:10 PM, CNA # 7 and #24 on 08/05/15 at 2:15 PM, and CNA #8 on 08/05/15 at 3:05 PM. The staff had good knowledge of the definition of abuse/neglect and how to report. In addition, the nursing staff had been trained on communication rounds between shifts, conducting safety checks, call light accessibility, and the grievance process. Review revealed the facility continued to education on the Abuse/Neglect Policy with post-test given. Review of the results of the post-test revealed staff scored 100%.</p> <p>10. Review of the new hire list and comparison to the training documentation revealed the new employees would receive training on abuse/neglect with a Post-test required. All new hires must have a 100% pass rate. Interview with the Interim Administrator, on 08/06/15 at 2:36 PM, revealed newly hired employees will be required to complete the "Hand in Hand" modules (6), one per month. He stated there had been no new hires since 07/29/15. He said the Staff Development Coordinator would monitor the training. Review of the August 2015 schedule for new employee training revealed the Hand in Hand modules would be reviewed on August 10, 11, 12, 18, 19, and 20th.</p> <p>11. Observation during the extended survey revealed the residents' call lights were functional</p>	F 282		
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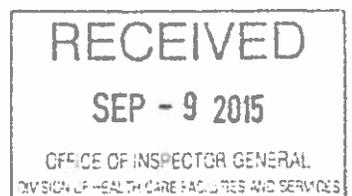
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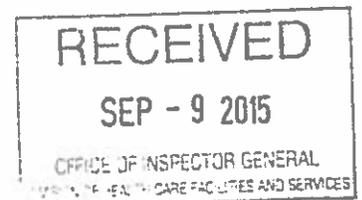
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F 282	<p>Continued From page 82</p> <p>and within reach. Observation of the call light response time during the survey revealed the call lights were answered within five (5) minutes of activation. Review of the call light audits revealed the facility conduct a facility wide inspection of each resident's room, on 07/24/15, to determine if each call light was functional and within reach of the resident. The call light audits continued through the extended survey. The audits revealed two call lights were replaced and Resident #16's call light was replaced with a soft touch call light. Observation of Resident #16's bathroom, on 08/05/15 at 2:08 PM, revealed a soft touch call light and was within the resident's reach. Observation of the resident activating the new call light revealed the call light activated and staff responded within one minute. Interview with the resident during this observation revealed his/her needs were being met.</p> <p>12. The facility utilized a computer program (Abaqis) that monitors the corrective actions through daily audits. Members included the Interim Administrator, DON, ADON, Customer Service Director, and a CNA. Review of the Performance Improvement Project (PIP) revealed monitoring of call lights audits (daily the IDT team will discuss), care plan conference concerns, Abuse/Neglect Post-test, physician notification, daily charting audits, Hand in Hand training, and Department Head rounds. Minutes from the PIP meetings were provided and reviewed. The facility met daily from 07/27/15 to 08/03/15. The PIP reviews were reviewed with Administrative Managers on 07/29/15. Interview with the Interim Administrator, on 08/06/05 at 2:36 PM, revealed the facility used PIP daily as this was another check for the audits.</p>	F 282		



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F 282	<p>Continued From page 83</p> <p>13. Each resident was observed during the facility wide inspection of each resident's call light. Seventy-three (73) residents were interviewed and asked the following questions: (1) Is everyone treating you well? (2) Do you feel safe? (3) Do you have any concerns? No allegations of abuse/neglect were received. Other complaints were forward to the grievance process. Review of the daily questionnaires conducted (10) by the facility revealed the same questions were asked during the initial interviews with the residents conducted 07/24-27/15. No allegations of abuse/neglect were received.</p> <p>14. Review of the daily assignment sheet for the nurse aides revealed the form had been revised to include a check off section that visual rounds had been conducted between the shifts. The nursing staff had been trained on the new process on 07/24/15-07/27/15. The shift reports were reviewed by the DON or Administrator. Observation, on 08/06/05 at 2:16 PM, revealed the nursing staff conducting the visual rounds on the 2-North Unit. Interviews with CNA # 10 on 08/05/15 at 1:42 PM, CNA #11 and #12 on 08/05/15 at 1:50 PM, CNA #3 on 08/05/15 at 2:00 PM, CNA #25 on 08/05/15 at 2:02 PM, CNA #14 on 08/05/15 at 2:05 PM, CNA #26 on 08/05/15 at 2:08 PM, CNA #6 on 08/05/15 at 2:10 PM, CNA #7 and #24, on 08/05/15 at 2:15 PM, and CNA #8 on 08/05/15 at 3:05 PM, revealed safety rounds were being conducted at the beginning and end of each working shift. Each resident must be seen on the rounds.</p> <p>15. Review of the chart audits revealed the clinical record of each resident was reviewed. Clinical record review of the sampled residents during the extended survey revealed no issues</p>	F 282		



