

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

PRINTED: 02/25/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185456	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/24/2016
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NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF SENECA PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205
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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 000}	<p>INITIAL COMMENTS</p> <p>An onsite re-visit for the standard health survey was initiated on 02/23/16 and concluded on 02/24/16 found the facility in compliance on 01/1/16 as alleged in their PoC.</p>	{F 000}		

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

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 185456	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 2/24/2016	Y3
NAME OF FACILITY DIVERSICARE OF SENECA PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205		

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 01/01/2016	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 01/01/2016	ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 01/01/2016
ID Prefix F0514 Reg. # 483.75(l)(1) LSC	Correction Completed 01/01/2016	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
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY <input checked="" type="checkbox"/>	REVIEWED BY (INITIALS) <i>RS</i>	DATE <i>2/26/16</i>	SIGNATURE OF SURVEYOR <i>Reynne Stewart</i>	DATE <i>2/26/16</i>
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 11/25/2015

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
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RECEIVED
JAN - 4 2016
OFFICE OF INSPECTION - GENERAL
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF SENECA PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3626 DUTCHMANS LANE LOUISVILLE, KY 40205
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F 000 F 282 SS=G	<p>INITIAL COMMENTS</p> <p>A Recertification Survey was initiated on 11/23/15 and concluded on 11/25/15 and found the facility not meeting the minimum requirements for recertification with deficiencies cited at the highest scope and severity of a "G".</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review, and facility policy review, it was determined the facility failed to follow the care plan for one (1) of nineteen (19) sampled residents (Resident #6). The facility care planned Resident #6 for pain and Registered Nurse (RN) #1 failed to complete a prompt assessment and administer pain medication as care planned for Resident #6 after sustaining an injury and pain from a fall.</p> <p>The findings include:</p> <p>Interview with the Administrator, on 11/25/15 at 3:20 PM, revealed the facility did not have a policy on care plans; however, utilized the Resident Assessment Instrument (RAI) as their policy.</p> <p>Review of the RAI, Minimum Data Set (MDS) Manual, Chapter 4.7, page 4-1, #12 revealed the Interdisciplinary Team (IDT) identifies specific,</p>	F 000 F 282	<p>To the best of my knowledge and belief, as an agent of Diversicare of Seneca Place, the following plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.</p> <p>Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.</p> <p>F282</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #6 records including pain assessment, care plans, and documentation were reviewed and updated on 11/25/2015 to reflect the care needs of the resident's status. Resident #6 is no longer a resident of the facility.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathy Jones TITLE: NHA (X6) DATE: 12/30/15

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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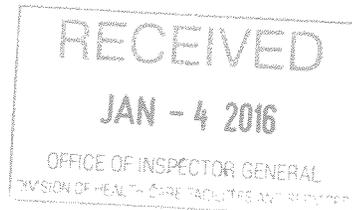
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185466	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/25/2015
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NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF SENECA PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3525 DUTCHMANS LANE LOUISVILLE, KY 40205
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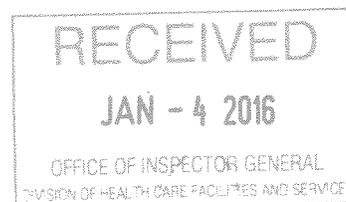
F 282	<p>Continued From page 1</p> <p>individualized steps or approaches that will be taken to help the resident achieve his or her goals. These approaches serve as instructions for resident care and provide for the continuity of care by all staff. Precise and concise instructions help staff understand and implement interventions.</p> <p>Review of the clinical record for Resident #6 revealed the facility admitted the resident on 08/26/15 with diagnoses of a Fracture of Lumbar Vertebra, History of Falling, Retention of Urine, Lack of Coordination, Difficulty Walking, Urinary Tract Infection (UTI), Myocardial Infarction, and Heart Disease.</p> <p>Review of Resident #6's quarterly Minimum Data Set (MDS) assessment, completed on 09/02/15, revealed the facility assessed the resident as requiring one (1) person extensive assist to walk and one (1) person limited assist to complete activities of daily living (ADLs). The facility conducted a Brief Interview for Mental Status (BIMS) exam during the MDS assessment with a score of nine (9) out of fifteen (15) on the BIMS exam indicating the resident was moderately impaired.</p> <p>Review of Resident #6's care plan related to pain, dated 09/04/15, revealed the resident experienced the frequent presence of pain in his/her back due to a lumbar compression fracture after a fall at home prior to admission to the facility. Interventions included staff evaluating the location and intensity of the resident's pain. Staff was to administer pain medication as ordered, report any uncontrolled pain to the physician, and evaluate vital signs as</p>	F 282	<p>How will the facility identify other residents having the potential to be affected by the same deficient practice?</p> <p>All current residents who have had falls in the past 30 days have had a pain assessment completed utilizing the Pain User Defined Assessment (UDA) these were completed on 1/1/2016 and reviewed by the DNS to ensure pain was assessed and addressed appropriately. Any updates needed to the plan of care found during this process have been identified and addressed.</p> <p>What measure will be put into place or systemic changes made to ensure the deficient practice will not recur?</p> <p>The Director of Nursing and/or the staff development coordinator will educate all licensed staff on falls management protocol including post fall documentation, pain assessment, medication effectiveness, care plan interventions and communication. Education will be completed by January 1, 2016. To maintain continued compliance, the</p>	
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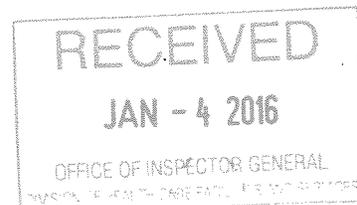
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185456	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/25/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF SENEGA PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40206	
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F 282	<p>Continued From page 2</p> <p>needed. The staff was to observe for both verbal and nonverbal indicators of pain.</p> <p>Review of the Physician Orders, dated October 2015, revealed the physician ordered Norco 5-325 milligram (mg) tablet by mouth every six (6) hours as needed (PRN) for pain. The order also stated the facility must document pain level on a scale of one (1) to ten (10).</p> <p>Review of the Incident Log, printed 11/27/15 at 8:35 AM, revealed Resident #6 sustained a fall on the night of 10/28/15 or early morning of 10/29/15. The fall occurred in the resident's room at an unknown time. The report stated the resident sustained an abrasion. No in-house treatment or other disposition was recorded on this form.</p> <p>Interview with RN #1, on 11/24/15 at 6:10 PM, revealed Resident #6 complained of pain and had difficulty moving on the morning of 10/29/15. The RN stated she did not give the resident pain medication at the time and decided to monitor the resident for continued pain instead. She could not state why she did not give pain medication at that time as directed by the care plan and policy.</p> <p>Further interview with RN #1, on 11/25/15 at 2:58 PM, revealed RN #1 did not complete all assessments after Resident #8 reported a fall on 10/29/15. The nurse stated she did not remember if she assessed the resident's pain on 10/29/15 and did not document any pain assessment as directed by the care plan.</p> <p>Review of the Departmental Notes completed by</p>	F 282	<p>education will be done during new hire orientation with all licensed staff by the 5DC, ADNS or DNS.</p> <p>Residents identified to have a fall will be reviewed at the next clinical start up meeting by the interdisciplinary team (IDT) to ensure the Diversicare falls guidelines are being followed. The IDT will follow the resident for at least 72 hours, in the clinical start up meeting, to ensure that the resident is not having any negative effects related to the fall and that any newly applied interventions are affective.</p> <p>How will the facility monitor performance to ensure solutions are sustained?</p> <p>To maintain continued compliance the DNS or ADNS will monitor falls through the clinical start up meeting which occurs with the interdisciplinary falls team 5 times a week (Monday through Friday). During the weekends (Saturday and Sunday) the weekend supervisor will be responsible to monitor the falls. The interdisciplinary falls team and/or weekend house supervisor will</p>	



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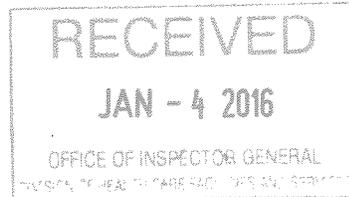
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NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF SENECA PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205	
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F 282	<p>Continued From page 3</p> <p>RN #1, on 10/31/15 at 8:53 AM, revealed the RN completed a late entry pertaining to Resident #6's fall on 10/29/15. The note stated Resident #6 complained on Thursday morning, 10/29/15, of some difficulty moving his/her left leg, was grimacing, and complaining of pain. The note did not contain information indicating the resident's pain rating on the pain scale nor any interventions used to assist the resident to control pain, as directed by the plan of care.</p> <p>Review of the narcotic sheet for Resident #6's Norco, dated 10/09/15, revealed the nursing staff signed as removing the medication from the narcotic drawer on 10/30/15 at 7:00 PM and on 10/31/15 at 1:00 AM. However, review of the Medication Administration Record (MAR), dated October 2015, revealed the nurse did not document the administration of the pain medication Norco on 10/30/15 or 10/31/15 nor was there any documented evidence the resident was assessed for effectiveness of the pain medication, per the resident's plan of care.</p> <p>Review of the facility's Departmental Notes, dated 10/27/15 through 10/31/15, revealed no documented evidence of pain assessments completed after Resident #6's reported fall as directed by the care plan.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 11/25/15 at 11:10 AM, revealed that by not identifying and documenting Resident #6's injury as directed by the care plan, the resident's pain may have been prolonged and he/she was at increased risk of injury and pain.</p> <p>Further interview with the Director of Nursing</p>	F 282	<p>utilize a QAPI Fall Event IDT Compliance Review Log, as well as a Fall Event IDT Review Checklist to ensure all aspects of the follow up is completed for each fall.</p> <p>If an issue of non-compliance is identified, the weekend supervisor, SDC, ADNS or DNS will provide 1:1 re-education to the team member and immediate follow-up on the incident will be completed. Care plans will be reviewed upon admission, quarterly, annually and with each change of condition. Care plan changes for falls will be initially updated on the post falls huddle form and then changes to the master care plan will be updated during the clinical start up meeting by an MDS team member, any changes made at that time will then communicated to the floor staff immediately.</p> <p>The nursing leadership team including unit coordinators, weekend supervisors, SDC, medical records, ADNS and DNS will observe 5 residents with falls in the past 30 days each week for 6 weeks to ensure staff are delivering care based on their care</p>	



