

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

Ky# 23340

PRINTED: 07/17/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 07/11/2015
NAME OF PROVIDER OR SUPPLIER DAWSON SPRINGS HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408		
(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 Based upon implementation of the acceptable POC, the facility was deemed to be in compliance 07/11/15, as alleged.	{F 000}			

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

TITLE

(X6) DATE

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

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F 000	INITIAL COMMENTS	F 000		
F 226 SS=D	<p>An Abbreviated Survey investigating Complaint #KY23340 was conducted 06/08/15 through 06/10/15. #KY23340 was substantiated with deficiencies cited at the highest S/S of a "D"</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's investigation, and review of the facility "Resident Abuse, Neglect and Exploitation", policy and procedure, it was determined the facility failed to have an effective system to ensure the facility's written policy and procedure was followed related to a resident to resident altercation involving two (2) of three (3) sampled residents. (Resident #1 and Resident #2).</p> <p>On 06/04/15 at 12:45 AM, Resident #1 was found standing outside Resident #2's room yelling and cursing, accusing Resident #2 of stealing a photo identification (ID) card. There was no documented evidence an examination of Resident #1 or #2 was conducted to identify if there was any symptoms of physical abuse for either resident per the facility policy.</p> <p>The findings include:</p>	F 226	<p>Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.</p>	

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F 228	Continued From page 1 Review of the facility policy and procedure titled "Resident Abuse, Neglect and Exploitation", last revised 03/12/13, revealed it was the goal of the facility to have a process in place to protect the health and welfare of each resident; to assure that each resident is free from verbal, sexual, physical and mental abuse; corporal punishment, neglect, involuntary seclusion, exploitation and injuries of unknown origin. If an incident involves alleged abuse by another resident, the following steps will be taken: If a resident to resident altercation occurs, the resident's safety and protection should be assured. An investigation should be performed to determine if abuse has occurred and an evaluation of the abusing resident should be completed to determine if there was a problem that would require medical intervention. A thorough examination of the resident should be conducted for any marks, bruises or injury. Injury documentation will be completed by the Charge Nurse. Record review revealed the facility admitted Resident #1 on 04/09/14 with diagnoses which included Dementia with Behavioral Disturbance, Glaucoma, Difficulty in Walking, Edema, Diabetes Type II, Psychosis, History of Methamphetamine use, Hypertension, and Schizophrenia. Review of the quarterly Minimum Data Set (MDS) assessment, dated 05/04/15, revealed the facility assessed Resident #1's cognition as moderately impaired with a Brief Interview of Mental Status (BIMS) score of "09", which indicated the resident was interviewable. Record review revealed the facility admitted Resident #2 on 01/12/10 with diagnoses to include, Unspecified Psychosis, Diabetes Mellitus, Schizophrenia, Carcinoma In situ of	F 228	<u>F 226 (D) 483.13 (C)</u> <u>DEVELOP/IMPLEMENT</u> <u>ABUSE/NEGLECT, ETC POLICIES</u> <i>Corrective Action for Residents Found to Have Been Affected</i> On 6-4-2015, Resident #1 and Resident #2 immediately received assessment for injuries by licensed nursing staff upon identification of injuries by Resident #2. On 6-4-2015, Resident #2 was sent to the hospital for further examination. Resident #1 and Resident #2 received care and treatment accordingly. <i>Identification of Other Residents Having the Potential to be Affected</i> Licensed staff began full assessments on all residents beginning on 6-4-2015 in the immediate area of the altercation and completion of these assessments occurred on 6-10-2015. No signs of injury were identified on any of the other residents. Routine care on and after 6-4-2015 did not reflect any signs of injury to any other resident.		