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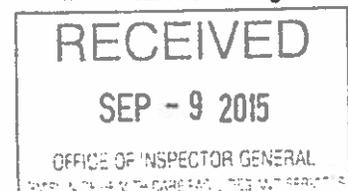
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F 282	Continued From page 84 with notification. The facility continued to conduct chart audits daily x two weeks. 16. Review of the sampled residents for the extended survey revealed the comprehensive care plan and the nurse aide care plans had been revised to reflect the resident's current status. No issues were found. 17. Review of the training records revealed administrative staff had been trained on the facility's grievance process on 07/27/15 with re-education provided to the DON and Chaplain on 07/29/15. Interview with the DON, on 08/06/15 at 1:36 PM, revealed she had been trained on the grievance process a few weeks ago. She stated through the resident and family interviews, it generated several concerns that needed to be investigated. Some were reportable and others went through the grievance process. Interview with the Interim Administrator, on 08/06/15 at 2:36 PM, revealed the information from the resident and family interviews were taken to the Quality Assurance (QA) meetings. The facility reviewed their grievance log from June 1, 2015 to present and discovered some of the grievances had not been resolved. There was evidence the facility investigated those complaints and reported to the Office of Inspector General (OIG) as appropriate. The OIG investigated the complaints during the extended survey and found the allegations to be unsubstantiated. 18. Review of the Resident Council Meeting minutes, held on 07/25/15, revealed no abuse/neglect allegations were received. The residents were provided education on how to report abuse/neglect.	F 282		
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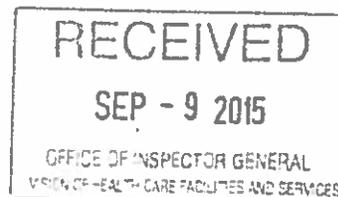
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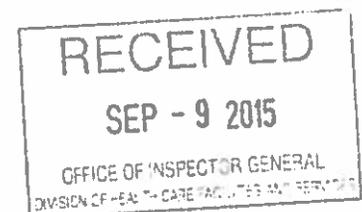
F 282	<p>Continued From page 85</p> <p>19. Review of the event reports provided by the facility revealed the facility performed a clinical record audit from June 1, 2015 to present. The facility identified fourteen (14) incidents were physician notification was not completed. The physicians were notified of each resident's condition on 07/29/15 by the DON. Interview with the DON, on 08/06/15 at 1:36 PM, revealed a complete chart audit was conducted for all residents with the above findings. She stated all physician orders and change in status conditions were discussed in the daily clinical meetings to ensure notification was made.</p> <p>20. Review of the training records from 07/24/15 to 07/27/15 revealed staff was educated on shift rounds, answering call lights, and physician notification. Observation, on 08/06/05 at 2:16 PM, revealed the nursing staff conducting the visual rounds on the 2-North Unit. Observation during the extended survey revealed the residents' call lights were being answered.</p> <p>21. Review of the Quality Assurance Performance Improvement (QAPI) signature sheets revealed a meeting was held on 07/26/15 at 3:15 PM with the required members including a physician representative. The facility provided the minutes of the meeting that revealed the facility discussed the corrective action plans for Immediate Jeopardy tags and the incident that triggered the Jeopardy. Additional QAPI meetings were held on 07/30/15 and 08/04/15. Interview with the Interim Administrator, on 08/06/15 at 2:36 PM, DON on 08/06/05 at 1:36 PM, and the Medical Director, on 08/04/15 at 12:36 PM, validated the QAPI meetings were held and what was discussed. The Interim Administrator stated results of the residents' interview, assessments, and staff</p>	F 282		
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F 282	<p>Continued From page 86</p> <p>questionnaires were discussed. Audits collected from the staff member were reviewed and discussed. Any concerns identified would be corrected immediately the Administrator would ensure investigation of suspected abuse/neglect was completed; reported guidelines met; care plans revised and followed; and physician and responsible party notification was made.</p> <p>22. Interview with the DON, on 08/06/15 at 1:36 PM, revealed the morning clinical meetings were being held with discussion of physician orders, change in status conditions, any allegations of abuse/neglect, and physician notification. She stated she used a white board to monitor compliance, review twenty-four reports and other information forms.</p> <p>23. Interview with the Regional Corporate Nurse Consultant, on 08/06/15 at 3:45 PM and the Corporate Vice President of Operations, on 08/06/15 at 2:45 PM, revealed someone from the Regional Team would be there daily until Immediate Jeopardy was removed for support and guidance. The Corporate representative would be onsite weekly with daily telephone calls after the immediacy was removed and if all went well, reduce to every other week, then monthly for administrative oversight.</p> <p>24. Interview with the DON, on 08/06/15 at 1:36 PM, and the Interim Administrator, on 08/06/15 at 2:36 PM, revealed all allegations of abuse/neglect are investigated, residents are protected, and the allegations are reported to the state agencies. The Administrator maintained an Abuse Log. Review of the allegations of abuse/neglect reported to the OIG revealed the facility reported promptly. Several allegations were investigated</p>	F 282			



