

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

PRINTED: 05/22/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185305</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/08/2014</b>
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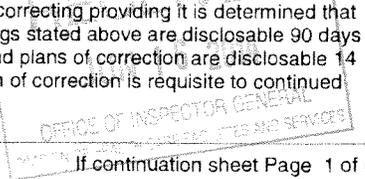
NAME OF PROVIDER OR SUPPLIER  <b>SPRINGHURST HEALTH AND REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3001 N. HURSTBOURNE PKWY. LOUISVILLE, KY 40241</b>
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F 000	INITIAL COMMENTS  A Recertification Survey was initiated on 05/05/14 and concluded on 05/08/14 with deficiencies cited at the highest scope and severity of a "G".  This was a Nursing Home Initiative survey with entrance on Monday 05/05/14 at 6:00 PM.	F 000		
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.	F 225	1. Resident 9 was interviewed on 5-9-14 and was found to be happy and offered no complaints. On 5-9-14, Resident 11 and daughter were asked if they had any current complaints or issues and we were informed that all was ok at this time. During interview conducted on 06/11/2014 the daughter stated "She does not think she caused a burn because she curls her mother's hair in the opposite direction." The daughter went on the voice" she now does not think it was a burn, it might have been impetigo." Area to resident forehead is healed with no further skin issues noted. Resident 11's comprehensive care plan was updated to reflect the resident's fragile skin that could result in bruising and or skin tears. Resident 11's ANRP to examine and update medical record to reflect resident's fragile skin issues by 6-4-14.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Leslie J. Butterfield</i>	TITLE  <i>Administrator</i>	(X6) DATE  <i>6/12/14</i>
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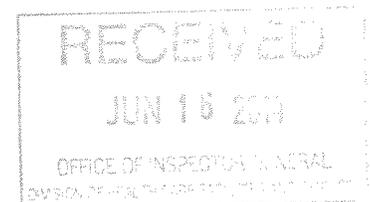
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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F 225	<p>Continued From page 1</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to identify, investigate and report allegations of abuse for two (2) of sixteen (16) sampled residents. (Residents #9 and #11). Resident #9 was hit with a Kleenex box several times by a roommate during an incident. Resident #11's family complained to staff that the resident looked like someone had grabbed his/her arms. In addition, Resident #11 had a burn, of unknown origin, on the forehead. The facility failed to investigate allegations to determine if possible abuse existed and to report as required.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Resident Abuse, Neglect and Misappropriation of Property, dated 07/23/12, revealed the facility would maintain a proactive approach for identifying occurrences that might constitute abuse, neglect, or exploitation, including injuries of unknown origin, and to determine the direction of the investigation. Anyone who suspects or gets a complaint regarding abuse must immediately report the information to the nursing supervisor</p>	F 225	<p>2. Any resident could be affected by the stated deficient practice.</p> <p>3. The medical record for each resident will be reviewed as of 6/21/14 to ensure that there are no reports of injury that were not reported to administration, investigated and reported to the proper agencies. Interviewable residents will be interviewed and educated on abuse and our policies on abuse by 6-21-14. All nursing department staff was in-seviced by our Staff Development Director 5/22-5/30/14 regarding when an injury should be reported to administration and that all allegations of abuse should be reported immediately per facility policy. A form has been developed and placed in the "Abuse Reporting" binder on each unit. This is a worksheet to guide the staff member in the reporting process. Also, the event forms for the clinical charting have been updated to state "If skin tear, bruise, etc., is of unknown origin, the Social Services Director will be notified"</p>		



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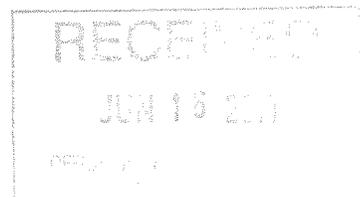
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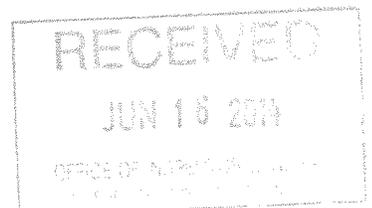
F 225	Continued From page 2 on duty. The nursing supervisor would notify the Administrator/designee. An investigation will be conducted by the administrator/designee in a timely, thorough and objective manner. Investigation documentation would include interviews, reporting of the initial incident and review of the medical records.  1. Observation of Resident #11, on 05/06/14 at 9:15 AM, revealed the resident was sitting up in a wheelchair by the nursing station. The resident was dressed, clean, and no odors were noted. The resident's skin appeared thin and several small bruises were noted on the upper arms and the legs. There were two small skin tears noted, one (1) to the left side of the forehead and one (1) on the right lower leg. The resident was confused as to person, place and time.  Review of the clinical record for Resident #11, revealed the facility admitted the resident with diagnoses of Dementia with Behavior, Anemia, Renal Insufficiency, Schizophrenia and Dysphagia. The facility completed a quarterly Minimum Data Set (MDS) assessment of the resident on 04/07/14 which revealed the resident had a moderate cognitive impairment and required extensive assistance with all care.  Review of the clinical record/nursing notes, dated 03/31/14 at 11:12 PM, for Resident #11, revealed the resident's family notified the facility that it looked like someone had grabbed the resident's arms. The supervisor was notified of the family's concerns. A skin assessment was completed on 03/31/14 and the following issues were identified: reddish buttocks, bruises on the left upper arm; multiple bruises on the left and right lower arms with no further information regarding these	F 225	4. The Administrator and Director of Nursing will oversee the review of 10 resident's progress notes a month, to ensure that injuries of unknown origin were reported and investigated and that facility policies were followed. Semi-annual resident and family surveys that include abuse will be conducted and finding presented, quarterly, to the QA committee.	6/21/14
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F 225	<p>Continued From page 3</p> <p>bruises, an open area 2 centimeters by 1.8 centimeters on the right lower posterior calf; and a bruise on the left lower leg. There was no evidence of documentation as to how the resident obtained the bruises. Review of the comprehensive care plan revealed no evidence of documentation regarding the resident's skin or any concerns with bruising or skin tears.</p> <p>Review of the Observation Report, dated 04/10/14 at 11:06 AM, revealed Resident #11's family attended the care plan meeting and expressed concerns regarding a burn on the resident's forehead that was present on 04/07/14. The family stated they did not burn the resident when setting the resident's hair on 04/05/14. The nurse agreed to follow-up on the burn.</p> <p>Interview with the Unit Manager, on 05/08/14 at 1:22 PM, revealed she was responsible for the North Unit. She stated she would notify the Director of Nursing if a resident had large bruises and normally did not. She stated Resident #11's skin was fragile and she bruised easily so there was no concern over bruises on both lower arms. She indicated she was aware of the incident where the resident had a burned forehead; however, she thought Social Services handled that concern. She stated she had training on abuse several months ago.</p> <p>Interview with the Director of Nursing, on 05/08/14 at 1:13 PM, revealed an investigation was not initiated when Resident #11 had bruising on both forearms and the origin was unknown or when a burn of unknown origin was discovered on the resident's forehead. She stated she had no information on the incident of 03/31/14 with the bruised arms. She stated the family must</p>	F 225			



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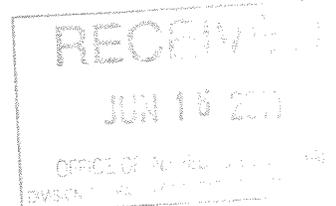
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F 225	<p>Continued From page 4</p> <p>have burned the resident's forehead while curling the resident's hair. She stated these incidents were not documented on an incident report or investigated as they were not suspicious in her opinion. She stated all staff were educated on abuse annually.</p> <p>Interview with the Social Services Director, on 05/08/14 at 2:46 PM, revealed she was responsible for investigation of the allegations of abuse. She stated she had no information regarding Resident #11's family concern that it looked like someone grabbed the resident's arms on 03/31/14. She stated nursing did not notify her regarding bruising on the resident's arms. She stated nursing should know to leave her a message on the computer when there was an allegation of abuse. She stated she would prefer the notification be in writing. She stated no investigation was initiated into the bruising on the resident's arms, even though the family expressed concern that it looked like someone grabbed the resident's arms. She stated nursing did not advise her of any problem with the resident. She stated she was aware of the resident having a burn on the forehead and she advised the family to fill out a complaint form regarding the burn; however, she never received anything from the family in writing. She stated she felt the resident was burned by the family member curling the resident's hair, so an investigation was not initiated.</p> <p>Continued interview with the Social Services Director, revealed she obtained information regarding activity in the facility from the nursing management at the morning meetings held each week day. She stated when she learned of an allegation of abuse, she investigated and</p>	F 225		