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F 228	<p>Continued From page 2</p> <p>Bladder, Hypertension, Hemiplegia, and Above Knee Amputation. Review of the quarterly MDS assessment, dated 05/07/15, revealed the facility assessed Resident #2's cognition as severely impaired with a BIMS score of "04", indicating the resident was not interviewable.</p> <p>Review of Investigation Report, dated 06/04/15 at 6:00 AM, revealed on 06/04/15 at 12:45 AM, Resident #1 was found standing in front of Resident #2's doorway yelling and cursing; and attempting to enter Resident #2' room. Resident #1 was yelling out Resident #2's name. Resident #1 became combative with staff, yelling, kicking and attempting to bite staff and had to be restrained at that time. Resident #1 was placed on one to one observation at the time of the incident and taken back to his/her room at around 1:30 AM. Further review revealed there was no evidence an examination of Resident #1 and/or Resident #2 was conducted at the time of the incident to identify if there were any marks, bruises or injury per the facility's policy until after completing the morning rounds at 5:30 AM on 06/04/15. Resident #2 was found to have sustained facial injuries to the left side of his/her face, forehead and eye and review of a skin assessment of Resident #1, conducted at 6:00 AM on 06/04/15 after the injuries were noted to Resident #2's face, revealed Resident #1's right hand was injured.</p> <p>Review of Resident #2's Emergency Room Discharge Note, dated 06/04/17 and an admission time of 7:46 AM, revealed the admitting diagnosis was physical assault. Further review of the Discharge Note revealed the resident received a blow to the head. The physical exam revealed multiple small abrasions</p>	F 228	<p>Measures or Systemic Changes Made to Avoid Reoccurrence</p> <p>The Abuse Prohibition policies of the facility were reviewed on 6-29-2015 by the Administrator. The Administrator educated the Director of Nursing on how to examine for allegations of abuse, what residents to include in those examinations and the timeliness of those examinations. On 6-29-2015 through 7-10-2015, all staff were inserviced by the Director of Nursing on the Abuse Prohibition policies with an emphasis on identification, response and reporting of abuse. On 6-29-2015 through 7-10-2015, all licensed nurses were educated by the Director of Nursing on the Abuse Prohibition policies with an emphasis on identification, reporting and response to any allegation of abuse. On 6-29-2015 through 7-10-2015 licensed nurses were instructed by the Director of Nursing on how to examine for allegations of abuse, what residents to include in those examinations and the timeliness of those examinations.</p>		

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F 226	<p>Continued From page 3</p> <p>of the central right and left side of the forehead, left periorbital area with moderate tenderness and swelling, a large abrasion and medium sized ecchymosis of the supraorbital and infraorbital area of the periorbital area (superficial laceration closed right upper eye lid). Resident #2 was discharged back to the facility with diagnoses to include Closed Head Injury, Contusion, and Multiple Abrasions to the Face.</p> <p>Interview with Certified Nurse Aide (CNA) #1, on 06/09/15 at 6:00 AM, revealed while making morning rounds at approximately 5:30 AM on 06/04/15, she found Resident #2 to have bruising and bleeding from the left eye and scratches on his/her forehead. She stated she reported the injuries to LPN #2 immediately.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 06/09/15 at 9:00 AM, revealed Resident #1 was found in the hallway yelling and screaming at 12:45 AM on 06/04/15. LPN #2 stated the resident was combative with staff and slapped CNA #2. LPN #1 revealed they were unable to get the resident to calm down until approximately 1:30 AM after the resident was given an injection of Ativan (anxiety medication). LPN #2 stated the other CNA on the floor made hourly rounds but Resident #2 was laying on his/her left side with the sheet covering the side of his/her face and they did not notice the eye injury until the morning round at 5:30 AM. LPN #2 revealed at that time Resident #1 was assessed and was found to have injuries to his/her right hand. LPN #2 stated it was possible Resident #1 hit Resident #2 before the staff got to him/her in the hallway. The LPN stated they did not think Resident #1 had entered Resident #2's room so no assessments were completed on either resident.</p>	F 226	<p>Plans to Monitor Performance for Sustained Solutions</p> <p>All allegations of abuse will be reported to the Quality Assessment Committee (members consisting of the Administrator, the Director of Nursing, the Quality Assurance Nurse, the MDS Coordinator and the Social Services Director), that meets monthly for verification of conformance to Abuse Prohibition policies. The Quality Assessment Committee will make recommendations and follow up on these allegations of abuse.</p>	7-11-15	

