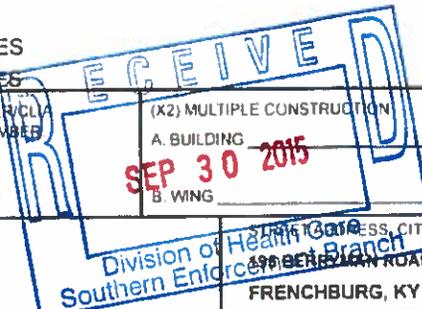


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/22/2015
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/20/2015
NAME OF PROVIDER OR SUPPLIER EDGEWOOD ESTATES		STREET ADDRESS, CITY, STATE, ZIP CODE 590 BEECHLICK ROAD FRENCHBURG, KY 40322	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

{F 000} INITIAL COMMENTS

{F 000}

An on-site revisit was conducted on 08/18-20/15 for the Standard Survey completed on 06/19/15, in conjunction with an Abbreviated Standard Survey (complaints #KY23677 and #KY23449).

Deficient practice cited on the 06/19/15 survey at 42 CFR 483.13 Resident Behavior and Facility Practices (F221 and F224), 42 CFR 483.20 Resident Assessment (F279 and F282), 42 CFR 483.25 Quality of Care (F315 and F318), 42 CFR 483.35 Dietary Services (F371), 42 CFR 483.60 Pharmacy Services (F431), 42 CFR 483.65 Infection Control (F441), and 42 CFR 483.75 Administration (514) was determined to be corrected effective 07/14/15, as alleged by the facility.

Both complaints were substantiated with deficient practice identified at "D" level. KY23449 was originally initiated on 07/13/15 and concluded on 07/14/15. The complaint was unsubstantiated with no deficient practice identified but was reopened on 08/18/15, after supervisory review.

Deficient practice cited on 06/19/15 at 42 CFR 483.10 Resident Rights (F164), 42 CFR 483.13 Resident Behavior and Facility Practices (F225), and 42 CFR 483.25 Quality of Care (F323) was determined to not be corrected. Noncompliance continued with the highest Scope and Severity at "G" level.

{F 164} 483.10(e), 483.75(l)(4) PERSONAL
SS=D PRIVACY/CONFIDENTIALITY OF RECORDS

{F 164} F164 Personal Privacy / Confidentiality of Records

The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

The facility has ensured the following corrective action:

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

Anne Hill

TITLE

Administrator

(X5) DATE

9/30/15

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

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{F 164}	Continued From page 1 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. 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. 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. 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. This REQUIREMENT is not met as evidenced by: Based on interview, review of the facility's investigation, and the facility's policy and procedure, it was determined the facility failed to ensure that privacy was provided during a shower for one (1) of ten (10) sampled residents (Resident #16). On 08/09/15, Registered Nurse (RN) #3 opened the shower room door and discovered two (2) staff members bathing two (2) residents (Resident #16 and a Personal Care Home resident) in the same shower stall (refer to	{F 164}	<ul style="list-style-type: none"> Immediately after nurse aides failed to follow privacy during treatment protocol they were suspended until the investigation was complete. Nurse aides received written counseling by the Director of Nursing regarding failure to follow facility policy. One nurse aide was terminated from employment. (Attachment #1 a-b) The Director of Nursing received verbal counseling by the Administrator regarding duties to ensure all employees receive mandated in-service training. (Attachment #2) <p>The facility has taken the following action to prevent this practice from affecting other residents:</p> <ul style="list-style-type: none"> Alert and oriented residents were interviewed by the Director of Nursing to investigate if privacy was provided / denied to them during treatment. All residents interviewed denied any issues. (Attachment #3) The Director of Nursing conducted a re-in-service training to all nursing department staff regarding the Privacy During Treatment Protocol. (Attachment #4 a-c) <p>The facility has initiated the following systemic changes to prevent this practice from recurring:</p>

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{F 164}	<p>Continued From page 2 F520).</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Privacy During Treatment," dated 06/19/15, revealed all residents would be provided privacy during routine care. The policy stated staff would ensure the closure of curtains, doors, and shades/blinds, or take any other measure deemed necessary to protect privacy.</p> <p>Review of Resident #16's medical record revealed the facility admitted the resident on 05/20/15, with diagnoses which included Dementia and Depression. Review of Resident #16's Minimum Data Set (MDS) Assessment completed 08/05/15, revealed the facility assessed the resident to be totally dependent for bathing (including full body shower). The facility assessed Resident #16 to have a Brief Interview for Mental Status (BIMS) score of 4, indicating the resident had severe cognitive impairment and was not interviewable.</p> <p>Observation of Resident #16 on 08/18/15, at 11:11 AM, revealed the resident was in bed and unable to answer questions appropriately.</p> <p>Interview with RN #1 on 08/18/15 at 4:10 PM revealed she entered the shower room on 08/09/15 at approximately 10:15 AM to obtain supplies. RN #1 stated as she opened the shower room door she discovered CNA #2 and CNA #8 had Resident #16 and a Personal Care Home resident naked in the same shower stall providing the residents' showers. RN #1 stated the privacy curtain which covers the opening to the shower stall was also open, which made both</p>	{F 164}	<ul style="list-style-type: none"> An additional privacy curtain was added to the north and south shower areas to provide staff with an extended space in which to assist a resident while dressing and to provide greater privacy. The Charge Nurse Round Sheet was modified to include one shower room check per shift to observe compliance with privacy during showers. (Attachment #5) <p>The facility will sustain performance through the following monitoring practices:</p> <ul style="list-style-type: none"> Observations regarding privacy during showers (10x/month) were added to the Unit Coordinator checklist. Unit Coordinators will immediately address any issues noted during their checks, and report the findings to the Administrator and DON. (Attachment #6) As part of the ongoing Quality Assurance for nursing services, the Director of Nursing will present a summary of shower room checks for privacy, and any required action to ensure compliance, to the Administrator on the monthly QA report. A summary of all quarterly findings will be presented to and reviewed with the facility Medical Director. (Attachment #7 – 3 pages) 	8/21/15
			COMPLETION DATE:	8/21/15

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{F 164}	Continued From page 3 residents visible to anyone who opened the shower room door. RN #1 stated she immediately instructed the CNAs to finish each resident's shower in a separate stall and notified the Administrator of the incident. Attempted interviews on 08/18/15 at 4:00 PM, on 08/18/15 at 6:22 PM, and on 08/19/15 at 8.30 AM with CNA #2 were unsuccessful. Review of the facility's Plan of Correction dated 07/16/15, revealed an in-service training related to the facility's "Privacy During Treatment" policy/procedure was provided to all nursing staff including certified nurse aides. The facility was cited on the 06/19/15 recertification survey for failure to provide resident privacy (failed to close blinds during resident treatment). Review of the facility's Investigative Report dated 08/10/15, revealed that on 08/09/15, RN #1 opened the shower room door and discovered Certified Nursing Assistant (CNA) #2 and CNA #8, bathing Resident #16 and a Personal Care Home Resident in the same shower stall. The investigation determined that CNA #2 and CNA #8 failed to follow the facility's policy and procedures related to ensuring residents were afforded privacy during care and treatment. Interview with CNA #8 on 08/19/15, at 12.50 PM, revealed that she and CNA #2 were showering Resident #16 and a Personal Care Home resident together in the same shower stall. She stated the privacy curtain was not pulled. CNA #8 stated that she and CNA #2 were in a hurry to get the showers done and they "just did not think." CNA #8 stated she did recognize that it was not appropriate to shower residents together in the	{F 164}			

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{F 164}	<p>Continued From page 4</p> <p>same stall. CNA #8 stated she had not attended an in-service or been provided training on providing privacy to residents in the facility.</p> <p>Review of the facility's in-service "Resident Privacy" Sign in Sheet dated 06/16/15, revealed neither CNA #2 nor CNA #8 had attended the training. Additionally, the facility also conducted in-services related to resident privacy on 07/03/15 and 07/19/15; however, review of these sign-in sheets revealed CNA #2 and CNA #8 had failed to attend these in-services also.</p> <p>Interview with the Director of Nursing (DON) on 08/20/15 at 3:20 PM, revealed that after reviewing all of the privacy in-services held by the facility, she discovered that she had overlooked the fact that CNA #2 and CNA #8 had not attended any of the privacy in-services. The DON stated it had been her responsibility to ensure all nursing staff had been trained on the privacy policy, however, she had failed to recognize that CNA #2 and CNA #8 had not attended the training until 08/20/15.</p> <p>Interview with the Administrator on 08/20/15 at 5:30 PM, revealed that CNA #2 had been terminated from employment at the facility after the incident, and that CNA #8 had not provided care in the facility since the incident occurred. The Administrator stated that she had not been aware that CNA #2 and CNA #8 had not attended the required training related to providing resident privacy.</p>	{F 164}		

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{F 164}	Continued From page 5	{F 164}		
{F 225} SS=D	<p>Surveyor: Partin, Douglas</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4)</p> <p>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>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.</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance</p>	{F 225}	<p>F225 INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility has ensured the following corrective action:</p> <ul style="list-style-type: none"> SRNA #2 was suspended from active duty at the request of the Administrator when informed of allegation the next day via telephone by the Director of Nursing and Social Services Director. The charge nurse on duty received a written warning by the Director of Nursing for failure to comply with facility policy regarding an allegation of abuse. (Attachment #1 a-b) <p>The facility has taken the following action to prevent this practice from affecting other residents:</p> <ul style="list-style-type: none"> All staff nurses (RNs and LPNs) were provided additional in-service training by the Director of Nursing on the Resident Abuse and Neglect Policy. (Attachment #2) <p>The facility has initiated the following systemic changes to prevent this practice from recurring:</p>	

