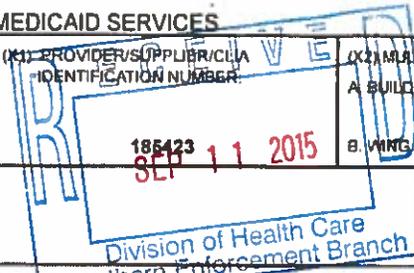


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185423 SEP 11 2015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/20/2015
NAME OF PROVIDER OR SUPPLIER EDGEWOOD ESTATES		STREET ADDRESS, CITY, STATE, ZIP CODE 196 BERRYMAN ROAD FRENCHBURG, KY 40322	
(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)



<p>F 000 INITIAL COMMENTS</p> <p>*Amended</p> <p>An abbreviated standard survey (KY23449) was initiated on 07/13/15 and concluded on 07/14/15. The complaint was unsubstantiated with no deficient practice identified.</p> <p>The investigation was reopened on 08/18/15 after supervisory review and completed on 08/20/15, in conjunction with the investigation of KY23677 and a revisit for the standard survey completed on 06/19/15. Both complaints were substantiated with deficient practice identified at "D" level.</p> <p>F 164 483.10(e), 483.75(l)(4) PERSONAL SS=D PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p>	<p>F 000</p> <p>F 164</p> <p>F164 Personal Privacy / Confidentiality of Records</p> <p>The facility has ensured the following corrective action:</p> <ul style="list-style-type: none"> • Immediately after nurse aides failed to follow privacy during treatment protocol they were suspended until the investigation was complete. Nurse aides received written counseling by the Director of Nursing regarding failure to follow facility policy. One nurse aide was terminated from employment. (Attachment #1 a-b) • The Director of Nursing received verbal counseling by the Administrator regarding duties to ensure all employees receive mandated in-service training. (Attachment #2) 	<p>(X5) COMPLETION DATE</p> <p>9-10-15</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Anne Mills, NHA* TITLE: *Administrator* (X6) DATE: *9-10-15*

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

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F 164	<p>Continued From page 1</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, review of the facility's investigation, and the facility's policy and procedure, it was determined the facility failed to ensure that privacy was provided during a shower for one (1) of ten (10) sampled residents (Resident #16). On 08/09/15, Registered Nurse (RN) #3 opened the shower room door and discovered two (2) staff members bathing two (2) residents (Resident #16 and a Personal Care Home resident) in the same shower stall.</p> <p>The findings include</p> <p>Review of the facility's policy titled "Privacy During Treatment," dated 06/19/15, revealed all residents would be provided privacy during routine care. The policy stated staff would ensure the closure of curtains, doors, and shades/blinds, or take any other measure deemed necessary to protect privacy.</p> <p>Review of Resident #16's medical record revealed the facility admitted the resident on 05/20/15, with diagnoses which included Dementia and Depression. Review of Resident #16's Minimum Data Set (MDS) Assessment completed 08/05/15, revealed the facility assessed the resident to be totally dependent for</p>	F 164	<p>The facility has taken the following action to prevent this practice from affecting other residents:</p> <ul style="list-style-type: none"> Alert and oriented residents were interviewed by the Director of Nursing to investigate if privacy was provided / denied to them during treatment. All residents interviewed denied any issues. (Attachment #3) The Director of Nursing conducted a re-in-service training to all nursing department staff regarding the Privacy During Treatment Protocol. (Attachment #4 a-c) <p>The facility has initiated the following systemic changes to prevent this practice from recurring:</p> <ul style="list-style-type: none"> An additional privacy curtain was added to the north and south shower areas to provide staff with an extended space in which to assist a resident while dressing and to provide greater privacy. The Charge Nurse Round Sheet was modified to include one shower room check per shift to observe compliance with privacy during showers. (Attachment #5) <p>The facility will sustain performance through the following monitoring practices:</p> <ul style="list-style-type: none"> Observations regarding privacy during showers (10x/month) were added to 		

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F 164 Continued From page 2

bathing (including full body shower). The facility assessed Resident #16 to have a Brief Interview for Mental Status (BIMS) score of 4, indicating the resident had severe cognitive impairment and was not interviewable.

Observation of Resident #16 on 08/18/15, at 11:11 AM, revealed the resident was in bed and unable to answer questions appropriately.

Interview with RN #1 on 08/18/15 at 4:10 PM revealed she entered the shower room on 08/09/15 at approximately 10:15 AM to obtain supplies. RN #1 stated as she opened the shower room door she discovered CNA #2 and CNA #8 had Resident #16 and a Personal Care Home resident naked in the same shower stall providing the residents' showers. RN #1 stated the privacy curtain which covers the opening to the shower stall was also open, which made both residents visible to anyone who opened the shower room door. RN #1 stated she immediately instructed the CNAs to finish each resident's shower in a separate stall and notified the Administrator of the incident.