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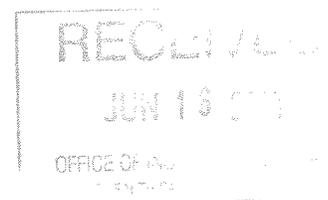
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F 225	<p>Continued From page 5</p> <p>reported to the state agency. She stated the facility policy required the Nursing Supervisor to immediately report suspected or observed abuse to the Administrator or the designee and an investigation was to be initiated timely and the allegation reported to the state agencies. She stated these allegations were not investigated.</p> <p>Interview with the Administrator, on 05/08/14 at 5:21 PM, revealed he was not aware of complaints from Resident #11. He stated that Social Services handled abuse complaints and grievances. He indicated all staff received training on abuse.</p> <p>2) Review of the clinical record for Resident #9 revealed the facility admitted the resident on 10/14/13 with diagnoses of Depressive Disorder, Congestive Heart Failure, Anxiety and Hypertension. Review of the Initial Minimum Data Set (MDS) assessment, dated 10/23/13, completed by the facility determined the resident had a Brief Interview for Mental Status (BIMS) score of 13 indicating the resident was cognitively intact. According to the Nursing Progress Note, dated 12/18/13 at 2:58 PM, the resident reported an incident where his/her roommate hit him/her several times with a Kleenex box. The nursing progress note also revealed the incident had been reported to the Social Services.</p> <p>Review of Resident #9's Physician Progress Note, dated 12/24/13, revealed a follow-up visit due to a resident to resident altercation. The physician's note indicated Resident #9's family reported Resident #9 defended himself/herself during the altercation and had hit the roommate.</p>	F 225		



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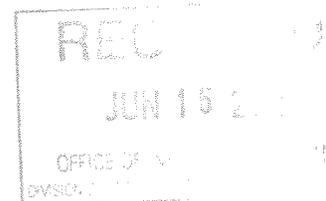
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F 225	Continued From page 6 Interview with Social Services, on 05/08/14 at 6:30 PM, revealed she could not find the investigation report of Resident #9's alleged altercation. She also stated she could not find supporting documentation that the alleged incident was reported to the appropriate Agencies.  Interview with the Administrator, on 05/08/14 at 6:40 PM, revealed all allegations of abuse should be reported to the appropriate State Agency. He revealed the facility also had a responsibility to report resident to resident altercations as alleged abuse. The Administrator further revealed the facility failed to conduct a thorough investigation of Resident #9's allegations and report the findings to the State Agency.	F 225			
F 226 SS=D	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, record review and facility policy review, it was determined the facility failed to follow the Abuse Policy as it related to investigating and reporting allegations of abuse for two (2) of sixteen (16) sampled residents. (Resident #9 and #11). On 12/18/13 at 8:19 AM, Resident #9 reported an alleged altercation with his/her roommate. Resident #11's family expressed concerns to staff regarding bruises on	F 226	1. Resident 9 was interviewed on 5-9-14 and was found to be happy and offered no complaints. On 5-9-14, Resident 11 and daughter were asked if they had any current complaints or issues and we were informed that all was ok at this time. Resident 11's comprehensive care plan was updated to reflect the resident's fragile skin that could result in bruising and or skin tears. Resident 11's ANRP to examine and update medical record to reflect resident's fragile skin issues by 6-4-14.		



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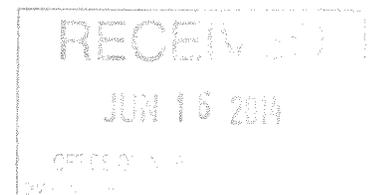
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F 226	<p>Continued From page 7</p> <p>Resident #11's arms and a burn to the Resident's forehead. The facility failed to initiate an investigation and failed to report the alleged altercation to the appropriate State Agencies.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Resident Abuse, Neglect and Misappropriation of Property, dated 07/23/12, defined abuse as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, mental anguish, or deprivation by an individual, including a caregiver, of goods or services that are necessary to attain or maintain physical, mental and psycho-social well-being. The nursing supervisor would immediately report allegations of resident abuse to the Administrator/designee. The Administrator/designee would then immediately contact Community Based Services (DCBS) and the Cabinet for Health Services (OIG) to report allegations. The Administrator/designee would conduct a thorough investigation; a thorough chart review; and interview staff, families, and physicians, as appropriate. Investigation documentation would include interviews with the staff member reporting the initial incident, employees, residents, and/or family members and review of the medical records. Results of the investigation would be reported to the Cabinet for Health Services within five (5) days of the report.</p> <p>Review of the clinical record for Resident #9 revealed the facility admitted the resident on 10/14/13 with diagnoses of Depressive Disorder, Congestive Heart Failure, Anxiety and Hypertension. Review of the Initial Minimum Data Set (MDS) assessment, dated 10/23/13,</p>	F 226	<p>Investigations were completed by Social Service Director by 6/13/14 for both residents #9 and #11. Statements from care givers, interviews with residents, and re-education with staff, by our Staff Development Director, were all part of the investigation process completed on 6/13/14</p> <p>2. Any resident could be affected by the stated deficient practice.</p> <p>3. The medical record for each resident will be reviewed as of 6/21/14, to ensure that facility alleged abuse policies were followed. Incident reports have been modified to instruct nursing to report injuries of unknown origin to social services. All nursing department staff was in-seviced by our Staff Development Director 5/22-5/30/14 regarding when an injury should be reported to administration and that all allegations of abuse should be reported immediately per facility policy.</p>		



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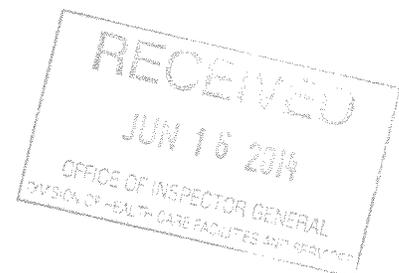
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F 226	<p>Continued From page 8</p> <p>completed by the facility determined the resident had a Brief Interview for Mental Status (BIMS) score of 13 indicating the resident was cognitively intact.</p> <p>Further review of the Nursing Progress Notes, for Resident #9, revealed the resident reported an alleged altercation with his/her roommate to the nursing staff. According to the note, dated 12/18/13 at 2:58 PM, the resident reported an incident where his/her roommate hit him/her with a Kleenex box several times. The nursing progress note, also revealed, the incident had been reported to Social Services.</p> <p>Review of Resident #9's Physician Progress Note, dated 12/24/13, revealed a follow-up visit due to a resident to resident altercation between Resident #9 and the roommate. The physician's note indicated Resident #9's family reported Resident #9 defended himself/herself during an altercation and had hit the roommate.</p> <p>Interview with the Director of Nursing (DON), on 05/08/14 at 6:20 PM, revealed the facility had a policy on abuse. The DON stated any allegations of abuse should be reported to the state agencies. She revealed resident to resident altercations were considered reportable and were investigated by the State. In addition, she stated the Social Services was responsible for investigating and reporting allegations of alleged abuse. The DON further revealed she had been notified of the altercation between Resident #9 and his/her roommate. She also revealed the Social Services had completed an investigation of Resident #9's alleged altercation.</p> <p>Interview with Social Services, on 05/08/14 at</p>	F 226	<p>4. Event reports will be reviewed weekly, by our unit supervisors, to ensure that reports indicating the need to report the incident to the administrator or the Social Service Director were actually reported as required by facility policy. Issues will be addressed with the Administrator immediately. The Administrator will report results, quarterly, to the QA Committee.</p>	6/21/14	