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F 226	Continued From page 4 Interview with Certified Nurse Aide (CNA) #2, on 06/09/15 at 6:20 AM, revealed she was in the television (TV) room trying to help calm Resident #1 down after he/she was found yelling in the hallway. CNA #2 stated Resident #1 was agitated, slapped her in the face, and was kicking and trying to bite. CNA #2 revealed the resident was yelling and we could not get the resident to calm down and as soon as we found the resident in the hallway, he/she was monitored. Interview with Registered Nurse (RN) #1 on 06/09/15 at 8:05 AM, revealed the night shift nurse was responsible for completing the assessments and completing the incident investigation reports. Interview with Director of Nursing (DON), on 06/08/15 at 1:00 PM, revealed during the investigative process we interview residents in the immediate area of the altercation and Resident #1 admitted to hitting Resident #2 so we did not feel the need to complete skin assessments due to that fact. The DON stated the staff did not assess the resident because they did not think Resident #1 had entered Resident #2's room.	F 226	<u>F 280 (D) 483.20(D)(3), 483.10(K)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</u> <i>Corrective Action for Residents Found to Have Been Affected</i> Resident #1 was discharged from the facility on 6-4-2015. <i>Identification of Other Residents Having the Potential to be Affected</i> The Comprehensive Care Plan has been reviewed for all residents who have identified behaviors utilizing the Behavior Observation Program (BOP). These residents were reviewed by the Quality Assurance Nurse and members of the Quality Assurance and Performance Improvement (QAPI) Team on 7-1-2015 to determine that residents with documented behaviors had been care planned with appropriate interventions. The QAPI Team members include: Administrator, Director		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the	F 280			

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F 280	<p>Continued From page 5</p> <p>comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of behavioral hospital discharge summary and review of the facility's policy and procedure, it was determined the facility failed to revise the plan of care of one (1) of three (3) sampled residents (Resident #1). Resident #1 had behaviors of being resistive and combative toward staff during care but the facility failed to revise the care plan to include interventions to try decrease the risk for abuse due to these behaviors.</p> <p>Resident #1 was admitted on 04/09/15 and assessed and identified to have behaviors of resisting care and being combative with staff during care. Resident #1 was care planned on 04/13/15 to allow time to calm when resists care. Resident #1 was transferred to Behavioral Health Center on 05/09/15 after an episode of aggressive behavior directed toward the staff required the police to be called. The resident returned to the facility on 05/25/15; however, the facility failed to revise the care plan with</p>	F 280	<p>of Nursing, Quality Assurance Nurse, Social Service Director and the MDS Coordinator.</p> <p><i>Measures or Systemic Changes Made to Avoid Reoccurrence</i> The Comprehensive Care Plan Policy was reviewed and approved for use on 6-24-2015 by the Corporate Policy Committee Members consisting of the Administrators of the Concord Health Systems' facilities, their Directors of Nursing and the corporate Admissions Coordinator and/or corporate representative. Licensed staff and Quality Assurance/Performance Improvement (QAPI) Team Members were inserviced by the corporate trainer on 7-1-2015 regarding the care planning of behaviors and the updated policy on Comprehensive Care Plans.</p>		

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F 280	<p>Continued From page 6</p> <p>interventions to address the resident's outbursts of aggressive behaviors. On 06/04/15 at 8:00 AM, Resident #1 had an altercation with Resident #2 and caused facial injuries to the left side Resident #2's face, forehead and eye and Resident #1's right hand was injured.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON), on 06/12/15 at 2:30 PM, revealed the facility does not have a specific care plan policy. The DON stated the care plan process is incorporated into every facility policy as it's part of the initial assessment process and continued on with each aspect of care. The DON revealed the care plan should be updated with any changes in behavior or if a new behavior was picked up the care plan would be revised by the Interdisciplinary Care Team.</p> <p>Review of the facility policy and procedure titled "Resident Abuse, Neglect and Exploitation", last revised 03/12/13, revealed it was the goal of the facility to have a process in place to protect the health and welfare of each resident; to assure that each resident is free from verbal, sexual, physical and mental abuse; corporal punishment, neglect, involuntary seclusion, exploitation and injuries of unknown origin. If an incident involves alleged abuse by another resident, the following steps will be taken: If a resident to resident altercation occurs, the resident's safety and protection should be assured. Residents with needs and behaviors which might lead to conflict or neglect are identified, assessed and have a care plan developed through the RAI process.</p> <p>Record review revealed the facility admitted</p>	F 280	<p>The QAPI Team members include: Administrator, Director of Nursing, Quality Assurance Nurse, Social Service Director and the MDS Coordinator. The corporate trainer included how to document changes in behaviors and appropriate interventions.</p> <p><i>Plans to Monitor Performance for Sustained Solutions</i></p> <p>The Interdisciplinary Team (same members as the Quality Assurance/Performance Improvement team--: Administrator, Director of Nursing, Quality Assurance Nurse, Social Service Director and the MDS Coordinator) will monitor Comprehensive Care Plans at their daily meetings to assure that solutions are sustained regarding the care planning of behaviors and appropriate interventions.</p>	7-11-15	

