

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

PRINTED: 11/12/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185423</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/19/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>EDGEWOOD ESTATES</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>195 BERRYMAN ROAD FRENCHBURG, KY 40322</b>		
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F 000	INITIAL COMMENTS	F 000			
F 164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 164		7/6/15	

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

TITLE

(X6) DATE

07/16/2015

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

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F 164	<p>Continued From page 1</p> <p>by:</p> <p>Based on observation, interview, and review of facility policy it was determined the facility failed to provide privacy during treatment for one (1) of fifteen (15) sampled residents (Resident #9). On 06/17/15, facility staff failed to provide privacy during "Foley" (an indwelling catheter) catheter care and during a skin assessment; staff did not close the window blinds. Resident #9's window faced the facility's courtyard.</p> <p>The findings include:</p> <p>Interview with the facility Administrator on 06/19/15 at 1:41 PM, revealed the facility did not have a policy related to providing privacy during resident care and treatment.</p> <p>Observation of facility staff on 06/17/15 at 3:00 PM, revealed staff provided Foley catheter care and conducted a skin assessment on Resident #9. The resident was in bed in his/her room and was not clothed during this observation. The resident's bed was by the window and the window faced the courtyard on the ground floor. Staff failed to close the window blinds.</p> <p>Review of Resident #9's medical record revealed the facility admitted the resident on 01/02/15 with diagnoses which included Depression, Anxiety, Congestive Heart Failure, Hypertension, Senile Dementia, Atrial Fibrillation, and Morbid Obesity. Review of the most recent Quarterly Minimum Data Set (MDS) dated 05/22/15, revealed the facility assessed Resident #9 to have a Brief Interview for Mental Status (BIMS) score of 13, which indicated the facility assessed Resident #9 to be cognitively intact.</p>	F 164			

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F 164	<p>Continued From page 2</p> <p>Interview conducted with State Registered Nurse Aide (SRNA) #7 on 06/17/15 at 3:10 PM, revealed she did not notice the window blinds were open when she provided care to the resident. SRNA #7 stated she should have closed the window blinds before she provided care to the resident.</p> <p>Interview with Registered Nurse (RN) #1 on 06/17/15 at 3:15 PM, revealed that after she started conducting a skin assessment on Resident #9 she noticed the window blinds were open. She stated she tried to close the blinds but the blinds would not close. The RN stated she should not have continued with care as the resident was exposed and privacy was not provided.</p> <p>Interview with Resident #9 on 06/19/15 at 3:56 PM revealed it would bother him/her if someone was able to look through the window and see him/her nude while the staff was providing care.</p> <p>Interview with the South Unit Manager on 06/19/15 at 1:09 PM revealed she conducted rounds at least two (2) times a week, but she had no way of actually monitoring to ensure privacy was provided during resident care and/or treatment. Continued interview with the South Unit Manager revealed she expected all staff to make sure privacy curtains were pulled and window blinds were closed when providing care and/or treatment to residents.</p> <p>Interview with the Director of Nursing (DON) on 06/19/15 at 1:22 PM, revealed she conducted monthly rounds which included looking at nine (9) to twelve (12) residents. Continued interview with the DON revealed she expected the privacy</p>	F 164			

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F 164	Continued From page 3 curtains to be pulled, the window blinds to be closed at all times, and the door to the room to be closed if possible while staff provided care and/or treatment to residents.	F 164			
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS  The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review it was determined the facility failed to ensure that two (2) of fifteen (15) sampled residents (Residents #7 and #11) were as free from restraints as possible. On 06/16/15, the facility failed to remove a lap buddy restraint from Resident #7 during the lunch meal service. On 06/18/15, Resident #11 was observed in a wheelchair with a self-release seatbelt in place. However, the resident was not able to release the seatbelt when asked and was not assessed by the facility to use a restraint.  The findings include:  Review of the facility's policy titled "Restraints," with a revision date of 04/09/14, revealed the facility would define restraints per federal regulations, provide education/information concerning the risks and benefits of restraint use, and obtain informed consent prior to the use of a restraint. Further review of the policy revealed the definition of physical restraints was any	F 221		7/6/15	

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F 221	<p>Continued From page 4</p> <p>manual method or physical or mechanical device, or equipment attached or adjacent to the resident's body, that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.</p> <p>Observation of Resident #7 on 06/16/15 at 12:40 PM revealed the resident had a lap buddy device and a lap tray present on his/her wheelchair during the lunch meal service.</p> <p>Review of Resident #7's medical record revealed the facility admitted Resident #7 on 02/22/10 with diagnoses which included Osteoarthritis, Malaise and Fatigue, Alzheimer's Disease, Muscle Weakness, Depression, Anemia, Legal Blindness, Hypertension, and Congestive Heart Failure.</p> <p>Review of the most recent Quarterly Minimum Data Set (MDS) assessment dated 04/15/15, revealed the facility assessed Resident #7 to have a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident was severely impaired cognitively. Continued review of the Quarterly MDS assessment revealed the facility assessed Resident #7 to use a trunk restraint daily when out of bed.</p> <p>Further review of Resident #7's medical record revealed the facility had assessed Resident #7 to utilize a lap buddy restraint to the wheelchair due to poor safety awareness, poor judgment, and impaired vision. Review of the Comprehensive Care Plan dated 04/21/15, revealed an intervention to remove the lap buddy and use the lap tray during meals. Review of Resident #7's current Treatment Administration Record (TAR), dated 06/01/15, revealed staff was to remove the</p>	F 221			

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F 221	<p>Continued From page 5</p> <p>lap buddy and use the lap tray during meals.</p> <p>Interview with State Registered Nurse Aide (SRNA) #3 on 06/19/15 at 9:38 AM revealed she looked on the resident's profile page (care plan) in the computer system in order to find out what type of care was required for each resident. Continued interview with SRNA #3 revealed when Resident #7 was eating, the lap buddy was to be removed and the lap tray used. Further interview with SRNA #3 revealed she was "nervous" because she was being watched and forgot to remove the lap buddy while Resident #7 was eating lunch on 06/16/15.</p> <p>Interview with the South Unit Manager on 06/19/15 at 1:09 PM revealed all nursing staff was to review the residents' care plans daily. Continued interview with the South Unit Manager revealed she conducted rounds two (2) times a week to ensure residents' care plans were being followed to include ensuring restraints were removed as ordered. The Unit Manager stated she had not identified any concerns.</p> <p>Interview with the Director of Nursing (DON) on 06/19/15 at 1:22 PM, revealed the nurse aides were to sign off daily that they had reviewed each resident's plan of care. Further interview with the DON revealed all nurses were to review each resident's plan of care on a daily basis. The DON stated she conducted rounds monthly to ensure care plans were being followed and resident care needs were met, and she had not identified any concerns related to restraint use.</p> <p>Interview with the Administrator on 06/19/15 at 1:41 PM, revealed she attended weekly care plan meetings for residents. Continued interview with</p>	F 221			

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F 221	<p>Continued From page 6</p> <p>the Administrator revealed all Nursing Department Heads had a "huddle" every morning to discuss any changes in residents' care. The Administrator stated she conducted rounds daily to ensure the residents' "well-being." She stated she had not identified any concerns.</p> <p>2. Record review revealed the facility assessed Resident #11 to be severely impaired for cognition. The resident had diagnoses of Senile Dementia, Anxiety, and Agitation. Review of the most recent Quarterly MDS assessment dated 04/05/15, revealed the facility assessed Resident #11 as not utilizing a restraint.</p> <p>Observations of Resident #11 conducted on 06/18/15 at 12:45 PM, 2:15 PM, and 3:00 PM revealed the resident was sitting in a wheelchair with a lap belt applied.</p> <p>Observations on 06/18/15 at 2:15 PM, revealed Resident #11 was asked to remove the lap belt by State Registered Nurse Aide (SRNA) #4 and the resident could not remove the lap belt. At 2:20 PM on the same day, Resident #11 was asked to remove the lap belt by Licensed Practical Nurse (LPN) #2 and again the resident could not remove the belt.</p> <p>Interview with the North Wing Unit Manager on 06/18/15 at 6:30 PM, revealed the Unit Manager occasionally evaluated Resident #11's ability to remove the lap belt but did not do this daily. According to the Unit Manager, she was not aware that Resident #11 could not release the lap belt. Further interview revealed the resident could release the belt approximately two weeks prior to 06/18/15 when she assessed the resident.</p>	F 221			

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F 221	Continued From page 7  An interview with the MDS Coordinator on 06/18/15 at 5:50 PM, revealed the MDS Coordinator had completed the MDS assessment on 04/15/15. She stated she did not assess the lap belt as a restraint for the resident because the resident could release the belt. According to the MDS Coordinator, if a resident could not release the lap belt it would be considered a restraint and assessed on the MDS assessment.  An interview with the Director of Nursing (DON) on 06/19/15, revealed Resident #11 received the lap belt as a fall intervention in February 2015. The DON said at that time the resident could release the belt and the belt was not considered a restraint. According to the DON, she was not aware the resident could not release the belt until 06/18/15 when staff requested the belt to be removed and the resident could not release the belt.	F 221			
F 224 SS=G	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy it was determined the facility failed to protect one (1) of fifteen (15)	F 224		7/13/15	