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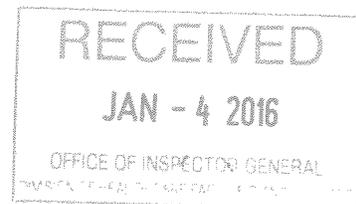
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F 282	Continued From page 4 (DON), on 11/25/15 at 9:00 AM, revealed the nurse should have completed and documented pain assessment per the care plan. Interview with the Administrator, on 11/25/15 at 3:20 PM, revealed the staff did not manage Resident #6's pain per the care plan and resulted in a delay in identifying the resident's fracture. Record review revealed the resident was diagnosed with a fracture involving the femoral neck with a lateral displacement on 10/31/15, two (2) days after the incident.	F 282	plan. Findings of these observations will be reviewed at the center's monthly QAPI meeting. If after 6 weeks, the team members are consistently following the care plan, the nursing administration team will continue observation of 5 residents with falls in the past 30 days monthly for 6 months to ensure sustained compliance. The QAPI team will determine the need for further review depending on the outcome of the observational rounds after 6 months.	
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the facility failed to ensure staff provided care and services to meet the clinical needs for one (1) of nineteen (19) sampled residents (Resident #6). The staff failed to assess, monitor, and manage pain after Resident #6 sustained a fall and delayed the identification of an injury after Resident #6 experienced significant pain from the fall. The	F 309	The DNS will maintain the QAPI Fall Event IDT Compliance Review Log to identify any patterns or trends and report these findings and any necessary plans of action at the monthly QAPI meeting. All findings will be reviewed in the monthly QAPI meeting, which is attended by the center's administrator, the Medical Director and other center departmental leadership team members. The QAPI Fall Event IDT Compliance Review Log will be completed monthly for 6 months and then quarterly thereafter. All findings will be reviewed in the QAPI meeting for 6 months for any	



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F 309	<p>Continued From page 5</p> <p>resident was diagnosed with a fracture involving the femoral neck with a lateral displacement on 10/31/15, two (2) days after the incident.</p> <p>The findings include:</p> <p>Review of the facility's Residents' Rights, not dated, revealed the residents had the right to receive adequate and appropriate care and services.</p> <p>Review of the facility's Care System Guideline for Pain Management, not dated, revealed the facility would complete a pain assessment upon admission, change of condition, and quarterly using a numeric rating scale or verbal descriptor scale. The facility would conduct a pain assessment after a resident fall or any acute change of condition where pain was suspected. The facility would then record the findings of the pain assessment in the clinical records including the evidence based rating or descriptor scale. Additionally, nursing would note ongoing monitoring and effectiveness of interventions in the medical record and progress notes. After a resident experienced a fall or other acute change, the Interdisciplinary Team (IDT) would then review the completed pain assessment and evaluate the effectiveness of the resident's pain management interventions.</p> <p>Interview with the Administrator, on 11/25/15 at 3:20 PM, revealed the facility used the Perry Potter Clinical Nursing Skills and Techniques, Eighth (8th) Edition, as the facility's policy for assessing range of motion and for conducting musculoskeletal and neurologic assessments.</p>	F 309	<p>additional interventions and/or suggestions recommended to maintain continued compliance. The QAPI team will determine the need for further review depending on the outcome of audits after 6 months.</p> <p>The facility will be in substantial compliance by January 1, 2016.</p> <p>F309</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #6 no longer a resident at Seneca Place. RN #1 was educated when she returned to work on 11/27/2015 regarding the Diversicare falls guidelines, pain assessment, musculoskeletal and neurological assessment and treatment of pain and skin alterations.</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice?</p> <p>All current residents who have had falls in the past 30 days have had a</p>	1/1/16	



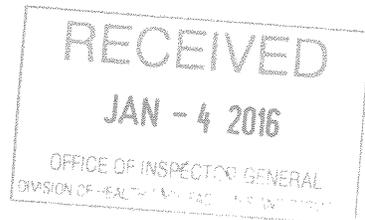
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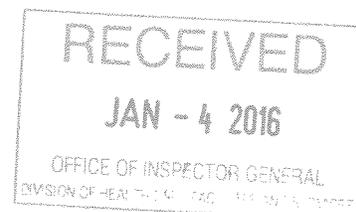
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F 309	Continued From page 6 Review of the Perry Potter Clinical Nursing Skills and Techniques, 8th Edition, revealed the facility would conduct a neurological assessment and musculoskeletal assessment when a resident reported pain or impairment. The facility would complete the assessments to determine the nature, extent, location, duration, and severity of the resident's reported pain. The assessments would include asking the resident to describe recent falls and to describe the type, location, and severity of the pain. The assessments also would include observing the resident for a change in Range of Motion (ROM) and other functioning. The steps for implementing the assessments included observing the resident's body for alignment while the resident was sitting, laying down, and in several other positions, inspecting gait as the resident walked, and asking the resident to move the major joints. Review of the facility's Care System Guideline for Falls, not dated, revealed the facility would physically assess a resident for injuries and render medical attention as needed after a resident fall. The facility would then notify the physician and resident's responsible party. Review of the facility's Incident Report Checklist, dated 12/24/13, revealed the information the facility would include in the nurse's note pertaining to a resident fall and the steps nursing staff would taken to complete an incident investigation. The form stated what information the nurse's note must entail which included: injury description; pain level; neuro checks for any head injury or unwitnessed fall; and range of motion. The checklist would include places for	F 309	pain assessment completed utilizing the Pain User Defined Assessment (UDA) these were completed on 1/1/2016 and reviewed by the DNS to ensure pain was assessed and addressed appropriately. Any updates needed to the plan of care found during this process have been identified and addressed. What measure will be put into place or systemic changes made to ensure the deficient practice will not recur? The Director of Nursing and/or the staff development coordinator will educate all licensed staff on the Care System Guideline for Pain Management, the Care System Guideline for fall, conducting a musculoskeletal and neurological assessment and the resident's rights including the right to receive adequate and appropriate care and services. Education will be completed by January 1, 2016. To maintain continued compliance, this education will be done during new hire orientation with all licensed staff by the SDC, ADNS or the DNS.	



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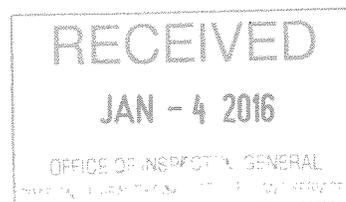
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185456	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/26/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF SENECA PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205	
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F 309	<p>Continued From page 7</p> <p>staff to document they completed a head to toe assessment and if they initiated neuro checks.</p> <p>Interview with the Director of Nursing (DON), on 11/26/15 at 9:00 AM, revealed nursing staff was required to use the Incident Report Checklist with each resident fall.</p> <p>Interview with Resident #6, on 11/23/15 at 4:30 PM, revealed the resident had fallen in his/her room a couple of weeks prior and that he/she needed increased assistance with transfers in and out of the bed since that fall. The resident stated he/she had first come to the facility after suffering a fall in the home that resulted in a broken backbone. However, the resident fell again while at the facility and suffered a broken hip. Resident #6 stated he/she got out of the bed in the night and tripped on a chair in the room. He/she bumped his/her head on the chair on the way to the floor and landed on his/her knee on the floor. Resident #6 stated he/she was unclear on the amount of time that passed between the fall and going to the hospital. The resident was unclear about any details regarding reporting the fall to the staff or any assessments or treatments following the fall.</p> <p>Review of the clinical record for Resident #6 revealed the facility admitted the resident on 08/26/15 with diagnoses of a Fracture of Lumbar Vertebra, History of Falling, Retention of Urine, Lack of Coordination, Difficulty Walking, Urinary Tract Infection (UTI), Myocardial Infarction, and Heart Disease.</p> <p>Review of Resident #6's quarterly Minimum Data Set (MDS) assessment, completed on 09/02/15,</p>	F 309	<p>Residents identified to have a fall will be reviewed at the next clinical start up meeting by the interdisciplinary team (IDT) to ensure the Diversicare falls guidelines are being followed. The IDT will follow the resident for at least 72 hours, in the clinical start up meeting, to ensure that the resident is not having any negative effects related to the fall and that any newly applied interventions are affective.</p> <p>How will the facility monitor performance to ensure solutions are sustained?</p> <p>To maintain continued compliance the DNS or ADNS will monitor falls through the clinical start up meeting which occurs with the interdisciplinary falls team 5 times a week (Monday through Friday). During the weekends (Saturday and Sunday) the weekend supervisor will be responsible to monitor the falls. The interdisciplinary falls team and/or weekend house supervisor will utilize a QAPI Fall Event IDT Compliance Review Log, as well as a Fall Event IDT Review Checklist to ensure all aspects of the follow up</p>	



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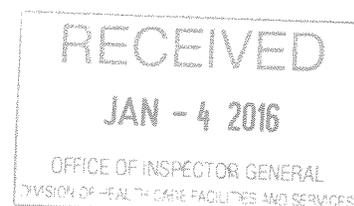
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F 309	<p>Continued From page 8</p> <p>revealed the facility assessed the resident as requiring one (1) person extensive assist to walk and one (1) person limited assist to complete activities of daily living (ADLs). The facility conducted a Brief Interview for Mental Status (BIMS) exam during the MDS assessment with a score of nine (9) out of fifteen (15) on the BIMS exam indicating the resident was moderately impaired.</p> <p>Review of Resident #8's care plan related to pain, dated 09/04/15, revealed the resident experienced the frequent presence of pain in his/her back due to a lumbar compression fracture after a fall at home prior to admission to the facility. Interventions included the staff was to evaluate the location and intensity of the resident's pain. The staff was to administer pain medication as ordered, report any uncontrolled pain to the physician, and evaluate vital signs as needed. The staff was to observe for both verbal and nonverbal indicators of pain.</p> <p>Review of the Physician Orders, dated October 2015, revealed on 08/26/15 the physician ordered Norco 5-325 milligram (mg) tablet by mouth every six (6) hours as needed (PRN) for pain. The order also stated the facility must document the pain level on a scale of one (1) to ten (10).</p> <p>Review of the Incident Log, printed 11/27/15 at 8:35 AM, revealed Resident #6 sustained a fall on the night of 10/28/15 or early morning of 10/29/15. The fall occurred in the resident's room at an unknown time. The report stated the resident sustained an abrasion. No in-house treatment or other disposition was recorded on</p>	F 309	<p>is completed for each fall.</p> <p>If an issue of non-compliance is identified, the weekend supervisor, SDC, ADNS or DNS will provide 1:1 re-education to the team member and immediate follow-up on the incident will be completed. Care plans will be reviewed upon admission, quarterly, annually and with each change of condition. Care plan changes for falls will be initially updated on the post falls huddle form and then changes to the master care plan will be updated during the clinical start up meeting by an MDS team member, any changes made at that time will then communicated to the floor staff immediately.</p> <p>The DNS will maintain the QAPI Fall Event IDT Compliance Review Log to identify any patterns or trends and report these findings and any necessary plans of action at the monthly QAPI meeting. All findings will be reviewed in the monthly QAPI meeting, which is attended by the center's administrator, the Medical Director and other center departmental leadership team members. The QAPI Fall Event IDT Compliance Review Log will be</p>		