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F 282	Continued From page 87 during the extended survey with finding of unsubstantiated. Interview with DCBS representative, on 08/03/15 at 2:57 PM, revealed their agency received several reports of allegations of abuse from the facility and they would be investigating.	F 282		
F 323 SS=D	<p>25. Review of seven (7) care plan conferences, dated 07/29/15, revealed each resident or resident's family was asked about abuse/neglect and provided information on how to report.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interview, record review, review of the facility's policies and procedure, Material Safety Data Sheet (MSDS), and review of the SBAR (Situation, Background, Assessment, Request) Communication Form, it was determined the facility failed to provide adequate supervision to prevent accidents for one (1) of the twenty-nine (29) sampled residents. Resident #20 sustained a fall attempting to self transfer from the wheelchair to the toilet without assistance.</p> <p>In addition, observation during the environment</p>	F 323	<p>F-323 Residents Affected: Resident # 20 was re-assessed for fall risks on August 26, 2015. Interventions were initiated related to the identified risk for falls. Interventions included: educated on wearing long skirts and hem her skirts during an ad hoc Care Plan Meeting on August 26, 2015. The housekeeping carts were locked on July 23, 2015. The Housekeepers assigned to the carts were educated. The housekeepers assigned to the carts were educated by July 23, 2015.</p> <p>Residents Potentially Affected: Residents of the facility have the potential to be affected by unattended and unlocked carts. Housekeeping carts were locked immediately upon findings. The housekeeping carts were locked on July 23, 2015. The housekeepers assigned to the carts were educated by July 23, 2015. An audit of residents with fall risk scores >10 will be completed by DON, Customer Experience Director, ADON, Unit Manager, MDS Coordinators, Restorative Nurse Coordinators by September 15, 2015 to ensure residents with high risk for falls had appropriate interventions in place to minimize risks.</p>	9/15/15