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F 224	<p>Continued From page 8</p> <p>sampled residents (Resident #13) from neglect. Facility policy required the use of a gait belt when assisting residents to transfer and ambulate. On 04/21/15, two (2) State Registered Nurse Aides (SRNAs) assisted Resident #13 to the bathroom where the resident started to fall and was lowered to the floor. When lifting the resident up from the floor, the SRNAs heard a pop. An x-ray of the resident's left arm revealed a fractured humerus. Although both SRNAs had been trained and knew the use of a gait belt was required, the SRNAs failed to use a gait belt when assisting Resident #13 to the bathroom.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Resident Abuse and Neglect," revision date of 01/09/15, revealed neglect was defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.</p> <p>Review of the facility's policy titled "General Safety Rules," date unknown, revealed, "All resident ambulation shall be accomplished with the use of a gait belt. No exceptions!" Review of the facility's policy titled "Fall Protocol," revision date of 05/01/14, revealed residents should be transferred using a gait belt.</p> <p>Record review revealed the facility originally admitted the resident on 08/02/13, and readmitted the resident on 03/31/15 with diagnoses which included Cerebral Vascular Accident (CVA), Left Arm Weakness related to CVA, Osteoarthritis, and Chronic Pain. Review of the Quarterly Minimum Data Set (MDS) assessment completed on 04/07/15, revealed the facility assessed the resident's Brief Interview for</p>	F 224			

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F 224	<p>Continued From page 9</p> <p>Mental Status (BIMS) score to be 11. The facility assessed the resident's cognition to be moderately impaired; however, the resident was interviewable. Further review of the MDS assessment revealed the facility assessed the resident to require extensive assistance with two (2) plus person physical assist with transfers.</p> <p>Review of the "Profile Care Plan Approaches" and the Comprehensive Care Plan, dated 12/28/13, revealed the facility determined the resident required one (1) to two (2) person assist with transfers.</p> <p>Review of the facility's investigation dated 04/21/15, revealed on that date at 11:30 AM, Resident #13 was "... being transferred from the commode when resident's leg gave out." State Registered Nurse Aides (SRNAs) then had to lower the resident to the floor. When lifting the resident back to the commode, they heard a "popping" noise.</p> <p>Observations of the resident on 06/18/15 at 12:35 PM and at 1:45 PM revealed the resident was sitting up in a Geri-chair and a sling was noted to the resident's left arm. During an interview with Resident #13 on 06/18/15 at 7:45 PM, he/she stated, "They broke my arm in the bathroom." Further interview revealed the resident stated he/she was starting to fall during the transfer and they (the SRNAs) "caught me."</p> <p>Interview with SRNA #5 on 06/18/15 at 7:33 PM, revealed she and SRNA #4 were assisting Resident #13 with a transfer from the commode to the wheelchair when the resident began to lose his/her balance and started to fall. The SRNA stated as they were assisting the resident back</p>	F 224			

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F 224	<p>Continued From page 10</p> <p>onto the commode, they "heard a pop." Further interview with SRNA #5 on 06/19/15 at 10:17 AM, revealed the SRNAs were not using a gait belt during the transfer of Resident #13 on 04/21/15. She stated she had been trained to use gait belts with transfers and had received a verbal write-up for not using one during the transfer. According to the facility's Fall Protocol policy, residents should be transferred using a gait belt.</p> <p>Interview with SRNA #4 on 06/18/15 at 7:59 PM, revealed she was assisting the resident on his/her left side during the transfer. The SRNA stated that the resident was starting to fall and the two (2) SRNAs assisted him/her back to the commode. SRNA #4 stated, "We heard it pop and I knew it was broke." Further interview with the SRNA on 06/18/15 at 8:49 PM, revealed a gait belt was not used during the transfer. The SRNA stated they had been trained to use gait belts with all transfers and had received a verbal write-up for not using a gait belt during the transfer.</p> <p>Review of the x-ray of Resident #13's left humerus and forearm, dated 04/21/15 at 2:04 PM, revealed an "acute proximal humeral and humeral neck fracture. Component of impaction at the fracture site."</p> <p>Review of the "Employee Counseling Form" dated 04/22/15, addressed to SRNAs #4 and #5 revealed verbal counseling related to noncompliance with standard of care. Further review revealed the stated problem being the SRNAs "... did not use gait belt when transferring resident, resulting in fracture."</p> <p>Interview with the Administrator and Director of</p>	F 224			

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F 224	Continued From page 11 Nursing (DON) on 06/18/15 at 8:45 PM revealed it was the facility's policy to use gait belts with all transfers. The DON stated, "They should have been using a gait belt."	F 224			
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).  The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.  The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and	F 225		7/6/15	

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F 225	<p>Continued From page 12</p> <p>certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy it was determined the facility failed to ensure an incident of alleged neglect was reported to the State Survey Agency for one (1) of fifteen (15) sampled residents (Resident #13). Facility staff transferred Resident #13 on 04/21/15 without utilizing a gait belt. The resident started to fall and was lowered to the floor. When staff was helping the resident up, a popping sound was heard. An x-ray obtained on 04/21/15 revealed a fracture to the resident's left humerus. The facility investigated the incident and determined staff's failure to utilize the gait belt when transferring the resident resulted in the fracture to the resident's left arm. However, the facility did not report this allegation of neglect to the State Survey Agency.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Resident Abuse and Neglect," revision date of 01/09/15, revealed, "All alleged violations involving mistreatment, suspicious bruising, abuse, or neglect, including injuries of unknown source and misappropriation of resident property are to be reported immediately to other officials outlined in state law, through established procedures, including state survey and certification agency."</p> <p>Record review revealed the facility admitted the</p>	F 225			

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F 225	<p>Continued From page 13</p> <p>resident on 08/02/13, and readmitted him/her on 03/31/15 with diagnoses that included Cerebral Vascular Accident (CVA), Left Arm Weakness related to CVA, Osteoarthritis, and Chronic Pain. Review of the Quarterly Minimum Data Set (MDS) completed on 04/07/15, revealed the facility assessed the resident to require extensive assistance with two (2) plus person physical assist with transfers. Further review of the MDS assessment revealed the facility assessed the resident's Brief Interview for Mental Status (BIMS) score to be 11, determining the resident to be interviewable. Review of the "Profile Care Plan Approaches" and the Care Plan, dated 12/28/13, revealed the facility determined an approach for the resident to require one (1) to two (2) person assist with transfers.</p> <p>Observations of the resident on 06/18/15 at 12:35 PM and 1:45 PM, revealed the resident to be sitting up in a Geri-chair and a sling noted to the left arm.</p> <p>Review of the facility's investigation, dated 04/21/15 at 11:30 AM, revealed State Registered Nurse Aides (SRNAs) #4 and #5 were assisting Resident #13 with a transfer from the commode, during which the resident began to fall prompting the SRNAs to transfer the resident back to the commode. Resident #13 sustained a humeral fracture of his/her left arm.</p> <p>Review of the "Employee Counseling Form" dated 04/22/15, addressed to SRNAs #4 and #5 revealed verbal counseling related to noncompliance with standard of care. Further review revealed the stated problem being the SRNAs " ...did not use gait belt when transferring resident, resulting in fracture."</p>	F 225			

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F 225	Continued From page 14  Interview with the Director of Nursing on 06/18/15 at 9:05 PM revealed, "It should be a part of the investigation to see if a gait belt was used. If I wrote them up for not using a gait belt then I found a problem with the transfer." Further interview on 06/19/15 at 1:18 PM revealed the DON had done verbal counseling with SRNAs #4 and #5 related to not using a gait belt during the transfer of Resident #13. The DON stated using gait belts for transfers was a facilitywide policy. She further stated, "We knew what happened. We didn't think it was neglect, which was why we didn't report." The DON stated, "We should have reported."  Interview with the Administrator on 06/18/15 at 9:18 PM, revealed it was facility policy to use gait belts with all transfers. The Administrator stated not providing goods and services per policy would be considered neglect. Further interview revealed it was the Administrator's responsibility to report concerns of neglect and the incident should have been reported.	F 225			
F 279 SS=G	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279		7/13/15	

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F 279	<p>Continued From page 15</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure comprehensive plans of care were developed that addressed the care needs for one (1) of fifteen (15) sampled residents (Residents #13) related to the utilization of gait belts for transfers. The facility assessed Resident #13 to require extensive assistance of two (2) staff persons with transfers and had a facility policy to use gait belts with all transfers. However, facility staff failed to utilize a gait belt during a transfer of Resident #13 on 04/21/15, resulting in a humeral fracture of the resident's left arm.</p> <p>Although the comprehensive care plan identified that Resident #13 needed assistance with transfers, the plan of care failed to include the intervention for staff to utilize a gait belt when transferring or ambulating the resident. In addition, the care plan interventions were also unclear on the number of staff required to assist the resident with transfers. The plan of care directed that one to two staff persons assist the resident with transfers.</p>	F 279			