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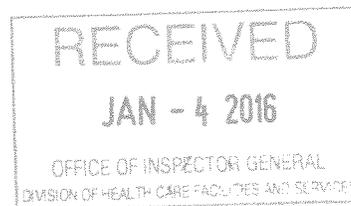
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F 309	<p>Continued From page 9 this form.</p> <p>Review of the Resident Incident Report, dated 10/30/15 at 12:11 AM, revealed Registered Nurse (RN) #1 created an incident report in the facility's medical records. The narrative explained the resident reported he/she had gotten out of bed, tripped on something, and fell forward hitting his/her head on a chair in the room. The resident then reported he/she went back to bed. The narrative continued to state the resident had a bruise on the top of his/her head, bruises on his/her left rib cage, and an abrasion on his/her left leg. The RN documented she placed steri strips on the resident's open areas. The incident report did not contain vital signs or report of pain assessment or if nursing completed any range of motion assessments as stated in their policy.</p> <p>Interview with Certified Nursing Assistant (CNA) #2, on 11/25/15 at 10:55 AM, revealed the resident reported pain and difficulty moving his/her left leg on the morning of 10/29/15. CNA #2 stated she was providing morning care to Resident #6 and asked the resident to straighten his/her leg. The resident stated he/she was unable to put the leg down due to pain in the leg and rubbed the inside of his/her leg. The CNA stated she noticed bruising on the inside of the leg. Resident #6 then told the CNA that he/she had gotten up in the night and fell over the chair in the room. CNA #2 stated because of the resident's increased confusion at that time, she was unsure at that time if the resident had really fallen or if he/she had dreamed they had fallen. However, the CNA stated she did report the possible fall to the nurse, RN #1. The CNA</p>	F 309	<p>completed monthly for 6 months and then quarterly thereafter. All findings will be reviewed in the QAPI meeting for 6 months for any additional interventions and/or suggestions recommended to maintain continued compliance. The QAPI team will determine the need for further review depending on the outcome of audits after 6 months.</p> <p>The facility will be in substantial compliance by January 1, 2016.</p>	1/1/16	



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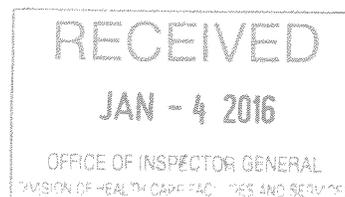
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F 309	<p>Continued From page 10</p> <p>witnessed RN #1 asking the resident what had happened and the resident stated he/she had fallen.</p> <p>Interview with RN #1, on 11/24/15 at 6:10 PM, revealed Resident #6 complained of pain and acted as though he/she had difficulty moving on the morning of 10/29/15. RN #1 stated Resident #6 had been experiencing a lot of confusion since his/her return from the hospital on 10/27/15. On the morning of 10/29/15, the resident reported pain and difficulty moving. Resident #6 reported he/she had fallen in the room and hit the chair. The RN stated she did not give the resident pain medication at the time and decided to monitor the resident for continued pain. She could not state why she did not give pain medication at that time. The nurse stated she looked at the resident and did not see any bruising on the resident nor see abnormalities with the resident's leg at that time. RN #1 did not take vitals after learning of the fall. She stated she did not feel they were necessary because the resident had fallen on a prior shift. She stated later in the afternoon the resident denied any pain. She stated she was off for a couple days following the incident and she made a note of the incident in the Departmental Notes a few days later when she returned to work.</p> <p>Further interview with RN #1, on 11/25/15 at 2:58 PM, revealed RN #1 did not initiate neurological checks on the resident because the fall happened prior to her shift. She stated she was unsure of how long before her shift the fall had taken place, but that she felt it was unnecessary to conduct neurological checks on the resident when the fall had taken place on a previous shift</p>	F 309			



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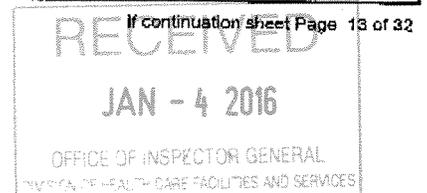
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F 309	<p>Continued From page 11</p> <p>and some time had already passed. The nurse stated she did not remember if she assessed the resident's pain on 10/29/15, and that she did not know if she documented any pain assessment as directed by the policy. RN #1 stated she completed a head to toe assessment of the resident, but was not sure if she touched the resident during the assessment. She stated the head to toe assessment revealed the resident had some scratches on his/her rib cage. RN #1 stated the scratches on the resident's rib cage were not unusual.</p> <p>Review of the Departmental Notes completed by Licensed Practical Nurse (LPN) #1, on 10/29/15 at 12:19 AM, revealed Resident #6 was in bed with periodic wakefulness. LPN #1 documented she did not observe Resident #6 attempting to get out of bed.</p> <p>Review of the Departmental Notes completed by RN #1, on 10/31/15 at 8:53 AM, revealed the RN completed a late entry. RN #1 documented Resident #6 complained on Thursday morning, 10/29/15, of some difficulty moving his/her left leg and was grimacing and complaining of pain. The note stated the nurse asked the resident about his/her pain through the day. The resident reported pain one additional time that morning and then reported no pain to the nurse the remainder of the day.</p> <p>However, review of the Medication Administration Record (MAR), October 2015, and the resident's narcotic count sheet for Narco revealed nursing did not administer PRN pain medication to Resident #6 on 10/29/15 even though documentation revealed the resident was</p>	F 309			



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F 309	<p>Continued From page 12 exhibiting pain.</p> <p>Review of Departmental Notes completed by LPN #1, on 10/30/15 at 10:16 PM, revealed Resident #6 complained of pain to left leg and was unable to lay leg flat. The LPN documented she called the Nurse Practitioner and obtained an order for an x-ray of the resident's left hip and leg. She also informed the resident's Power of Attorney (POA).</p> <p>Review of the MAR revealed PRN pain medication was administered on 10/30/15. However, there was no documented evidence LPN #1 assessed resident's level of pain or effectiveness of the PRN pain medication she administered per the MAR.</p> <p>Interview with LPN #1, on 11/24/15 at 4:55 PM, revealed Resident #6 reported pain to the nursing staff on 10/30/15. LPN #1 stated Resident #6 experienced a lot of confusion at the time he/she reported pain to her on 10/30/15. She stated the resident also had a UTI at the time and had increased confusion. LPN #1 stated she was assisting with getting the resident ready for bed when he/she reported having leg pain. The LPN conducted a pain assessment and visually inspected the resident's leg. She stated the resident's leg had some outward rotation and she called for an order for an x-ray. LPN #1 stated she had no knowledge of the resident having reported a fall the previous morning. She saw no notes and did not remember receiving notification in report prior to starting her shift.</p> <p>Review of the Departmental Notes completed by</p>	F 309			



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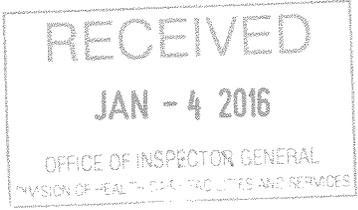
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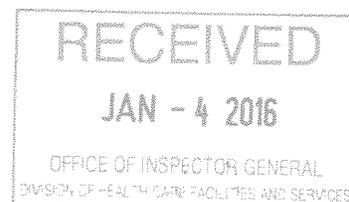
F 309	<p>Continued From page 13</p> <p>LPN #1, on 10/31/15 at 12:52 AM, revealed the LPN received the x-ray results. The x-ray results were positive for a fracture involving the femoral neck with a lateral displacement two (2) days after the incident. LPN updated the POA and called the ambulance service to transport the resident to the emergency room.</p> <p>Review of the MAR revealed PRN pain medication was administered on 10/31/15. However, there was no documented evidence LPN #1 assessed the resident's level of pain or effectiveness of the PRN pain medication she administered per the MAR.</p> <p>Review of the Medication Administration Record (MAR), October 2015, revealed the nurse did not document the administration of the pain medication Norco on 10/30/15 or 10/31/15.</p> <p>Further review of the Departmental Notes, 10/27/15 through 10/31/15, revealed no evidence of post fall neurological checks, no recorded pain assessment rating scale, and no evidence of a ROM assessment completed after Resident #6's reported fall as directed by the policy.</p> <p>Interview with the DON, on 11/24/15 at 5:45 PM, revealed the DON kept a copy of notes she made during the investigation into Resident #6's fall and fracture. The investigation notes stated the fall took place after Tuesday, 10/27/15, as evidenced by staff interviews who reported no abrasions, bruises, or complaints of pain on that day (10/27/15).</p> <p>Interview with the Assistant Director of Nursing (ADON), on 11/25/15 at 11:10 AM, revealed the</p>	F 309		
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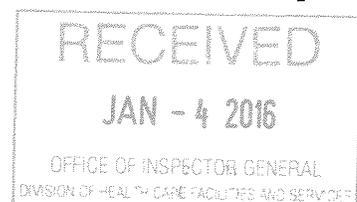
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F 309	<p>Continued From page 14</p> <p>standard of care the nurses should have done after discovering a resident fall included a head to toe assessment, skin check, and neurological checks. The purpose of completing these assessments and checks was to determine if the resident sustained an injury and to ensure the resident's safety. The nurse should have then documented the results of the assessments, along with vital signs, on the incident report. The DON then reviewed the incident reports. The ADON further stated that by not identifying Resident #6's fracture, the resident was at increased risk of injury and pain.</p> <p>Interview with the DON, on 11/24/15 at 5:45 PM, revealed the nursing staff did not inform her of the fall until she received a call from the nurse about the resident's confirmed fracture on 10/31/15.</p> <p>Further interview with the DON, on 11/25/15 at 9:00 AM, revealed the nurse should have completed and documented vitals, a ROM assessment, and a pain assessment. The DON reviewed the incident report and stated based on the report it did not appear the nurse complete a pain assessment, vitals, range of motion check, or initiate neurological checks. The Incident Report Checklist directs staff to complete a head to toe assessment.</p> <p>Interview with the Administrator, on 11/25/15 at 3:20 PM, revealed the staff did not follow facility policy which resulted in a delay in identifying the resident's fracture. Nursing staff did not conduct the appropriate assessments after the resident fell and the nurse's notes were "sketchy". The lack of assessments was concerning and</p>	F 309		