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{F 225}	<p>Continued From page 6</p> <p>with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to protect residents during the investigation of an abuse allegation to prevent further potential abuse for one (1) of two (2) allegations of abuse/neglect (Resident #22). On 06/22/15, Resident #22 reported that Certified Nursing Assistant (CNA) #2 "threw" the resident against the bed rails and was "rough" during care. The facility failed to immediately remove CNA #2 from the work environment to protect the residents as required by the facility's policy.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled "Resident Abuse and Neglect," last revised 01/09/15, revealed "staff members must report any allegations of abuse/neglect immediately to their supervisor, or, if after hours or on weekends, report shall be made to the Charge Nurse on duty." Further review revealed any employee that was accused of resident abuse would be immediately removed from the work environment and suspended without pay until an investigation was completed.</p> <p>Record review revealed the facility admitted Resident #22 on 08/04/14, with diagnoses that included Multiple Sclerosis, Vitamin D Deficiency.</p>	{F 225}	<ul style="list-style-type: none"> The Abuse Prevention Policy was developed. (Attachment #3) All facility staff were provided in-service training on the Abuse Prevention Policy by the Administrator. (Attachment #4 a-c) <p>The facility will sustain performance through the following monitoring practices:</p> <ul style="list-style-type: none"> The facility investigative team (ADM, DON, SSD) will be informed of all allegations of abuse/neglect immediately upon occurrence and will ensure that any accused employee is removed from active duty. As part of the ongoing Quality Assurance for nursing services, the Director of Nursing will provide a summary review of all allegations to ensure compliance with the removal of accused employees from active duty during the monthly report to the Administrator and quarterly summary report to the Medical Director. Any corrective action required will be reviewed by the Quality Assurance team for compliance. (Attachment #5) <p>COMPLETION DATE: 9/1/15</p>	

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{F 225}	<p>Continued From page 7</p> <p>Anemia, Congestive Heart Failure, Pain, and Neurogenic Bladder.</p> <p>Review of a Quarterly Minimum Data Set (MDS) assessment dated 04/23/15 revealed the facility assessed Resident #1's cognition as intact with a Brief Interview Mental Status (BIMS) score of 15, indicating the resident was interviewable.</p> <p>Review of a facility Investigative Report dated 06/22/15, revealed CNA #2 reported to the Charge Nurse, Registered Nurse (RN) #2, that Resident #22 had accused her (CNA #2) of rough treatment during a brief change. Further review revealed Resident #22 reported CNA #2 "threw" him/her against the bed rail. The resident stated the CNA was "bossy."</p> <p>Interview with CNA #2 on 07/13/15 at 4:00 PM revealed she and CNA #8 performed incontinence care for Resident #22 on 06/22/15 at approximately 3:00 PM. CNA #2 stated during the care Resident #22 became upset and accused her of throwing him/her against the bed rail. She stated she stopped care and immediately got the Charge Nurse, RN #2. CNA #2 stated she completed the incontinence care for the resident with RN #2 and CNA #8. Further interview revealed she did not "throw the resident against the bed rail" and she did not handle the resident in a rough manner. CNA #2 stated her assignment was changed and she no longer works with Resident #22.</p> <p>Interview with CNA #8 on 07/14/15 at 11:40 AM revealed she assisted CNA #2 with performing incontinence care for Resident #22 on 06/22/15 at approximately 3:00 PM. CNA #8 stated as soon as the resident was rolled over he/she</p>	{F 225}		

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{F 225}	Continued From page 8 stated he/she wanted to report that CNA #2 was being too rough. CNA #8 stated CNA #2 immediately notified the Charge Nurse. She stated the Charge Nurse came in and assisted with the incontinent care. CNA #8 stated she did not observe CNA #2 throw the resident against the bed rail or treat him/her in a rough manner. Interview with the Charge Nurse, RN #2, on 07/14/15 at 1:56 PM, revealed CNA #2 notified her that Resident #22 had reported rough treatment. RN #2 stated she immediately entered the room and assessed the resident for signs and symptoms of injury. She stated she assisted with completing the incontinence care. RN #2 stated she immediately knew the resident had not been abused. She stated she notified the Director of Nursing (DON) later on in her shift and was told to go ahead and get statements from the CNAs and Resident #22. RN #2 stated she did not send CNA #2 home because she did not feel like anything had happened. She stated in hindsight she should have sent the CNA home and immediately initiated an investigation. RN #2 stated she received a written disciplinary action because she did not follow the facility's policy and procedure for abuse and neglect. She stated, "I just did what the DON said to do." Interview with Resident #22's Daughter on 07/14/15 at 1:45 PM revealed she had no concerns with the care of Resident #22 at the facility. The Daughter stated the facility notified her of the incident and stated CNA #2 would no longer provide care for Resident #22. Interview with the DON on 07/14/15 at 2:46 PM, revealed she was not notified of the allegation of abuse on 06/22/15. The DON stated if she had	{F 225}		

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{F 225}	Continued From page 9 been made aware, she would have instructed the Charge Nurse, RN #2, to immediately begin an investigation and the CNA would have been immediately sent home until the investigation was completed. The DON stated she was made aware of the allegation the next day and the CNA was suspended at that time. She further stated the Charge Nurse did not follow the policy and procedure and received written disciplinary action. F 226 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 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 interview and review of the facility's policy/procedure, it was determined the facility failed to develop operational policies and procedures for protection of residents and for the prevention, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property. On 06/23/15, the facility revised the "Resident Abuse and Neglect" policy/procedure. However, the policy failed to establish procedures for staff to utilize to ensure allegations were reported immediately to the Administrator of the facility and to other officials in accordance with State law, and protected residents and prevented further potential abuse while the investigation was in progress.	{F 225}	F 226 F226 DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES The facility has ensured the following corrective action: • Revision was made to the facility's policy regarding abuse/neglect to ensure compliance with state regulation in regards to (1) who is responsible for reporting alleged abuse/neglect to the state survey agency and other state agencies, (2) how injuries of unknown origin are to be identified and investigated /reported, and, (3) training for employees on the Abuse Prevention Policy. (Attachment #1) The facility has taken the following action to prevent this practice from affecting other residents: • The Administrator provided in-service training to all facility staff on the revised policy. (Attachment #2 a-b)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 226 Continued From page 10

The findings include:

Review of the facility's "Resident Abuse and Neglect" Policy and Procedure revised on 06/23/15, revealed "All reported suspicions of resident abuse would be followed up by the Charge Nurse and/or investigated by the Administrator or his/her designee." The Policy stated that staff members must report any allegation of abuse/neglect immediately to their supervisor or, if after hours or on weekends, reports should be made to the Charge Nurse on duty. The Policy/Procedure then directed the Charge Nurse to complete steps outlined in the "Charge Nurse Duties for Suspected Abuse/Neglect" attachment. However, the Policy/Procedure gave no direction for other supervisory staff to follow if the abuse/neglect was reported to supervisory staff other than the Charge Nurse.

Further review of the "Resident Abuse and Neglect" Policy/Procedure revealed after an allegation was reported to the Charge Nurse, the Nurse "shall preferably within one (1) hour but not to exceed two (2) hours" complete the steps outlined in the "Charge Nurse Duties for Suspected Abuse/Neglect" attachment. The steps for the Charge Nurse to complete, detailed in the attachment, included notifying the Administrator of the allegation. However, the procedure did not direct the Charge Nurse to notify the Administrator immediately.

Continued review of the Policy/Procedure revealed it was the Charge Nurse's responsibility to complete the following steps within the two-hour timeframe: interviewing the person making the report, interviewing and assessing the

F 226 • All facility employees receive a copy and training on the Abuse Prevention Policy: 1) upon hire during new employee orientation, and annually thereafter by the Social Services Director. (Attachment #3)

The facility has initiated the following systemic changes to prevent this practice from recurring:

- Policy revision and in-service training were completed regarding the Abuse Prevention Policy. The policy outlines protocol for the identification of abuse, neglect, or injuries of unknown origin, and required (immediate) reporting of suspected abuse to the facility Administrator and other entities as required by law.

The facility will sustain performance through the following monitoring practices:

- The facility Administrator will ensure that any allegation of abuse/neglect is investigated per state law and facility policy, and that reporting is made immediately to required state agencies and all required parties.
- The Administrator will provide a copy of the completed Investigative Report to the Office of Inspector General

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<p>F 226 Continued From page 11</p> <p>resident named in the allegation, interviewing alert and oriented residents, interviewing staff assigned to the resident, interviewing other staff in the facility, interviewing staff from previous shifts, and all other potential witnesses such as visitors, contract staff, and vendors. The Policy then directed that only if suspected abuse/neglect was believed to have occurred, or further investigation was warranted, would the Charge Nurse notify the Administrator, Director of Nursing (DON), and Social Services Director (SSD) of the investigative findings. Additionally, the Policy/Procedure stated that only if abuse/neglect was believed to have occurred would the resident's Responsible Party, Physician, or State Agencies be notified of the allegation. The Policy/Procedure failed to identify what action was to be taken if the alleged perpetrator was the Charge Nurse on Duty.</p> <p>Additionally, the Policy/Procedure stated that an Investigative Review Team comprised of the Administrator, DON, and SSD, would work in collaboration throughout the investigation completing assignments as directed by the Administrator. The Policy/Procedure stated that if the allegation occurred during a time other than "normal business hours (nights/weekends)" the Investigative Review Team would convene on the next business day to review the information gathered by the Charge Nurse.</p> <p>Interview with the Administrator on 08/20/15 at 5:30 PM revealed she had made the revisions on 06/23/15 to the "Resident Abuse and Neglect" Policy/Procedure, and included the "Charge Nurse Duties for Suspected Abuse/Neglect" attachment. The Administrator stated that she wanted to make sure that the Charge Nurse knew</p>	<p>F 226</p> <p>within five (5) working days of the event.</p> <ul style="list-style-type: none"> • The Administrator, Director of Nursing, and Social Services Director will review all investigative reports on occurrence, and initiate any corrective action that may result from investigative findings. • The Social Services Director will provide a summary of all investigations/ corrective action on the monthly Social Services Quality Assurance report to the Administrator. A summary of all investigations conducted during each quarter will be provided to and reviewed with the Medical Director at the scheduled QA meetings. (Attachment #4) <p>COMPLETION DATE: 9/26/15</p>
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F 226 Continued From page 12 F 226

it was his/her responsibility to complete the abuse/neglect investigation and "did not throw it off on us" to complete. The Administrator stated that if the allegation occurred during the "normal weekday," the Administrator, DON, or SSD, "could possibly assist" the Charge Nurse with completing the investigation. She stated that if the allegation occurred during the evening or night shifts, the Charge Nurse would be responsible to complete the investigation along with his/her normal duties including direct patient care.