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F 279	<p>Continued From page 16</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Care Planning for the Resident," review date of 05/01/14, revealed the objection was to develop a plan of care to "... ensure care and services are provided to help each resident improve as possible and maintain the highest practicable well-being." Further review of the policy revealed the Interdisciplinary Care Plan Team was responsible for the development of an individual comprehensive plan of care for each resident. The policy also stated that clinical approaches that require quick reference when providing care would be identified on the resident profile (nurse aide care plan).</p> <p>Review of the facility's policy titled "General Safety Rules," date unknown, stated, "All resident ambulation shall be accomplished with the use of a gait belt. No exceptions!"</p> <p>Review of the facility's policy titled "Fall Protocol," revision date of 05/01/14, revealed residents should be transferred using a gait belt.</p> <p>Record review revealed the facility admitted the resident on 08/02/13. The resident was readmitted on 03/31/15 with diagnoses that included Cerebral Vascular Accident (CVA), Left Arm Weakness related to CVA, Osteoarthritis, and Chronic Pain.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment completed on 04/07/15, revealed the facility assessed the resident's Brief Interview for Mental Status (BIMS) score to be 11, determining the resident's cognition to be moderately impaired. The resident was assessed</p>	F 279			

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F 279	<p>Continued From page 17</p> <p>to be interviewable. Further review of the MDS assessment revealed the facility assessed the resident to require the physical extensive assistance of two (2) plus persons with transfers.</p> <p>Review of the facility's investigation dated 04/21/15 at 11:30 AM revealed two (2) State Registered Nurse Aides (SRNAs) were assisting Resident #13 with a transfer from the commode. The resident began to fall and the SRNAs lifted the resident back to the commode. During this transfer, the SRNAs heard a "pop." After an assessment was completed, a left forearm x-ray was ordered and completed. Review of the x-ray, dated 04/21/15 at 2:04 PM, revealed a humeral fracture of the resident's left arm. Further review of the facility's investigation revealed the SRNAs received verbal counseling related to not using a gait belt during the transfer of Resident #13, which resulted in a fracture.</p> <p>Review of the "Profile Care Plan Approaches," used by the facility as the Nurse Aide Care Guide and the Comprehensive Care Plan, both dated 12/28/13, revealed the facility assessed the resident to require one (1) to two (2) person assist with transfers. The plan of care did not specify whether one (1) person assist or two (2) person assist should be provided. Neither did the Profile Care Plan Approaches or the Comprehensive Care Plan instruct staff to use a gait belt during transfers of Resident #13.</p> <p>Interview with SRNA #4 on 06/18/15 at 8:49 PM revealed she was responsible for following the nurse aide care plan daily and using a gait belt was not a care area listed on the care plan. Further interview revealed the nurse aide care plan was the guide for care required by the</p>	F 279			

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F 279	<p>Continued From page 18</p> <p>residents. The SRNA stated she was aware of the gait belt use policy; however, a gait belt was not used during the transfer of Resident #13 on 04/21/15. The inappropriate transfer resulted in a humeral fracture of the resident's left arm.</p> <p>Interview with SRNA #5 on 06/19/15 at 10:17 AM, revealed a gait belt was not used during the transfer of Resident #13 on 04/21/15. She stated the information was not listed on the nurse aide care plan. The SRNA stated she was responsible for reviewing and following the nurse aide care plan daily.</p> <p>Interview with Unit Manager (UM) #1 on 06/19/15 at 12:28 PM, revealed she was a part of the Interdisciplinary Care Planning Team that was involved with the development of residents' comprehensive care plans. The UM stated that staff was responsible for reviewing and following the care plan for each resident. According to the UM, staff was to utilize the gait belt when assisting residents with transfers and ambulation. The UM stated since it was facility policy to use the gait belt, the use of the gait belt was not included as an intervention on the resident's comprehensive plan of care or the nurse aide plan of care. She further stated she had identified a concern with the lack of gait belt usage during rounds and she had increased rounds. The UM said she constantly reminded staff to use gait belts.</p> <p>Interview with the Director of Nursing (DON) on 06/19/15 at 1:18 PM revealed using gait belts with transfers and ambulation was a facility policy; however, because this was a "facilitywide policy it is not care planned." Further interview revealed nurse aides were expected to review and sign the</p>	F 279			

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F 279	Continued From page 19 care plan needs sheet daily. The nurses were expected to review the care needs daily as well.  Interview with the Administrator on 06/19/15 at 1:39 PM revealed direct care staff should be reviewing and following the resident care needs daily. Further interview revealed using a gait belt should have been addressed on the care plan for Resident #13.	F 279			
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review it was determined the facility failed to follow and implement interventions in the plan of care for four (4) of fifteen (15) sampled residents (Residents #3, #5, #7, and #9). Resident #3's leg brace was not applied as planned on the plan of care on 06/16/15, 06/17/15, and 06/18/15. Residents #5 and #9's indwelling urinary catheters were not anchored/secured in accordance with the plan of care. Resident #7's lap buddy restraint was not removed during mealtime per interventions in the plan of care.  The findings include:  Review of the facility's policy titled "Comprehensive Plan of Care," revised 04/09/14	F 282		7/13/15	

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F 282	<p>Continued From page 20</p> <p>revealed it was the responsibility of the Charge Nurse to ensure all interventions were followed on the care plan.</p> <p>1. Review of Resident #7's medical record revealed the facility admitted Resident #7 on 02/22/10, with diagnoses which included Osteoarthritis, Malaise and Fatigue, Alzheimer's Disease, Muscle Weakness, Depression, Anemia, Legal Blindness, Hypertension, and Congestive Heart Failure.</p> <p>Review of the most recent Quarterly Minimum Data Set (MDS) assessment dated 04/15/15 revealed the facility assessed Resident #7 to have a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident was severely cognitively impaired. Continued review of the Quarterly MDS assessment for Resident #7 revealed the facility assessed Resident #7 to use a trunk restraint daily when out of bed. Further review of Resident #7's medical record revealed the facility assessed Resident #7 to utilize a lap buddy restraint to the wheelchair due to poor safety awareness, poor judgment, and due to impaired vision. Review of the Comprehensive Care Plan for Resident #7 dated 04/21/15 revealed an intervention to remove the lap buddy and use the lap tray during meals.</p> <p>Observation of Resident #7 on 06/16/15 at 12:40 PM revealed the resident to have a lap buddy device and a lap tray present on his/her wheelchair during the lunch meal service.</p> <p>Interview with State Registered Nurse Aide (SRNA) #3 on 06/19/15 at 9:38 AM, revealed she looked on the resident's profile page (care plan) in the computer system in order to find out what</p>	F 282			

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F 282	<p>Continued From page 21</p> <p>type of care was required for each resident. Continued interview with SRNA #3 revealed when Resident #7 was eating, the lap buddy was to be removed and the lap tray used. SRNA #3 revealed she was "nervous" because she was being watched and failed to remove the lap buddy while Resident #7 was eating.</p> <p>Interview with the South Unit Manager on 06/19/15 at 1:09 PM, revealed all nursing staff was to review the resident care plans daily. Continued interview with the South Unit Manager revealed she conducted rounds two (2) times a week to ensure residents' care plans were being followed to include ensuring restraints were removed as ordered. The South Unit Manager stated she had not identified any concerns.</p> <p>Interview with the Director of Nursing (DON) on 06/19/15 at 1:22 PM, revealed the facility's nurse aides were to sign off daily that they had reviewed each resident's plan of care. Further interview revealed all nurses were to review each resident's plan of care on a daily basis. The DON stated she conducted rounds monthly to ensure care plans were being followed and residents' care needs were being met. She stated she had not identified any concerns related to restraint use.</p> <p>2. Review of Resident #9's medical record revealed the facility admitted Resident #9 on 01/02/15 with diagnoses which included Diabetes Mellitus Type II, Stage IV Kidney Disease, Urinary Retention, and Urinary Tract Infection. Review of Resident #9's most recent Quarterly Minimum Data Set (MDS) dated 05/22/15, revealed the facility assessed Resident #9 to have a Brief Interview for Mental Status (BIMS) score of 13, which indicated the facility assessed Resident #9</p>	F 282			

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F 282	<p>Continued From page 22 to be cognitively intact.</p> <p>Review of Resident #9's Comprehensive Care Plan, dated 05/28/15, revealed an intervention for the resident to have his/her catheter secured with a leg strap on at all times.</p> <p>Observation of Resident #9 during catheter care on 06/17/15 at 3:05 PM revealed Resident #9's indwelling urinary catheter was not properly secured to the resident's leg.</p> <p>Interview with SRNA #7 on 06/17/15 at 3:10 PM, revealed she had been trained on catheter care. She stated she had forgotten to make sure that the catheter was secured to Resident #9's leg after performing catheter care.</p> <p>Interview with the South Unit Manager on 06/19/15 at 1:09 PM, revealed she conducted rounds to ensure residents were receiving the proper care to include making sure indwelling urinary catheters were anchored properly. She stated she had not identified any concerns. Continued interview with the South Unit Manager revealed all indwelling urinary catheters were to be secured.</p> <p>Interview with the Director of Nursing (DON) on 06/16/15 at 1:22 PM, revealed all catheters should be secured at all times. Continued interview with the DON revealed that in the past, she had identified a concern with catheters not being secured but this was not a recent concern. Further interview with the DON revealed the nurse aides were to sign off daily indicating that they had reviewed each resident's plan of care. The DON stated all nurses were to review each resident's care plan daily. Continued interview</p>	F 282			