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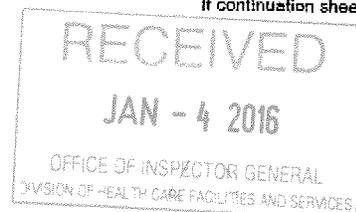
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F 309	<p>Continued From page 15</p> <p>indicated a "lackadaisical approach to nursing care". This could have put the resident in pain for longer than necessary.</p> <p>Interview with the Director of Clinical Operations, on 11/25/15 at 9:00 AM with the DON, revealed per the documentation after Resident #6 fell, the nurse did not complete vitals, conduct neuro checks, and complete a range of motion assessment. The staff did not report the incident to the DON. As a result, the DON, Administrator, and Director of Clinical Operations were unaware of the resident's fall until after LPN #1 was notified of the fracture on 10/31/15.</p> <p>Review of the Weekly Event Report Summary, dated 11/05/15, revealed the Director of Clinical Services recorded the resident had increased pain to his/her left hip on 10/30/15 and was assessed by the nurse. The nurse noted the hip was bruised and obtained an order for an x-ray on the evening of 10/30/15. The facility received the results of the x-ray on 10/31/15 that revealed a fracture to the left femoral head. The resident had reported he/she fell earlier in the week. The facility discharged the resident to the hospital for surgical repair of the fracture.</p> <p>Review of the hospital discharge packet, dated 11/03/15 at 9:01 AM, revealed the hospital admitted the resident on 10/31/15 and he/she underwent left hip replacement for his/her displaced, fractured left hip. The report further stated the resident developed severe left hip pain, limited range of motion, and an inability to bear weight after falling out of bed two (2) days prior to the date of admission, 10/31/15. The hospital reported the findings of the x-rays</p>	F 309		



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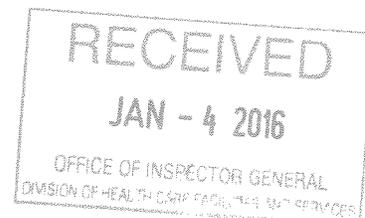
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F 309	Continued From page 16 included a fracture through the femoral neck with a fifty percent (50%) displacement of the femoral shaft relative to the head.	F 309			
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must 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. This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, it was determined the facility failed to complete a full Fall investigation for one (1) of nineteen (19) sampled residents (Resident #6). Resident #6 fell on 10/29/15; however, Registered Nurse (RN) #1 failed to complete the fall assessment which would have included a head to toe assessment and assessing the resident's pain level. On 10/29/15 and 10/30/15 Resident #6 complained of pain to the left leg and was unable to lay leg flat. The resident was diagnosed with a fracture involving the femoral neck with a lateral displacement on 10/31/15, two (2) days after the incident. The findings include: Review of the facility's Care System Guideline, Falls, not dated, revealed the facility would conduct a fall huddle to investigate the circumstances around the resident's fall. Next,	F 323	F323 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #6 no longer a resident at Seneca Place. RN #1 was educated when she returned to work on 11/27/2015 regarding the Diversicare falls guidelines, pain assessment, musculoskeletal and neurological assessment and treatment of pain and skin alterations. How will the facility identify other residents having the potential to be affected by the same deficient practice? All current residents who have had falls in the past 30 days have had a pain assessment completed utilizing the Pain User Defined Assessment (UDA) these were completed on 1/1/2016 and reviewed by the DNS to ensure pain was assessed and addressed appropriately. Any needed care		



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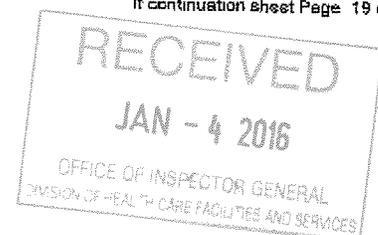
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185466	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/25/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF SENECA PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3626 DUTCHMANS LANE LOUISVILLE, KY 40205	
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F 323	<p>Continued From page 17</p> <p>the facility would complete a Post Fall Investigation and include information to assist in choosing interventions to prevent future falls. The facility would then place the fall event and intervention on the twenty-four (24) hour report.</p> <p>Interview with the Director of Nursing (DON), on 11/25/15 at 9:00 AM, revealed nursing staff was required to use the Incident Report Checklist with each resident fall.</p> <p>Review of the facility's tool, Incident Report Checklist, dated 12/24/13, revealed the information the facility would include in the nurse's note pertaining to a resident fall and the steps nursing staff would take to complete an incident investigation. The form stated the nurse's note must include the following information: date and time; type of incident; location; title of individual reporting the incident; appearance or position of the resident when staff discovered the incident; injury description; treatment order; if staff used a lift; pain level; neuro checks for any head injury or unwitnessed fall; range of motion; notification of healthcare provider; notification of Power of Attorney (POA); notification of DON or Assistant Director of Nursing (ADON); and, any immediate interventions. The checklist also included places for staff to document they completed a head to toe assessment and if they initiated neuro checks.</p> <p>Review of the clinical record for Resident #6 revealed the facility admitted the resident on 08/26/15 with diagnoses of Fracture of Lumbar Vertebra, History of Falling, Retention of Urine, Lack of Coordination, Difficulty Walking, Urinary</p>	F 323	<p>plan updates found during this process have been identified and addressed.</p> <p>What measure will be put into place or systemic changes made to ensure the deficient practice will not recur?</p> <p>The Director of Nursing and/or the staff development coordinator will educate all licensed staff on the Care System Guideline for Pain Management, the Care System Guideline for fall, conducting a musculoskeletal and neurological assessment and the resident's rights including the right to receive adequate and appropriate care and services. Education will be completed by January 1, 2016.</p> <p>To maintain continued compliance, this education will be done during new hire orientation with all licensed staff by the SDC, ADNS or the DNS.</p> <p>Residents identified to have a fall will be reviewed at the next clinical start up meeting by the interdisciplinary team (IDT) to ensure the Diversicare falls guidelines are being followed. The IDT will follow the resident for at</p>	



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F 323	<p>Continued From page 18</p> <p>Tract Infection (UTI), Myocardial Infarction, and Heart Disease.</p> <p>Review of Resident #6's quarterly Minimum Data Set (MDS) assessment, completed on 09/02/15, revealed the facility assessed the resident as requiring a one (1) person extensive assist to walk and one (1) person limited assist to complete activities of daily living (ADL). The facility conducted a Brief Interview for Mental Status (BIMS) exam during the MDS assessment. The resident scored a nine (9) out of fifteen (15) on the BIMS exam which meant the resident had a moderate cognition impairment.</p> <p>Review of the care plan related to falls, dated 09/04/15, revealed Resident #6 was at risk of falls due to a history of falls, decreased cognition, and impaired mobility. The facility included several interventions to prevent falls. The staff was to monitor Resident #6 for changes in condition that may have warranted increased supervision or assistance. The staff was to assist the resident with transfers and ambulation with the use of a walker. Additional interventions included staff reminding the resident to use the call light and ensuring the resident's bed was at the appropriate height, the call light was within the resident's reach, and the resident was to wear non-skid socks.</p> <p>Review of the Incident Log, printed 11/27/15 at 8:35 AM, revealed Resident #6 sustained a fall on the night of 10/28/15 or early morning of 10/29/15. The fall occurred in the resident's room at an unknown time. The report stated the resident sustained an abrasion. The staff was to</p>	F 323	<p>least 72 hours, in the clinical start up meeting, to ensure that the resident is not having any negative effects related to the fall and that any newly applied interventions are affective.</p> <p>How will the facility monitor performance to ensure solutions are sustained?</p> <p>To maintain continued compliance the DNS or ADNS will monitor falls through the clinical start up meeting which occurs with the interdisciplinary falls team 5 times a week (Monday through Friday). During the weekends (Saturday and Sunday) the weekend supervisor will be responsible to monitor the falls. The interdisciplinary falls team and/or weekend house supervisor will utilize a QAPI Fall Event IDT Compliance Review Log, as well as a Fall Event IDT Review Checklist to ensure all aspects of the follow up is completed for each fall, which includes monitoring the completion of neurological checks and pain assessments.</p> <p>If an issue of non-compliance is identified, the weekend supervisor,</p>		



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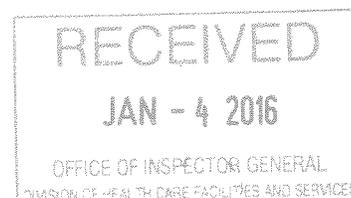
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185456	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/25/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF SENECA PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40206		
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F 323	<p>Continued From page 19</p> <p>have continued observation of the resident. No in-house treatment or other disposition was recorded on this form.</p> <p>Review of the Resident Incident Report, dated 10/30/15 at 12:11 AM, revealed Registered Nurse (RN) #1 created an Incident Report in the facility's medical records. The narrative explained the resident reported he/she had gotten out of bed, tripped on something, and fell forward hitting his/her head on a chair in the room. The resident then reported he/she went back to bed. The narrative continued to state the resident had a bruise on the top of his/her head, a bruise on his/her left rib cage, and an abrasion on his/her left leg. The RN recorded she placed steri strips on the resident's open areas. However, record review revealed the Incident Report was not completed per the facility's policy and procedures. The incident report did not contain vital signs or report of pain assessment. Nursing did not place the date and time of the incident on the form. In the narrative of the Resident Incident Report, the nurse failed to include information about who first discovered the incident, if nursing staff initiated neuro checks related to the resident reporting hitting his/her head, or if nursing completed any range of motion assessments. Additionally, the nurse did not include information pertaining to notification of the DON or ADON of the incident.</p> <p>Interview with Resident #6, on 11/23/15 at 4:30 PM, revealed the resident stated he had fallen in his/her room a couple of weeks prior and that he/she needed increased assistance with transfers in and out of the bed since that fall. Resident #6 stated he/she got out of the bed in</p>	F 323	<p>SDC, ADNS or DNS will provide 1:1 re-education to the team member and immediate follow-up on the incident will be completed. Care plans will be reviewed upon admission, quarterly, annually and with each change of condition. Care plan changes for falls will be initially updated on the post falls huddle form and then changes to the master care plan will be updated during the clinical start up meeting by an MDS team member, any changes made at that time will then communicated to the floor staff immediately.</p> <p>The nursing leadership team including unit coordinators, weekend supervisors, SDC, medical records, ADNS and DNS will observe 5 residents with falls in the past 30 days each week for 6 weeks to ensure staff are delivering care based on their care plan. Findings of these observations will be reviewed at the center's monthly QAPI meeting. If after 6 weeks, the team members are consistently following the care plan, the nursing administration team will continue observation of 5 residents with</p>		