Attempted interviews on 08/18/15 at 4:00 PM, on 08/18/15 at 6:22 PM, and on 08/19/15 at 8:30 AM with CNA #2 were unsuccessful.

Review of the facility's Plan of Correction dated 07/16/15, revealed an in-service training related to the facility's "Privacy During Treatment" policy/procedure was provided to all nursing staff including certified nurse aides. The facility was cited on the 06/19/15 recertification survey for failure to provide resident privacy (failed to close blinds during resident treatment).

F 164

the Unit Coordinator checklist. Unit Coordinators will immediately address any issues noted during their checks, and report the findings to the Administrator and DON. (Attachment #6)

- As part of the ongoing Quality Assurance for nursing services, the Director of Nursing will present a summary of shower room checks for privacy, and any required action to ensure compliance, to the Administrator on the monthly QA report. A summary of all quarterly findings will be presented to and reviewed with the facility Medical Director. (Attachment #7 – 3 pages)

COMPLETION DATE: 8/21/15

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F 164	Continued From page 3 Review of the facility's Investigative Report dated 08/10/15, revealed that on 08/09/15, RN #1 opened the shower room door and discovered Certified Nursing Assistant (CNA) #2 and CNA #8, bathing Resident #16 and a Personal Care Home Resident in the same shower stall. The investigation determined that CNA #2 and CNA #8 failed to follow the facility's policy and procedures related to ensuring residents were afforded privacy during care and treatment. Interview with CNA #8 on 08/19/15, at 12:50 PM, revealed that she and CNA #2 were showering Resident #16 and a Personal Care Home resident together in the same shower stall. She stated the privacy curtain was not pulled. CNA #8 stated that she and CNA #2 were in a hurry to get the showers done and they "just did not think." CNA #8 stated she did recognize that it was not appropriate to shower residents together in the same stall. CNA #8 stated she had not attended an in-service or been provided training on providing privacy to residents in the facility. Review of the facility's in-service "Resident Privacy" Sign in Sheet dated 06/16/15, revealed neither CNA #2 nor CNA #8 had attended the training. Additionally, the facility also conducted in-services related to resident privacy on 07/03/15 and 07/19/15; however, review of these sign-in sheets revealed CNA #2 and CNA #8 had failed to attend these in-services also. Interview with the Director of Nursing (DON) on 08/20/15 at 3:20 PM, revealed that after reviewing all of the privacy in-services held by the facility, she discovered that she had overlooked the fact that CNA #2 and CNA #8 had not attended any of the privacy in-services. The DON stated it had	F 164			

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F 164	Continued From page 4 been her responsibility to ensure all nursing staff had been trained on the privacy policy; however, she had failed to recognize that CNA #2 and CNA #8 had not attended the training until 08/20/15. Interview with the Administrator on 08/20/15 at 5:30 PM, revealed that CNA #2 had been terminated from employment at the facility after the incident, and that CNA #8 had not provided care in the facility since the incident occurred. The Administrator stated that she had not been aware that CNA #2 and CNA #8 had not attended the required training related to providing resident privacy.	F 164			
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225	F225 INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility has ensured the following corrective action: <ul style="list-style-type: none"> SRNA #2 was suspended from active duty at the request of the Administrator when informed of allegation the next day via telephone by the Director of Nursing and Social Services Director. The charge nurse on duty received a written warning by the Director of Nursing for failure to comply with facility policy regarding an allegation of abuse. (Attachment #1 a-b) The facility has taken the following action to prevent this practice from affecting other residents:		

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F 225	Continued From page 5 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to protect residents during the investigation of an abuse allegation to prevent further potential abuse for one (1) of two (2) allegations of abuse/neglect (Resident #22). On 06/22/15, Resident #22 reported that Certified Nursing Assistant (CNA) #2 "threw" the resident against the bed rails and was "rough" during care. The facility failed to immediately remove CNA #2 from the work environment to protect the residents as required by the facility's policy. The findings include: Review of the facility's policy and procedure titled "Resident Abuse and Neglect," last revised 01/09/15, revealed "staff members must report any allegations of abuse/neglect immediately to their supervisor, or, if after hours or on weekends, report shall be made to the Charge Nurse on	F 225	<ul style="list-style-type: none"> All staff nurses (RNs and LPNs) were provided additional in-service training by the Director of Nursing on the Resident Abuse and Neglect Policy. (Attachment #2) <p>The facility has initiated the following systemic changes to prevent this practice from recurring:</p> <ul style="list-style-type: none"> The Abuse Prevention Policy was developed. (Attachment #3) All facility staff were provided in-service training on the Abuse Prevention Policy by the Administrator. (Attachment #4 a-c) <p>The facility will sustain performance through the following monitoring practices:</p> <ul style="list-style-type: none"> The facility investigative team (ADM, DON, SSD) will be informed of all allegations of abuse/neglect immediately upon occurrence and will ensure that any accused employee is removed from active duty. As part of the ongoing Quality Assurance for nursing services, the Director of Nursing will provide a summary review of all allegations to ensure compliance with the removal of accused employees from active duty during the monthly report to the Administrator and quarterly summary 		