Continued interview with the Administrator revealed she "expected" that other supervisory staff would know to notify her if an abuse allegation was made to them, but she had not realized the revised policy/procedure did not detail the steps other supervisory staff was to follow. The Administrator stated that she had not been aware that notifications were required to be made to the Responsible Party, Physician, and State Agencies if it was believed that no abuse occurred.

(F 323) 483.25(h) FREE OF ACCIDENT
SS=G 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:

(F 323)

F323 FREE OF ACCIDENT HAZARDS / SUPERVISION / DEVICES

The facility has ensured the following corrective action:

- The charge nurse immediately had the resident removed from the bed.
- The Environment Services Director removed the bed from the facility on the date of the incident and provided the resident with a different bed.

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{F 323} Continued From page 13

Based on interview, record review, facility policy review, and review of the facility's investigation it was determined the facility failed to ensure the environment remained free from accident hazards for one (1) of ten (10) sampled residents (Resident #19). The facility failed to obtain the manufacturer's guidelines for maintenance of Resident #19's bed to ensure the bed was in safe working order. On 07/04/15, Resident #19's bed malfunctioned while the resident was in bed. The head of the bed and foot of the automatic bed rose to the highest positions, with the resident in bed, and then stopped working. After this incident, the resident was diagnosed with a femur (upper leg) fracture.

The findings include:

Review of the facility's policy titled "Incident Reporting," dated 05/01/14, revealed careful documentation of incidents is important for continuous quality improvement, learning from mistakes, and managing risk.

Interview with the Administrator on 08/20/15 at 5:30 PM, revealed the facility did not have a policy related to the maintenance of resident care equipment.

Record review revealed the facility admitted Resident #19 on 02/04/08 with diagnoses which included Dementia, Chronic Pain, and Contracture. Review of the Quarterly Minimum Data Set (MDS), dated 06/17/15, revealed the facility assessed the resident's Brief Interview for Mental Status (BIMS) score to be 15, indicating the resident was cognitively intact and interviewable. Further review revealed the resident was assessed to require extensive

- {F 323}
- A copy of the operator's manual for the beds was obtained and reviewed. The manufacturer recommended an annual inspection as standard maintenance on the Hill-Rom 720 beds.
 - The facility contacted a Hill-Rom representative who stated that they no longer provide support for the 720 bed. A representative of Hill-Rom inspected the bed and determined that it did not exceed the standard operation limits as set for the bed (did not exceed the manufacturer's set points for the bed)
 - On 9/16/15, all Hill-Rom 720 beds were removed from the facility.

The facility has taken the following action to prevent this practice from affecting other residents:

- Immediately following the incident other facility Hill-Rom bed control boxes (11 additional beds) were checked for potential compromise. No other issues were identified. Inside area of control boxes were dry and without foreign matter or moisture.
- On 8/21/15, all facility electrical beds (those other than Hill-Rom 720 beds) were checked for potential damage / compromise. All other electrical beds were found to have the control box enclosed in a protective cover. No other issues were identified. (Attachment #1 – 3 pages)

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{F 323}	<p>Continued From page 14</p> <p>assistance for bed mobility and had functional limitation in range of motion with impairments on both sides of his/her lower extremities.</p> <p>Review of the facility's investigation, dated 07/04/15, revealed the resident's water pitcher had spilled at the end of the bed resulting in water getting into the electrical control box causing the bed to malfunction. The resident was found in bed with the head and foot of the bed locked in the highest position. The resident was transferred from the bed to a Geri-chair and later placed in a new bed. Further review revealed the resident had no complaints of pain at the time of the incident; however, he/she began experiencing pain during the evening medication pass. A Computerized Tomography (CT) scan was completed on 07/06/15 which revealed the resident had a non-displaced distal femur fracture with joint effusion.</p> <p>Review of the nurse's notes dated 07/04/15 at 9:40 PM, revealed the resident began complaining of right knee pain, the Physician was notified, and an order to obtain an x-ray was received. Further review revealed the nurse's note stated the portable x-ray company was notified of the order at that time. However, the x-ray was not completed until 07/05/15 at 1:11 PM.</p> <p>Review of Resident #19's right knee x-ray obtained on 07/05/15, revealed a deformity of the distal femur, possible result of remote trauma.</p> <p>Review of the Computerized Tomography (CT) scan, dated 07/06/15, revealed the clinical history of the resident stated the resident experienced "pain after nursing home bed malfunction and</p>	{F 323}	<ul style="list-style-type: none"> • All electric beds with potential control box exposure to moisture were removed from the facility. <p>The facility has initiated the following systemic changes to prevent this practice from recurring:</p> <ul style="list-style-type: none"> • The <i>Electrical Bed Prevention Maintenance Policy</i> was developed on 8/21/15 outlining the required procedure for bed maintenance. All staff were provided in-service training on the policy. (Attachment #2 a-c) • The Director of Nursing conducted an in-service training with the nurse aide staff on 8/21/15 regarding the proper use/functioning of electrical beds. Staff were directed to report any noted issues identified during normal duty to the charge nurse who will contact maintenance. In an emergency situation, the facility will continue with the practice of removing the resident from a malfunctioning bed and providing them with a different bed, or utilize the lock-out – tag out practice until such repairs can be made. (Attachment #3) <p>The facility will sustain performance through the following monitoring practices:</p> <ul style="list-style-type: none"> • The Environmental Services Director, or his designee, will complete a minimum 	

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{F 323}	Continued From page 15 smashed patient's right knee." Further review revealed a non-displaced distal femur fracture with joint effusion. Interview with Resident #19 on 08/19/15 at 2:30 PM, revealed the resident's water pitcher had been spilled on the bed resulting in the bed malfunction. The resident stated the foot and head of the bed came up and "I was a sandwich." Interview with Maintenance Staff Person #1 on 08/19/15 at 3:46 PM revealed Resident #19's bed was donated from another facility along with eleven (11) other beds of the same model. The Manufacturer's Guidelines or instructions for maintenance of the bed were not sent with the beds at the time of the donation. Maintenance Staff Person #1 stated the facility had been unable to obtain the manufacturer's guidelines or instructions since the donation; however, the facility made the beds available for resident use. Further interview revealed "spare parts" were used for maintenance of the beds because parts for that model of bed were no longer available for purchase. He stated that after Resident #19's bed malfunctioned, the Maintenance Director and Maintenance Staff Person #1 checked the other eleven (11) beds of the same model being used in the facility. Maintenance Staff Person #1 stated they took the cover off of the control box for each bed and checked for moisture or corrosion and no concerns were identified. Maintenance Staff Person #1 stated the facility did not contact the manufacturer for preventive maintenance instructions, nor notify them of the bed malfunction. The facility removed Resident #19's bed from the facility; however, they continued to utilize the remaining eleven (11) beds for resident use.	{F 323}	of a monthly bed inspection on all facility beds. (Attachment #4 – includes checklist) • The Environmental Services Director has modified the monthly Quality Indicator report for Environmental Services to include a summary of inspections and repairs made to facility beds as part of the Quality Assurance program for the Environmental Services Department. A monthly report will be provided to the Administrator, and a quarterly summary will be provided to and reviewed with the Medical Director (Attachment #5).	COMPLETION DATE: 9/17/15	

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{F 323}	Continued From page 16 Interviews with Registered Nurse (RN) #1 on 08/19/15 at 4:01 PM, Certified Nurse Assistant (CNA) #2 on 08/19/15 at 4:36 PM, and Licensed Practical Nurse (LPN) #1 on 08/20/15 at 1:15 PM, revealed they had fixed loosened plugs and had to "jiggle" cords under resident beds in order for the beds to function properly. The staff members were unable to identify specific dates and times of the occurrences. Interview with CNA #2 also revealed facility staff had been instructed per Maintenance that in the event a resident's side rail controls stopped functioning the staff was to use the control panel at the foot of the bed to raise the entire bed to the highest position until a "click" was heard. At that point, the bed was to be lowered and the side rail controls would function properly. The staff members were not aware of Resident #19's bed having repairs prior to the malfunction. Interview with the bed Manufacturer Representative on 08/20/15 at 10:20 AM revealed Resident #19's bed model had been discontinued in 1993 and parts for this bed model had not been manufactured since 1998. The Manufacturer Representative stated he was unable to obtain a User Manual because the bed was "obsolete." Further interview revealed any bed malfunction that resulted in patient injury should have been reported to the manufacturer. The Manufacturer Representative stated the facility should have had the manufacturer's instructions or recommendations to refer to for maintenance or repairs. Interview with the Maintenance Director on 08/20/15 at 2:12 PM revealed facility staff had not received specific training for maintaining the	{F 323}	