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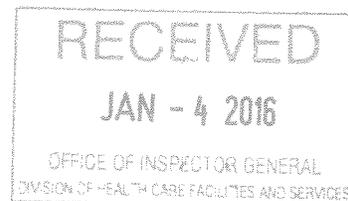
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NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF SENECA PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205		
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F 323	<p>Continued From page 20</p> <p>the night and tripped on a chair in the room. He/she bumped his/her head on the chair on the way to the floor and landed on his/her knee on the floor.</p> <p>Interview with the DON, on 11/24/15 at 5:45 PM, revealed the DON kept a copy of notes she made during the investigation into Resident #6's fall.</p> <p>Review of the DON's investigation notes, not dated, revealed Certified Nursing Assistant (CNA) #2 reported on Thursday, 10/29/15, Resident #6 told her he/she fell. The CNA reported this to Registered Nurse (RN) #1 on Thursday morning, 10/29/15. The notes further stated the resident was not able to state what day the fall took place. RN #1 reported the fall to the MDS Coordinator. The investigation notes further revealed the fall took place after Tuesday, 10/27/15, as evidenced by staff report of no abrasions, bruises, or complaints of pain on that day.</p> <p>Interview with Certified Nursing Assistant (CNA) #2, on 11/25/15 at 10:55 AM, revealed she was providing morning care to Resident #6 on 10/29/15 and asked the resident to straighten his/her leg. The resident stated he/she was unable to put the leg down due to pain in the leg and rubbed the inside of his/her leg. The CNA stated she noticed bruising on the inside of the leg. Resident #6 then told the CNA that he/she had gotten up in the night and fell over the chair in the room. CNA #2 stated because of the resident's increased confusion at that time, she was unsure at that time if the resident had really fallen or if he/she had dreamed they had fallen.</p>	F 323	<p>falls in the past 30 days monthly for 6 months to ensure sustained compliance. The QAPI team will determine the need for further review depending on the outcome of the observational rounds after 6 months.</p> <p>The DNS will maintain a QAPI Fall Event IDT Compliance Review Log to identify any patterns or trends and report these findings and any necessary plans of action at the monthly QAPI meeting. All findings will be reviewed in the monthly QAPI meeting, which is attended by the center's administrator, the Medical Director and other center departmental leadership team members. The QAPI Fall Event IDT Compliance Review Log will be completed monthly for 6 months and then quarterly thereafter. All findings will be reviewed in the QAPI meeting for 6 months for any additional interventions and/or suggestions recommended to maintain continued compliance. The QAPI team will determine the need for further review depending on the outcome of audits after 6 months.</p> <p>The facility will be in substantial compliance by January 1, 2016.</p>	1/1/16	



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NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF SENECA PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40206		
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F 323	<p>Continued From page 21</p> <p>However, the CNA stated she did report the possible fall to the nurse, RN #1. CNA #2 stated per the policy, if a CNA sees or suspects a fall, the CNA was to report the incident to the floor nurse. The CNA witnessed RN #1 asking the resident what had happened and the resident stated he/she had fallen.</p> <p>Interview with RN #1, on 11/24/15 at 6:10 PM, revealed Resident #6 complained of pain and appeared to have some difficulty his/her leg on the morning of 10/29/15. Resident #6 reported he/she had fallen in the room and hit the chair. The nurse further stated the fall had happened prior to her coming on shift that day, and other staff did not appear aware of the fall. RN #1 did not take vitals after learning of the fall. She stated she did not feel they were necessary because the resident had fallen on a prior shift. RN #1 stated she initiated an incident report later that day. She stated she was off for a couple days following the incident and she made a note of the incident in the Departmental Notes a few days later when she returned to work.</p> <p>Further interview with RN #1, on 11/25/15 at 2:58 PM, revealed RN #1 did not initiate neurological checks on the resident because the fall happened prior to her shift. She stated she was unsure of how long before her shift the fall had taken place but that she felt it was unnecessary to conduct neurological checks on the resident when the fall had taken place on a previous shift and some time had already passed. The nurse stated she did not remember if she assessed the resident's pain on 10/29/15, and that she did not know if she documented any pain assessment. RN #1 stated she completed a head to toe</p>	F 323		



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NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF SENECA PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205
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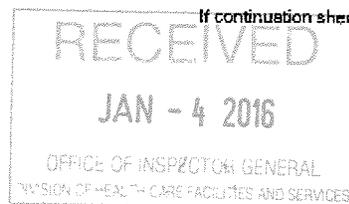
F 323	<p>Continued From page 22</p> <p>assessment of the resident but was not sure if she touched the resident during the assessment. She stated the head to toe assessment revealed the resident had some scratches on his/her rib cage. RN #1 further stated she informed the MDS Coordinator of the fall. She stated the MDS Coordinator used to be the acting DON and when he was acting DON, nursing staff reported falls to him. RN #1 further stated nurses were supposed to report falls to the DON; however, she believed the DON was already aware of the fall and so she told the MDS Coordinator to get instruction. RN #1 was unable to state what led her to believe the DON knew of the fall.</p> <p>Interview with MDS Coordinator, on 11/25/15 at 10:32 AM, revealed on the morning of 10/29/15 RN #1 reported Resident #6 had fallen. She told the MDS Coordinator about the fall and asked what she should do since the nurse who worked third (3rd) shift had not put an incident report in the system. The MDS Coordinator advised the RN to generate an incident report. The MDS Coordinator also revealed the nurse should have informed the DON of the fall. He stated prior to the DON's employment, nursing staff did report falls to the MDS Coordinator. He stated he did not follow-up to ensure the nurse reported the fall to the DON and that he did not report the fall to the DON. After reviewing the Resident Incident Report, the MDS Coordinator stated the report was not completed per the facility's policy.</p> <p>Interview with the Staff Development Coordinator, on 11/24/15 at 5:15 PM, revealed the first employee to witness or discover an incident, such as a fall or injury of unknown origin, was responsible to report the incident to</p>	F 323		
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F 323	<p>Continued From page 23</p> <p>the floor nurse. The nurse should have then initiated the incident report as soon as they learned of the situation after ensuring the resident's safety. The nurse should have then notified the POA, physician, and the DON. The IDT should also have known about the incident. The Staff Development Coordinator also stated he was not employed at this facility at the time of the incident and could not speak to the incident itself. However, after reviewing the Resident Incident Report, he did state the report appeared incomplete.</p> <p>Interview with the ADON, on 11/25/15 at 11:10 AM, revealed nursing staff did not inform her of Resident #6's fall. The ADON stated the nursing staff should have reported the fall to the DON. She also the nurses should have completed a head to toe assessment, skin check, and neurological checks and documented the results of the assessments, along with vital signs, on the incident report. Per interview, the DON reviews the incident reports.</p> <p>Interview with the DON, on 11/24/15 at 5:45 PM, revealed the nursing staff did not inform the DON of the fall until 10/31/15. The DON stated she was off work ill on 10/29/15 when nursing discovered the resident had fallen. The resident reported the fall to CNA #2 on the morning of 10/29/15. The CNA reported the fall to the RN #1. RN #1 entered an incident report stating she had notified the physician and the POA on 10/29/15. RN #1 made a note in the medical record about the incident on 10/31/15.</p> <p>Further Interview with the DON, on 11/25/15 at 9:00 AM, revealed the nursing staff did not</p>	F 323			



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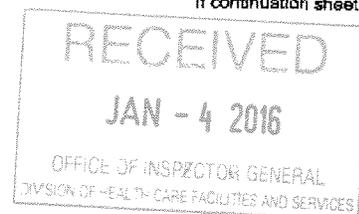
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F 323	<p>Continued From page 24</p> <p>complete and document the investigation per the facility's policy to ensure the resident's safety. The nurse should have completed and documented vitals, a ROM assessment, and a pain assessment. The DON reviewed the incident report and stated based on the report it did not appear the nurse complete a pain assessment, vitals, range of motion check, or initiate neurological checks. After the incident report was completed, the staff should have initiated an Incident Report Checklist and a "huddle." The Incident Report Checklist instructs staff on what information to include in the documentation, such as date and time, type of incident, location, who reported it, appearance when found, injury description, treatment order, pain level, neuro checks, range of motion, notifications, and immediate interventions. The Incident Report Checklist directs staff to complete a head to toe assessment. The checklist further instructs staff to conduct a huddle to discuss the fall and interventions and includes a Resident Fall Analysis worksheet. The DON stated she was unable to find an Incident Report Checklist for Resident #6's fall reported on 10/29/15.</p> <p>Interview with the Director of Clinical Operations, on 11/25/15 at 9:00 AM with the DON, revealed the staff did not conduct the investigation and ensure the safety of the resident per the facility's standard. Per the documentation, after Resident #6 fell, the nurse did not complete vitals, conduct neuro checks, and complete a range of motion assessment. RN #1 reported the fall to the MDS Coordinator verbally and the MDS Coordinator informed the therapy department of Resident #6's fall verbally. Staff did not document this</p>	F 323		

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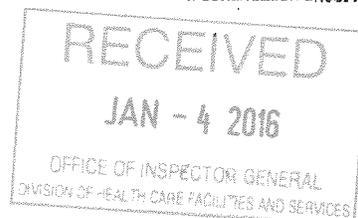
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F 323	Continued From page 25 communication. Per interview, the RN notified the physician and the POA and documented this communication on the incident form. However, staff did not report the incident to the DON. As a result, the DON, Administrator, and Director of Clinical Operations were unaware of the resident's fall until 10/31/15. Interview with the Administrator, on 11/25/15 at 3:20 PM, revealed the staff did not manage Resident #6's fall per policy and resulted in a delay in identifying the resident's fracture. Nursing staff did not conduct the appropriate assessments after the resident fell. The lack of assessments were concerning and indicated a "lackadaisical approach to nursing care."	F 323		
F 514 SS=G	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by:	F 514	F514 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #6 no longer a resident at Seneca Place. RN #1 was educated when she returned to work on 11/27/2015 regarding the Diversicare falls guidelines, pain assessment, musculoskeletal and neurological assessment and treatment of pain and skin alterations. How will the facility identify other residents having the potential to be affected by the same deficient practice?	