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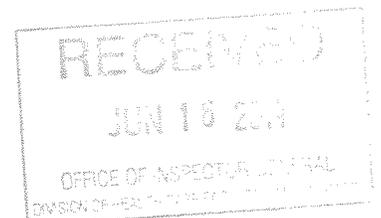
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185305</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/08/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SPRINGHURST HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3001 N. HURSTBOURNE PKWY. LOUISVILLE, KY 40241</b>		
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F 226	<p>Continued From page 9</p> <p>6:30 PM, revealed she could not find the investigation report of Resident #9's alleged altercation. She also stated she could not find supporting documentation that the alleged incident had been reported to appropriate State Agencies.</p> <p>Interview with the Administrator, on 05/08/14 at 05:35 PM, revealed resident to resident altercations were reportable to and investigated by the State Agencies. He stated he recalled Resident #9's alleged altercation and indicated the Social Worker was responsible for investigating and reporting the incident. He stated the facility process was to report all allegations of abuse to the State Agency within the first 24-hours of the incident. The Administrator revealed he was unaware the Social Services was unable to locate the investigation documents for Resident #9's allegation.</p> <p>Review of the clinical record for Resident #11, revealed the facility admitted the resident with diagnoses of Dementia with Behavior, Anemia, Renal Insufficiency, Schizophrenia and Dysphagia. The facility completed a quarterly Minimum Data Set (MDS) assessment of the resident on 04/07/14 which revealed the resident had a moderate cognitive impairment and required extensive assistance of one to two staff for all care.</p> <p>Review of the clinical record, dated 03/31/14 at 11:12 PM, Resident #11's family expressed concern that it looked like someone had grabbed the resident's arms. The supervisor was notified of the family's concerns. A skin assessment was completed on 03/31/14 and the following issues</p>	F 226			



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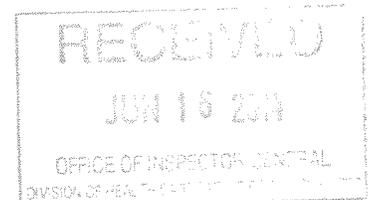
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F 226	<p>Continued From page 10</p> <p>were identified: reddish buttocks, bruises on the left upper arm; multiple bruises on the left and right lower arms; an open area 2 centimeters by 1.8 centimeters on the right lower posterior calf; and a bruise on the left lower leg. There was no evidence of documentation as to how the resident was bruised. There was no evidence provided to show the facility followed their policies on Abuse and investigated and reported the bruising. Review of the comprehensive care plan revealed no evidence of documentation regarding the resident's skin or any concerns with bruising or skin tears.</p> <p>Review of the Observation Report, dated 04/10/14 at 11:06 AM, revealed Resident #11's family attended a care plan meeting and had numerous complaints including concerns over a burn on the resident's forehead that was present on 04/07/14. The family stated they did not burn the resident when curling the resident's hair on 04/05/14. The nurse agreed to follow-up on the burn. No other documentation was provided to show the facility investigated or reported the burn.</p> <p>Interview with the Unit Manager, on 05/08/14 at 1:22 PM, revealed she was responsible for the North Unit. She stated she would have notified the Director of Nursing if the resident had large bruises and normally did not. She stated Resident #11's skin was fragile and she bruised easily so there was no concern over bruises on both lower arms. She indicated she was aware of the incident where the resident had a burned forehead; however, she thought Social Services handled that concern. She stated she did not follow facility policy and complete an incident report or talk with Social Services regarding any investigation. She stated she had training on</p>	F 226			



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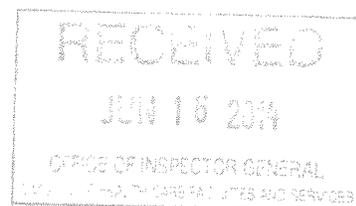
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F 226	Continued From page 11 abuse several months ago.  Interview with the Director of Nursing, on 05/08/14 at 1:13 PM, revealed an investigation was not initiated when Resident #11 had bruising on both forearms and the origin was unknown or when a burn of unknown origin was discovered on the resident's forehead. She stated she did not think these were abuse. She stated she had no information on the incident of 03/31/14 with the bruised arms. She stated the family must have burned the resident's forehead while curling the resident's hair. She stated these incidents were not documented on an incident report, investigated or reported per facility policy. She stated the facility should not have taken for granted that these injuries were not abuse and an investigation should have been completed. She stated all staff were educated on abuse annually.  Interview with the Social Services Director, on 05/08/14 at 2:46 PM, revealed she was responsible for investigation and reporting of allegations of abuse. She stated she had no information regarding Resident #11's family concern it looked like someone grabbed the resident's arms on 03/31/14. She stated nursing did not notify her regarding bruising on the resident's arms. She stated no investigation was initiated into the bruising on the resident's arms, even though the family expressed concern that it looked like someone grabbed the resident's arms. She stated nursing did not advise her of any problem with the resident. She stated she was aware the resident had a burn on the forehead and she advised the family to fill out a complaint form regarding the burn; however, she never received anything from the family in writing. She stated she felt the resident was burned by	F 226			



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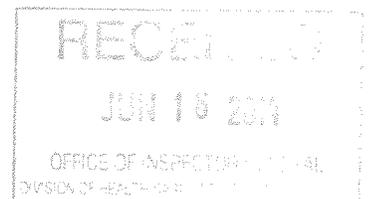
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F 226	Continued From page 12 the family member curling the resident's hair, so an investigation was not initiated.  Continued interview with the Social Services Director, revealed she obtained information regarding activity in the facility from the nursing management at the morning meetings held each week day. She stated when she learned of an allegation of abuse, she investigated and reported to the state agency. She stated the facility policy required the Nursing Supervisor to immediately report suspected abuse to her so she could report it to the state agencies. She stated these allegations were not investigated per facility policy.  Interview with the Administrator, on 05/08/14 at 5:21 PM, revealed he was not aware of complaints from Resident #11. He stated that Social Services handled abuse complaints and grievances. He indicated all staff received training on abuse.  Interviews with Licensed Practical Nurses (LPN) #1, 4, 6, and 8, on 05/08/14 at 3:30 PM, revealed alleged abuse was reported to the Nursing Supervisor, if there was a supervisor in the building. If not, they called Social Services. They stated they had received training on abuse several weeks ago.	F 226			
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241	1. Residents in rooms 123-1, 123-2, 168-2, 126, 174-1, 158-1 and 129 have had the signs removed.		



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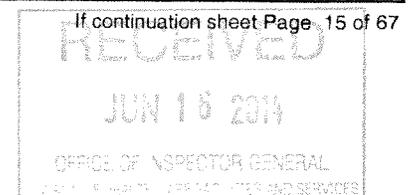
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F 241	<p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to have a homelike environment that enhanced respect of individuals related to signs containing personal information regarding care posted on the walls above seven (7) beds of the facility's 90 beds.</p> <p>The findings include:</p> <p>Review of the facility's Resident Rights Policy, not dated, revealed the facility must care for its residents in a manner and in an environment that promoted maintenance or enhancement of each residents quality of life.</p> <p>Observation of the units during initial tour, on 05/05/14 at 6:10 PM, revealed paper signs taped to residents' walls and closet doors including: Room 123-1 the sign read pull ups only-no briefs and then laundry instructions; Room 123-2 the sign read do not place a pillow under knees to prevent contractures and it also contained laundry instructions; Room 168-2 the sign had a name and a phone number taped to the wall; Room 126 the sign read place in recliner with a protective seat cover after meals.</p> <p>Observation of bed 174-1, on 05/06/14 at 10:18 AM, revealed a sign instructing staff on positioning and hip splinting at midnight posted on the wall above the resident's bed.</p> <p>Interview with Resident #10, who lived in 174-1, on 05/06/14 at 1:30 PM, revealed when his/her family came to visit, the family laughed and asked</p>	F 241	<p>2. All residents could be affected by the stated deficient practice.</p> <p>3. On 5/28 - 5/30 the facility Staff Development Director inserviced all nursing and therapy staff regarding the inappropriate use of signs in residents rooms. Families were sent a letter, on 05-30-14, explaining our new enforcement of signs in the resident rooms. A Policy and Procedure was developed to provide direction for use of signage in resident rooms.</p> <p>4. The Director of Nursing and the Administrator will be responsible for checking every room monthly and documenting findings on a log sheet. The Administrator will report their finding, quarterly, to the QA committee to insure compliance.</p>	6/20/14	