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F 280	<p>Continued From page 7</p> <p>Resident #1 on 04/09/14 with diagnoses which included Dementia with Behavioral Disturbance, Glaucoma, Difficulty in Walking, Edema, Diabetes Type II, Psychosis, History of Methamphetamine use, Hypertension, and Schizophrenia.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 05/04/15, revealed the facility assessed Resident #1's cognition as moderately impaired with a Brief Interview of Mental Status (BIMS) score of "09", which indicated the resident was interviewable.</p> <p>Review of Resident #1' Comprehensive Care Plan for "Potential for Disturbances of Thinking, Mood, or Behavior. Altered Concept of Reality, Delusions, and Hallucinations related to Diagnosis of Dementia with Behaviors, Resist Activity Daily Living (ADL)", dated 04/22/14 , revealed an intervention to allow time to calm when resists ADL care.</p> <p>Review of Discharge Summary, dated 05/25/15, revealed Resident #1 was admitted to a Behavioral Hospital on 05/09/15 for having flare-ups of temper, which occasionally would progress to aggression. The resident would fly into rages when the staff offered to assistance with the resident's incontinent care. Resident #1 had a temper outburst, became aggressive with staff and the police had to be called. At that point it was felt the resident needed inpatient stabilization related to his/her temper and behavior. The resident returned to the facility on 05/25/15.</p> <p>Further review of the Comprehensive Care Plan revealed there was no documented evidence the facility revised the care plan with interventions to</p>	F 280			