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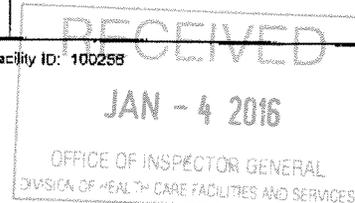
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185456	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/25/2015	
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF SENECA PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205		
(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 514	<p>Continued From page 26</p> <p>Based on interview, record review and facility policy review, it was determined the facility failed to maintain an accurate clinical record for one (1) of nineteen (19) sampled residents (Resident #6). Resident #6 fell on 10/29/15; however, Registered Nurse (RN) #1 failed to complete the fall assessment which would have included a head to toe assessment and assessing the resident's pain level. On 10/29/15 and 10/30/15 Resident #6 complained of pain to the left leg and was unable to lay leg flat. The resident was diagnosed with a fracture involving the femoral neck with a lateral displacement on 10/31/15, two (2) days after the incident. (Refer to F309 and F323)</p> <p>The findings include:</p> <p>Interview with the Administrator, on 11/25/15 at 3:20 PM, revealed the facility did not have a policy regarding documentation or accuracy of the clinical record.</p> <p>Review of the facility's Care System Guideline for Pain Management, not dated, revealed the facility would complete a pain assessment after each resident's fall. The facility would then record the findings of the pain assessment in the clinical records including evidence based pain scales. Additionally, the facility would note the ongoing monitoring and effectiveness of pain interventions in the electronic medical record system and progress notes. After the pain assessment, the Interdisciplinary Team (IDT) would then evaluate the effectiveness of the resident's pain management after a fall or other acute change.</p>	F 514	<p>All current residents who have had falls in the past 30 days have had a pain assessment completed utilizing the Pain User Defined Assessment (UDA) these were completed on 1/1/2016 and reviewed by the DNS to ensure pain was assessed and addressed appropriately. Any needed care plan updates found during this process have been identified and addressed.</p> <p>What measure will be put into place or systemic changes made to ensure the deficient practice will not recur?</p> <p>The Director of Nursing and/or the staff development coordinator will educate all licensed staff on the Care System Guideline for Pain Management, the Care System Guideline for fall, conducting a musculoskeletal and neurological assessment and the resident's rights including the right to receive adequate and appropriate care and services. Education will be completed by January 1, 2016.</p> <p>The Post Incident Checklist will be utilized by the direct care nurses to ensure that after a fall occurs all necessary items have been</p>	



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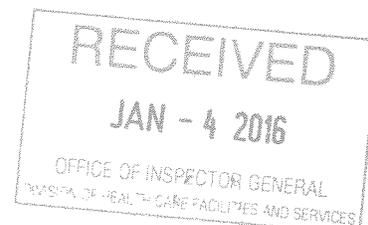
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F 514	<p>Continued From page 27</p> <p>Review of the facility's guideline for Falls, not dated, revealed the facility would physically assess a resident for injuries and render medical attention as needed after any resident experienced a fall. The facility would then notify the physician and responsible party.</p> <p>Review of the facility's Incident Report Checklist, dated 12/24/13, revealed the facility would include in the nurse's note the steps nursing staff would take when completing an incident investigation. The form stated the nurse's note must include the following information: date and time; type of incident; location; title of the individual reporting the incident; appearance or position of the resident when staff discovered the incident; injury description; treatment order; if staff used a lift; pain level; neuro checks for any head injury or unwitnessed fall; range of motion; notification of healthcare provider; notification of Power of Attorney (POA); notification of the Director of Nursing (DON) or Assistant Director of Nursing (ADON); and, any immediate intervention. The checklist also included places for staff to document they completed a head to toe assessment and if they initiated neuro checks and would become part of the medical record.</p> <p>Review of the Resident Incident Report, dated 10/30/15 at 12:11 AM, revealed Registered Nurse (RN) #1 created an incident report in Resident #6's medical record. The narrative explained the resident reported he/she had gotten out of bed, tripped on something, and fell forward hitting his/her head on the chair in the room. However, continued review of the Resident Incident Report revealed RN #1 did not record vital signs or pain level in the incident</p>	F 514	<p>completed. This checklist includes: vital sign documentation, pain level documentation, neurological evaluations (if applicable) and notification of the ADNS or DNS. Pain medications PRN and routine have also had a special requirement added to them in the electronic medical record to include documentation of pain level prior to and after administration of pain medication.</p> <p>To maintain continued compliance, this education will be done during new hire orientation with all licensed staff by the SDC, ADNS or the DNS.</p> <p>Residents identified to have a fall will be reviewed at the next clinical start up meeting by the interdisciplinary team (IDT) to ensure the Diversicare falls guidelines are being followed. The IDT will follow the resident for at least 72 hours, in the clinical start up meeting, to ensure that the resident is not having any negative effects related to the fall and that any newly applied interventions are affective.</p>		



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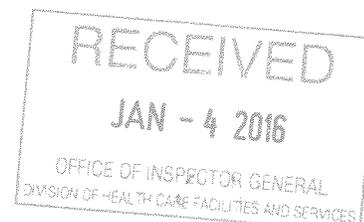
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NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF SENECA PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3626 DUTCHMANS LANE LOUISVILLE, KY 40206	
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F 514	<p>Continued From page 28</p> <p>report. RN #1 did not place the date and time of the incident on the form and did not include who first discovered the incident had taken place. RN #1 also did not document if she initiated neuro checks related to the resident reporting he/she hit his/her head. RN #1 did not include if she completed any range of motion assessments. Additionally, the nurse did not note if she did or did not notify the DON or ADON of the incident as directed by policy.</p> <p>Interview with RN #1, on 11/24/15 at 6:10 PM, revealed it was her responsibility; however, she did not document the resident's level of pain using a pain scale. RN #1 stated she initiated an incident report later that day, but did not document vitals or neuro checks because she did not do them. She stated she did not make a note in the Departmental Notes until she returned to work a few days later.</p> <p>Interview with the Director of Nursing (DON), on 11/24/15 at 5:45 PM, revealed RN #1 entered an incident report after midnight on 10/30/15. RN #1 did not create a note in the medical record about the incident until 10/31/15.</p> <p>Review of the Departmental Notes completed by RN #1, on 10/31/15 at 8:53 AM, revealed the RN completed a late entry and documented Resident #6 complained on Thursday morning, 10/29/15, of some difficulty moving his/her left leg and was grimacing and complaining of pain. RN #1 did not record the resident's pain rating on the pain scale nor any interventions used to assist the resident to control the pain.</p> <p>Further interview with RN #1, on 11/25/15 at 2:58</p>	F 514	<p>How will the facility monitor performance to ensure solutions are sustained?</p> <p>To maintain continued compliance the DNS or ADNS will monitor falls through the clinical start up meeting which occurs with the interdisciplinary falls team 5 times a week (Monday through Friday). During the weekends (Saturday and Sunday) the weekend supervisor will be responsible to monitor the falls. The interdisciplinary falls team and/or weekend house supervisor will utilize a QAPI Fall Event IDT Compliance Review Log, as well as a Fall Event IDT Review Checklist to ensure all aspects of the follow up is completed for each fall, which includes follow up auditing of vital sign documentation, pain level documentation, neurological evaluation completion (if applicable) and notification of the ADNS or DNS of fall.</p> <p>If an issue of non-compliance is identified, the weekend supervisor, SDC, ADNS or DNS will provide 1:1 re-education to the team member and immediate follow-up on the incident will be completed. Care</p>	



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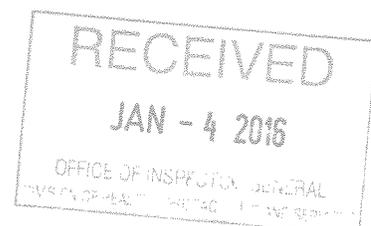
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NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF SENECA PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205	
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F 514	<p>Continued From page 29</p> <p>PM, revealed she did not document the resident's pain level on 10/29/15 and did not remember if she assessed the resident's pain at that time.</p> <p>Review of Departmental Notes completed by Licensed Practical Nurse (LPN) #1, on 10/30/15, revealed Resident #6 complained of pain to the left leg and was unable to lay the leg flat. The nurse did not document in the Departmental Note the resident's pain scale rating, the intervention used to control the pain, nor the effectiveness of the pain medication administered.</p> <p>Review of the narcotic sheet for Resident #6's Norco, dated 10/09/15, revealed the nursing staff signed as removing the medication from the narcotic drawer on 10/30/15 at 7:00 PM and on 10/31/15 at 1:00 AM. However, review of the Medication Administration Record (MAR), dated October 2015, revealed the nurse did not document the administration of the pain medication Norco on 10/30/15 or 10/31/15 nor any evidence the resident was assessed for effectiveness of the pain medication.</p> <p>Interview with LPN #1, on 11/24/15 at 4:55 PM, revealed Resident #6 reported having leg pain and stated the resident had reported pain to the nursing staff on 10/30/15. LPN #1 stated she had no knowledge of the resident having reported a fall the previous morning. She stated she did review the departmental notes and saw no notes pertaining to a fall.</p> <p>Interview with MDS Coordinator, on 11/25/15 at 10:32 AM, revealed on the morning of 10/29/15 RN #1 told the MDS Coordinator Resident #6</p>	F 514	<p>plans will be reviewed upon admission, quarterly, annually and with each change of condition. Care plan changes for falls will be initially updated on the post falls huddle form and then changes to the master care plan will be updated during the clinical start up meeting by an MDS team member, any changes made at that time will then communicated to the floor staff immediately.</p> <p>The DNS will maintain the QAPI Fall Event IDT Compliance Review Log to identify any patterns or trends and report these findings and any necessary plans of action at the monthly QAPI meeting. All findings will be reviewed in the monthly QAPI meeting, which is attended by the center's administrator, the Medical Director and other center departmental leadership team members. The QAPI Fall Event IDT Compliance Review Log will be completed monthly for 6 months and then quarterly thereafter. All findings will be reviewed in the QAPI meeting for 6 months for any additional interventions and/or suggestions recommended to maintain continued compliance. The QAPI team will determine the</p>	