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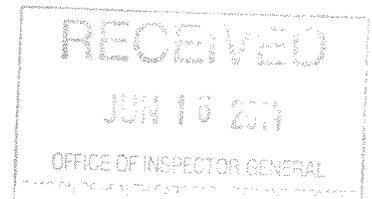
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F 241	<p>Continued From page 14</p> <p>him/her had they had their meal yet. Resident #10 stated the sign did not make him/her feel good about him/herself.</p> <p>Observation of bed 158-1, on 05/07/14 at 8:15 AM, revealed a sign above the bed which stated the resident was to be out of bed for all meals. The resident had increased difficulty with self feeding and positioning in bed was not adequate.</p> <p>Observations made during the Environment Tour, on 05/08/14, revealed bed 129 had a sign that stated urgent dental care.</p> <p>Interview with Family Member #1, on 05/07/14 at 4:15 PM, revealed the paper signs used in the facility were unsightly; however, staff would forget to do things for the residents without the signs.</p> <p>Interview with CNA #2, on 05/08/14 at 1:48 PM, revealed she would not want to be a resident at the facility with paper signs taped to her wall. She stated it was embarrassing and should not be done. She stated each CNA had a care plan for information on how to care for each resident.</p> <p>Interview with the South Unit Manager, on 05/08/14 at 4:50 PM, revealed she was not aware of the signs in residents' rooms. The South Unit Manager stated she was not responsible for putting the signs in the residents' rooms. If there was a sign about eating then most likely it was therapy who placed the sign on the wall. The South Unit Manager stated she had heard no complaints from the residents.</p> <p>Interview with the Social Services Director (SSD), on 05/08/14 at 2:34 PM, revealed no residents had complained to her about signs on their walls.</p>	F 241		



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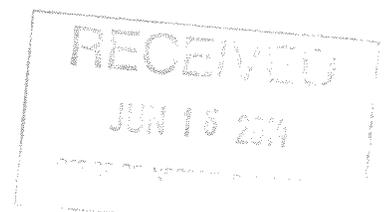
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F 241	Continued From page 15 The SSD stated she was aware the families were putting signs on resident walls. The SS Director stated she did not think the signs on the walls were very homelike and was not sure as to who was responsible for putting the signs on the walls. The SSD stated she talked to the residents in their rooms and was obviously not paying attention to the signs on the walls.	F 241			
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.  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 review of the Resident Assessment Instrument (RAI) Manual, it was determined the	F 279	1. As stated in the Statement of Deficiencies, resident #9 now has a comprehensive care plan for falls. The resident's CNA care plan has been reviewed to ensure that current interventions are present on the CNA care plan. Resident #9 will have a 3 day bowel and bladder assessment completed by 6/6/14, to note patterns in voiding, so an individual check / change schedule can be initiated.  2. All residents could be affected by this deficient practice.		



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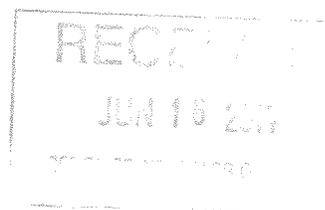
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F 279	<p>Continued From page 16</p> <p>facility failed to develop a comprehensive care plan for one (1) of sixteen (16) sampled residents, Resident #9. The facility staff assessed Resident #9 as at risk for falls; however, failed to develop a comprehensive care plan for Resident #9. Resident #9 sustained six falls during the month of January, 2014. On 01/16/14 the sixth fall resulted in an injury that required an acute hospital intervention of staples to the back of his/her head.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing, on 05/08/14 at 3:54 PM, revealed the facility utilized Minimum Data Set (MDS) 3.0 when developing, revising and updating the care plan.</p> <p>Review of the Resident Assessment Instrument (RAI) Manual, MDS 3.0, Chapter 4, page 4-8, Section 4.6, revealed facilities were responsible for assessing and addressing all care issues that were relevant to individual residents, regardless of whether or not they were covered by the RAI, including monitoring each resident's condition and responding with appropriate interventions. In addition, the care plan should be revised on an ongoing bases to reflect changes in the resident and the care the resident was receiving.</p> <p>Observation of Resident #9, on 05/06/14 at 1:10 PM, revealed Resident #9 was in his/her room standing at the bedside. Interview at this time with Resident #9, revealed he/she was going to the bathroom unassisted.</p> <p>Review of Resident #9's clinical record revealed the facility admitted the resident on 10/14/13 with diagnoses of Diarrhea Symptoms, Cataract Right</p>	F 279	<p>3. The Director of Nursing will keep a schedule as to when comprehensive care plans are due to ensure that all are completed timely. All resident's medical records will be reviewed to determine if there is a comprehensive care plan. CNA care plans will be reviewed to verify that CNA care plans contain current and accurate information. The Director of Nursing and the Staff Development Director re-educated the nurses 5/22-5/30/14 regarding the importance up updating the comprehensive care plans as needed and the CNA care plans to match. Same education will be given to new nurses hired indefinitely.</p>		



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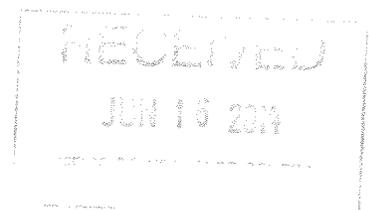
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F 279	<p>Continued From page 17</p> <p>Eye, Urinary Tract Infection, Lack of Coordination, Osteoporosis, Debility, Symptoms of Insomnia, Difficulty Walking, Anxiety.</p> <p>Review of the initial Fall Care Plan, dated 10/14/13, revealed the resident was to be toileted upon rising, before and after meals and at bed time. There was no evidence of a care plan for falls prevention to assist in the management of falls.</p> <p>Review of Resident #9's MDS, Admission Assessment, dated 10/23/13, revealed the facility completed a Brief Interview for Mental Status (BIMS) on Resident #9 that determined the resident was a thirteen (13). The facility identified the resident had falls since admission with no injuries. Review of Resident #9's Care Area Assessment (CAA) on falls, revealed the facility identified Resident #9 as at risk for falling related to history of falls both before and since admission. The facility decision was to initiate a Comprehensive Fall Care Plan. However, review of the resident's Comprehensive Care Plans revealed the facility did not develop a care plan for falls.</p> <p>Review of the facility's investigation Fall Circumstance Forms, revealed the resident sustained falls on 01/04/14 at 2:04 PM, on 01/05/14 at 4:50 AM, on 01/05/14 at 12:35 PM, on 01/14/14 at 2:35 PM, on 01/16/14 at 3:20 PM, and on 01/16/14 at 9:45 PM the resident was found on the floor after self transfers to the bathroom. The resident was found wet five (5) of the six (6) falls. There was no evidence a Falls Care Plan was developed with interventions to prevent further falls, until after the sixth fall that resulted in injury.</p>	F 279	<p>4. The unit supervisors will audit 2 CNA care plans a week, for 6 months, to verify that all new interventions and instructions added to the Resident Comprehensive Care Plan are reflected on the CNAs Resident's Care Plan. The Unit Managers will report their finding, weekly, to the Director on Nursing. The Director on Nursing and the Staff Development Director will audit 4 of the records completed by the Unit Managers. Results will be presented, quarterly, to the QA committee for comment and suggestions.</p>	6/21/14	