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F 280	<p>Continued From page 8</p> <p>address the resident's outbursts of aggressive behaviors that required hospitalization to ensure other residents and staff were safe.</p> <p>Review of Investigation Report, dated 06/04/15 at 8:00 AM, revealed on 06/04/15 at 12:45 AM, Resident #1 was found standing in front of Resident #2's doorway yelling and cursing; and attempting to enter Resident #2' room. Resident #1 became combative with staff, yelling, kicking and attempting to bite staff and had to be restrained at that time. Resident #1 was placed on one to one observation at the time of the incident and taken back to his/her room at around 1:30 AM. Resident #2 was found to have sustained facial injuries to the left side of his/her face and evlew of a skin assessment of Resident #1, conducted at 6:00 AM on 06/04/15 after the injuries were noted to Resident #2's face, revealed Resident #1's right hand was injured.</p> <p>Review of Resident #2's Emergency Room Discharge Note, dated 06/04/17 and an admission time of 7:46 AM, revealed Resident #2 had multiple small abrasions of the central right and left side of the forehead, left periorbital area with moderate tenderness and swelling, a large abrasion and medium sized ecchymosis of the supraorbital and infraorbital area of the periorbital area (superficial laceration closed right upper eye lid). Resident #2 was discharged back to the facility with diagnoses to include Closed Head Injury, Contusion, and Multiple Abrasions to the Face.</p> <p>Interview with CMA #1 on 06/08/15 at 1:00 PM and CNA #1 on 06/09/15 at 6:30 AM, revealed Resident #1 would resist care and have explosive combative behavior directed toward the staff.</p>	F 280			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186253	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2015
NAME OF PROVIDER OR SUPPLIER DAWSON SPRINGS HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408	
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F 280	Continued From page 9 Interview with the DON, on 06/08/15 at 11:50 AM , revealed Resident #1 had been living in the facility for about a year with no episodes of behavior directed to other residents; however would be combative when the aids were providing incontinent care. Further interview with the DON, on 06/12/15 at 10:00 AM, revealed Resident #1 would usually calm down after he/she refused a shower and the facility was not used to calling his/her behavior aggressive as they just considered it as resisting care. The DON stated the process for updating care plans consisted of updating with any change in behavior. The DON revealed care plan updates were part of the Interdisciplinary Care Team Meetings and were done at that time.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy and procedure it was determined the facility failed to provide necessary care and services to maintain the highest practicable, physical, mental and psychosocial well-being of two (2) of three (3)	F 309	<u>F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</u> <i>Corrective Action for Residents Found to Have Been Affected</i> On 6-4-2015, Resident #1 and Resident #2 immediately received assessment for injuries by licensed nursing staff upon identification of injuries received by Resident #2. On 6-4-2015, Resident #2 was sent to the hospital for further examination. Resident #1 and Resident #2 received care and treatment accordingly. Resident #1 was discharged from the facility on 6-4-2015. Resident #3 was assessed on 6-5-2015 with no identified injuries. <i>Identification of Other Residents Having the Potential to be Affected</i> Licensed staff began full assessments on all residents beginning on 6-4-2015 in the	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	<p>Continued From page 10</p> <p>sampled residents (Resident #2 and #3) related to Resident #1's behaviors of aggression.</p> <p>Resident #1 was admitted on 04/09/15 and assessed and identified to have behaviors of resisting care and being combative with staff during care. Resident #1 was care planned on 04/13/15 to allow time to calm when resists care. Resident #1 was transferred to Behavioral Health Center on 05/09/15 after an episode of aggressive behavior directed toward the staff required the police to be called. The resident returned to the facility on 05/25/15; however, the facility failed to revise the care plan with interventions to address the resident's outbursts of aggressive behaviors. On 06/04/15 at 12:45 AM, Resident #1 was found standing in front of Resident #2's doorway yelling Resident #2's name and cursing. When staff attempted to redirect Resident #1, the resident became combative with staff, yelling, kicking and attempting to bite staff and had to be restrained and placed on one to one observation. However, the facility failed to assess Resident #1 and Resident #2 to ensure there were no signs of a physical altercation. At approximately 5:30 AM, Certified Nurse Aide (CNA) #1 was making rounds and found Resident #2 had facial injuries to the left side of his/her face, forehead and eye and a skin assessment of Resident #1 revealed the resident's right hand was injured. Refer to F226 and F280</p> <p>The findings include:</p> <p>Review of the facility policy and procedure titled "Resident Abuse, Neglect and Exploitation", last revised 03/12/13, revealed it was the goal of the facility to have a process in place to protect the</p>	F 309	<p>immediate area of the altercation and completion of these assessments occurred on 6-10-2015. No signs of injury were identified on any of the other residents. Routine care on and after 6-4-2015 did not reflect any signs of injury to any other resident. The Comprehensive Care Plan has been reviewed for all residents who have identified behaviors utilizing the Behavior Observation Program (BOP). These residents were reviewed by the Quality Assurance Nurse and members of the Quality Assurance and Performance Improvement (QAPI) Team on 7-1-2015 to determine that residents with documented behaviors had been care planned with appropriate interventions. The QAPI Team members include: Administrator, Director of Nursing, Quality Assurance Nurse, Social Service Director and the MDS Coordinator.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	<p>Continued From page 11</p> <p>health and welfare of each resident; to assure that each resident is free from verbal, sexual, physical and mental abuse; corporal punishment, neglect, involuntary seclusion, exploitation and injuries of unknown origin. If an incident involves alleged abuse by another resident, the following steps will be taken: If a resident to resident altercation occurs, the resident's safety and protection should be assured. An investigation should be performed to determine if abuse has occurred and an evaluation of the abusing resident should be completed to determine if there was a problem that would require medical intervention. A thorough examination of the resident should be conducted for any marks, bruises or injury. Injury documentation will be completed by the Charge Nurse.</p> <p>Review of the facility policy and procedure titled "Resident Abuse, Neglect and Exploitation", last revised 03/12/13, revealed it was the goal of the facility to have a process in place to protect the health and welfare of each resident; to assure that each resident is free from verbal, sexual, physical and mental abuse; corporal punishment, neglect, involuntary seclusion, exploitation and injuries of unknown origin. If an incident involves alleged abuse by another resident, the following steps will be taken: If a resident to resident altercation occurs, the resident's safety and protection should be assured. Residents with needs and behaviors which might lead to conflict or neglect are identified, assessed and have a care plan developed through the RAI process.</p> <p>Interview with the Director of Nursing (DON), on 06/12/15 at 2:30 PM, revealed the facility does not have a specific care plan policy. The DON stated the care plan process is incorporated into</p>	F 309	<p>Measures or Systemic Changes Made to Avoid Reoccurrence</p> <p>The facility will provide the necessary care and services to maintain the highest practicable, physical, mental and psychosocial well-being of the residents cited in F 309 with these systemic changes. The Abuse Prohibition policies of the facility were reviewed by the Administrator. The Administrator educated the Director of Nursing on how to examine for allegations of abuse, what residents to include in those examinations and the timeliness of those examinations. On 6-29-2015 through 7-10-2015, all staff were inserviced by the Director of Nursing on the Abuse Prohibition policies with an emphasis on identification, response and reporting of abuse. On 6-29-2015 through 7-10-2015, all licensed nurses were educated by the Director of Nursing on the Abuse Prohibition policies with an emphasis on identification, reporting and response to any allegation of abuse.</p>		