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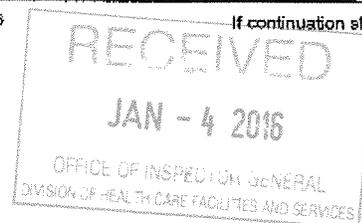
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NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF SENECA PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205		
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F 514	<p>Continued From page 30</p> <p>had fallen. She stated the nurse that work third (3rd) shift had not put an incident report into the system. The MDS Coordinator stated the RN should have completed the Resident Incident Report in the medical record per policy.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 11/25/15 at 11:10 AM, revealed the standard of care the nurses should have done after discovering a resident fall included the completion and documentation of a head to toe assessment, Range of Motion (ROM) check, skin assessment, and neurological checks. The nurse should have then documented the results of the assessments, along with vital signs, on the incident report. The ADON reviewed the incident report and stated it was not completed.</p> <p>Further interview with the DON, on 11/25/15 at 9:00 AM, revealed the nursing staff did not complete the investigation and document to ensure the resident's safety per the facility's standard. The nurse should have completed and documented vitals, a skin assessment, a pain assessment, a range of motion check, and neurological checks. However, there was no documented evidence these assessments were completed. Additionally, after the incident report was completed, nursing should have initiated the Incident Report Checklist. The checklist instructed the nurse on what information to include in the documentation, such as date and time, type of incident, location, who reported it, appearance when found, injury description, treatment order, pain level, neuro checks, range of motion, notifications, and immediate interventions. However, the facility was unable to locate an Incident Report Checklist in the</p>	F 514	<p>need for further review depending on the outcome of audits after 6 months.</p> <p>The facility will be in substantial compliance by January 1, 2016.</p>	1/1/16	



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F 514	<p>Continued From page 31</p> <p>medical record for this resident's fall. She stated the nurse should have initiated a checklist to ensure all assessments were completed and documented in the medical record according to policy.</p> <p>Interview with the Director of Clinical Operations, on 11/25/15 at 9:00 AM with the DON, revealed the staff did not complete the required documentation in the medical record. After Resident #6 fell, the nurse did not complete vitals, conduct neuro checks, or complete a range of motion assessment. As a result, the DON, Administrator, and Director of Clinical Operations were unaware of the resident's fall until after LPN #1 discovered the fracture on 10/31/15.</p> <p>Interview with the Administrator, on 11/25/15 at 3:20 PM, revealed the nursing staff did not conduct or document the appropriate assessments after the resident fell and the nurse's notes were "sketchy". The Administrator stated the lack of assessments were concerning.</p>	F 514			



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

PROVIDER NUMBER K1 185456	FACILITY NAME DIVERSICARE OF SENECA PLACE	SURVEY DATE *K4 11/25/2015
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K6 DATE OF PLAN APPROVAL 01/01/1960	K3 : MULTIPLE CONSTRUCTION TOTAL NUMBER OF BUILDINGS <u> 1 </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"/> (COMP. WITH ALL PROVISIONS)	A2 <input checked="" type="checkbox"/> (ACCEPTABLE POC)	A3 <input type="checkbox"/> (WAIVERS)	A4 <input type="checkbox"/> (FSES)	A5 <input type="checkbox"/> (PERFORMANCE BASED DESIGN)
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FACILITY DOES NOT MEET LSC: B. <input type="checkbox"/>	K180: A. <input checked="" type="checkbox"/> B. <input type="checkbox"/> C. <input type="checkbox"/> FULLY SPRINKLERED PARTIALLY SPRINKLERED NONE (All required areas are sprinklered) (Not all required areas are sprinklered) (No sprinkler system)
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*MANDATORY

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185456	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - DIVERSICARE OF SENECA PLACE B. WING _____	(X3) DATE SURVEY COMPLETED R 02/23/2016
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF SENECA PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205	
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{K 000}	INITIAL COMMENTS An onsite Life Safety Code re-visit survey was conducted on 02/23/16 and found the facility in compliance on 01/1/16 as alleged in their PoC.	{K 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

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 185456 Y1	MULTIPLE CONSTRUCTION A. Building 01 - DIVERSICARE OF SENECA PLACE B. Wing Y2	DATE OF REVISIT 2/23/2016 Y3
NAME OF FACILITY DIVERSICARE OF SENECA PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205	

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # _____	Completed
LSC K0046	11/30/2015	LSC K0147	01/01/2016	LSC _____	_____
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	_____	LSC _____	_____	LSC _____	_____
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	_____	LSC _____	_____	LSC _____	_____
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	_____	LSC _____	_____	LSC _____	_____
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	_____	LSC _____	_____	LSC _____	_____

REVIEWED BY STATE AGENCY <input checked="" type="checkbox"/>	REVIEWED BY (INITIALS) <i>KT</i>	DATE <i>02/25/16</i>	SIGNATURE OF SURVEYOR <i>Walter Zimstein</i>	DATE <i>2/25/16</i>
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 11/25/2015	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO
---	--

RECEIVED

DEC 23 2015

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NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF SENECA PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205
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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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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1960, 1962, 1970, 1991, 1998</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF DP</p> <p>TYPE OF STRUCTURE: One (1) story with a partial basement, Type III Protected.</p> <p>SMOKE COMPARTMENTS: Twelve (12) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors, upgraded in 1998.</p> <p>SPRINKLER SYSTEM: Complete automatic, dry sprinkler system, upgraded in 1998.</p> <p>GENERATOR: Type II, 125 KW rating, fuel source is diesel.</p> <p>A Recertification Life Safety Code Survey, utilizing the 2786S Short Form, was conducted on 11/25/15. 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>	K 000	<p>To the best of my knowledge and belief, as an agent of Diversicare of Seneca Place, the following plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.</p> <p>Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Kathy Jones

TITLE

Administrator

(X6) DATE

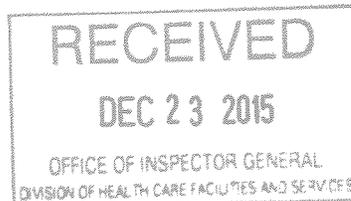
12/23/15

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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FORM APPROVED
OMB NO. 0938-0391

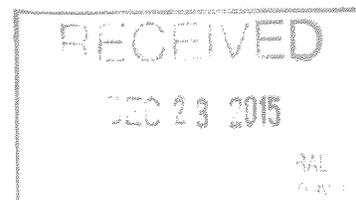
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185456	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - DIVERSICARE OF SENECA PLACE B. WING _____	(X3) DATE SURVEY COMPLETED 11/25/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF SENECA PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205	
(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)	(X6) COMPLETION DATE
K 000	Continued From page 1	K 000		
K 046 SS=D	<p>Deficiencies were cited with the highest deficiency identified at D level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide proper functioning of battery-powered emergency lighting in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect each of the twelve (12) smoke compartments, residents, staff and visitors. The facility has one-hundred and seven (107) certified beds and the census was ninety-two (92) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 11/24/15 at 10:07 AM, with the Maintenance Director revealed the battery-powered emergency light fixture located in the Emergency Generator's, Transfer Switch Room, did not function when tested.</p> <p>Interview, on 11/24/15 at 10:09 AM, with the Maintenance Director revealed the battery-powered emergency light fixture located in the Emergency Generator's Transfer Switch Room had functioned properly when it was installed new, approximately two (2) weeks prior to the date of the Survey. He stated the newly installed light fixture must have been defective</p>	K 046	<p>K046</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The battery operated emergency light fixture above the emergency generator transfer switch was reinstalled and functioning on 11/30/2015.</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice?</p> <p>All residents had the potential to be affected; however, the battery operated emergency light fixture is now functioning properly.</p> <p>What measure will be put into place or systemic changes made to ensure the deficient practice will not recur?</p> <p>The maintenance director will complete compliance rounds weekly for 4 weeks then monthly thereafter to ensure the</p>	



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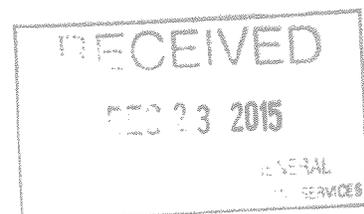
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185456	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - DIVERSICARE OF SENECA PLACE B. WING _____	(X3) DATE SURVEY COMPLETED 11/25/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF SENECA PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3626 DUTCHMANS LANE LOUISVILLE, KY 40205	
(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 046	<p>Continued From page 2 when it was installed new.</p> <p>The census of ninety-two (92) was verified by the Administrator on 11/24/15. The survey findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 11/24/15.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.9.2.1* Emergency illumination shall be provided for not less than 11/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 11/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.</p> <p>7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.</p> <p>Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment</p>	K 046	<p>emergency light is functioning properly. The Maintenance Director was educated by the administrator and regional maintenance on the life safety code regarding the importance of the functionality of the battery operated emergency light fixture above the transfer switch on 12/21/2015.</p> <p>How will the facility monitor performance to ensure solutions are sustained?</p> <p>To maintain continued compliance, the maintenance director will include the emergency lighting fixture on his weekly preventative maintenance rounds. The administrator will review the weekly audits to ensure the fixture continues to be functioning. All findings will be reviewed in the monthly QAPI meeting, which is attended by the center's administrator, the Medical Director and other center departmental leaders. The findings will be reviewed in QAPI for 3 months for any additional interventions and suggestions that the QAPI team may recommend to maintain continued compliance. The QAPI team will determine the need for further review depending on the</p>	



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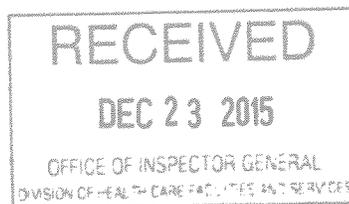
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185456	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - DIVERSICARE OF SENECA PLACE B. WING _____	(X3) DATE SURVEY COMPLETED 11/25/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF SENECA PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205	
(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 046	Continued From page 3 that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046	outcome of audits after 3 months. The facility was in substantial compliance by 11/30/2015.	11/30/15
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of twelve (12) smoke compartments, approximately eighteen (18) residents, staff, and visitors. The facility has one-hundred and seven (107) certified beds and the census was ninety-two (92) on the day of the survey. The findings include: Observation, on 11/24/15 at 10:21 AM, with the Maintenance Director revealed a TV and a DVD player were plugged into an extension cord located at Bed 2 in Resident Room A11. Interview, on 11/24/15 at 10:23 AM, with the Maintenance Director revealed he was not aware of an extension cord being used to power the TV	K 147	K147 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The extension cord in room A11 Bed B was removed on 12/21/2015 after installing another receptacle for TV and DVD use. How will the facility identify other residents having the potential to be affected by the same deficient practice? The maintenance director completed a 100% audit of all rooms in the facility and identified all rooms that needed to eliminate extension cords and replace with accepted receptacles. What measure will be put into place or systemic changes made to ensure the deficient practice will not recur?	