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F 225	<p>Continued From page 6</p> <p>duty." Further review revealed any employee that was accused of resident abuse would be immediately removed from the work environment and suspended without pay until an investigation was completed.</p> <p>Record review revealed the facility admitted Resident #22 on 08/04/14, with diagnoses that included Multiple Sclerosis, Vitamin D Deficiency, Anemia, Congestive Heart Failure, Pain, and Neurogenic Bladder.</p> <p>Review of a Quarterly Minimum Data Set (MDS) assessment dated 04/23/15 revealed the facility assessed Resident #1's cognition as intact with a Brief Interview Mental Status (BIMS) score of 15, indicating the resident was interviewable.</p> <p>Review of a facility Investigative Report dated 06/22/15, revealed CNA #2 reported to the Charge Nurse, Registered Nurse (RN) #2, that Resident #22 had accused her (CNA #2) of rough treatment during a brief change. Further review revealed Resident #22 reported CNA #2 "threw" him/her against the bed rail. The resident stated the CNA was "bossy."</p> <p>Interview with CNA #2 on 07/13/15 at 4:00 PM revealed she and CNA #8 performed incontinence care for Resident #22 on 06/22/15 at approximately 3:00 PM. CNA #2 stated during the care Resident #22 became upset and accused her of throwing him/her against the bed rail. She stated she stopped care and immediately got the Charge Nurse, RN #2. CNA #2 stated she completed the incontinence care for the resident with RN #2 and CNA #8. Further interview revealed she did not "throw the resident against the bed rail" and she did not handle the</p>	F 225	<p>report to the Medical Director. Any corrective action required will be reviewed by the Quality Assurance team for compliance. (Attachment #5)</p> <p>COMPLETION DATE: 9/1/15</p>

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F 225 Continued From page 7 F 225

resident in a rough manner. CNA #2 stated her assignment was changed and she no longer works with Resident #22.

Interview with CNA #8 on 07/14/15 at 11:40 AM revealed she assisted CNA #2 with performing incontinence care for Resident #22 on 06/22/15 at approximately 3:00 PM. CNA #8 stated as soon as the resident was rolled over he/she stated he/she wanted to report that CNA #2 was being too rough. CNA #8 stated CNA #2 immediately notified the Charge Nurse. She stated the Charge Nurse came in and assisted with the incontinent care. CNA #8 stated she did not observe CNA #2 throw the resident against the bed rail or treat him/her in a rough manner.

Interview with the Charge Nurse, RN #2, on 07/14/15 at 1:56 PM, revealed CNA #2 notified her that Resident #22 had reported rough treatment. RN #2 stated she immediately entered the room and assessed the resident for signs and symptoms of injury. She stated she assisted with completing the incontinence care. RN #2 stated she immediately knew the resident had not been abused. She stated she notified the Director of Nursing (DON) later on in her shift and was told to go ahead and get statements from the CNAs and Resident #22. RN #2 stated she did not send CNA #2 home because she did not feel like anything had happened. She stated in hindsight she should have sent the CNA home and immediately initiated an investigation. RN #2 stated she received a written disciplinary action because she did not follow the facility's policy and procedure for abuse and neglect. She stated, "I just did what the DON said to do."

Interview with Resident #22's Daughter on

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F 225	<p>Continued From page 8</p> <p>07/14/15 at 1:45 PM revealed she had no concerns with the care of Resident #22 at the facility. The Daughter stated the facility notified her of the incident and stated CNA #2 would no longer provide care for Resident #22.</p> <p>Interview with the DON on 07/14/15 at 2:46 PM, revealed she was not notified of the allegation of abuse on 06/22/15. The DON stated if she had been made aware, she would have instructed the Charge Nurse, RN #2, to immediately begin an investigation and the CNA would have been immediately sent home until the investigation was completed. The DON stated she was made aware of the allegation the next day and the CNA was suspended at that time. She further stated the Charge Nurse did not follow the policy and procedure and received written disciplinary action.</p>	F 225		