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F 282	<p>Continued From page 23</p> <p>with the facility revealed she conducted rounds monthly to ensure care plans were being followed and resident care needs were being met.</p> <p>3. Record review revealed the facility admitted Resident #3 on 03/12/08, with diagnoses which included Post Traumatic Brain Injury, Peripheral Neuropathy, and Right Sided Hemiparesis.</p> <p>Review of Resident #3's Quarterly Minimum Data Set (MDS) dated 04/02/15, revealed the facility assessed the resident to have limitations in range of motion on one side of the body and utilized a splint/brace during the assessment period.</p> <p>Review of Resident #3's care plan, dated 02/26/15, revealed the facility identified the resident had rehabilitation potential and developed interventions to assist the resident in maintaining his/her "highest level of functional ability within a safe environment." The care plan stated staff was required to apply a right knee immobilizer and a plantar flexion boot for eight (8) hours every day.</p> <p>Observation of Resident #3 on 06/16/15 at 3:25 PM, 4:05 PM, and 5:30 PM, and on 06/17/15 at 9:05 AM, 10:40 AM, 11:50 AM, 1:15 PM, and 6:10 PM, revealed a right knee immobilizer and plantar flexion boot were not being utilized. Further observation on 06/18/15 at 5:40 PM, with SRNA #4 revealed Resident #3's knee immobilizer and plantar flexion boot were on a chair in the resident's room.</p> <p>Interviews with SRNA #4 on 06/18/15 at 5:40 PM revealed she provided care for Resident #3 on 06/16/15, 06/17/15, and 06/18/15. She stated she was aware the resident required the</p>	F 282			

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F 282	<p>Continued From page 24</p> <p>splints/braces. SRNA #4 stated on 06/16/15, Resident #3 was combative and she could not get the splints/braces on the resident. She stated she recalled applying the devices the morning of 06/17/15 and removing the devices that day after breakfast. The SRNA stated she "may have forgot to put it back on."</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 06/18/15 at 6:45 PM revealed SRNAs were required to apply splints/braces and nurses were required to ensure they were applied. LPN #1 stated she was aware Resident #3 required splints/braces to his/her right leg; however, LPN #1 stated she did not check to ensure the resident's splints/braces were in use.</p> <p>Interview with the North Wing Unit Coordinator (Charge Nurse) on 06/19/15 at 12:55 PM revealed she was not aware staff had not applied Resident #3's splints/braces to the resident's right leg.</p> <p>4. Record review revealed the facility admitted the resident on 08/21/14 with diagnoses that included Urinary Retention and Prostate Cancer.</p> <p>Review of the Physician's Orders for Resident #5 revealed an order dated 03/06/15, for the resident to have an indwelling urinary catheter due to the diagnoses of Urinary Retention and Prostate Cancer.</p> <p>Review of a Quarterly MDS assessment dated 05/27/15, revealed the facility assessed Resident #5 to have severely impaired cognition. The facility assessed the resident to require the extensive assistance of two (2) staff persons for toileting; the resident was frequently incontinent</p>	F 282			

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F 282	<p>Continued From page 25 of bowel and required an indwelling urinary catheter.</p> <p>Review of the plan of care for Resident #5 dated 03/06/15, revealed the facility planned an intervention to secure Resident #5's urinary catheter to the resident's leg with a securing device at all times.</p> <p>Observation of catheter care for Resident #5 by SRNA #1 and SRNA #2 on 06/18/15 at 1:50 PM revealed SRNA #2 draped the catheter over Resident #5's left leg after completion of catheter care and repositioning of Resident #5. The SRNAs left the room and failed to secure the urinary catheter to the resident's leg.</p> <p>Interview conducted with SRNA #2 on 06/18/15 at 2:20 PM revealed she was aware Resident #5 required his/her urinary catheter to be anchored to his/her leg. SRNA #1 stated anchors were readily available for the SRNAs to get if needed. She stated the resident's "catheter is usually secured."</p> <p>Interview with the South Wing Unit Coordinator on 06/19/15 at 1:05 PM, revealed SRNAs were required to review residents' care plans at the beginning of each shift. She stated, "I tell them every day to look at the care plans." Further interview revealed she did rounds to make sure care plans were being followed. She stated, "One of the things I look for is that catheters are anchored."</p> <p>Interview conducted with the Director of Nursing (DON) on 06/19/15 at 1:20 PM, revealed she made rounds along with the Unit Coordinators throughout the facility to ensure residents were</p>	F 282			

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F 282	Continued From page 26 being provided care and treatment as directed by the care plans. The DON stated staff was required to secure the residents' urinary catheters. She stated, "The SRNAs are supposed to review residents' care plans daily and understand what they are supposed to do." The DON stated that she hasn't noticed an issue with care plans not being followed.	F 282			
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined that the facility failed to ensure residents who had an indwelling catheter received appropriate treatment and services to prevent trauma or injury for two (2) of fifteen (15) sampled residents (Resident #5 and Resident #9). Residents #5 and #9 required use of indwelling urinary catheters and the facility developed care plan interventions to secure the catheter tubing to prevent trauma or injury. However, observations revealed the catheter tubing was not secured for Residents #5 and #9 to prevent trauma.	F 315		7/13/15	

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F 315	<p>Continued From page 27</p> <p>The findings include:</p> <p>Review of the facility's Urinary Catheter Management Policy (dated 05/01/14) revealed how nursing staff would identify if a resident with an indwelling urinary catheter met the criteria to justify the use of the appliance. However, the facility's policy did not address how the catheter tubing would be secured to protect the resident from potential pulling, pressure, and/or potential trauma or injury to the resident's urinary tract.</p> <p>1. Review of the medical record revealed the facility admitted Resident #5 on 08/21/14, with diagnoses that included Prostate Cancer and Urinary Retention.</p> <p>Review of the Physician's Orders for Resident #5 revealed an order dated 03/06/15 for Resident #5 to have an indwelling urinary catheter due to diagnoses of Urinary Retention and Prostate Cancer.</p> <p>Review of the Minimum Data Set (MDS) assessment dated 05/27/15, revealed the facility assessed Resident #5 to have moderate impairment in cognition on his/her Brief Interview for Mental Status (BIMS), which indicated the resident was unable to be interviewed. The MDS also revealed the resident required the extensive assistance of two (2) staff persons for toileting, was frequently incontinent of bowel, and required an indwelling urinary catheter.</p> <p>Review of the Comprehensive Care Plan dated 03/06/15, revealed the facility addressed the use of the indwelling catheter for Resident #5 with interventions which included ensuring the</p>	F 315			

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F 315	<p>Continued From page 28</p> <p>drainage tubing was secured to the resident's leg at all times to prevent tension or accidental removal.</p> <p>Resident #5 was observed on 06/16/15 at 3:20 PM to be lying in bed on a pressure-relieving mattress with a urinary drainage bag hanging from the bed railing. Further observation on 06/18/15, at 1:50 PM revealed facility staff performed catheter care for Resident #5. After completion of the catheter care, the catheter tubing was not secured to prevent potential tension/trauma for Resident #5.</p> <p>Interview conducted on 06/18/15 at 2:20 PM with SRNA #2 revealed she was aware Resident #5 required his/her urinary catheter to be anchored to his/her leg. SRNA #2 stated that his/her urinary catheter was usually secured.</p> <p>2. Review of Resident #9's medical record revealed the facility admitted Resident #9 on 01/02/15 with diagnoses which included Diabetes Mellitus Type II, Stage IV Kidney Disease, Urinary Retention, and Urinary Tract Infection.</p> <p>Review of Resident #9's most recent Quarterly Minimum Data Set (MDS) dated 05/22/15 revealed the facility assessed Resident #9 to have a Brief Interview for Mental Status (BIMS) score of 13, which indicated the facility assessed Resident #9 to be cognitively intact.</p> <p>Review of Resident #9's Comprehensive Care Plan dated 05/28/15 revealed an intervention for the resident to have the catheter secured with a leg strap on at all times.</p> <p>Observation of urinary catheter care conducted</p>	F 315			

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F 315	<p>Continued From page 29</p> <p>on 06/17/15 at 3:05 PM, revealed the urinary catheter was not secured in a manner to prevent pulling and trauma. Further observation of the urinary catheter care revealed SRNA #7 did not secure the catheter tubing when cleaning the catheter tubing and was observed to pull on the unsecured tubing.</p> <p>An interview conducted with SRNA #7 on 06/17/15, revealed the SRNA forgot to secure the tubing of the catheter when providing catheter care and forgot to secure the catheter tubing to the resident's thigh. In addition, the SRNA stated she forgot to remove her gloves and wash her hands after cleaning the catheter.</p> <p>Interview conducted on 06/19/15 at 1:05 PM with the South Wing Unit Coordinator revealed SRNAs were required to review residents' care plans at the beginning of each shift. She stated that she conducted rounds to make sure care plans were being followed and looked to ensure that urinary catheters were anchored.</p> <p>Interview conducted on 06/19/15 at 1:20 PM with the Director of Nursing (DON) revealed she made rounds along with the Unit Coordinators throughout the facility to ensure residents were being provided care and treatment as directed by the care plans. The DON stated staff was required to secure urinary catheter tubing to the resident's leg to prevent trauma to the urethra.</p> <p>Interview on 06/19/15 at 1:40 PM with the Administrator revealed the facility had an indwelling catheter management policy, but it did not address catheter care.</p>	F 315			
F 318	483.25(e)(2) INCREASE/PREVENT DECREASE	F 318		7/13/15	