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F 309	<p>Continued From page 12</p> <p>every facility policy as it's part of the initial assessment process and continued on with each aspect of care. The DON revealed the care plan should be updated with any changes in behavior or if a new behavior was picked up the care plan would be revised by the Interdisciplinary Care Team.</p> <p>Record review revealed the facility admitted Resident #1 on 04/09/14 with diagnoses which included Dementia with Behavioral Disturbance, Glaucoma, Difficulty in Walking, Edema, Diabetes Type II, Psychosis, History of Methamphetamine use, Hypertension, and Schizophrenia. Review of the quarterly Minimum Data Set (MDS) assessment, dated 05/04/15, revealed the facility assessed Resident #1's cognition as moderately impaired with a Brief Interview of Mental Status (BIMS) score of "09", which indicated the resident was interviewable.</p> <p>Review of Resident #1' Comprehensive Care Plan for "Potential for Disturbances of Thinking, Mood, or Behavior. Altered Concept of Reality, Delusions, and Hallucinations related to Diagnosis of Dementia with Behaviors, Resist Activity Daily Living (ADL)", dated 04/22/14, revealed an intervention to allow time to calm when resists ADL care.</p> <p>Review of Discharge Summary, dated 05/25/15, and interviews with Certified Medication Aide (CMA) #1 on 06/08/15 at 1:00 PM and Certified Nurse Aide (CNA) #1, on 06/09/15 at 6:30 AM, with revealed Resident #1 was admitted to a Behavioral Hospital on 05/09/15 for having flare-ups of temper, which occasionally would progress to aggression. The resident would fly into rages when the staff offered to assistance</p>	F 309	<p>On 6-29-2015 through 7-10-2015 licensed nurses were instructed by the Director of Nursing on how to examine for allegations of abuse, what residents to include in those examinations and the timeliness of those examinations. The Comprehensive Care Plan Policy was reviewed and approved on 6-24-2015 by the Corporate Policy Committee consisting of the Concord Health Systems' Administrators, their Directors of Nursing and the corporate Admissions Coordinator and/or corporate representative. Licensed staff and QAPI Team Members were inserviced by the corporate trainer on 7-1-2015 regarding the care planning of behaviors and the policy on Comprehensive Care Plans.</p>		