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{F 323}	Continued From page 17 donated beds. The Maintenance Director confirmed the facility did not have the Manufacturer's Guidelines or instructions for maintaining Resident 19's bed model. The Maintenance Director stated routine monthly bed checks were performed to ensure residents' beds were functioning properly. The facility did not utilize a guideline for the bed inspections and did not have a policy pertaining to the maintenance of resident care equipment. Further interview revealed no preventive measures were put into place to ensure a similar bed malfunction did not occur with the other eleven (11) beds located in the facility. The Maintenance Director stated the only preventive measure he knew to try was to "pour a whole pitcher of water on the control box." The Maintenance Director stated he had instructed staff if a resident's side rail controls were not functioning properly to raise the bed to the highest position until a clicking sound was heard. Further interview revealed maintenance staff had to replace a motor in one of the other beds related to resident overuse. The Maintenance Director stated "spare parts" were used during the repair. No other repairs were reported. Interview with the Administrator on 08/20/15 at 5:30 PM, revealed the facility had eleven (11) beds that were the same bed model as Resident #19's bed; and residents were still utilizing these beds. The Administrator stated the facility had taken no action to ensure these beds did not malfunction the same as Resident #19's bed. Further interview revealed facility staff had not been educated on the "believed cause" of Resident #19's bed malfunction, nor on ways to prevent further malfunctions. The Administrator stated Resident #19's type of bed was some of	{F 323}	

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{F 323}	Continued From page 18 the facility's "better beds."	{F 323}	F456 ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION		
F 456 SS=G	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's investigation it was determined the facility failed to maintain patient care equipment in safe operating condition according to manufacturer's guidelines for twelve (12) of sixty (60) facility beds. On 07/04/15, Resident #19's bed malfunctioned while the resident was lying in bed. The head and foot of the automatic bed rose spontaneously to the highest position and became locked in place. The resident was diagnosed with a femur (bone in the upper leg) fracture after the incident. The facility failed to obtain or follow manufacturer's guidelines for the maintenance of Resident #19's bed along with eleven (11) other beds of the same model to ensure they were in safe operating condition. The findings include: Interview with the Administrator on 08/20/15 at 5:30 PM, revealed the facility did not have a policy related to the maintenance of resident care equipment. Review of the "Transfer of Ownership" document revealed the facility obtained the donated beds on	F 456	The facility has ensured the following corrective action: <ul style="list-style-type: none"> The charge nurse immediately had the resident removed from the bed. The Environment Services Director removed the bed from the facility on the date of the incident and provided the resident with a different bed. A copy of the operator's manual for the beds was obtained and reviewed. The manufacturer recommended an annual inspection as standard maintenance on the Hill-Rom 720 beds. The facility contacted a Hill-Rom representative who stated that they no longer provide support for the 720 bed. A representative of Hill-Rom inspected the bed and determined that it did not exceed the standard operation limits as set for the bed (did not exceed the manufacturer's set points for the bed) On 9/16/15, all Hill-Rom 720 beds were removed from the facility. The facility has taken the following action to prevent this practice from affecting other residents: <ul style="list-style-type: none"> Immediately following the incident other facility Hill-Rom bed control boxes (11 additional beds) were checked for potential compromise. No other issues were identified. Inside 		

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F 456	Continued From page 19 06/22/11. Review of the facility's investigation, dated 07/04/15, revealed Resident #19's water pitcher spilled down the foot of the resident's bed onto the electrical control box. The facility determined the spilled water entered the control box and caused the bed to malfunction. Resident #19 was found folded in the malfunctioned bed with the head and foot of the bed in the highest position and locked in place. Facility staff was unable to unlock the resident's bed from the upright position, but was able to utilize the bed linens to lift Resident #19 out of the bed and transfer the resident to a Geri-chair and later to a new bed. Further review revealed the resident did not complain of pain at the time of the incident; however, during the evening medication pass the resident complained of right knee pain. A Computerized Tomography (CT) scan, dated 07/06/15, revealed a distal femur fracture. Interview with Resident #19 on 08/19/15 at 2 30 PM, revealed the resident's water pitcher had been spilled on the bed and a short time later the bed malfunctioned. The resident stated the foot and head of the bed came up and "I was a sandwich." Interview with Maintenance Staff Person #1 on 08/19/15 at 3:46 PM, revealed Resident #19's bed was one (1) of twelve (12) same model beds that had been donated to the facility. Maintenance Staff Person #1 stated the Manufacturer's Guidelines were not given to the facility at the time of the donation and the facility had not obtained guidelines since then. Further interview revealed the beds were repaired using "spare parts" that were also donated to the	F 456	area of control boxes were dry and without foreign matter or moisture. <ul style="list-style-type: none"> On 8/21/15, all facility electrical beds (those other than Hill-Rom 720 beds) were checked for potential damage / compromise. All other electrical beds were found to have the control box enclosed in a protective cover. No other issues were identified. (Attachment #1 – 3 pages) All electric beds with potential control box exposure to moisture were removed from the facility. <p>The facility has initiated the following systemic changes to prevent this practice from recurring:</p> <ul style="list-style-type: none"> The <i>Electrical Bed Prevention Maintenance Policy</i> was developed on 8/21/15 outlining the required procedure for bed maintenance. All staff were provided in-service training on the policy. (Attachment #2 a-c) The Director of Nursing conducted an in-service training with the nurse aide staff on 8/21/15 regarding the proper use/functioning of electrical beds. Staff were directed to report any noted issues identified during normal duty to the charge nurse who will contact maintenance. In an emergency situation, the facility will continue with the practice of removing the resident from a malfunctioning bed and providing them with a different bed, or 		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 456	Continued From page 20 facility. Maintenance Staff Person #1 stated parts for the beds were no longer available for purchase. Further interview revealed after Resident #19's bed malfunctioned on 07/04/15, maintenance staff "checked" the remaining eleven (11) beds. The electrical control box covers were removed and inspected for moisture or corrosion. No concerns were identified with the eleven (11) beds and the facility continued to utilize the beds. Maintenance Staff Person #1 stated the bed manufacturer was not notified of the bed malfunction and the facility did not attempt to obtain preventive guidelines or instructions. Preventive measures were not implemented for the remaining eleven (11) beds and facility staff was not educated on malfunction precautions. Further interview with Maintenance Staff Person #1 on 08/20/15 at 1:52 PM revealed all resident beds were inspected monthly to ensure the bed controls, brakes, wheels, loose parts, plugs, and rails functioned properly. Maintenance Staff Person #1 stated the facility did not have a specific checklist or guideline to determine what needed to be inspected on the beds. Interview with the bed Manufacturer Representative on 08/20/15 at 10:20 AM, revealed manufacturer guidelines were no longer available related to that bed model being "obsolete." The Manufacturer Representative stated Resident #19's bed model had been discontinued in 1993 and parts for the model had not been manufactured since 1998. Further interview revealed prior to any maintenance or repairs to the beds the facility should have referred to the Manufacturer instructions or recommendations for maintenance. The Manufacturer Representative also stated the	F 456	utilize the lock-out – tag-out practice until such repairs can be made. (Attachment #3) The facility will sustain performance through the following monitoring practices: <ul style="list-style-type: none"> • The Environmental Services Director, or his designee, will complete a minimum of a monthly bed inspection on all facility beds. (Attachment #4 – includes checklist) • The Environmental Services Director has modified the monthly Quality Indicator report for Environmental Services to include a summary of inspections and repairs made to facility beds as part of the Quality Assurance program for the Environmental Services Department. A monthly report will be provided to the Administrator, and a quarterly summary will be provided to and reviewed with the Medical Director (Attachment #5). 	9/17/15	

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F 456	<p>Continued From page 21</p> <p>facility should have reported any bed malfunction that resulted in resident harm.</p> <p>Interview with the Maintenance Director on 08/20/15 at 2:12 PM, revealed twelve (12) beds were donated to the facility and the maintenance staff did not receive training or manufacturer's guidelines to ensure the donated beds were maintained properly. The Maintenance Director confirmed monthly bed inspections were completed on all facility beds; however, the facility did not have a policy pertaining to the maintenance of resident care equipment and no specific guidelines were utilized for the bed inspections. The Maintenance Director stated after Resident #19's bed malfunctioned the bed was removed from the facility and the eleven (11) remaining models were inspected for moisture or corrosion. The facility did not utilize manufacturer guidelines during the inspection of the eleven (11) beds and did not identify any concerns. Further interview revealed no preventive measures were put into place to ensure another bed malfunction did not occur. The facility continued to utilize the remaining eleven (11) beds for resident use. The Maintenance Director stated that type of malfunction "shouldn't happen ever again." The Maintenance Director stated he had instructed staff to raise the beds to the highest level, using the control panel at the foot of the bed, in the event side rail controls failed to work properly. Further interview revealed maintenance staff had replaced the motor in one of the other eleven (11) beds due to resident overuse. The Maintenance Director stated "spare parts" were used during the repair</p> <p>Interview with the Administrator on 08/20/15 at 5:30 PM revealed she was aware of Resident</p>	F 456		