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F 318 SS=D	<p>Continued From page 30 IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure one (1) of fifteen (15) sampled residents (Resident #3) received treatment to prevent further decrease in range of motion. The facility failed to ensure Resident #3's splints/braces were applied to the resident's right leg as required by the resident's care plan.</p> <p>The findings include:</p> <p>Review of the facility's Comprehensive Plan of Care policy revised on 04/09/14, revealed it was the Charge Nurse's responsibility to ensure all resident care plan interventions were followed.</p> <p>Interview with the Administrator on 06/22/15 at 1:00 PM revealed the facility did not have a policy related to range of motion.</p> <p>Review of Resident #3's medical record revealed the facility admitted Resident #3 on 03/12/08 with diagnoses that included Post Traumatic Brain Injury, Peripheral Neuropathy, and Right Sided Hemiparesis.</p>	F 318			

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F 318	<p>Continued From page 31</p> <p>Review of Resident #3's Quarterly Minimum Data Set (MDS) dated 04/02/15, revealed the facility assessed the resident to have limitations in range of motion on one side of the body and the resident utilized a splint/brace during the assessment period.</p> <p>Review of Resident #3's Care Plan revealed the facility developed an intervention to apply a right knee immobilizer and a plantar flexion boot for eight (8) hours every day to assist the resident in maintaining his/her highest level of functional ability.</p> <p>Review of "Point of Care History" for Resident #3 revealed on 06/16/15, 06/17/15, and 06/18/15 staff documented "840" for the "Number of minutes for splint or brace assistance."</p> <p>An interview with the Director of Nursing (DON) on 06/18/15 at 6:00 PM revealed "840" was documented on the point of care history because staff documented that was the combined total time in minutes that the knee immobilizer and plantar flexion boot was worn by the resident. The DON further stated the time on the Point of Care History was the time that the splint/device was initiated. The DON gave no explanation as to why the time documented did not total 960 minutes (eight hours per device).</p> <p>Further review of the Point of Care History for Resident #3 revealed staff documented the resident's splint/brace was applied at 10:43 AM on 06/16/15, at 3:31 PM on 06/17/15, and at 10:46 AM on 06/18/15.</p> <p>However, observation of Resident #3 on 06/16/15 at 3:25 PM, 4:05 PM, and 5:30 PM, and on</p>	F 318			

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F 318	<p>Continued From page 32</p> <p>06/17/15 at 9:05 AM, 10:40 AM, 11:50 AM, 1:15 PM and 6:10 PM, revealed a right knee immobilizer and plantar flexion boot was not being utilized. Further observation on 06/18/15 at 5:40 PM with State Registered Nurse Aide (SRNA) #4 revealed Resident #3's knee immobilizer and plantar flexion boot were lying on a chair in the resident's room.</p> <p>Interview with SRNA #4 on 06/18/15 at 5:40 PM revealed she was aware the resident required splints/braces. SRNA #4 stated on 06/16/15, Resident #3 was combative and she could not get the splints/braces on the resident. She stated she recalled applying the devices the morning of 06/17/15 and removing the devices that day after breakfast. The SRNA stated she "may have forgot to put it back on."</p> <p>On 06/18/15 at 6:45 PM, an interview with Licensed Practical Nurse (LPN) #1 revealed SRNAs were required to apply splints/braces and nurses were required to monitor to ensure they were applied. LPN #1 stated she was aware Resident #3 required splints/braces to the right leg; however, she did not check to ensure the resident's splints/braces were in use.</p> <p>Interview with the North Wing Unit Coordinator (Charge Nurse) on 06/19/15 at 12:55 PM revealed she was not aware staff had not applied Resident #3's splints/braces to the right leg. She stated, "It is a problem that they are charting it and not doing it."</p> <p>Interview with the Administrator on 06/19/15 at 1:40 PM revealed documenting that braces were in use when they were not was a "serious issue."</p>	F 318			

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F 323 F 323 SS=G	Continued From page 33 483.25(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 observation, interview, record review, facility policy review, and review of the facility's investigation it was determined the facility failed to ensure staff utilized assistive devices when assisting one (1) of fifteen (15) sampled residents (Resident #13) to transfer and ambulate. It was facility policy to use gait belts when assisting residents with transfers and ambulation. During a transfer on 04/21/15, two (2) State Registered Nurse Aides (SRNAs) were assisting Resident #13 in the bathroom when the resident began to fall. The SRNAs were lifting the resident from the floor when they heard "a pop." An x-ray was obtained which determined the resident had a humeral fracture of the left arm.  The findings include:  Review of the facility's policy titled "General Safety Rules," date unknown, revealed all resident lifting and transfer shall be done by two (2) employees with the use of a gait belt.  Review of the facility's policy titled "Preventing Slips and Falls," date unknown, revealed steps	F 323 F 323		7/14/15	

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F 323	<p>Continued From page 34</p> <p>shall be taken by all employees to minimize the risks of slips and falls.</p> <p>Review of the facility's policy titled "Fall Protocol," with a revision date of 05/01/14, revealed transfer assistive devices such as a gait belt should be used during resident transfers.</p> <p>Record review revealed the facility admitted Resident #13 on 08/02/13 and readmitted him/her on 03/31/15 with diagnoses that included Cerebral Vascular Accident (CVA), Left Arm Weakness related to CVA, Osteoarthritis, and Chronic Pain.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment completed on 04/07/15, revealed the facility assessed the resident's Brief Interview for Mental Status (BIMS) score to be 11, determining the resident's cognition to be moderately impaired; however, the facility assessed the resident to be interviewable. Further review of the MDS assessment revealed the facility assessed the resident to require extensive assistance with two (2) plus person physical assist with transfers.</p> <p>Review of the "Profile Care Plan Approaches" and the Comprehensive Care Plan, dated 12/28/13, revealed the facility determined the resident required one (1) to two (2) person assist with transfers.</p> <p>Review of the facility's investigation dated 04/21/15 at 11:30 AM, revealed during a transfer from the commode Resident #13 began to fall. The two (2) SRNAs assisting the resident raised the resident from the floor back to the commode. During the transfer, the SRNAs heard a popping</p>	F 323			

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F 323	<p>Continued From page 35</p> <p>sound. An assessment was completed by facility staff and an x-ray was obtained. Further review revealed the SRNAs failed to use a gait belt during the transfer resulting in a humeral fracture of the resident's left arm. Further review revealed the SRNAs received verbal counseling related to the incident and not using a gait belt with the transfer that resulted in a fracture.</p> <p>Observations of the resident made on 06/18/15 at 12:35 PM and 1:45 PM, revealed the resident to be sitting up in a Geri-chair and a sling noted to the left arm. Interview with Resident #13 on 06/18/15 at 7:45 PM stated, "They broke my arm in the bathroom." Further interview revealed the resident stated he/she was starting to fall during the transfer and they (the SRNAs) "caught me."</p> <p>Interview with the Administrator and Director of Nursing (DON) on 06/18/15 at 8:45 PM, revealed it was facility policy to use gait belts with all resident transfers and the staff was expected to use them.</p> <p>Interview with SRNA #4 on 06/18/15 at 8:49 PM, revealed although she had been trained to use a gait belt during transfers, a gait belt was not used during the transfer of Resident #13 on 04/21/15.</p> <p>Interview with SRNA #5 on 06/19/15 at 10:17 AM, revealed that she had also been trained to use gait belts during resident transfers. However, she failed to use one during the transfer of Resident #13.</p> <p>Interview with Unit Manager (UM) #1 on 06/19/15 at 12:28 PM revealed she was responsible for monitoring gait belt use and she had identified a problem prior to the incident. The UM stated she</p>	F 323			

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F 323	Continued From page 36 had increased the frequency that she conducted rounds and constantly reminded staff to use gait belts.	F 323			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review it was determined the facility failed to serve food under sanitary conditions for twenty-four (24) of twenty-four (24) residents who ate in the dining room. Observation on 06/16/15 revealed Dietary Aide (DA) #1 removed a pair of soiled gloves and placed them on the side of the steam table close to the clean plates where food preparation was in progress.  The findings include:  Review of the facility's policy titled "Kitchen/Service Area Sanitation," with a review date of 03/04/13, revealed, "The Nutrition Service Department shall practice a strict environment sanitation program."	F 371		6/26/15	