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F 309	<p>Continued From page 13</p> <p>with the resident's incontinent care. Resident #1 had a temper outburst, became aggressive with staff and the police had to be called. At that point it was felt the resident needed inpatient stabilization related to his/her temper and behavior. The resident returned to the facility on 05/25/15; however, further review of the Comprehensive Care Plan revealed the facility failed to revise the care plan with interventions to address the resident's outbursts of aggressive behaviors that required hospitalization to ensure other residents and staff were safe.</p> <p>Review of Investigallon Report, dated 06/04/15 at 8:00 AM and interviews with Licensed Practical Nurse (LPN) #2, on 06/09/15 at 9:00 AM; CNA #1 on 06/09/15 at 6:00 AM and CNA #2, on 06/09/15 at 6:20 AM; revealed on 06/04/15 at 12:45 AM, Resident #1 was found standing in front of Resident #2's doorway yelling and cursing, and accusing Resident #3 of taking an identification card. Resident #1 was combative with staff and was yelling, kicking, and attempted to bite staff. Resident #1 slapped CNA #2 in the face and had to be restrained and placed on one to one observation at the time. However, licensed staff failed to assess Resident #1 and Resident #2 to determine if there were any signs of a physical altercation. LPN #2 stated they did not think Resident #1 had entered Resident #2's room at the time so she did not conduct skin assessments. At approximately 5:30 AM, CNA #1 conducted morning rounds and identified Resident #2 had sustained facial injuries to the left side of his/her face, forehead and eye and Resident #1's right hand was injured.</p> <p>Record review revealed the facility admitted Resident #2 on 01/12/10 with diagnoses to</p>	F 309	<p>The QAPt Team members include: Administrator, Director of Nursing, Quality Assurance Nurse, Social Service Director and the MDS Coordinator. The corporate trainer included how to document changes in behaviors and appropriate interventions.</p> <p><i>Plans to Monitor Performance for Sustained Solutions</i></p> <p>The facility will provide the necessary care and services to maintain the highest practicable, physical, mental and psychosocial well-being of the residents cited in F 309 with these monitoring solutions. All allegations of abuse will be reported to the Quality Assessment Committee (that meets monthly for verification of conformance to Abuse Prohibition policies. The Quality Assessment Committee</p>		

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F 309	<p>Continued From page 14</p> <p>include, Unspecified Psychosis, Diabetes Mellitus, Schizophrenia, Carcinoma in situ of Bladder, Hypertension, Hemiplegia, and Above Knee Amputation. Review of the quarterly MDS assessment, dated 05/07/15, revealed the facility assessed Resident #2's cognition as severely impaired with a BIMS score of "04", indicating the resident was not interviewable.</p> <p>Review of Resident #2's Emergency Room Discharge Note, dated 08/04/17 and an admission time of 7:46 AM, revealed the resident had multiple small abrasions of the central right and left side of the forehead, a left periorbital area with moderate tenderness and swelling, a large abrasion and medium sized ecchymosis of the supraorbital and infraorbital area of the periorbital area (superficial laceration closed right upper eye lid). Resident #2 was discharged back to the facility with diagnoses to include Closed Head Injury, Contusion, and Multiple Abrasions to the Face.</p> <p>Interview with Registered Nurse (RN) #1 on 06/09/15 at 8:05 AM, revealed the night shift nurse should have completed the assessments.</p> <p>Interview with DON, on 06/08/15 at 8:30 AM and 11:50 AM, revealed the facility specialized in behavior residents. The DON stated Resident #1 had been living in the facility for about a year with no episodes of behavior directed to other residents; however, he/she would be combative when the aides were providing incontinent care. The DON stated the process for updating care plans consisted of updating with any change in behavior. The DON revealed care plan updates were part of the Interdisciplinary Care Team Meetings and were done at that time. The DON</p>	F 309	<p>members include: Administrator, Director of Nursing, Quality Assurance Nurse, Social Service Director and the MDS Coordinator, will make recommendations and follow up on these allegations of abuse. The Interdisciplinary Team (same members as Quality Assurance/Performance Improvement (QAPI) team or Quality Assurance Committee-- The QAPI Team members include: Administrator, Director of Nursing, Quality Assurance Nurse, Social Service Director and the MDS Coordinator, will monitor Comprehensive Care Plans at their daily meetings to assure that solutions are sustained regarding the care planning of behaviors and appropriate interventions.</p>	7-11-15	

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F 309	Continued From page 15 stated Resident #1 was found standing in front of Resident #2's doorway and it was thought Resident #1 was found prior to entering Resident #2's room. The DON stated Resident #1 was immediately placed on one on one observation due to his/her behavior and they did not realize Resident #2 had been injured until making morning rounds at 5:30 AM. The DON revealed Resident #1 admitted to hitting Resident #2.	F 309			