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F 456	Continued From page 22 #19's bed malfunction. The Administrator stated the eleven (11) beds that were the same model as Resident #19's bed were inspected after the bed malfunction and no concerns were identified. Further interview confirmed no manufacturer guidelines were utilized. The Administrator stated no preventive measures were put into place to ensure the other eleven (11) beds did not malfunction and facility staff was not educated on precautions to take with the beds. The Administrator stated Resident #19's bed model was some of the facility's "better beds and functions very well." Further interview revealed she did not feel the maintenance staff should have done anything more.	F 456			
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520	F520 COMMITTEE-MEMBERS / MEET QUARTERLY / PLANS The facility has ensured the following corrective action:		
			<ul style="list-style-type: none"> SRNA #2 was contacted via telephone due to suspension from active duty and informed of failure to follow facility policy during treatment. Employee was informed of termination of employment due to prior disciplinary actions accrued during her employment. (Attachment #1a) SRNA #8 was provided immediate in-service training / written warning regarding failure to comply with the facility policy on privacy during treatment. (Attachment #1b) The Administrator provided written counseling to the Director of Nursing 		

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F 520	<p>Continued From page 23</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, review of the facility's Investigation, and review of the facility's Plan of correction dated 07/16/15, it was determined the facility failed to implement plans of action to correct identified quality deficiencies. The facility developed a Plan of Correction and stated all nursing staff would be educated regarding the facility's Privacy During Treatment Protocol. However, the facility failed to ensure two (2) Certified Nursing Assistants (CNAs) received the training. On 08/09/15, the CNAs bathed two (2) residents in the same shower stall (refer to F164).</p> <p>The findings include:</p> <p>Review of a Statement of Deficiencies (CMS-2567) dated 06/19/15, revealed a deficiency was issued to the facility for failure to provide privacy (failed to close the window blinds) for a resident during care of the resident's urinary catheter and an assessment of the resident's skin.</p> <p>Review of the facility's Plan of Correction (POC) dated 07/16/15, revealed in-service training regarding the facility's "Privacy During Treatment" Policy/Procedure was provided to all nursing staff including nurse aides on 06/19/15. The POC stated nurses would do daily "spot checks" for privacy during treatment for thirty (30) days and</p>	F 520	<ul style="list-style-type: none"> regarding duty to complete all in-service training as assigned. <p>The facility has taken the following action to prevent this practice from affecting other residents:</p> <ul style="list-style-type: none"> All nursing staff were provided re-training on the Privacy During Treatment Protocol by the Director of Nursing on 8/20/15. (Attachment #3) All facility staff were provided re-training / additional review on the Privacy During Treatment Protocol by the Administrator on 8/28/15. (Attachment #4) <p>The facility has initiated the following systemic changes to prevent this practice from recurring:</p> <ul style="list-style-type: none"> The charge nurse daily round sheet was modified to include one spot check per shift for the additional measure of privacy during showers as noted during the recent investigation. (Attachment #5) Results of the charge nurse findings will be immediately brought to the attention of the Unit Coordinators for correction or other disciplinary action. (Attachment #5) 	

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F 520 Continued From page 24
Unit Coordinators would "randomly spot check" ten (10) times per month. The POC further stated the Director of Nursing (DON) would summarize the results and any required corrective action as part of the monthly Quality Assurance (QA) report to the Administrator. Review of the "Quarterly Nursing CQI [Continuous Quality Improvement] Report" revealed Unit Coordinators were observing for privacy during treatment. The POC did not address any Quality Assurance activity to ensure all staff was educated on the facility's privacy policy.

Review of the facility's Investigative Report dated 08/10/15, revealed that on 08/09/15, Certified Nurse Aides (CNAs) #2 and #8 bathed Resident #16 and a Personal Care Home resident in the same shower stall at the same time. The investigation determined that CNA #2 and CNA #8 failed to follow the facility's policy and procedures related to ensuring residents were afforded privacy during care and treatment.

Interview with CNA #8 on 08/19/15, at 12:50 PM, revealed she did recognize that it was inappropriate to shower residents together in the same stall. CNA #8 stated she had not attended an in-service or received training related to providing privacy to residents in the facility.

Review of the facility's in-service "Resident Privacy" Sign in Sheet dated 06/16/15, revealed neither CNA #2 nor CNA #8 had attended the training. The facility also conducted in-services on 07/03/15 and 07/19/15 related to ensuring resident privacy; however, review of these sign-in sheets revealed CNA #2 and CNA #8 did not attend these in-services either.

F 520 • The Unit Coordinator monthly check list was further modified to include privacy checks 10x/month. Immediate report of non-compliance with the measure will be reported to the Director of Nursing and / or the Administrator. (Attachment #6)

The facility will sustain performance through the following monitoring practices:

- As part of the ongoing Quality Assurance program for nursing services, the Director of Nursing will inform the Administrator of any employee failure to comply with the facility policy. Immediate corrective action will be taken to ensure compliance, up to and including termination of employment. The DON will present a summary of checks (charge nurse and Unit Coordinators) and findings to the Administrator each month, and a quarterly report / review will be conducted with the facility Medical Director. (Attachment #7)

COMPLETION DATE:

9/1/15

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F 520 Continued From page 25

F 520

Interview with the Director of Nursing (DON) on 08/20/15 at 3:20 PM, revealed that after reviewing all of the privacy in-services held by the facility, she discovered that she had overlooked the fact that CNA #2 and CNA #8 had not attended any of the privacy in-services. The DON stated it had been her responsibility to ensure all nursing staff had been trained on the privacy policy; however, she failed to recognize that CNA #2 and CNA #8 had not attended the training until 08/20/15.

Interview with the Administrator on 08/20/15 at 5:30 PM, revealed she was not aware that CNA #2 and CNA #8 had not attended the required training related to providing resident privacy.

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F 000	INITIAL COMMENTS	F 000	
F 164 SS=D	<p>A standard health survey was conducted on 06/16-19/15. Deficient practice was identified with the highest scope and severity at "G" level.</p> <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	<p>F164 Personal Privacy/Confidentiality or Records</p> <p>The facility has ensured the following corrective action:</p> <ul style="list-style-type: none"> The Director of Nursing provided 1:1 counseling with staff member who conducted skin assessment and provided cath care. (Attachment #1) <p>The facility has taken the following action to prevent this practice from affecting other residents:</p> <ul style="list-style-type: none"> The Director of Nursing interviewed alert and oriented residents x 7 to ensure other facility residents were provided privacy during care and treatment. No further issues were noted. <p>The facility has initiated the following systemic changes to prevent this practice from recurring:</p> <ul style="list-style-type: none"> The Privacy During Treatment Protocol was developed and all facility staff were provided in-service training on 6/19/15. (Attachment #2) On 6/19/15 an in-service training was provided to all nurse aide / CMA / nurse

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 System Enforcement Branch

REGULATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Anne Wills* TITLE: *Administrator* (X6) DATE: *8/4/15*

A 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: 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	<ul style="list-style-type: none"> staff regarding privacy during routine care. (Attachment #3a-b) <p>The facility will sustain performance through the following monitoring practices:</p> <ul style="list-style-type: none"> Nurse checklist modified to include daily spot checks regarding privacy during care for the next 30 days. (Attachment #4) Unit Coordinators to randomly spot check 10x/month. (Attachment #5) As part of the ongoing Quality Assurance program for nursing, the Director of Nursing will summarize results and any required corrective action taken, as part of the monthly QA report to the Administrator. Quarterly reports / review will be made to the facility Medical Director. (Attachment #6) <p>COMPLETION DATE: 7/6/15</p>

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F 164	Continued From page 2 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. 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. 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. 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. 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	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	F221 Right to be Free from Restraints The facility has ensured the following corrective action: <ul style="list-style-type: none"> The Director of Nursing provided 1:1 counseling with staff member regarding the scheduled release of restraint for Resident #7. (Attachment #1) Resident #11 was reassessed for safety device following inability to self-release during annual survey inspection. The self-releasing seat belt was subsequently discontinued, and a tab alarm trial was initiated. The facility has taken the following action to prevent this practice from affecting other residents: <ul style="list-style-type: none"> The Director of Nursing and Unit Coordinators reviewed all resident restraint usage to ensure appropriate devices were in place for each resident. Adjustments were made to safety devices and care plans as indicated. (Attachment #2) The Director of Nursing provided an in-service / re-training to nursing staff on the Restraint Policy. (Attachment #3a-c) 		

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F 221	Continued From page 4 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. 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. 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. 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. 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				
F 221	The facility has initiated the following systemic changes to prevent this practice from recurring: <ul style="list-style-type: none"> Daily monitoring of restraint usage and scheduled release was added to the Charge Nurse checklist for ongoing monitoring. (Attachment #4) <p>The facility will sustain performance through the following monitoring practices:</p> <ul style="list-style-type: none"> As part of the ongoing Quality Assurance program for the nursing department, the Unit Coordinators will perform spot checks for restraint removal at meal times, and will conduct a minimum of a quarterly review of restraints / safety devices for each facility resident. (Attachment #5) The Director of Nursing will present a summary of the monthly findings and corrective actions, if needed to the Administrator. A quarterly summary of QA indicator results will be presented to the Medical Director. (Attachment #6) <p>COMPLETION DATE: 7/6/15</p>				

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NAME OF PROVIDER OR SUPPLIER EDGEWOOD ESTATES		STREET ADDRESS, CITY, STATE, ZIP CODE 195 BERRYMAN ROAD FRENCHBURG, KY 40322	
CAID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 221 Continued From page 5 F 221

lap buddy and use the lap tray during meals.

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.

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.

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.