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F 371	Continued From page 37  Observation made on 06/16/15 at 5:00 PM revealed DA #1 removed a soiled pair of gloves and placed them on the side of the steam table during the evening meal service prior to preparing trays for the residents that were to eat in the dining room. She placed the gloves between the steam table lids and the clean plates.  Interview with the Dietary Manager (DM) on 06/18/15 at 2:40 PM revealed the area that DA #1 placed her gloves was considered a "clean" area. The DM stated soiled gloves should not be placed in that area. Further interview with the DM revealed it was her responsibility to monitor kitchen sanitation and she had not identified concerns with staff not properly disposing of soiled gloves.  Interview with DA #1 on 06/18/15 at 3:34 PM revealed her soiled gloves should not have been placed in a clean area. Further interview revealed the DA had immediately sanitized the area after realizing she had placed the soiled gloves in a clean area. DA #1 stated the soiled gloves should have been disposed in the garbage.	F 371			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		7/14/15	

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F 431	Continued From page 38  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of facility policy, it was determined the facility failed to ensure medications were accurately labeled and expired medications were removed from stock and discarded for three (3) unsampled residents (Residents A, B, and C). The pharmacy had supplied Resident A with a medication that was mislabeled with the wrong dose. Residents B and C had open vials of insulin that were	F 431			

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F 431	<p>Continued From page 39 expired and available for resident use.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>An interview conducted with the Director of Nursing (DON) on 06/18/15 at 7:00 PM revealed the facility did not have a policy specific to pharmacy labels. According to the DON, the labels were supplied by the pharmacy.</li> </ol> <p>Observation of the medication administration for Resident A on 06/17/15 at 3:25 PM, revealed the resident's medication AZO Standard (a drug used for urinary pain relief) was labeled as 95 milligrams (mg) on the pharmacy label adhered to the box. Review of the box and the medication packages revealed the actual dosage of the medication was 97.5 mg. Review of the physician's order for Resident A revealed the resident was to receive 97.5 mg of the AZO Standard.</p> <p>An interview conducted with the facility's Pharmacist on 06/18/15 at 6:05 PM, revealed the medication was provided by the resident's family and labels were sent to the facility for the medication. According to the Pharmacist, he checked the medications monthly to ensure correct labeling and he did not notice the labels were printed with the wrong dosage.</p> <ol style="list-style-type: none"> <li>Review of the facility's policy titled "Multidose Vials Storage and Disposal," with a revision date of 03/04/13, revealed insulin vials were to be dated when opened and discarded within twenty-eight (28) days.</li> </ol> <p>Observations on 06/18/15 of the medication room on the South Wing at 5:05 PM revealed an</p>	F 431			

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F 431	Continued From page 40 opened vial of Humulin Regular insulin for Resident B. The insulin was stored in the refrigerator available for resident use and was dated as opened on 05/20/15 (a period of 30 days).  3. Observations on 06/18/15 at 6:45 PM, of the North Wing medication room revealed an opened vial of Lantus insulin stored in the refrigerator for Resident C. The insulin was dated as opened on 05/18/15 (a period of 32 days).  An interview with the Director of Nursing on 06/18/15 at 7:00 PM, revealed it was facility policy to discard the insulin after twenty-eight (28) days. The DON stated the nurses and the medication technicians were to check the refrigerator daily for expired medications and they had overlooked the vials.	F 431			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		7/14/15	

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F 441	<p>Continued From page 41</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and policy review it was determined the facility failed to maintain effective infection technique in a manner to prevent the development and transmission of disease and infection for four (4) of fifteen (15) sampled residents (Residents #3, #5, #8, and #9). Licensed Practical Nurse #1 and Registered Nurse #1 initiated skin assessments for Resident #3 and Resident #5 at the residents' feet, assessed the residents' perineal area, and did not wash their hands and change gloves prior to assessing the rest of the resident's skin. In addition, staff failed to wash their hands and change gloves during urinary catheter</p>	F 441			

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F 441	<p>Continued From page 42 care/incontinence care for Resident #5, Resident #8, and Resident #9.</p> <p>The findings include:</p> <p>Review of the facility's Infection Control Measures policy (revision dated 09/20/13) revealed staff should wash their hands vigorously with antimicrobial soap and water for fifteen (15) seconds. The policy further stated staff should decontaminate their hands in the following circumstances: before having direct contact with patients, whenever they are moving their hands from a contaminated body site to a clean body site during patient care, and after removing gloves.</p> <p>Review of the facility's Skin Assessment protocol revealed the assigned nurse would complete a comprehensive skin assessment upon admission and weekly as scheduled. The protocol did not address how to perform a skin assessment.</p> <p>1. Review of the medical record revealed the facility admitted Resident #3 to the facility on 03/12/08 with diagnoses that included Hemiplegia, Late Effect Intracranial Injury, Dysphagia, and Polyneuropathy.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment, dated 04/02/15, revealed the resident was unable to be interviewed. The assessment also revealed the resident required total assistance for toileting of at least two (2) staff persons and utilized a urinary catheter (condom catheter).</p> <p>Observation on 06/17/15 at 6:10 PM, revealed Licensed Practical Nurse (LPN) #1 conducted a</p>	F 441			

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F 441	<p>Continued From page 43</p> <p>skin assessment of Resident #3. LPN #1 washed her hands and donned gloves. The LPN started the skin assessment at the resident's feet, looking between the resident's toes and proceeded to continue the skin assessment. She then assessed the resident's perineal area and continued the skin assessment up the resident's body to the resident's head, while also holding the resident's hand. Observation revealed LPN #1 examined the resident's feet and perineal area and did not wash her hands and change gloves before touching the rest of the resident's body, excluding the resident's face.</p> <p>Interview conducted with LPN #1 on 06/18/15 at 6:45 PM, revealed she learned how to do a skin assessment in nursing school, and she knew a skin assessment should start at the resident's head. LPN #1 stated she started Resident #3's skin assessment at the resident's feet because the resident was combative. She also stated that she starts her skin assessment based on the resident and their behavior. LPN #1 stated she had been trained to wash her hands and change gloves before, after, and during resident care/assessment if she was going from a dirty area to a clean area. She also stated, "I realize I didn't change my gloves after touching the resident's genital area."</p> <p>2. Record review revealed the facility admitted Resident #5 on 08/21/14 with diagnoses that included Urinary Retention and Prostate Cancer.</p> <p>Review of the Quarterly MDS assessment, dated 05/27/15, revealed the resident had moderate cognitive impairment, required total assistance for toileting, and had a urinary catheter.</p>	F 441			

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F 441	<p>Continued From page 44</p> <p>On 06/17/15 at 9:50 AM, observation of RN #1 during a skin assessment of Resident #3 in the shower room revealed the resident had received a bath. When surveyors entered the shower room, RN #1 was already wearing gloves. RN #1 initiated the skin assessment at Resident #3's feet, looking between his/her toes and proceeded to assess the resident's perineal area. RN #1 then continued the skin assessment of the resident's upper torso and face without changing her gloves and washing her hands.</p> <p>Interview with RN #1 on 06/19/15 at 2:08 PM, revealed that she checked all areas of the skin when she conducted weekly skin assessments.</p> <p>Interview conducted with the South Unit Coordinator on 06/19/15 at 1:05 PM, revealed she was unaware that nurses were starting their resident skin assessments at the feet and working their way up the resident's body. She also stated that nurses and nurse aides "usually come and get me if something is going on and they want me to look at a specific area of the skin. I don't watch full skin assessments."</p> <p>On 06/19/15 at 1:20 PM, interview with the Director of Nursing (DON) revealed during skin assessments nurses were supposed to start at the resident's head and work their way down the resident's body. The DON stated nurses should always wash their hands and change gloves if going from a dirty area to a clean area during skin assessments.</p> <p>3. Review of the medical record revealed the facility admitted Resident #5 on 08/21/14, with diagnoses that include Urinary Retention and Prostate Cancer.</p>	F 441			

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F 441	<p>Continued From page 45</p> <p>Review of the Quarterly MDS assessment, dated 05/27/15, revealed the facility assessed the resident to have moderate cognitive impairment, which required total assistance for toileting. The assessment revealed the resident had a urinary catheter.</p> <p>Observation on 06/18/15 at 1:50 PM of urinary catheter care/incontinence care for Resident #5 revealed SRNA #2 cleaned the resident's perineal area and removed her dirty gloves, but she did not wash her hands before donning clean gloves. SRNA #2 then removed the resident's adult brief and noticed the resident had been incontinent of bowel. SRNA #2 proceeded to clean the resident's perineal area, applied ointment to the resident's buttocks, and placed a clean adult brief on the resident. The SRNA did not change her gloves or wash her hands throughout the observations of incontinence care. SRNA #2 then helped to reposition the resident on his/her left side, positioned a pillow behind the resident's head, and also held the resident's hand during this time. SRNA #2 was also observed with the same gloved hands to open the resident's dresser drawer and put incontinence care supplies into the drawer. SRNA #2 then reached into her scrub top pocket and removed a trash bag. After getting trash out of the can, SRNA #2 then removed her gloves and put a new trash bag in the trashcan. SRNA #2 then went into a resident lounge and washed her hands with soap and water at the sink.</p> <p>Interview with SRNA #2 on 06/18/15 at 2:20 PM revealed that she did not remember the last in-service on catheter care/incontinence care. The SRNA stated, "I signed an in-service paper</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER  <b>EDGEWOOD ESTATES</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>195 BERRYMAN ROAD FRENCHBURG, KY 40322</b>		
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F 441	<p>Continued From page 46</p> <p>on it when I started back in February 2015." She also stated, "I know I should have changed gloves and washed my hands after catheter care/incontinent care but I forgot to." SRNA #2 stated she did not recall anyone observing her provide catheter care or incontinence care for accuracy in the past. She stated, "I have never been watched."</p> <p>Interview with the DON on 06/19/15 at 1:20 PM revealed that staff should always wash their hands and change gloves during catheter/incontinence care. The DON stated the facility had provided an in-service on hand washing and they had all of the SRNAs practice washing their hands during the in-service.</p> <p>4. Observation of a skin assessment conducted on Resident #9 on 06/17/15 at 3:00 PM, revealed RN #1 washed her hand, donned gloves, and proceeded with the skin assessment by starting with the resident's feet. The RN then progressed to the resident's legs, groin, chest, neck, and head without changing her gloves or washing her hands.</p> <p>Review of Resident #9's medical record revealed the facility admitted Resident #9 on 01/02/15 with diagnoses including Diabetes Mellitus Type II, Diaper or Napkin Rash, Stage IV Kidney Disease, Urinary Retention, and Urinary Tract Infection. Review of Resident #9's most recent Quarterly MDS dated 05/22/15 revealed the facility assessed Resident #9 to have a Brief Interview for Mental Status (BIMS) score of 13, which indicated the facility assessed Resident #9 to be cognitively intact.</p> <p>An interview conducted with RN #1 on 06/18/15</p>	F 441			