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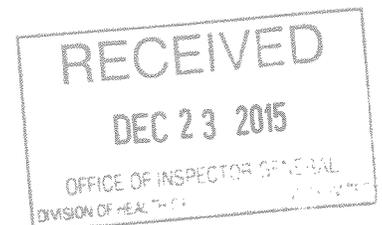
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185456	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - DIVERSICARE OF SENECA PLACE B. WING _____		(X3) DATE SURVEY COMPLETED 11/25/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF SENECA PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205		
(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 147	<p>Continued From page 4 and DVD player located at Bed 2 in Resident Room A11.</p> <p>The census of ninety-two (92) was verified by the Administrator on 10/14/15. The findings were acknowledged by the Administrator and verified by the Maintenance Tech at the exit interview on 10/14/15.</p> <p>Reference: NFPA 99 (1999 edition).</p> <p>3-3.2.1.2 (D) Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.</p> <p>Reference: NFPA 70 (1999 Edition).</p> <p>400-8 (Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or</p>	K 147	<p>The maintenance director will complete compliance rounds weekly for 4 weeks then monthly thereafter to ensure the facility is not using extension cords or multiple plug adaptors. The facility's staff will be educated on not utilizing extension cords in the center by the Administrator and/or the director of Nursing by Jan. 1, 2015. Family members and/or responsible parties of all residents were notified via letter from the administrator on 12/9/2015 for the need for each of them to ensure their loved one does not have an extension cord. The letter stated that the responsible parties needed to take the extension cords home and stated the facility would try to replace the need for the extra plug ins on an Individualized basis.</p> <p>How will the facility monitor performance to ensure solutions are sustained?</p> <p>To maintain continued compliance, the maintenance director will include an audit of extension cords on his weekly preventative maintenance rounds. The administrator will review the weekly audits for 4 weeks then monthly to ensure no residents are utilizing an</p>		



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185456	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - DIVERSICARE OF SENECA PLACE B. WING _____	(X3) DATE SURVEY COMPLETED 11/25/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF SENECA PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40206	
(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 147	Continued From page 5 similar openings (4) Where attached to building surfaces	K 147	extension cord. All findings will be reviewed in the monthly QAPI meeting, which is attended by the center's administrator, the Medical Director and other center departmental leaders. The findings will be reviewed in QAPI for 3 months for any additional interventions and suggestions that the QAPI team may recommend to maintain continued compliance. The QAPI team will determine the need for further review depending on the outcome of audits after 3 months. The facility was in substantial compliance by Jan. 1, 2016.	1/1/16



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185456	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - DIVERSICARE OF SENECA PLACE B. WING _____	(X3) DATE SURVEY COMPLETED R 02/23/2016
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NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF SENECA PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205
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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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{K 000}	<p>INITIAL COMMENTS</p> <p>An onsite re-visit for the Life Safety Code Comparative Federal Monitoring survey was conducted on 02/23/16 and found the facility in compliance on 01/07/16 as alleged in their PoC.</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

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 185456	Y1	MULTIPLE CONSTRUCTION A. Building 01 - DIVERSICARE OF SENECA PLACE B. Wing	Y2	DATE OF REVISIT 2/23/2016	Y3
NAME OF FACILITY DIVERSICARE OF SENECA PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205		

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix _____ Reg. # NFPA 101 LSC K0052	Correction Completed 01/07/2016	ID Prefix _____ Reg. # NFPA 101 LSC K0062	Correction Completed 01/07/2016	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 STATE AGENCY <input checked="" type="checkbox"/>	REVIEWED BY (INITIALS) <i>LT</i>	DATE <i>02/25/16</i>	SIGNATURE OF SURVEYOR <i>Melita Zumatun</i>	DATE <i>2/25/16</i>
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 12/28/2015	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/08/2016
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185456	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - DIVERSICARE OF SENECA PLACE B. WING _____	(X3) DATE SURVEY COMPLETED 12/28/2015
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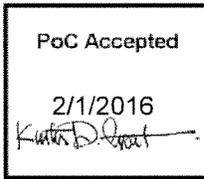
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF SENECA PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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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K 000 INITIAL COMMENTS

K 000

Stories: 1
Construction Type: V (000)
Constructed: 1995
Sprinkled: Yes
Census: 83
Certified beds: 109



To the best of my knowledge and belief, as an agent of Diversicare of Seneca Place, the following plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.

Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.

A Life Safety Code Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 12/28/2015 following a Kentucky Cabinet for Health and Family Service, Office of the Inspector General survey on 11/25/2015. At this Comparative Federal Monitoring Survey, Diversicare of Seneca Place was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101 - 2000 edition.

The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:

K 052 NFPA 101 LIFE SAFETY CODE STANDARD
SS=E

K 052

A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4

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

Kathy Jones

TITLE

LHA

(X6) DATE

1/29/16

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

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

PRINTED: 01/08/2016
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185456	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - DIVERSICARE OF SENECA PLACE B. WING _____	(X3) DATE SURVEY COMPLETED 12/28/2015
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NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF SENECA PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3626 DUTCHMANS LANE LOUISVILLE, KY 40205
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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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K 052 Continued From page 1

K 052

Diversicare of Seneca Place strives to ensure that all automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested.

This STANDARD is not met as evidenced by:
Based on review of the fire alarm inspection and testing documents and staff interview, the facility failed to maintain the fire alarm system per the requirements of:

2000 NFPA 101 Section 19.3.4.1, 9.6.1.4,
4.6.12.1

1999 NFPA 72 Section 7-1.1.2

The deficiency affected three of seven smoke compartments.

On 12/28/2015 at 3:45 p.m., the fire alarm inspection and testing report prepared by Koosen on 10/29/2015 indicated the FACP (Fire Alarm Control Panel) batteries failed when tested for E, F and G halls. The facility did not have work order showing that the batteries were replaced.

The Maintenance Director was present when the deficiency was identified.

Failure to maintain and complete repairs of the Fire Alarm System increases the risk of death or injury due to smoke and fire.

K 062 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D

Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested

Although the fire panel was fully operational, per the vendor's recommendation, the batteries were replaced on 12/29/2015. No residents were affected by this practice.

The fire panel batteries were replaced on 12/29/2015.

The batteries were replaced on 12/29/2015; therefore, no residents are potentially affected by the deficient practice.

The Regional Maintenance Director visited the Center on 1/7/16 and verified compliance.

Administrator will request and review all reports from the fire alarm company to ensure compliance.

The Maintenance Director will conduct a monthly fire panel audit to include testing the batteries, in addition to the fire alarm system contracted company's

K 062

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

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OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185466	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - DIVERSICARE OF SENECA PLACE B. WING _____	(X3) DATE SURVEY COMPLETED 12/28/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF SENECA PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205	
(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)
K 062	<p>Continued From page 2</p> <p>periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to meet the requirements for properly maintaining the automatic sprinkler system per the requirements of:</p> <p>2000 NFPA 101 Section 19.3.5.1, 9.7.5 1998 NFPA 25 2-2.1.3, 2-4.1.4, 2-4.1.5 and 2000 NFPA 101 Section 19.5.1, 9.1.2 1999 NFPA 70 Article 370-28(c)</p> <p>The deficiency affected one of four sprinkler types in the building.</p> <p>On 12/28/2015: At 3:30 p.m., there were no spare QR (quick response) sprinklers with red frangible bulbs in the spare sprinkler box in the riser room. The box was not mounted on the wall. An electrical junction box in the riser room did not have a cover plate.</p> <p>The Maintenance Director was present when the deficiencies were identified.</p>	K 062	<p>routine inspections. The monthly audit will be completed for 6 months. Results of the audits will be reviewed in the safety committee meeting monthly as well as the monthly Quality Assurance and Process Improvement Meeting. The safety committee and QAPI members will review and determine the need for further action.</p> <p>12/29/2015.</p> <p>K062</p> <p>Diversicare of Seneca Place endeavors to ensure that the facility staff monitor and maintain the automatic sprinkler system per regulations.</p> <p>No residents were impacted. The facility purchased extra sprinkler heads on 1/7/2016.</p> <p>The sprinkler box was mounted to the wall on 1/7/2016 and the electrical junction box in the riser room had a cover plate added on 1/7/2016.</p> <p>An audit of the facility's sprinkler system was completed on 1/7/2016. Spare sprinklers were added on 1/7/16. No residents were affected.</p>

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: 185456	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - DIVERSICARE OF SENECA PLACE B. WING _____		(X3) DATE SURVEY COMPLETED 12/28/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF SENECA PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205		
(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 062 C		K 062	<p>The Regional Maintenance Director visited the Center on 1/5/15 and 1/7/16 and verified compliance. The sprinkler box with spare sprinklers being mounted to wall and cover plate on junction box will be audited monthly to ensure compliance.</p> <p>The Maintenance director and/or the Maintenance Assistant will complete a monthly check of extra sprinkler heads to ensure they continue to be available if needed and audit that box is mounted to wall and electrical junction box has a cover plate. The results of the audit will be reviewed in the monthly safety meeting for 3 months as well as the QAPI meeting for 3 months. The safety committee will discuss the need for additional action.</p> <p>January 7, 2016.</p>		