Interview with the Administrator on 06/19/15 at 1:41 PM, revealed she attended weekly care plan meetings for residents. Continued interview with

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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

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 224 483 13(c) PROHIBIT
SS=G MISTREATMENT/NEGLECT/MISAPPROPRIATE

F 224 F224 Prohibit Mistreatment / Neglect / Misappropriation

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

The facility has ensured the following corrective action:

- The Director of Nursing provided written counseling to staff members regarding failure to use gait belt during transfer of resident. (Attachment #1)
- The Director of Nursing provided in-service / re-training with all nursing department employees regarding the facility policy that gait belts are to be used for all resident transfers for optimum safety. (Attachment #2)

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)

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F 224 Continued From page 8

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.

The findings include:

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.

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.

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

F 224 The facility has taken the following action to prevent this practice from affecting other residents:

- The Director of Nursing and Unit Coordinators reviewed skin assessments, resident records, and falls for the prior 3 months to identify if any resident injury resulted from neglect of care. None were identified.
- The Resident Abuse / Neglect Policy was revised on 6/23/15 with the definition of neglect expanded for further clarity. (Attachment #3)
- The Investigative Report was modified to include specific questioning regarding neglect of services. (Attachment #4)
- The Administrator provided in-service training to all facility employees regarding the revised Resident Abuse / Neglect Policy. (Attachment #5)

The facility has initiated the following systemic changes to prevent this practice from recurring:

- The Charge Nurse checklist was modified to include daily documented checks for the use of gait belts during resident transfers. (Attachment #6)

The facility will sustain performance through the following monitoring practices:

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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.

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.

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.

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."

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

F 224 As part of the ongoing Quality Assurance for nursing services, the following measures have been initiated:

- The North and South Unit Coordinators will monitor gait belt usage 20x/month. A summary report will be forwarded to the Director of Nursing with any corrective action, if required. (Attachment #7)
- The Director of Nursing will review summary report and initiate additional measures as needed. A monthly QA summary will be provided to the Administrator. Quarterly summary review will be made to the facility Medical Director. (Attachment #8)

COMPLETION DATE: 7/13/15

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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	F225 Investigate/Report Allegations / Individuals The facility has ensured the following corrective action: <ul style="list-style-type: none"> The Administrator conducted in-service / re-training with all facility staff regarding the Resident Abuse / Neglect policy and reporting requirements. (Attachment #1) The facility has taken the following action to prevent this practice from affecting other residents: <ul style="list-style-type: none"> The Resident Abuse and Neglect policy was revised as to duties and definitions. (Attachment #2) The Investigative Report was modified to include findings of neglect as well as abuse. (Attachment #3) The facility has initiated the following systemic changes to prevent this practice from recurring: <ul style="list-style-type: none"> The revised Resident Abuse and Neglect policy outlines duties of the Charge Nurse in the reporting of investigative findings. (Attachment #4) 		

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F 225 Continued From page 12
certification agency) within 5 working days of the
incident, and if the alleged violation is verified
appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced
by:
Based on 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.

The findings include:

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."

Record review revealed the facility admitted the

F 225 The facility will sustain performance
through the following monitoring
practices:

- The Administrator, Director of Nursing,
and Social Services Director / Corporate
Compliance Officer will review all
reports / investigations for compliance
with the Resident Abuse and Neglect
policy and initiate any further
corrective action as required.
- The Social Services Director will present
a summary of Investigative Reports
monthly to the Administrator as part of
the ongoing Quality Assurance
program. Quarterly summary reports
will be provided to and reviewed with
the facility Medical Director.
(Attachment #5)

COMPLETION DATE: 7/5/15

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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	F279 Comprehensive Assessment / Care Plans The facility has ensured the following corrective action: • The Director of Nursing and North Unit Coordinator reviewed / revised the comprehensive care plan for Resident #13 to designate the use of the mechanical lift for all transfers. (Attachment #1)	

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NAME OF PROVIDER OR SUPPLIER EDGEWOOD ESTATES		STREET ADDRESS, CITY, STATE, ZIP CODE 195 BERRYMAN ROAD FRENCHBURG, KY 40322	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)
			(X5) COMPLETION DATE

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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).

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.

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.

F 279 The facility has taken the following action to prevent this practice from affecting other residents:

- The North and South Unit Coordinators reviewed / amended all resident care plans to include the use of gait belts / lifts during transfers, unless otherwise contraindicated (independent with transfers). (Attachment #2a-b)

The facility has initiated the following systemic changes to prevent this practice from recurring:

- The Charge Nurse checklist was modified to include daily monitoring for gait belts / lift usage. Nurses are to initiate immediate corrective action to ensure compliance. (Attachment #3)
- In-service / re-training was provided to staff nurses regarding Comprehensive Care Plan assessment and development. (Attachment #4a-b)

The facility will sustain performance through the following monitoring practices:

As part of the on-going Quality Assurance program for nursing services, the following measure have been initiated:

- The North and South Unit coordinators will conduct random checks to ensure compliance, initiating additional corrective

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The findings include:

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).

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!"

Review of the facility's policy titled "Fall Protocol," revision date of 05/01/14, revealed residents should be transferred using a gait belt.

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.

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

F 279

action, if required. A monthly summary report will be provided to the Director of Nursing for review. (Attachment #5)

- The Director of Nursing will review summary report and include findings / corrective measures as part of the monthly QA report to the Administrator. Quarterly QA reports will be provided to and reviewed with the facility Medical Director. (Attachment #6)

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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.

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.

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.

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

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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 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN
SS=E

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 279

F 282

F282 Services by Qualified Persons/ Per Care Plan

The facility has ensured the following corrective action:

- The Director of Nursing and Unit Coordinators reviewed Care Plans for residents #3, 5, 7, 9 to ensure braces, splints and catheters were listed as ordered by their physicians.
- The Director of Nursing provided 1:1 counseling with staff members regarding failure to follow the resident's plan of care. (Attachment #1)

The facility has taken the following action to prevent this practice from affecting other residents:

- The Director of Nursing and Unit Coordinators reviewed all other resident care plans to ensure that braces, splints, catheter, etc. devices were listed as ordered by the physician.
- In-service / re-training was provided to all facility nursing staff on Care Plan

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revealed it was the responsibility of the Charge Nurse to ensure all interventions were followed on the care plan.

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.

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.

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.

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

F 282

- Assessments and Restraint Policies. (Attachment #2a-c)
- In-service training was provided to all facility nursing staff on Catheter Care Protocol. (Attachment #3)

The facility has initiated the following systemic changes to prevent this practice from recurring:

- The Charge Nurse checklist was modified to include daily checks per shift on brace application, securing catheters during peri-care, and restraint removal. Staff nurses will initiate immediate corrective action, if required, to ensure compliance with resident care plans. (Attachment #4)

The facility will sustain performance through the following monitoring practices:

As part of the on-going Quality Assurance program for nursing services, the following measures have been initiated:

- The North and South Unit coordinators will conduct designated random checks of catheter care, restraint usage, and splint / brace application. Additional measures will be initiated by Unit Coordinators as needed to ensure compliance with resident needs per their plan of care. A monthly summary report

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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	<p>will be provided to the Director of Nursing. (Attachment #5)</p> <ul style="list-style-type: none"> The Director of Nursing will review summary report and make corrections as needed. A monthly QA summary will be included on the nursing department report to the Administrator. Quarterly reports will be provided to and reviewed with the facility Medical Director. (Attachment #6) <p>COMPLETION DATE: 7/13/15</p>

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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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with the facility revealed she conducted rounds monthly to ensure care plans were being followed and resident care needs were being met.

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.

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.

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.

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.

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

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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."

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.

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.

4 Record review revealed the facility admitted the resident on 08/21/14 with diagnoses that included Urinary Retention and Prostate Cancer.

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.

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.

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of bowel and required an indwelling urinary catheter.

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.

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.

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."

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."

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

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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 315 483.25(d) NO CATHETER, PREVENT UTI,
SS=E RESTORE BLADDER

F 315 **F315 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.

The facility has ensured the following corrective action:

- The Director of Nursing ensured the secure placement of catheters for residents #5 and #9, and verbally addressed the standard of care with Charge Nurse and aides on duty.
- The Director of Nursing provided 1:1 counseling to staff member regarding best practice guidelines for catheter care. (Attachment #1)

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.

The facility has taken the following action to prevent this practice from affecting other residents:

- The North and South Unit Coordinators visually checked other facility residents who have catheters ordered to ensure security and proper anchoring of the device.
- Catheter Care Protocol was developed 6/23/15. (Attachment #2)
- In-service / re-training to all nursing department staff regarding best practice

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F 315 Continued From page 27

The findings include:

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.

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.

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.

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.

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

F 315 • guidelines for catheter care, peri-care, and infection control. (Attachment #3 a-c)

The facility has initiated the following systemic changes to prevent this practice from recurring:

- The Charge Nurse daily checklist has been modified to include random monitoring of resident catheter care to ensure compliance with best practice guidelines. All residents with catheters will be monitored a minimum of weekly. The Charge Nurse will randomly check the security of all resident catheters daily. Daily reports will be submitted to the Unit Coordinators. (Attachment #4)

The facility will sustain performance through the following monitoring practices:

As part of the ongoing Quality Assurance program for nursing services, the following practice has been initiated:

- The North and South Unit Coordinators will review nurse reports daily and initiate corrective action as indicated.
- The North and South Unit Coordinators will report summary of daily monitoring to the Director of Nursing. (Attachment #5)
- The Director of Nursing will review the summary and initiate any further corrective actions as indicated. A summary of the monthly QA report will be submitted to the Administrator

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F 315 Continued From page 28
drainage tubing was secured to the resident's leg
at all times to prevent tension or accidental
removal.

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.

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.

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 to be cognitively intact.

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.