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F 441	<p>Continued From page 47</p> <p>at 3:03 PM revealed the RN was not aware she had started the skin assessment at the resident's feet. According to the RN, she was nervous and should have started the skin assessment at the resident's head. The RN said she then should have moved toward the resident's toes, removing her gloves and washing her hands when assessing the resident's groin area.</p> <p>5. Observation on 06/17/15 at 3:05 PM, revealed SRNA #7 did not remove her gloves or wash her hands after providing catheter care for Resident #9. The SRNA was observed to reapply the resident's brief and adjust the resident's bed covers while wearing the soiled gloves.</p> <p>An interview conducted with SRNA #7 on 06/17/15, revealed the SRNA forgot to remove the soiled gloves and wash her hands before reapplying the resident's brief and touching the resident's bed clothing.</p> <p>6. Record review revealed the facility admitted Resident #8 on 06/22/10 with diagnoses that included Cerebral Palsy, History of Methicillin-Resistant Staphylococcus Aureus (MRSA), Urinary Retention, and Muscle Weakness. Review of the Quarterly MDS assessment, dated 04/03/15, revealed the facility assessed the resident to require extensive assistance for bed mobility and total assistance for toileting and personal hygiene. The facility assessed the resident's daily decision-making skills to be severely impaired, indicating the resident was not interviewable.</p> <p>Observation of indwelling catheter care conducted on 06/17/15 at 9:17 AM revealed SRNA #3 failed to wash her hands after removing</p>	F 441			

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F 441	Continued From page 48 soiled gloves four (4) times during the course of care. After the SRNA finished perineal care and removed her gloves, she failed to wash her hands according to the facility policy prior to putting on clean gloves. The SRNA cleaned the resident's buttocks next, but failed to change her gloves or wash hands. The SRNA then placed a clean brief under the resident and prepared the resident to be placed on the mechanical lift pad. After placing the mechanical lift pad under the resident, the SRNA changed her gloves; however, she failed to wash her hands according to the facility policy. Further observation revealed SRNA #3 failed to wash her hands after removing gloves and exiting the resident's room after care was provided.  Interview with SRNA #3 on 06/18/15 at 2:56 PM revealed she had been trained to wash hands after glove removal. Further interview revealed she had returned to the room after disposing of the soiled items and washed her hands. The SRNA stated, "I should have washed my hands."	F 441			
F 514 SS=D	483.75(I)(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;	F 514		7/14/15	

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F 514	<p>Continued From page 49 and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined the facility failed to maintain an accurate clinical record for one (1) of fifteen (15) sampled residents (Resident #3). Resident #3 was required to have a right knee immobilizer and plantar flexion boot applied daily for (8) eight hours according to the resident's care plan. Observations on 06/16/15, 06/17/15, and 06/18/15 of the resident revealed the knee immobilizer and plantar flexion boot were not applied; however, staff documented the resident utilized the splints/braces during the time the observations were conducted.</p> <p>The findings include:</p> <p>Interview with the Administrator on 06/22/15 at 1:00 PM revealed the facility did not have a policy regarding accuracy of records.</p> <p>Record review revealed the facility admitted the resident on 03/12/08, with diagnoses that included Traumatic Brain Injury, Hemiplegia, Anxiety State, Dysphagia, and Psychosis.</p> <p>Review of Resident #3's Minimum Data Set (MDS) revealed the resident could not be interviewed, and had a functional limitation in range of motion on one side, and had a splint/brace.</p> <p>Review of Resident #3's care plan for Activities of</p>	F 514			

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F 514	<p>Continued From page 50</p> <p>Daily Living (ADL) Functional/Rehabilitation Potential revealed staff was required to apply the resident's right knee immobilizer and plantar flexion boot for eight (8) hours daily.</p> <p>Review of Resident #3's "Point of Care History" (State Registered Nurse Aide documentation) revealed documentation that both devices were applied to the resident on 06/16/15 at 10:43 AM, on 06/17/15 at 3:31 PM, and on 06/18/15 at 10:46 AM, each for a total of 840 minutes each day by SRNA #4.</p> <p>Observation of Resident #3 on 06/16/15 at 3:25 PM, 4:05 PM, 5:00 PM, and 5:30 PM; on 06/17/15 at 9:05 AM, 10:40 AM, 11:50 AM, 1:15 PM and 6:10 PM; and on 06/18/15 at 5:45 PM revealed the resident did not have on his/her knee immobilizer or plantar flexion boot. On 06/18/15 at 5:45 PM, the resident's knee immobilizer or plantar flexion boot was observed on a chair by the resident's bed.</p> <p>Interview with SRNA #4 on 06/18/15 at 5:40 PM revealed she was aware the resident's knee immobilizer and plantar flexion brace were to be applied daily for eight (8) hours. She stated on 06/16/15, Resident #3 was combative and she could not get the splints/braces on the resident. SRNA #4 stated she applied the splints/braces "yesterday morning" (06/17/15) but took them off before breakfast and "may have" forgotten to put them back on the resident. SRNA #4 did not state why she documented that the resident's knee immobilizer and plantar flexion brace had been on for 840 minutes when it was not.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 06/18/15 at 6:10 PM, revealed she was aware</p>	F 514			

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F 514	<p>Continued From page 51</p> <p>SRNA #4 was supposed to put on Resident #3's knee immobilizer and plantar flexion brace daily. She stated she did not realize that SRNA #4 had documented that Resident #3's knee immobilizer and plantar flexion had been on for eight (8) hours on 06/16/15, 06/17/15, and 06/18/15 when they were not in use.</p> <p>Interview with the North Unit Coordinator on 06/19/15 at 12:55 PM revealed that it was a "problem" when nurse aides were charting that they were putting Resident #3's knee immobilizer and plantar flexion boot on the resident daily for the ordered time when they were not.</p> <p>Interview with the Administrator on 06/19/15 at 1:40 PM revealed that she was unaware that SRNA #4 had documented the use of Resident #3's knee immobilizer and plantar flexion boot when it was not put on the resident. She stated it is a "serious issue" when the nurse aide is charting braces are being utilized when they are not.</p>	F 514			

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K 000	INITIAL COMMENTS  CFR: 42 CFR 483.70(a)  BUILDING: 01  SURVEY UNDER: NFPA 101 (2000 Edition)  PLAN APPROVAL: 1997  FACILITY TYPE: SNF/NF  TYPE OF STRUCTURE: One story, Type V (111)  SMOKE COMPARTMENTS: Three (3)  FIRE ALARM: Complete automatic fire alarm system.  SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system.  GENERATOR: Type II, fuel source is Natural Gas.  A life safety code survey using a 2786S (Short Form) was initiated on 06/17/15 and concluded on 06/17/15, for compliance with Title 42, Code of Federal Regulations, 483.70(a) and found the facility to not be in compliance with NFPA 101 Life Safety Code, 2000 Edition.  The following demonstrates noncompliance with Title 42, Code of Federal Regulations, 483.70(a). Deficient practice was cited with the highest deficiency identified at "F" level.	K 000		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour	K 029		6/24/15

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

TITLE

(X6) DATE

07/16/2015

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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K 029	<p>Continued From page 1</p> <p>fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure hazardous areas were protected according to National Fire Protection Association standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, sixty-six (66) residents, staff, and visitors.</p> <p>The findings include:</p> <p>Observation on 06/17/15 at 2:58 PM, with the Maintenance Director, revealed the North side utility room contained a fuel fired water heater. Further observation revealed the fresh air intake was open to the attic area. Interview at the time of observation with the Maintenance Director revealed he was not aware of the fresh air intake being open to the attic and the area had been constructed according to building plans submitted to Housing, Buildings and Construction.</p> <p>Observation on 06/17/15 at 3:03 PM, with the Maintenance Director, revealed the South side</p>	K 029			

