

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

PRINTED: 08/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/17/2014
NAME OF PROVIDER OR SUPPLIER  PROVIDENCE PINE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40504	
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F 000	INITIAL COMMENTS  AMENDED  An Abbreviated Survey, investigating KY00021906 and KY00021960, was initiated on 07/07/14 and concluded on 07/17/14. KY00021906 was substantiated with related and unrelated deficiencies cited. KY00021960 was unsubstantiated.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident, consult with the resident's physician, and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	F157  Please note for the record that RN#8 is a Licensed Practical Nurse; not an RN.  1. Resident #5 returned to the facility on 7/4/14 with a diagnosis of GERD. When the Interim Nursing Director and Social Services Director were notified of the incident, both went to Resident #5 and immediately investigated the incident. The residents care plan was updated for the new diagnosis.	

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

TITLE

(X6) DATE

*Maureen Dobson, MHA*

Regional Director/Administrator 8/25/14

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 157

Continued From page 1

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:  
Based on interview, record review and review of the facility's policy, it was determined the facility failed to immediately consult with the resident's physician when there was a significant change in condition, for one (1) of nine (9) sampled residents, Resident #5.

The findings include:

Review of the facility's policy titled "Condition Change of Resident (Observing, Recording, and Reporting)", undated, revealed it was the basic responsibility of the licensed nurse to observe, record, and report any condition change to the attending physician so proper treatment could be implemented.

Record review revealed Resident #5 was admitted by the facility on 06/18/14 with diagnoses which included Status Post Coronary Artery Bypass Graft, Diabetes, Coronary Atherosclerosis and Hypertension.

Interview with Resident #5 during the initial tour, on 07/08/14 at 9:06 AM, revealed on the morning of 07/04/14 Resident #5 reported to Licensed Practical Nurse (LPN) #13 symptoms of severe burning from the top of his/her chest to the abdomen, and difficulty swallowing. Further interview revealed Resident #5 had recently undergone cardiac a few weeks prior to 07/04/14,

F 157

2. All residents have the potential to be affected. The facility will utilize the twenty-four hour report sheet to assist with identifying potential residents that may be affected.
3. The nursing staff was in serviced on August 11 and August 12, 2014 by the Interim DON and ADON about recognizing changes in resident's condition and immediately reporting the change to the resident's physician or physician extender. The 24 hour report sheet was changed to one that has carbon copies. The 24 hour report sheet will be audited daily in the morning nursing meeting by the Interim DON, ADON or nursing

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F 157	<p>Continued From page 2</p> <p>and the resident was concerned the symptoms were indicative of another "heart attack". Resident #5 stated LPN #13 did not contact the Physician immediately, but encouraged the resident to go ahead and take his/her prescribed morning medications despite the resident's report of difficulty swallowing. Continued interview revealed Resident #5 continued to experience the symptoms throughout the day on 07/04/14. Resident #5 reported he/she voiced concerns about whether the symptoms could be another "heart attack" to the Physical Therapist at approximately 2:00 PM on 07/04/14. The resident further stated shortly after the Physical Therapist left the room, LPN #13 entered and asked if the resident would like to go to the hospital for evaluation. Resident #5 reported he/she told LPN #13 of his/her concern about possibly having a "heart attack".</p> <p>Review of the Interdisciplinary Care Plan, dated 06/27/14, revealed Resident #5 was at risk for cardiovascular complications. Interventions for managing the risk included to observe for change in condition and notify the Medical Doctor.</p> <p>Review of the Nurses Notes for 07/04/14 revealed no documentation related to Resident #5's complaints until 2:00 PM when LPN #13 noted the resident's report of burning in the chest, inability to swallow, and an elevated blood pressure. Further review of the Nurses Notes revealed LPN #13 notified the Advanced Registered Nurse Practitioner (ARNP) on 07/04/14 at approximately 2:15 PM of Resident #5's symptoms, and received an order to send the resident to the Emergency Room for evaluation. Continued review revealed LPN #13 documented, on 07/04/14 at 7:30 PM, Resident</p>	F 157	<p>supervisor to ensure any documentation presenting as a change of a resident's condition will have nursing documentation in the nursing notes stating that the physician/extender was notified and what, if any, orders were received. If the audit finds that the nurse failed to contact the physician or write an appropriate nursing note, the nurse will be re-educated by the DON. This could include disciplinary action of the nurse as well.</p> <p>4. The 24 hour report sheet will be audited daily for one month by the DON, ADON or nursing supervisor for four (4) weeks, the audits will be taken to the QA committee. This</p>		

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F 157	<p>Continued From page 3</p> <p>#5 was diagnosed with Gastroesophageal Reflux Disease (GERD) while at the Emergency Room.</p> <p>Interview with the Physical Therapist (PT), on 07/10/14 at 1:25 PM, revealed he went to Resident #5's room in the afternoon of 07/04/14 but he could not recall the exact time. Further interview revealed Resident #5 reported to the PT that he/she had been having problems with swallowing, and a burning sensation, earlier in the morning on 07/04/14. The PT stated a nurse was in the room with Resident #5 when he entered, and the nurse stated the resident was not feeling well enough for therapy and was just going to stay in bed and rest. Continued interview with the Physical Therapist revealed he did not recall Resident #5 mentioning concerns of having a heart attack to him.</p> <p>Interview with LPN #13, on 07/10/14 at 2:45 PM, revealed Resident #5 told LPN #13 on 07/04/14 around 9:00 AM to 10:00 AM of having symptoms of burning in the stomach. She stated she thought Resident #5 was having symptoms of heartburn, and she did not notify the physician. LPN #13 further stated Resident #5 drank some milk and was going to lie down. Continued interview revealed she checked on Resident #5 at 12:00 PM and again at 2:00 PM, although there was no documentation regarding Resident 5's complaints on 07/04/14 until 2:00 PM. LPN #13 reported when she checked on Resident #5 at 2:00 PM, the resident did not appear to be in any physical distress, but stated his/her symptoms were more intense. LPN #13 reported she checked Resident #5's vital signs at that time and noted an elevated blood pressure of 168/108. LPN #13 stated she asked Resident #5 if he/she would like to go to the hospital and the resident</p>	F 157	<p>plan will be followed for 3 months and if no trends are found the audit will be changed to random checks reviewed monthly. The DON will ensure compliance with this regulation through audits of the twenty-four report each day in morning meeting and following up with any nurse who fails to follow this policy.</p>	8/22/14	