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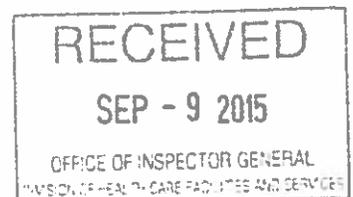
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 323	<p>Continued From page 88</p> <p>tour, on 07/23/15 at 10:12 AM-10:30 AM, revealed two (2) of four (4) housekeeping carts on the second floor was left unattended and unlocked. The carts contained chemicals. There were cognitively Impaired residents who wandered on those units.</p> <p>The findings include:</p> <p>Review of the Falls Policy provided by the facility, dated as reviewed on 06/01/15, revealed the care plan would be reviewed following each fall, staff would begin an investigation, the Interdisciplinary Team (IDT) would determine the root cause of the fall if possible, and then the care plan would be updated.</p> <p>1. Review of the clinical record for Resident #20 revealed the facility admitted the resident on 10/29/14 with diagnoses of Heart Failure, Hypertension, Peripheral Vascular Disease, End-Stage Renal Disease (ESRD), Diabetes Mellitus, and Bilateral Below Knee Amputation (BKA) with Prothesis.</p> <p>Review of the Annual Minimum Data Set (MDS) assessment, dated 04/15/15, revealed the facility assessed Resident #20 as requiring the extensive to total assist of two (2) person with transfers.</p> <p>Review of the Comprehensive Care Plan, dated 04/17/15, revealed staff was to assist him/her daily as needed with transfers and locomotion to desired locations.</p> <p>Review of the facility's Fall Risk Assessment Evaluation, dated 04/17/15, revealed Resident #20 scored an eighteen (18) which meant the</p>	F 323	<p><u>Systemic Measures:</u></p> <p>A Nurse Consultant will educate/train the nursing management and IDT team on September 8, 2015, on providing adequate supervision to prevent accidents for residents whose Fall Risk Assessment is 10 or greater. This education includes SBAR, Falls Policy, Fall Investigations, Fall Risk Assessment, Determining root cause of a fall, immediate care plan interventions post fall, incident and accident reporting, and updating the care plan. The Nursing Management Team and IDT Team will train this to nursing staff. Housekeeping supervisor will re-educate the Housekeeping staff on the importance of securing unattended housekeeping carts by July 23, 2015. Residents will be assessed on admission regarding their risk for falls. New interventions will be initiated immediately to decrease the risk. Newly admitted residents identified with a high risk for falls (score >10 on the fall risk assessment) and any resident who experiences a fall will be discussed by the interdisciplinary team in the next scheduled Clinical meeting, which are held Monday through Friday each morning, to ensure that appropriate interventions have been added to their care plan.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/20/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/06/2015
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NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
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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) COMPLETION DATE
F 323	<p>Continued From page 89 resident was at risk of falls.</p> <p>Review of the SBAR Communication Form, dated 06/11/15, revealed Resident #20 lost his/her balance and fell forward attempting to transfer from the wheelchair to the toilet without assistance.</p> <p>Interview with RN #1, on 07/23/15 at 3:17 PM, revealed she filled out the SBAR Communication Form and notified the Floor Manager. RN #1 stated she understood when she notified the Floor Manager it was their responsibility to put an intervention in place.</p> <p>Interview with the Director of Nursing (DON), on 07/23/15 at 2:45 PM, revealed at the time of the fall the staff who identified the fall should have notified the Nursing Supervisor on call so an immediate intervention could have been implemented based on the root cause of the fall. The DON reviewed Resident #20's chart and could not identify any interventions put in place related to the fall described by the SBAR Communication Form, dated 06/11/15.</p> <p>2. The facility did not provide a specific policy for chemical storage. The facility provided MSDS sheets on the chemicals stored in the housekeeping carts. Review of the MSDS sheet for the air fresher revealed the aerosol spray could cause serious eye damage. The multi-surface cleaner and disinfectant had hazard warnings that the chemical was harmful if swallowed or in contact with the skin. It would cause severe skin burns and eye damage. Avoid breathing.</p>	F 323	<p><u>Monitoring Measures:</u> The Director of Nursing will complete an audit of 10% of the residents identified as high risk for falls weekly for 8 weeks then monthly times 6 months to ensure that appropriate fall interventions have been added to the care plan. The Housekeeping Supervisor will audit Housekeeping carts daily to ensure they are locked and/or attended by their assigned housekeeper. Findings of the above stated audits will be reviewed and discussed by the QAPI Committee monthly for 6 months for recommendations and further follow up as indicated.</p>	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
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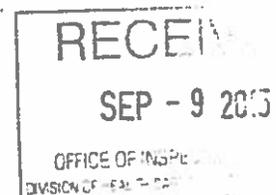
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F 323	<p>Continued From page 90</p> <p>Observation during the environment tour, on 7/23/15 at 10:12 AM through 10:30 AM, revealed the housekeeping carts on 2-South and 2-North were left unlocked and unattended. There were cleaning chemicals observed on the carts.</p> <p>Interview with Housekeeper #1, on 07/23/15 at 10:35 AM, revealed she had failed to lock the housekeeping carts but normally she would lock the area where the chemicals were stored.</p> <p>Interview with the Housekeeping Supervisor, on 07/23/15 at 10:36 AM, revealed all carts were to be locked if left unattended for resident safety.</p> <p>Interview, on 07/23/15 at 10:36 AM, with the Interim Administrator who was present during the environmental tour, revealed all housekeeping carts were to be locked when unattended. He voiced concern regarding the chemical accessible to cognitively impaired residents.</p>	F 323		
F 371 SS=F	<p>483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 371	<p>F-371</p> <p>Residents Affected:</p> <p>No specific residents were identified in this citation. The food and liquids were removed from each of the five identified refrigerators and discarded.</p> <p>Residents Potentially Affected:</p> <p>Residents of the facility have the potential to be affected by the citation. All other refrigerators were checked by Dietary Staff with no issues identified.</p>	9/15/15