Observation of urinary catheter care conducted

F 315 Quarterly reports will be presented and
reviewed with the Medical Director.
(Attachment #6)

COMPLETION DATE: 7/13/15

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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		

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F 318 Continued From page 30
SS=D IN RANGE OF MOTION

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.

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.

The findings include:

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.

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.

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.

F 318 F318 Increase/Prevent Decrease in Range of Motion

The facility has ensured the following corrective action:

- Upon identification of the deficient practice, the Director of Nursing immediately instructed and observed the Charge Nurse and aides on duty in the application of resident #3's brace per physician orders.
- The Director of Nursing provided 1:1 counseling for nursing staff regarding the application of physician-ordered services. (Attachment #1)

The facility has taken the following action to prevent this practice from affecting other residents:

- The Director of Nursing, North Unit Coordinator and South Unit Coordinator conducted a review of all facility residents who are prescribed splints/braces to ensure compliance with physician orders.

The facility has initiated the following systemic changes to prevent this practice from recurring:

- All resident nurse aide care plans were amended to include the flagging of brace/splint usage and required documentation/compliance. (Attachment #2)

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			(K5) COMPLETION DATE

F 318 Continued From page 31
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.

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.

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."

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).

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.

However, observation of Resident #3 on 06/16/15 at 3:25 PM, 4:05 PM, and 5:30 PM, and on

F 318 • The Charge Nurse checklist was modified to include daily monitoring for brace/splint placement to all facility residents who have a physician's order for the device to ensure compliance. (Attachment #3)

The facility will sustain performance through the following monitoring practices:

As part of the on-going Quality Assurance program for nursing services, the following practice has been initiated:

- The North and South Unit Coordinators will conduct random spot checks for brace/splint placement 5x/month and PRN. A summary report of findings, and corrective action taken for any noted deficient practice, will be presented to upon completion to the Director of Nursing. (Attachment #4)
- The Director of Nursing will review reports and initiate any further corrective action, if required. A monthly summary of QA indicators and corrective measures will be presented to the Administrator. Quarterly QA reports will be provided to and reviewed with the facility Medical Director. (Attachment #5)

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F 318 Continued From page 32

F 318

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.

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."

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.

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."

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."

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F 323 Continued From page 33
F 323 483 25(h) FREE OF ACCIDENT
SS=G 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 F323 Free of Accident
F 323 Hazards/Supervision/Devices

The facility has ensured the following corrective action:

- The Director of Nursing provided written counseling to facility Unit Coordinator and Charge Nurse staff regarding the monitoring of use / placement of resident safety devices. (Attachment #1)

The facility has taken the following action to prevent this practice from affecting other residents:

- The Director of Nursing provided in-service / re training for all department staff regarding facility policy that gait belts are to be utilized with all resident transfers, unless contraindicated on a resident's plan of care. (Attachment #2)
- The Director of Nursing, North Unit Coordinator, and South Unit Coordinator completed a review of resident care plans to ensure accuracy of transfer assistance. Nurse aide care plans were updated to include a flagged reminder when a resident requires transfer assistance and use of gait belt.

The facility has initiated the following systemic changes to prevent this practice from recurring:

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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	<ul style="list-style-type: none"> The Charge Nurse checklist was modified to include daily documented checks for the use of gait belts during transfers. (Attachment #3) <p>The facility will sustain performance through the following monitoring practices:</p> <p>As part of the on-going Quality Assurance program for nursing services, the following practice has been initiated:</p> <ul style="list-style-type: none"> The North and South Unit Coordinators will conduct random spot checks of gait belt usage 2x per week / shift to ensure that gait belts are utilized during resident transfer. A weekly report will be presented to the Director of Nursing of findings and any corrective action required to ensure compliance. (Attachment #4) The Director of Nursing will review weekly reports and present a summary of Nurse and Unit Coordinator findings on the monthly QA report submitted to the Administrator, and the quarterly QA report submitted to the Medical Director. (Attachment #5) <p style="text-align: right;">COMPLETION DATE: 7/14/15</p>	

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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 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 • As part of the ongoing Quality Assurance program for the dietary department, the Director of Dietary Services will monitor the proper disposal of soiled gloves twice weekly. (Attachment #4) • Summary of the weekly checks and any required corrective action will be presented monthly to the Administrator, and quarterly review will be made to the facility Medical Director. (Attachment #5) COMPLETION DATE: 6/26/15		
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.		F431 Drugs Records, Label/Store Drugs & Biologicals The facility has ensured the following corrective action: • A corrected label was obtained from pharmacy to ensure accurate dosage for medication. • Out-of-date medication was discarded.		

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F 431	<p>Continued From page 38</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 expired and available for resident use.</p>	F 431	<ul style="list-style-type: none"> The Director of Nursing provided 1:1 counseling with Certified Medication Aide staff on the timely disposal of out-of-date medication. (Attachment #1) <p>The facility has taken the following action to prevent this practice from affecting other residents:</p> <ul style="list-style-type: none"> The North Unit Coordinator and South Certified Medication Aide immediately reviewed all stored medication upon identification of the deficient practice to ensure labels were accurate and medication was within current date-of-use. All insulin medication was checked to ensure expiration dates were within a 28 day period. (Attachment #2) The Director of Nursing conducted an in-service / re-training to facility Certified Medication Aide staff and Staff Nurses on the facility 1) Expired Medications Protocol; and, 2) Multidose Vials Storage & Disposal Protocol. (Attachment #3a-c) In-service training was provided to all facility nurse / certified medication aide staff regarding the Medication Administration Protocol. (Attachment #4a-b) <p>The facility has initiated the following systemic changes to prevent this practice from recurring:</p>	
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F 431 Continued From page 39

The findings include:

1. 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.

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

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.

2. 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.

Observations on 06/18/15 of the medication room on the South Wing at 5:05 PM revealed an opened vial of Humulin Regular insulin for

- F 431
- A 30-day / monthly checklist was developed and initiated requiring staff signature on expiration dates for medication. (Attachment #5)
 - The facility Pharmacist modified the monthly nursing station review form to monitor for labels and expired medication. (Attachment #6)

The facility will sustain performance through the following monitoring practices:

As part of the ongoing Quality Assurance program for nursing services, the following practice has been initiated:

- The North and South Unit Coordinators will conduct a weekly review of the checklist to ensure insulin / other medication is being monitored accurately. The Unit Coordinators will initiate immediate corrective action regarding any deficient practice identified. (Attachment #7)
- The Unit Coordinators will conduct random checks to insulin dates 5x/month. A monthly summary will be presented to the Director of Nursing for review.
- The Director of Nursing will initiate any further corrective action, if indicated. The nursing monthly QA report will include a summary of findings, and will be presented to the Administrator. Quarterly review of nursing QA

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F 431	Continued From page 40 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	indicators will be presented to and reviewed with the Medical Director. (Attachment #8) COMPLETION DATE: 7/14/15		
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. (b) Preventing Spread of Infection	F 441	F441 Infection Control, Prevent Spread, Linens The facility has ensured the following corrective action: • The Director of Nursing provided 1:1 counseling with staff members regarding best practice guidelines for preventing the spread of infections. (Attachment #1) The facility has taken the following action to prevent this practice from affecting other residents:		

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F 441	Continued From page 41 (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT 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 care/incontinence care for Resident #5, Resident	F 441	<ul style="list-style-type: none"> Detailed hand washing techniques were outlined in the revised Infection Control Policy (Attachment #2a/ page3) In-service training was provided to all facility nursing staff regarding the Infection Control Policy. (Attachment #2b) <p>The facility has initiated the following systemic changes to prevent this practice from recurring:</p> <ul style="list-style-type: none"> In-service training was provided to all facility nursing staff regarding the Skin Assessment Protocol. (Attachment #3) In-service training was provided to all facility nursing staff regarding the Catheter Care Protocol. (Attachment #4) <p>The facility will sustain performance through the following monitoring practices:</p> <p>As part of the ongoing Quality Assurance program for nursing services, the following practice has been initiated:</p> <ul style="list-style-type: none"> The North and South Unit Coordinators will perform 5 visual checks (each) for resident skin assessments. Corrective action / instruction will be documented at the time of the assessment with specific staff, if required. A monthly summary of skin assessment checks will be provided 		

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<p>F 441 Continued From page 42 #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 skin assessment of Resident #3. LPN #1 washed</p>	<p>F 441</p> <p>to the Director of Nursing for review. (Attachment #5)</p> <ul style="list-style-type: none"> The Director of Nursing will review skin assessment checks and include a summary of findings / corrective action as part of the nursing department monthly QA report to the Administrator. Quarterly review of nursing indicators will be reviewed with the Medical Director. (Attachment #6) <p>COMPLETION DATE: 7/14/15</p>
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F 441	<p>Continued From page 43</p> <p>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> <p>On 06/17/15 at 9:50 AM, observation of RN #1</p>	F 441	

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F 441	Continued From page 44 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. 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. 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." 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. 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.	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 on it when I started back in February 2015." She</p>	F 441	

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F 441	<p>Continued From page 46</p> <p>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 at 3:03 PM revealed the RN was not aware she</p>	F 441		

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F 441	<p>Continued From page 47</p> <p>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 soiled gloves four (4) times during the course of</p>	F 441		

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STATEMENT OF DEFICIENCIES TITLE PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185423	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/19/2015
NAME OF PROVIDER OR SUPPLIER EDGEWOOD ESTATES		STREET ADDRESS, CITY, STATE, ZIP CODE 195 BERRYMAN ROAD FRENCHBURG, KY 40322		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 48 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 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; and progress notes.	F 441		
F 514		F 514	F514 Records- Complete/ Accurate/Accessible The facility has ensured the following corrective action: <ul style="list-style-type: none">The Director of Nursing reviewed resident #3's care plan to ensure accuracy of device per physician orders.The Director of Nursing provided 1:1 counseling with staff member regarding care plan compliance and accurate documentation. (Attachment #1)	

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F 514 Continued From page 49

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.