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K 029	<p>Continued From page 2</p> <p>utility room contained a fuel fired water heater. Further observation revealed the fresh air intake was open to the attic area. Interview at the time of observation with the Maintenance Director revealed he was not aware of the fresh air intake being open to the attic and the area had been constructed according to building plans submitted to Housing, Buildings and Construction.</p> <p>The findings were acknowledged by the Administrator during the exit conference.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ol style="list-style-type: none"> <li>(1) Boiler and fuel-fired heater rooms</li> <li>(2) Central/bulk laundries larger than 100 ft2 (9.3 m2)</li> <li>(3) Paint shops</li> <li>(4) Repair shops</li> <li>(5) Soiled linen rooms</li> <li>(6) Trash collection rooms</li> <li>(7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction</li> </ol>	K 029			

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K 029	<p>Continued From page 3</p> <p>(8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.</p> <p>19.5.2.2* Any heating device other than a central heating plant shall be designed and installed so that combustible material will not be ignited by the device or its appurtenances. If fuel-fired, such heating devices shall be chimney connected or vent connected, shall take air for combustion directly from the outside, and shall be designed and installed to provide for complete separation of the combustion system from the atmosphere of the occupied area. Any heating device shall have safety features to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperature or ignition failure. Exception No. 1: Approved, suspended unit heaters shall be permitted in locations other than means of egress and patient sleeping areas, provided that such heaters are located high enough to be out of the reach of persons using the area and are equipped with the safety features required by 19.5.2.2.</p> <p>Exception No. 2: Fireplaces shall be permitted and used only in areas other than patient sleeping areas, provided that such areas are separated from patient sleeping spaces by construction having not less than a 1-hour fire resistance rating and that such fireplaces comply with the provisions of 9.2.2. In addition, the fireplace shall be equipped with a fireplace enclosure guaranteed against breakage up to a temperature of 650°F (343°C) and constructed of</p>	K 029			

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K 029	Continued From page 4 heat-tempered glass or other approved material. If, in the opinion of the authority having jurisdiction, special hazards are present, a lock on the enclosure and other safety precautions shall be permitted to be required.	K 029		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure automatic sprinkler heads were not obstructed according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, one (1) resident, staff, and visitors.  The findings include:  Observation on 06/17/15 at 4:05 PM, with the Maintenance Director, revealed two sprinkler heads in the South Hall shower room were obstructed by light fixtures located five inches away. Interview at the time of observation with the Maintenance Director revealed he had never identified the automatic sprinkler heads as being obstructed.  The findings were acknowledged by the Administrator during the exit interview.	K 062		6/23/15

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K 062	Continued From page 5 Reference: NFPA 13 (1999 Edition).  5-5.5.2.1 Continuous or non-continuous obstructions less than or equal to 18 in. (457 mm) below the sprinkler deflector that prevent the pattern from fully developing shall comply with 5-5.5.2.  5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures.  Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)  Distance from Sprinklers to side of Obstruction (A). Maximum Allowable Distance of Deflector above Bottom of Obstruction (in.) (B)  Side of Obstruction (A)      Obstruction (in.) (B) Less than 1 ft                      0 1 ft to less than 1 ft 6 in.      2 1/2 1 ft 6 in. to less than 2 ft      3 1/2 2 ft to less than 2 ft 6 in.      5 1/2 2 ft 6 in. to less than 3 ft      7 1/2 3 ft to less than 3 ft 6 in.      9 1/2 3 ft 6 in. to less than 4 ft      12 4 ft to less than 4 ft 6 in.      14 4 ft 6 in. to less than 5 ft      16 1/2 5 ft and greater                  18  For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a).	K 062			
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 147		6/19/15	

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K 147	<p>Continued From page 6</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure clearances in front of electrical panels were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments and eight (8) staff members.</p> <p>The findings include:</p> <p>Observation on 06/17/15 at 3:40 PM, with the Maintenance Director, revealed cardboard boxes placed in front of electrical panels K and H. Interview with the Maintenance Director and Dietary Manager at the time of observation revealed both were unsure if staff had been trained not to place items in front of electrical panels.</p> <p>The findings were acknowledged by the Administrator during the exit conference.</p> <p>Reference: NFPA 70 (1999 Edition).</p> <p>110-26. Spaces 10.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by</p>	K 147			

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K 147	<p>Continued From page 7</p> <p>lock and key shall be considered accessible to qualified persons.</p> <p>(A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2), and (3) or as required or permitted elsewhere in this Code.</p> <p>(1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (b), or (c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed.</p> <p>Table 110.26(A)(1) Working Spaces</p> <table border="1"> <thead> <tr> <th>Nominal Voltage to Ground</th> <th colspan="3">Minimum Clear Distance</th> </tr> <tr> <th></th> <th>Condition 1</th> <th>Condition 2</th> <th>Condition 3</th> </tr> </thead> <tbody> <tr> <td>0-150:</td> <td>900 mm (3 ft)</td> <td>900 mm (3 ft)</td> <td>900 mm (3 ft)</td> </tr> <tr> <td>151-600:</td> <td>900 mm (3 ft)</td> <td>1 m (3½ ft)</td> <td>1.2 m (4 ft)</td> </tr> </tbody> </table> <p>Note: Where the conditions are as follows:</p> <p>Condition 1 - Exposed live parts on one side and no live or grounded parts on the other side of the working space, or exposed live parts on both sides effectively guarded by suitable wood or other insulating materials. Insulated wire or insulated busbars operating at not over 300 volts to ground shall not be considered live parts.</p> <p>Condition 2 - Exposed live parts on one side and grounded parts on the other side. Concrete, brick, or tile walls shall be considered as</p>	Nominal Voltage to Ground	Minimum Clear Distance				Condition 1	Condition 2	Condition 3	0-150:	900 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)	151-600:	900 mm (3 ft)	1 m (3½ ft)	1.2 m (4 ft)	K 147		
Nominal Voltage to Ground	Minimum Clear Distance																			
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K 147	Continued From page 8 grounded. Condition 3 - Exposed live parts on both sides of the work space (not guarded as provided in Condition 1) with the operator between.  (a) Dead-Front Assemblies. Working space shall not be required in the back or sides of assemblies, such as dead-front switchboards or motor control centers, where all connections and all renewable or adjustable parts, such as fuses or switches, are accessible from locations other than the back or sides. Where rear access is required to work on nonelectrical parts on the back of enclosed equipment, a minimum horizontal working space of 762 mm (30 in.) shall be provided. (b) Low Voltage. By special permission, smaller working spaces shall be permitted where all uninsulated parts operate at not greater than 30 volts rms, 42 volts peak, or 60 volts dc. (c) Existing Buildings. In existing buildings where electrical equipment is being replaced, Condition 2 working clearance shall be permitted between dead-front switchboards, panelboards, or motor control centers located across the aisle from each other where conditions of maintenance and supervision ensure that written procedures have been adopted to prohibit equipment on both sides of the aisle from being open at the same time and qualified persons who are authorized will service the installation.  (2) Width of Working Space. The width of the working space in front of the electric equipment shall be the width of the equipment or 750 mm (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels. (3) Height of Working Space. The work space shall be clear and extend from the grade, floor, or	K 147			

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K 147	Continued From page 9 platform to the height required by 110.26(E). Within the height requirements of this section, other equipment that is associated with the electrical installation and is located above or below the electrical equipment shall be permitted to extend not more than 150 mm (6 in.) beyond the front of the electrical equipment. (B) Clear Spaces. Working space required by this section shall not be used for storage. When normally enclosed live parts are exposed for inspection or servicing, the working space, if in a passageway or general open space, shall be suitably guarded. (C) Entrance to Working Space. (1) Minimum Required. At least one entrance of sufficient area shall be provided to give access to working space about electrical equipment. (2) Large Equipment. For equipment rated 1200 amperes or more and over 1.8 m (6 ft) wide that contains overcurrent devices, switching devices, or control devices, there shall be one entrance to the required working space not less than 610 mm (24 in.) wide and 2.0 m (6½ ft) high at each end of the working space. Where the entrance has a personnel door(s), the door(s) shall open in the direction of egress and be equipped with panic bars, pressure plates, or other devices that are normally latched but open under simple pressure. A single entrance to the required working space shall be permitted where either of the conditions in 110.26(C)(2)(a) or (b) is met. (a) Unobstructed Exit. Where the location permits a continuous and unobstructed way of exit travel, a single entrance to the working space shall be permitted. (b) Extra Working Space. Where the depth of the working space is twice that required by 110.26(A) (1), a single entrance shall be permitted. It shall be located so that the distance from the	K 147			

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K 147	Continued From page 10 equipment to the nearest edge of the entrance is not less than the minimum clear distance specified in Table 110.26(A)(1) for equipment operating at that voltage and in that condition. (D) Illumination. Illumination shall be provided for all working spaces about service equipment, switchboards, panelboards, or motor control centers installed indoors. Additional lighting outlets shall not be required where the work space is illuminated by an adjacent light source or as permitted by 210.70(A)(1), Exception No. 1, for switched receptacles. In electrical equipment rooms, the illumination shall not be controlled by automatic means only.	K 147			