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NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748		
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F 371	<p>Continued From page 91</p> <p>Based on observation, interview, and review of the refrigerator logs, it was determined the facility failed to consistently record temperatures for five (5) of five (5) refrigerators on the units to store the residents' food.</p> <p>The findings include:</p> <p>Review of the facility's Food Storage Policy, not dated, revealed food was stored at an appropriate temperature and by methods designed to prevent contamination. Refrigerator temperatures should be forty-one (41) degrees Fahrenheit (F) and must be recorded daily.</p> <p>Observation during a tour of the facility, on 07/23/15 at 9:23 AM, revealed five (5) refrigerators on the residents' units and one in the first floor dining room had no documented evidence that temperatures were obtained daily. There was a thermometer in each refrigerator and the temperatures were within safe range when checked during the tour.</p> <p>Interview with Dietary Aide #25, on 07/23/15 at 3:38 PM, revealed evening staff was supposed to check and record the refrigerator temperatures when they stocked the refrigerators with food for the residents. She stated there was a concern regarding spoiled food if the refrigerator temperatures were out of range.</p> <p>Interview with the Dietary Manager, on 07/23/15 at 3:00 PM, revealed it was the responsibility of the evening dietary staff to check and record the refrigerators. He stated there was a concern about contamination of food if not stored properly.</p>	F 371	<p>Systemic Measures: Dietary Staff was educated by Regional Director of Dining Services on August 25, 2015 checking and documenting refrigerator temperature, and the proper storage of foods policy and procedure. Ongoing education will be provided by Lead Dietary Cook. Refrigerators will be checked by Dietary Staff twice per day, on first and second shift. The Administrator will complete an audit of 2 refrigerators per week of the refrigerator logs for 4 weeks then monthly to ensure that appropriate temperatures are maintained.</p> <p>Monitoring Measures: Findings of the above stated audits will be reviewed and discussed by the QAPI monthly for 6 months for frequency of ongoing audits or recommendations and further follow up as indicated.</p>		



**FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)**

PROVIDER NUMBER K1 185057	FACILITY NAME SUNRISE MANOR NURSING HOME	SURVEY DATE *K4 07/21/2015
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K6 DATE OF PLAN APPROVAL	K3 : MULTIPLE CONSTRUCTION TOTAL NUMBER OF BUILDINGS <u>2</u> NUMBER OF THIS BUILDING <u>01</u>	<input checked="" type="checkbox"/> A A BUILDING B WING C FLOOR D APARTMENT UNIT
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LSC FORM INDICATOR

Health Care Form		
12	2786 R	2000 EXISTING
13	2786 R	2000 NEW
ASC Form		
14	2786 U	2000 EXISTING
15	2786 U	2000 NEW
ICF/MR Form		
16	2786 V, W, X	2000 EXISTING
17	2786 V, W, X	2000 NEW

*K7 12 SELECT NUMBER OF FORM USED FROM ABOVE

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: 1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: 4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: 7 PROMPT
8 SLOW
9 IMPRACTICAL

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X, Y and Z.)

K29: 3 K56: 3

ENTER E-SCORE HERE

K5: e.g 2.5

*K9 : FACILITY MEETS LSC BASED ON: *(Check all that apply)*

A1 <input type="checkbox"/>	A2 <input checked="" type="checkbox"/>	A3 <input type="checkbox"/>	A4 <input type="checkbox"/>	A5 <input type="checkbox"/>
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC: B. <input type="checkbox"/>	K180: A. <input checked="" type="checkbox"/> FULLY SPRINKLERED (All required areas are sprinklered) B. <input type="checkbox"/> PARTIALLY SPRINKLERED (Not all required areas are sprinklered) C. <input type="checkbox"/> NONE (No sprinkler system)
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*MANDATORY

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

PRINTED: 10/01/2015
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SUNRISE MANOR NURSING HOME B. WING _____	(X3) DATE SURVEY COMPLETED R 09/15/2015
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NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
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{K 000}	<p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 09/15/15 as alleged.</p>	{K 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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.