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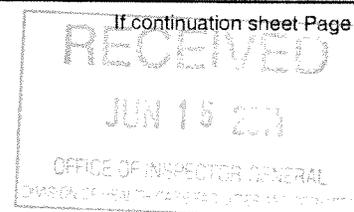
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F 279	Continued From page 18  Review of the facility's investigation Fall Circumstance Form, event date 01/16/14 at 9:45 PM, revealed Resident #9 was observed on the floor with his/her head on the bedside table. The fall was unwitnessed. Resident #9 stated he/she was returning from the bathroom and fell. Resident #9 was observed to have copious amounts of blood on the floor from a laceration on the back of his/her head. The physician was notified and authorized Resident #9 be sent to the Emergency Room for treatment and evaluation, which included staples to the back of his/her head.  Review of the resident's Comprehensive Care Plan, revealed a fall care plan was not developed until 01/16/14 on the day Resident #9 sustained an injury.  Interview with South Unit Manager, on 05/08/14 at 4:50 PM, revealed a lot of Resident #9's falls were from him/her coming and going to the bathroom. The South Unit Manager stated the staff was to check on Resident #9 hourly for toileting. However, this intervention was not on the care plan. As a Manager she stated she was responsible to ensure the staff had up to date care plans. If the care plan did not contain all the pertinent issues identified for the resident with interventions to direct the staff in the care of that issue, the CNA's would not know what they were to do, and an injury could occur.  Interview with the CNA #5, on 05/08/14 at 2:17 PM, revealed staff was expected to follow the care plan and without the care plan she would not know what care to provide. CNA #5 stated Resident #9 liked to get up by him/herself. She	F 279			



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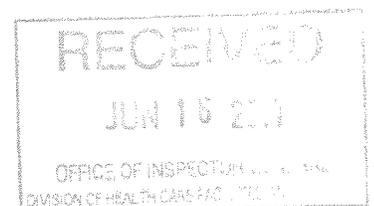
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F 279	<p>Continued From page 19</p> <p>remembered when a tab alarm was used, but the resident would remove the alarm. However, review of the initial care plan and the comprehensive care plan revealed no evidence a tab alarm was ever applied. Further interview with CNA #5, on 05/08/14 at 4:21 PM, revealed she could not remember Resident #9 having to be toileted every hour.</p> <p>Interview with the MDS Coordinator, on 05/08/14 at 3:38 PM, revealed there was an interim care plan for falls for Resident #9 that stated beginning 10/20/13 staff was to place the resident in a wheelchair for meals; and obtain a stool culture for loose stools/C-Diff. On 10/30/13 the staff was to wake up the resident at 3:30 AM to toilet. On 11/16/13 the staff was to toilet the resident upon rising, before and after meals and at bedtime. On 12/03/13 the staff were to keep the walker in reach. However review of Resident #9's clinical record revealed there was no comprehensive care plan for falls until 01/16/14. The MDS Coordinator stated there should have been a comprehensive care plan as outlined by the CAA because it triggered on the Admission Assessment.</p> <p>Interview with the Director of Nursing (DON), on 05/08/14 at 3:51 PM, revealed nurses were able to initiate, revise and update the care plan and were expected to follow the plan of care. The DON felt she had done everything that needed to be done for Resident #9 though she could not ensure the staff was toileting Resident #9 every hour or that the resident had a comprehensive care plan for falls. The DON stated when discussing falls in the daily morning meetings she checked to see if there was a care plan and did not remember the resident not having a falls care</p>	F 279			



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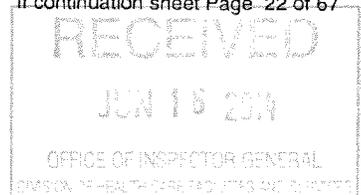
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F 279	Continued From page 20 plan. She stated if an intervention was not written down, then the staff would not know what was expected of them.  Interview with the Administrator, on 05/08/14 at 6:30 PM, revealed he expected the staff to develop care plans for the residents as determined by the MDS . The staff not having a care plan to follow was a problem and if not given the current plan, "things" could happen to the resident and the resident would not be given proper care.	F 279		
F 280 SS=E	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 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.  This REQUIREMENT is not met as evidenced	F 280	1. The Care Plans for Resident #2, #6 and #11 have been reviewed and were revised as required to reflect the current care needs as of 5/30/14. Resident # 2 had a palliative care plan added. Existing care plans for incontinence and antidepressant med use were updated. Resident # 6 has a new intervention for each fall. Event report checked against care plan. A three day bowel and bladder assessment was completed for Resident #6. Resident #11's care plan was updated to reflect fragile skin as well as use of antipsychotic and antidepressant meds.	



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F 280	<p>Continued From page 21</p> <p>by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to revise the care plans for three (3) of sixteen (16) sampled residents (Residents #6, #2 and #11). The facility staff failed to revise the care plan of Resident #6 to reflect repeated falls and how to prevent further falls. The facility failed to revise the care plan for Resident #2 to address incontinence, the use of an anti-depressant medication, and palliative care. In addition, the facility failed to revise the care plan for Resident #11 regarding fragile skin, the use of anti-psychotics and anti-anxiety medications.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing, on 05/08/14 at 3:15 PM, revealed the facility did not have a policy for care plan revision.</p> <p>1. Observation of Resident #6, on 05/06/14 at 8:40 AM, revealed the resident was seated in a wheelchair in the room with the television playing.</p> <p>Review of the clinical record for Resident #6, revealed the facility admitted the resident with diagnoses of Dementia with Behaviors, Diabetes and Hypertension. The facility completed an annual Minimum Data Set (MDS) assessment for the resident on 04/14/14 which revealed the resident had a moderate cognitive impairment, required extensive assistance with bed mobility and transfers, was unable to walk or assist with hygiene.</p> <p>Review of the Care Areas of the MDS for Resident #6, revealed the resident was at a high</p>	F 280	<p>2. All residents could be affected by this deficient practice.</p> <p>3. The Unit Managers will review and update all resident care plans and CNA care plans as required by June 20, 2014 to ensure all resident's care plans addressed appropriate and specific interventions. New medication orders will be reviewed weekly by the Unit Managers to ensure that care plans have been updated as needed and fall interventions will be updated on the resident and CNA care plans. The Director of Nursing and the Staff Development Director will inservice all nursing staff regarding the need to become more aggressive with interventions and the benefits of a bowl and bladder program to attempt to prevent future falls. . The Unit Managers and the Director of Nursing receives a list of all new medications from the pharmacy every day. The Care Plans will be checked by utilizing the daily pharmacy report for new medicine to ensure the care plan is updated.</p>		



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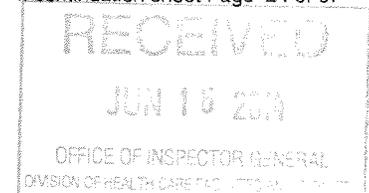
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F 280	<p>Continued From page 22</p> <p>risk for falls and had a history of falls due to transferring self from the bed and from the chair. The resident had poor balance, advanced dementia and received antidepressant medication. The resident had not experienced any serious injury from falling. The focus of the care plan would be preventing serious injury.</p> <p>Review of the Comprehensive Care Plan for Resident #6, last dated 04/29/14, revealed the resident had a history of falling related to poor balance and decreased safety awareness. The goal for the resident was to remain free from serious injury. Interventions by the staff included: use of a lap buddy; verbal reminders not to rise; sensor alarm while in bed; keep call light in reach; one-fourth (1/4) side rails; keep personal items in reach; place in supervised area when out of bed; do not awaken to change during the night; check every two (2) hours during the night; and toilet as needed. The resident had functional incontinence and required extensive assistance for transfers. The goal for the resident was not to sustain skin breakdown. Interventions included: perineal care after incontinent episodes; and take resident to the bathroom before and after meals and at bedtime.</p> <p>Review of the Fall Reports for Resident #6, revealed the resident had multiple falls. The facility completed a Fall Risk Assessment on 01/09/14, which indicated the resident was at risk for falls, had a history of falls, was not on a Falls Prevention Program and that no referrals were necessary. The facility documented that they would continue with the current care plan and make no revisions to prevent further falls.</p> <p>On 01/17/14 at 7:51 AM, the resident was found</p>	F 280	<p>The Director of Nursing will ensure that new anti-depressants, anti-psychotics and anti-anxiety medications are care planned to include reason for the medication, non-pharmacologic approaches, signs and symptoms of exacerbation or improvement symptoms to be monitored to determine improvement or decline, and information such as a medication reduction plan. Palliative care will be care planned to include individualized care to include but not limited to, behaviors, pain, restlessness and depression. The Director of Nursing and Staff Development Director will provide education with the CNAs regarding Palliative care that will continue throughout the month of June concluding on or before 6/20/14. The nurses and C.N.A.s will be required to sign work sheets daily attesting to the fact they have provided care as per the resident's individual care plan.</p>		