The findings include:

Interview with the Administrator on 06/22/15 at 1:00 PM revealed the facility did not have a policy regarding accuracy of records.

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.

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.

Review of Resident #3's care plan for Activities of Daily Living (ADL) Functional/Rehabilitation

F 514 The facility has taken the following action to prevent this practice from affecting other residents:

- The Director of Nursing, North Unit Coordinator and South Unit Coordinator reviewed all resident care plans and documentation. At the present time, there is only one splint / brace ordered by a resident's physician.
- The Administrator and Director of Nursing conducted an in-service / re-training to all facility nursing staff regarding accuracy of documentation. (Attachment #2)

The facility has initiated the following systemic changes to prevent this practice from recurring:

- The Charge Nurse checklist was modified to include daily checks for splint / brace placement. Charge nurse to initiate corrective action, if required, for any noted non-compliance. (Attachment #3)
- The nurse aide care plans were modified with splint / brace area flagged for accurate documentation.

The facility will sustain performance through the following monitoring practices:

As part of the ongoing Quality Assurance for nursing services, the following measures have been initiated:

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F 514	Continued From page 50 Potential revealed staff was required to apply the resident's right knee immobilizer and plantar flexion boot for eight (8) hours daily. 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. 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. 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. Interview with Licensed Practical Nurse (LPN) #1 on 06/18/15 at 6:10 PM, revealed she was aware SRNA #4 was supposed to put on Resident #3's	F 514	<ul style="list-style-type: none"> The North and South Unit Coordinators will perform a random visual check and record review for splint / brace placement 5x/month. A summary report, including any further required corrective measures, will be presented to the Director of Nursing for review monthly. (Attachment #4) The Director of Nursing will review the summary and include findings as part of monthly QA report to Administrator. Quarterly report and review will be made to the facility Medical Director. (Attachment #5) 	COMPLETION DATE: 7/14/15	

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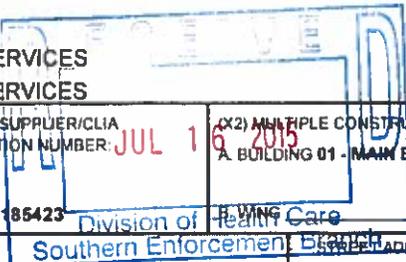
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F 514	<p>Continued From page 51</p> <p>knee immobilizer and plantar flexion brace daily. She stated she did not realize that SRNA #4 had documented that Resident #3's knee immobilizer and plantar flexion had been on for eight (8) hours on 06/16/15, 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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NAME OF PROVIDER OR SUPPLIER EDGEWOOD ESTATES	ADDRESS, CITY, STATE, ZIP CODE 196 BERRYMAN ROAD FRENCHBURG, KY 40322
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K 000 INITIAL COMMENTS

K 000

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 029 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F

K 029

One hour fire rated construction (with ¾ hour

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

Anne Hills

TITLE

Administrator

(X6) DATE

7/16/15

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

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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	<p>The facility has ensured the following corrective action:</p> <ul style="list-style-type: none"> An outside venting pipe and an outside fresh air return pipe were installed in the North and South hot water heater rooms. <p>The facility has taken the following action to prevent this practice from affecting other residents:</p> <ul style="list-style-type: none"> Both hot water heater areas are now vented to the outside and have adequate fresh air return. <p>The facility has initiated the following systemic changes to prevent this practice from recurring:</p> <ul style="list-style-type: none"> The installation of outside venting and fresh air return pipes was accomplished 6/24/15. <p>The facility will sustain performance through the following monitoring practices:</p> <ul style="list-style-type: none"> The Environmental Services Director will ensure that venting pipes remain free of debris and damage as part of the ongoing monthly maintenance review. (Attachment #1) <p>COMPLETION DATE: 6/24/15</p>	

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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"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (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 	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. 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 K 062 SS=D	<p>Continued From page 4</p> <p>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.</p> <p>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</p> <p>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.</p> <p>The findings include:</p> <p>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.</p> <p>The findings were acknowledged by the Administrator during the exit interview.</p>	K 029 K 062	<p>The facility has ensured the following corrective action:</p> <ul style="list-style-type: none"> New low-clearance lights were installed in the South shower area to ensure full clearance of sprinkler system. <p>The facility has taken the following action to prevent this practice from affecting other residents:</p> <ul style="list-style-type: none"> North shower area was inspected by the Environmental Services Department and low-clearance lights were also installed to replace old lighting and ensure adequate clearance for the sprinkler system. <p>The facility has initiated the following systemic changes to prevent this practice from recurring:</p> <ul style="list-style-type: none"> The lights and sprinkler system will be maintained per manufacturer directions. <p>The facility will sustain performance through the following monitoring practices:</p> <ul style="list-style-type: none"> The Environmental Services Director will ensure that the sprinkler system is fully operational and maintained per regulatory standards. (Attachment #1) <p>COMPLETION DATE: 6/23/15</p>

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K 062	<p>Continued From page 5 Reference: NFPA 13 (1999 Edition).</p> <p>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.</p> <p>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.</p> <p>Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)</p> <p>Distance from Sprinklers to side of Obstruction (A). Maximum Allowable Distance of Deflector above Bottom of Obstruction (in.) (B)</p> <table border="1"> <thead> <tr> <th>Side of Obstruction (A)</th> <th>Obstruction (in.) (B)</th> </tr> </thead> <tbody> <tr> <td>Less than 1 ft</td> <td>0</td> </tr> <tr> <td>1 ft to less than 1 ft 6 in.</td> <td>2 1/2</td> </tr> <tr> <td>1 ft 6 in. to less than 2 ft</td> <td>3 1/2</td> </tr> <tr> <td>2 ft to less than 2 ft 6 in.</td> <td>5 1/2</td> </tr> <tr> <td>2 ft 6 in. to less than 3 ft</td> <td>7 1/2</td> </tr> <tr> <td>3 ft to less than 3 ft 6 in.</td> <td>9 1/2</td> </tr> <tr> <td>3 ft 6 in. to less than 4 ft</td> <td>12</td> </tr> <tr> <td>4 ft to less than 4 ft 6 in.</td> <td>14</td> </tr> <tr> <td>4 ft 6 in. to less than 5 ft</td> <td>16 1/2</td> </tr> <tr> <td>5 ft and greater</td> <td>18</td> </tr> </tbody> </table> <p>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).</p> <p>K 147 NFPA 101 LIFE SAFETY CODE STANDARD SS=D</p>	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	K 062	
Side of Obstruction (A)	Obstruction (in.) (B)																								
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185423	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/17/2015
NAME OF PROVIDER OR SUPPLIER EDGEWOOD ESTATES		STREET ADDRESS, CITY, STATE, ZIP CODE 196 BERRYMAN ROAD FRENCHBURG, KY 40322	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
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	<p>The facility has ensured the following corrective action:</p> <ul style="list-style-type: none"> Empty supply boxes were immediately removed from the electrical panel area. The area in front of the electrical panel was marked off with yellow tape to identify the mandatory minimum clearance space (3 feet). The individual employee received 1:1 counseling regarding placement of boxes in the electrical panel area. (Attachment #1) <p>The facility has taken the following action to prevent this practice from affecting other residents:</p> <ul style="list-style-type: none"> The area in front of all facility electrical panels were marked off with yellow tape to identify the mandatory minimum clearance space (3 feet). <p>The facility has initiated the following systemic changes to prevent this practice from recurring:</p> <ul style="list-style-type: none"> Dietary employees received in-service training regarding the electrical panel safety on 6/17/15 by the Director of Dietary Services. (Attachment #2) All facility employees received in-service training regarding the electrical panel safety on 6/19/15 by the facility Administrator. (Attachment #3) <p>The facility will sustain performance through the following monitoring practices:</p>

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K 147 Continued From page 7
lock and key shall be considered accessible to qualified persons.
(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.
(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.

Table 110.26(A)(1) Working Spaces

Nominal Voltage to Ground Distance	Minimum Clear Distance		
	Condition 1	Condition 2	Condition 3
0-150: mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)
151-600: mm (3 ft)	900 mm (3 ft)	1 m (3½ ft)	1.2 m (4 ft)

Note: Where the conditions are as follows:

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.
Condition 2 - Exposed live parts on one side and grounded parts on the other side. Concrete, brick, or tile walls shall be considered as

- K 147 • As part of the ongoing Quality Assurance for maintenance, the Environmental Services Director will monitor electrical panel clearance a minimum of once weekly per panel. (Attachment #4)
- Summary of the weekly checks will be included as part of the monthly Environmental Services Department QA report submitted to the Administrator. Quarterly summary will be provided to and reviewed with the Medical Director. (Attachment #5)

COMPLETION DATE: 6/19/15

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K 147	<p>Continued From page 8</p> <p>grounded.</p> <p>Condition 3 - Exposed live parts on both sides of the work space (not guarded as provided in Condition 1) with the operator between.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(3) Height of Working Space. The work space shall be clear and extend from the grade, floor, or</p>	K 147		
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<p>K 147 Continued From page 9</p>	<p>K 147</p> <p>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.</p> <p>(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.</p> <p>(C) Entrance to Working Space.</p> <p>(1) Minimum Required. At least one entrance of sufficient area shall be provided to give access to working space about electrical equipment.</p> <p>(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.</p> <p>(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.</p> <p>(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</p>
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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	