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207, and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185057	(Y2) Multiple Construction A. Building 02 - SUNRISE MANOR NURSING HOME B. Wing	(Y3) Date of Revisit 9/15/2015
Name of Facility SUNRISE MANOR NURSING HOME		Street Address, City, State, Zip Code 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix _____ Reg. # NFPA 101 LSC K0050	Correction Completed 09/15/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <u>SF-M</u>	Reviewed By <u>[Signature]</u>	Date <u>10/01/15</u>	Signature of Surveyor: <u>[Signature]</u>	Date: <u>10-01-15</u>
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 7/21/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
---	--

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

PRINTED: 10/01/2015
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SUNRISE MANOR NURSING HOME B. WING _____		(X3) DATE SURVEY COMPLETED R 09/15/2015
NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748		
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{K 000}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 09/15/15 as alleged.	{K 000}			

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

TITLE

(X6) DATE

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(Y1) Provider / Supplier / CLIA / Identification Number 185057	(Y2) Multiple Construction A. Building B. Wing 02 - SUNRISE MANOR NURSING HOME	(Y3) Date of Revisit 9/15/2015
Name of Facility SUNRISE MANOR NURSING HOME		Street Address, City, State, Zip Code 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

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ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <u>SF-M</u> State Agency	Reviewed By <u>VH</u>	Date <u>10/01/15</u>	Signature of Surveyor: <u>Susan Fuller-Me</u>	Date: <u>10-01-15</u>
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: <u>7/21/2015</u>	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/20/2015
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SUNRISE MANOR NURSING HOME B. WING _____	(X3) DATE SURVEY COMPLETED 07/21/2015
NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748	
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 02</p> <p>PLAN APPROVAL: 2011</p> <p>SURVEY UNDER: 2000 New</p> <p>FACILITY TYPE: SNF/NF DP</p> <p>TYPE OF STRUCTURE: Two (2) stories with a partial basement, Type II (222) construction.</p> <p>SMOKE COMPARTMENTS: Five (5) on the first floor and three (3) on the second floor.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Automatic, wet sprinkler system, hydraulically designed.</p> <p>GENERATOR: Type II, 275 KW generator, fuel source is diesel.</p> <p>A Recertification Life Safety Code Survey was conducted on 07/21/14. The facility was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire).</p> <p>Deficiencies were cited with the highest</p>	K 000		

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

TITLE

(X6) DATE

Debra Daley for Tom Kase

Facility Administrator X 9/3/15

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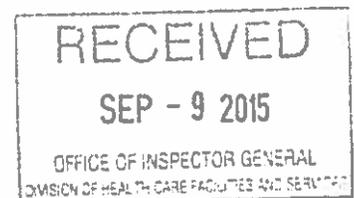
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NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY 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 K 050 SS=F	Continued From page 1 deficiency identified at F level. NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Based on interview and record review of fire drills, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect each of the eight (8) smoke compartments, residents, staff and visitors. The facility has one-hundred and thirty-seven (137) certified beds and the census was one-hundred and twenty-nine (129) on the day of the survey. The findings include: Review of the facility's fire drill records, on 07/21/15 at 3:22 PM, with the Plant Operations Director and the Maintenance Assistant revealed the facility failed to conduct a fire drill on the second shift during the fourth quarter of 2014.	K 000 K 050	1. No specific residents were cited in this K-Tag 2. All residents have the potential to be affected by this deficiency. Fire Drills will be reviewed the Administrator since December 2014 to ensure that fire drills are up to date. 3. Plant Operations Assistant will be responsible for conducting fire drills when there is a transition in Plant Operations Director or the Plant Operations Director is out. The Plant Operations Assistant will be in-serviced on the fire drill requirements and policy and procedure by the Administrator 4. Fire Drills will be audited by the Administrator monthly x 3 months to ensure that they are occurring as scheduled. The findings of the above stated audits will be reported to QAPI meeting monthly for three months. The QAPI Committee will determine whether to continue or discontinue the audit based on the results of reported to the committee.	9-15-15	



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

PRINTED: 06/20/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SUNRISE MANOR NURSING HOME B. WING _____	(X3) DATE SURVEY COMPLETED 07/21/2015
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NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
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K 050	<p>Continued From page 2</p> <p>Interviews, on 07/21/15 at 3:24 PM, with the Plant Operations Director and the Maintenance Assistance revealed the current Plant Operations Director was hired during the second week of January of 2015 and the facility did not have a full time Plant Operations Director in the month of December of 2014, in which a fire drill was required the be conducted to be in compliance with Code requirements.</p> <p>Reference NFPA 101 (2000 Edition)</p> <p>18.7.1 Evacuation and Relocation Plan and Fire Drills.</p> <p>18.7.1.1 The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator ' s position or at the security center.</p> <p>The provisions of 18.7.1.2 through 18.7.2.3 shall apply.</p> <p>18.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are</p>	K 050		
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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: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SUNRISE MANOR NURSING HOME B. WING _____		(X3) DATE SURVEY COMPLETED 07/21/2015
NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748		
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K 050	Continued From page 3 conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050			