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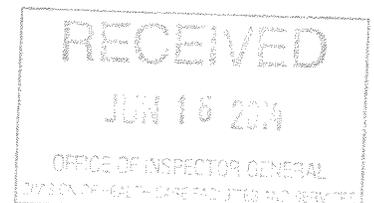
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F 280	<p>Continued From page 23</p> <p>sitting on the floor beside the bed and was wet. The fall was unwitnessed. The last time the resident was toileted was 9:30 PM on 01/16/14. The facility determined the root cause of the fall was the resident being uncomfortable due to being soiled and the resident attempted to transfer self out of the bed. There was a small one (1) centimeter skin tear on the resident's buttocks. There were no new care plan interventions put into place and the facility would continue to monitor. There was no evidence the facility revised the care plan to prevent further falls.</p> <p>On 02/09/14 at 4:09 AM, the resident was found sitting on the floor next to the bed and was wet. The fall was unwitnessed and there were no injuries. The resident was last changed at 9:26 PM on 02/08/14. The facility determined there was no injury and the root cause of the fall was documented as the resident slid out of bed. The care plan team documented to continue the current care plan since no injury was sustained. There was no evidence located to show the facility revised the care plan to prevent further falls.</p> <p>On 02/17/14 at 2:02 AM, the resident was found sitting on the floor next to the bed and was wet. The last time the resident was checked and changed was 9:00 PM on 02/16/14. The fall was unwitnessed and there were no injuries. The facility determined the root cause of the fall was the resident attempted a self-transfer. The care plan team documented that the resident may have been awakened by the roommate and the roommate would be removed from the room when awake. No evidence was located to show the facility revised the care plan to prevent further</p>	F 280	<p>4. The Director of Nursing will audit one resident's medical record a week, for six months, to ensure that the care plan accurately reflects the current medical needs of the resident. Residents audited will be chosen from residents flagged as having falls, being incontinent, being put on an antidepressant or antipsychotic or having been identified as having fragile skin. Changes will be reviewed with the Unit Managers and the Unit Managers will ensure that the CNA care plan is updated if required. The Director of Nursing findings will be presented to the QA committee quarterly. The QA committee will determine if more audits or additional measures are required.</p>	6/21/14	



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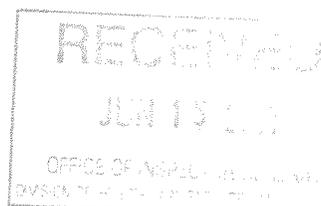
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F 280	<p>Continued From page 24 falls.</p> <p>On 03/18/14 at 3:00 PM, the resident was found on the floor by the bed wet and soiled. The fall was not witnessed and there were no injuries. The facility documented the resident was last checked and changed at 1:34 PM. The facility documented the root cause as the resident attempted self-transfer. A new intervention was noted for the resident to be placed on a perimeter mattress. The care plan team documented the perimeter mattress would be placed on the bed due to increasing number of falls. On 03/20/14, the intervention was added to the care plan; however, the mattress was discontinued on 04/14/14 related to a skin problem.</p> <p>On 04/06/14 at 4:30 PM, the resident was found on the floor by the side of the bed without any injuries. The facility documented that a staff member sat the resident on the side of the bed then turned away to get supplies and the resident fell to the floor. The facility determined the root cause of the fall was the resident attempting self-transfer. The new intervention was to educate staff on having supplies ready. There was no evidence the facility revised the care plan to prevent further falls.</p> <p>On 04/27/14 at 8:05 AM, the resident was found on the floor and was wet. The fall was unwitnessed. The facility documented the last time the resident was toileted or changed was 9:00 PM 04/26/14. The root cause of the fall was determined by the facility to be restlessness. The resident was agitated and orders were obtained from the physician for a urinalysis. A new intervention was for staff to check the resident more frequently through the night. The care plan</p>	F 280			



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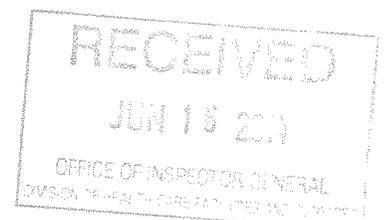
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F 280	Continued From page 25 team determined to await the results of the urinalysis and this intervention was added to the care plan. There was no evidence the facility revised the care plan to prevent further falls.  Interview with Certified Nurse Aide (CNA) #1, on 05/07/14 at 10:35 AM, revealed Resident #6 fell frequently and was confused. She stated the resident was incontinent of bladder and tried to get out of bed and toilet him/herself. She stated the resident did not use the call light. She indicated the resident was checked and changed every two hours and she was not aware the staff were using a sensor alarm when the resident was in bed or anything about a toileting program. She stated the resident could injure him/herself from so many falls.  Interview with CNA #2, on 05/07/14 at 2:15 PM, revealed Resident #6 usually fell when in the room in bed. She revealed the resident was at risk of falls according to the CNA Care Plan; however, the CNA care plan did not say anything about how to prevent falls or to check the resident more often than the usual every two hours. She stated the resident tried to self-transfer out of bed and could be injured from falling. She stated the resident did not use a sensor alarm or any other type of alarm and was not aware of any type of toileting program being used for the resident. She stated there was no information regarding toileting on the CNA care plan.  Interview with Licensed Practical Nurse (LPN) #2, on 05/07/14 at 2:45 PM, revealed Resident #6 did fall from bed most of the time. She stated the facility did not like to use alarms and she was not aware of any special interventions to prevent the resident from falling from bed. She stated she	F 280			



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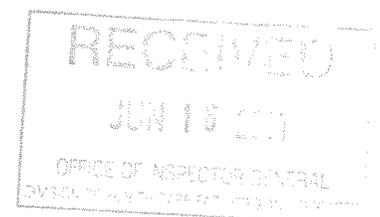
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F 280	<p>Continued From page 26</p> <p>had been in-serviced several weeks ago on fall prevention; however, she could not identify how this information was put to use for Resident #6. She stated the resident could have a serious injury from falling.</p> <p>Interview with the North Unit Manager, on 05/07/14 at 3:19 PM, revealed staff were told not to be specific on care plan interventions. She stated Resident #6 did have a history of falls and nothing more could be done to prevent the resident from falling. She stated the facility focused on preventing injuries from falls. She stated if the resident fell and was uninjured, the care plan goal was met and further interventions were not needed. She could not specifically say what interventions were in place to ensure falls did not result in injuries. She stated the resident could sustain an injury from a fall.</p> <p>Interview with the Director of Nursing, on 05/08/14 at 2:08 PM, revealed she was aware of the falls for Resident #6 and added the resident had not sustained a serious injury. She stated the goal was to prevent injuries from falls as falls were impossible to prevent. She indicated that the root causes for the falls of Resident #6 was the resident attempting self-transfers; however, the resident was on a toileting program. She revealed there was not a policy for establishing toileting programs. She stated the care plan was not revised after the falls since preventing this resident from falling was impossible</p> <p>2. Observation of Resident #2, on 05/06/14 at 8:05 AM, revealed the resident was in bed with his/her eyes closed.</p> <p>Review of the clinical record for Resident #2,</p>	F 280			



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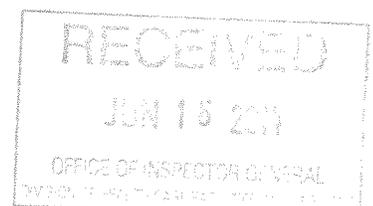
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F 280	<p>Continued From page 27</p> <p>revealed the facility admitted the resident with diagnoses of Diastolic Heart Failure, Renal Insufficiency, Diabetes, Anxiety and Depression. The facility completed a Quarterly MDS, on 03/31/14, and assessed the resident as cognitively intact, required extensive assistance with transfers and hygiene and was frequently incontinent of bowel and bladder. The resident received an antidepressant and palliative care.</p> <p>Review of the Comprehensive Care Plan and the CNA care plan for Resident #2, revealed no evidence of a care plan to address palliative care nor where any specific interventions for palliative care addressed in other care plans.</p> <p>Interview with CNA #2, on 05/08/14 at 8:20 AM, revealed she carried a CNA Care Plan containing information regarding care for her assigned residents. She stated she frequently provided care for Resident #2 and was not aware the resident received palliative care. She stated the CNA care plan did not address palliative care for the resident. She indicated palliative care provided to residents was essentially the same as regular care provided to residents. She stated she had received no training on palliative care.</p> <p>Interview with LPN #2, on 05/08/14 at 2:15 PM, revealed palliative care was bathing, toileting, assessment of pain and making residents comfortable. She stated she had received some training on palliative care; however, she was not sure what interventions, if any, made the care palliative. She stated residents on palliative care were at the end of life.</p> <p>Interview with the Director of Nursing, on 05/08/14 at 2:08 PM, revealed the facility did not</p>	F 280			



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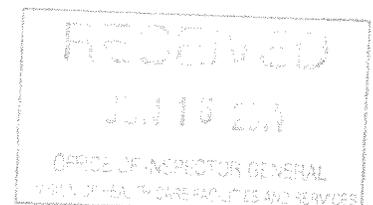
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F 280	<p>Continued From page 28</p> <p>have a policy for palliative care and stated it was end of life care. She further stated it was not addressed on Resident #2's care plan.</p> <p>3. Observation of Resident #11, on 05/06/14 at 8:05 AM, revealed the resident dressed and sitting in the room in a wheelchair. The resident wore longer sleeves; however, there were traces of healing bruises on both lower wrists and several small bruises on the lower legs along with a small healing skin tear.</p> <p>Review of the clinical record for Resident #11, revealed the facility admitted the resident with diagnoses of Dementia with Behavior Disturbance, Anemia, Urinary Tract Infection and Depression. A Quarterly MDS assessment was completed on 04/07/14, the facility assessed the resident with a significant cognitive impairment with no behaviors; required extensive assistance to transfer from bed to chair and to walk; was incontinent of bladder and bowel; and received an antidepressant.</p> <p>Review of the physician orders for Resident #11, revealed the resident was placed on Haldol, an anti-psychotic, on 02/26/14 and Lorazepam, an anti-anxiety, on 02/06/14. Neither medication was included in the quarterly MDS completed by the facility on 04/07/14.</p> <p>Review of the Comprehensive Care Plan for Resident #11, last update not documented, revealed a care plan for antidepressants had been developed; however, there was no evidence a care plan was developed to address the anti-anxiety medication and anti-psychotic medication. In addition, the care plan developed for the Trazodone (anti-depressant) did not</p>	F 280			



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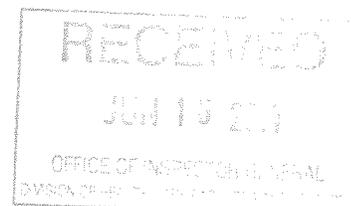
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F 280	<p>Continued From page 29</p> <p>include the side effects or adverse drug reactions for staff to monitor. Further noted Resident #11 had fragile skin and multiple bruises on all extremities. There was no evidence the facility addressed the fragile skin or steps to prevent bruising.</p> <p>Interview with CNA #2, on 05/07/14 at 2:20 PM, revealed Resident #11 had fragile skin and refused to wear geri-sleeves. She stated great care needed to be taken when transferring the resident or dressing/undressing the resident. She stated the resident's skin tore easily and the less pressure on the skin the better. She stated the resident bruised easily, but she had no idea as to where all the bruises came from.</p> <p>Interview with LPN #8, on 05/07/14 at 3:10 PM, revealed there was no care plan for Haldol or Lorazepam on Resident #11. She stated the drugs should be care planned to address any side effects promptly. She indicated the resident had very fragile skin and bruised easily. She revealed the resident needed to be dressed/undressed and transferred with care. She stated she could not locate a care plan to address these issues and any skin tears could become infected and make the resident sick. She stated the cause of the resident's bruising was unknown to her.</p> <p>Interview with the Director of Nursing, on 05/08/14 at 3:19 PM, revealed her expectation would be that the MDS was accurate and that the care plan was developed from the assessment information. She had no explanation regarding why resident problems were not care planned.</p> <p>Interview with LPN #5, on 05/08/14 at 1:48 PM,</p>	F 280			



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F 280	<p>Continued From page 30</p> <p>revealed when a resident fell the nurse could initiate an event report in the computer. LPN #5 stated she could not create or revise a care plan. The supervisor completed the care plan section of the event report.</p> <p>Interview with the South Unit Manager, on 05/08/14 at 3:00 PM, revealed the nursing staff could initiate a care plan upon admission. If a resident was to fall the nurse could place an appropriate intervention on the Event Form. The South Unit Manager stated the nurses could leave the care plan section blank on the event report because she looked at the falls daily and updated as needed.</p> <p>Interview with CNA #5, on 05/08/14 at 4:21 PM, revealed when she comes into the facility she would obtain report from the on duty CNA. CNA #5 stated she would have to print out a CNA care plan for herself, because no one would print one out for her. CNA #5 stated she would update her own care plan if she was in a hurry. Review of CNA #5's care plan revealed she was carrying around a care plan dated 03/24/14. CNA #5 stated the Unit Manager would inform her if there were any changes even though she did not talk to the South Unit Manager daily.</p> <p>Interview with LPN #6, on 05/08/14 at 5:29 PM, revealed she would expect the CNA's to have updated care plans in their pockets. LPN #6 stated she found it shocking that CNA #5 still had a care plan in her pocket dated 03/26/14. LPN #6 stated if she had an outdated care plan in her pocket she would not be sure if she was providing the appropriate care to the resident. LPN #6 stated a resident could become injured if the staff did not have the appropriate care plans.</p>	F 280			



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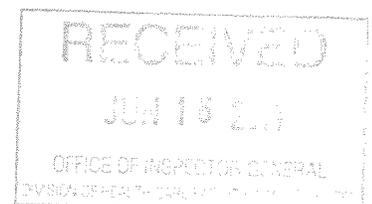
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F 280	Continued From page 31  Interview with South Unit Manager, on 05/08/14 at 4:50 PM, revealed it would be a problem if an aide had a care plan that was dated 03/26/14. The South Unit Manager stated the way it looked was that CNA #5 did not know what she was supposed to do. Nurses could report off to each other, but the CNA's obtain report from other CNAs and the information could be missed.  Interview with the DON, on 05/08/14 at 5:56 PM, revealed the nurse aides were to obtain a new care plan each day. The DON stated the new care plans were made available each day to the CNA's. The DON stated if the CNA's do not have a care plan, all of the information that the Aide needs to take care of a resident would not be there and if the Aide did not have the right care plan, the Aide would not be able to take care of the resident.	F 280			
F 282 SS=D	<b>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b>  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 the comprehensive care plan for one (1) of sixteen (16) sampled residents, Resident #4. The facility care planned Resident #4 for the use an edema glove; however, it was not in place for one (1) day of the survey,	F 282	1. Resident #4 is wearing the edema glove as ordered and care planed. Resident 4's restorative aides were re educated on 5/28/14 regarding the importance of following their part of the care plan.  2. Administration determined that any resident requiring splints, edema gloves, etc. from the restorative staff could be affected by this deficient practice.		

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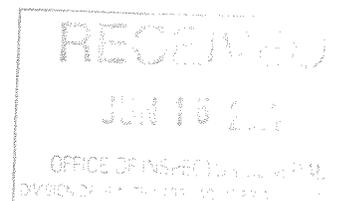
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F 282	Continued From page 32 05/06/14.  The findings include:  Interview with the Director of Nursing, on 05/08/14 at 3:54 PM, revealed the facility utilized Minimum Data Set (MDS) 3.0 when developing, revising and updating the care plan. The facility did not have a policy specifically for following the care plan.  Review of the clinical record for Resident #4 revealed the facility admitted the resident on 05/01/13 with diagnoses of Congestive Heart Failure, Hypertension and History of Bilateral Mastectomy. The monthly orders, dated 04/02/14, revealed Resident #4 was to wear a right hand edema glove daily except for meals to decrease swelling and increase functional use of the right hand. The Care Plan for Activities of Daily Living and Rehabilitation was dated 04/12/14 to provide Resident #4 with application of an edema glove seven (7) days a week by the Restorative Assistant. Review of the clinical documentation for Restorative Nursing on 05/06/14 revealed Resident #4 received only Active Range of Motion (AROM) and no application of the edema glove.  Observation, on 05/06/13 at 10:00 AM to 4:45 PM, revealed the resident was not wearing his/her edema glove, the edema glove was observed inside an open pink box on top of his/her dresser.  Interview, on 05/08/14 at 10:45 AM, with Restorative Nurse Assistant (RNA) #1 revealed	F 282	3. The Director of Nursing and the Staff Development Director inserviced the restorative staff regarding the importance of using assistive devices as ordered by the physician and or placed on the resident care plan. Inservice was held on 5/28/14. All newly hired restorative staff will receive this education during orientation by the Staff Development Director.  4. The Unit Managers and Restorative Nurse will audit one resident per week requiring a device that our restorative aides are responsible for putting on and taking off. Results will be reported to the Director of Nursing who will maintain a record of findings. If the audit reveals the care plan was not followed, the resident will be assessed for any adverse reaction which will be addressed as appropriate. If the audit reveals a restorative CNA is not following the resident's care plan, progressive disciplinary action will be taken. Director of Nursing will report finding, quarterly, to QA committee.	6/21/14	



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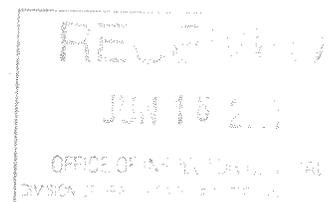
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F 282	Continued From page 33 she was working on 05/06/14 and was caring for Resident #4. The RNA was aware that Resident #4's edema glove was to be worn at all times except for meals.  Interview, on 05/08/14 at 12:00 PM, with Unit Manager (UM) #1 revealed she sometimes saw the RNA perform their duties, but did not monitor if the devices were applied and removed. The UM reviewed Resident #4's care plan and stated it was a concern the resident was not getting his/her glove the full length of time ordered and felt the RNA's needed more training.  Interview, on 05/08/14 at 3:54 PM, with the Director of Nursing revealed Resident #4 was in the RNA program and should have had his/her glove on his/her hand and if the resident was without his/her glove on 05/06/14 the care plan was not being followed.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS  A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to implement the Restorative Program to maintain and achieve the highest practicable outcome for one (1) of sixteen (16) sampled residents (Resident #4). The facility failed to place an edema glove on Resident #4's right hand, as instructed in the Restorative	F 311	1. Resident #4 is wearing the edema glove as care planed. Resident 4's restorative aides were re educated on 5/28/14 regarding the importance of following the Resident's Restorative Program to maintain and achieve the highest practicable outcome.  2. Administration determined that any resident requiring splints, edema gloves, etc. from the restorative staff could be affected by this deficient practice.	



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F 311	<p>Continued From page 34 Program and the care plan.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding the Restorative Program, not dated, revealed the Restorative Rehabilitation Program worked to promote the Resident's ability to function independently. The focus was to achieve and maintain optimal physical, social and functional well-being. Each resident with restorative needs should be evaluated by nursing and therapy, and should be classified into one of four categories prior to implementing the program. The appropriate staff would then be assigned to provide the specific restorative care. Active participants received their care from Restorative Nurse Assistants, (RNA's) under the oversight of a nurse. Maintenance care plans with clear delineation of responsibilities, time schedules, etc., and prepared and signed by the RNAs responsible for implementing the restorative care. RNAs must immediately report any significant change in condition. When warranted, a change in the care plan would be implemented.</p> <p>Review of the clinical record for Resident #4 revealed the facility admitted the resident on 05/01/13 with diagnoses Congested Heart Failure, Hypertension and History of Bilateral Mastectomy and a Brief Interview for Mental Status (BIMS) score was 10 out of 15, and appropriate for an individual interview. The monthly orders dated 04/02/14 revealed Resident #4 was to wear a right hand edema glove daily except for meals to decrease swelling and increase functional use of the right hand. The Care Plan for Activities of Daily Living and Rehabilitation was dated 4/12/14 and to provide</p>	F 311	<p>3. The Director of Nursing and the Staff Development Director inserviced the restorative staff on 5/28/14 regarding the importance of using assistive devices as ordered by the physician and or placed on the resident care plan. All newly hired restorative staff will receive this education during orientation by the Staff Development Director.</p> <p>4. The unit managers and restorative nurse will audit one resident per week requiring a device that our restorative aides are responsible for putting on and taking off. Results will be reported to the Director of Nursing who will maintain a record of findings. If the audit reveals the care plan was not followed, the resident will be assessed for any adverse reaction which will be addressed as appropriate. If the audit reveals a restorative CNA is not following the resident's care plan, progressive disciplinary action will be taken. Director of Nursing will report finding, quarterly, to QA committee.</p>	6/21/14



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F 311	<p>Continued From page 35</p> <p>Resident #4 with the application of an edema glove seven (7) days a week by the Restorative Nursing Assistant (RNA). Review of the clinical documentation for Restorative Nursing on 05/06/14 revealed Resident #4 received only Active Range of Motion (AROM) and no application of the edema glove.</p> <p>Interview, on 05/08/14 at 10:45 AM, with RNA #1 revealed she was working the day of 05/06/14 and cared for Resident #4. RNA #1 stated she was to place the edema glove on Resident #4 hand, provide AROM and to take the glove off for meals only. The RNA further stated she put the glove on the resident at 9:30 AM on this day. The RNA acknowledged it was her responsibility to put Resident #4's glove back on after meals during her working hours 8:30 AM to 4:30 PM.</p> <p>Interview with Resident #4, on 05/08/14 at 1:20 PM, revealed he/she has never refused to wear his/her edema glove and further stated it felt good to wear the glove.</p> <p>Interview with License Practical Nurse (LPN) #5, on 05/08/14 at 1:35 PM, revealed to her knowledge it was not a part of her duties to monitor the RNA's and the application of devices such as Resident #4's edema glove.</p> <p>Interview, on 05/08/14 at 12:00 PM, with Unit Manager (UM) #1 revealed she sometimes saw the RNA perform their duties, but did not monitor if the devices were applied and removed. The UM stated she was not aware if Resident #4 had his/her glove on or not, but the purpose of the edema glove was to control edema and avoid any set-back requiring the need for more therapy. UM #1 also stated there was a need for coaching</p>	F 311		



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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 311	Continued From page 36 and counseling of the facility staff.	F 311		
F 312 SS=E	<p>Interview, on 05/08/14 at 3:54 PM, with the Director of Nursing revealed Resident #4 was in the RNA program. The DON stated Resident #4 should have had his/her edema glove on 05/06/14, as the purpose was to control the resident's edema.</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to provide nail care for three (3) of sixteen (16) sampled residents and two (2) of two (2) unsampled residents (Residents #1, #6, #11, A, B). Residents were observed with unclean nails.</p> <p>The findings include:</p> <p>Interview with the North Unit Manager, on 05/08/14 at 1:22 PM, revealed the facility practice with no policy in place was for residents to receive nail care on shower/bath days and as needed.</p> <p>Observation of Resident #6, on 05/06/14 at 10:00 AM, revealed a dark brown substance under the</p>	F 312	<ol style="list-style-type: none"> <li>Residents #1, #6, #11, A and B's nails were trimmed and cleaned immediately. Mentioned residents are receiving necessary care and services to maintain good grooming and personal hygiene.</li> <li>All residents could be affected by this deficient practice.</li> <li>All residents' nails were checked on 5/22/14 by the Unit Managers and the Director of Nursing, to ensure that good grooming and personal hygiene is being provided. Resident nails will be inspected on shower days and daily during hand hygiene prior to meals. CNAs will be inserviced on our new procedures and documentation requirements by our Staff Development Director on 5/22 - 5/30/14.</li> </ol>	