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F 157	<p>Continued From page 4</p> <p>responded yes. LPN #13 reported after receiving the order from the ARNP, Resident #5 was sent out to the Emergency Room, where he/she was diagnosed with GERD.</p> <p>Interview with the Unit 1 Coordinator, on 07/10/14 at 1:35 PM, revealed she was unaware of Resident #5's complaints of having a burning sensation in her chest and swallowing problems, until around 2:00 PM on 07/04/14. She stated Resident #5 told her he/she had reported the symptoms to LPN #13 earlier in the day on 07/04/14. Further interview revealed Resident #5 was concerned because of recent cardiac problems. The Unit 1 Coordinator stated LPN #13 should have notified her as soon as Resident #5 started complaining of swallowing difficulties and a burning sensation in his/her chest. Continued interview revealed the process when there was a change of condition was to notify the Unit Coordinator, and then notify the Physician. The Unit 1 Coordinator stated she would consider the symptoms Resident #5 was experiencing to be a change in condition and cause for concern related to the resident's recent cardiac surgery.</p> <p>Interview with the Interim Director of Nursing (DON), on 07/10/14 at 5:15 PM, revealed she first became aware of Resident #5's care concerns on 07/08/14. She stated, based on the resident's recent medical history, she would have expected the physician to have been notified when the resident first complained of discomfort in the chest area.</p> <p>Interview with the ARNP, on 07/17/14 at 4:26 PM, revealed she was not on call on 07/04/14, but had since talked with Resident #5 about the symptoms he/she experienced on 07/04/14.</p>	F 157		
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F 157 Continued From page 5  
Further interview revealed since Resident #5 had burning in the chest, and did not have any medication ordered for the symptom, she would have expected the nursing staff to notify the Physician/ARNP about the resident's change in condition, due to the resident's recent history of cardiac surgery.

F 157

F 226 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES

F 226

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 review of the facility's policy, it was determined that the facility failed to report all alleged violations of abuse to the State Agency, for one (1) of nine (9) sampled residents and one (1) unknown resident. Resident #6 was involved in an altercation with Unsampld Resident A, and involved in a separate altercation with an unknown resident. Resident #6 and Unsampld Resident A were determined to not be significantly cognitively impaired; therefore, since both residents were alleged perpetrators in separate resident to resident altercations, it was determined that willful intent could have been possible.

The findings include:  
Review of the facility's Abuse Policy, in the section titled "Reporting Abuse to State Agencies

F226

1. The incidents involving unknown Resident A and Resident #6 occurred before this survey exit conference; therefore, no interventions were made at this time.
2. All residents have the potential to be affected. The 24 hour report and facility incident reports that are prepared by the floor nurses will be utilized to identify residents who could potentially be affected. Both the 24 hour report and the incident reports are gone over in the daily morning meeting.

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F 226	Continued From page 6 and Other Entities/Individuals" (revised December 2009), revealed all suspected violations and all substantiated incidents of abuse were to be immediately reported to the appropriate State Agencies, and other entities or individuals as required by law. Continued review of the policy revealed a verbal/written notice to agencies would be made within twenty-four (24) hours, by special carrier, fax, e-mail or telephone, of the occurrence of such incident. Further review of the policy revealed the Administrator, or his/her designee, would provide the appropriate agencies with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident.  1. Record review revealed Resident #6 was admitted by the facility on 03/28/12 with diagnoses which included Chronic Obstructive Pulmonary Disease, Hypertension, Alzheimer's Dementia, Depression, and Anxiety. Review of Resident #6's Brief Interview for Mental Status (BIMS), dated 05/30/14, revealed the resident scored a thirteen (13), which indicated the resident was cognitively intact and interviewable.  Review of the Social Services Progress Notes for Resident #6 revealed, on 04/23/14, Resident #6 and an unknown resident had an altercation when Resident #6 attempted to take the unknown resident's candy. When the unknown resident attempted to take the candy back, Resident #6 struck the unknown resident on the hand and kicked him/her on the shin. Continued review revealed the Social Services Director interviewed Resident #6 on 04/23/14, and found the resident to be alert and oriented after the altercation, although the resident denied any recollection of the event.	F 226	Management staff will be able to identify any issue at this time that should have been investigated or reported to the appropriate authorities. On the weekend and holiday's, the nursing supervisor will be responsible for looking at this documentation and notifying the administrator of any issue that may need to be investigated and/or reported to the appropriate authorities.  3. The Social Service Director was in serviced 7/11/2014 by the Regional Director of Operations on reporting abuse and neglect. All facility staff, including 100% of nursing staff were in serviced on August 1, 2, and 6, 2014		

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F 226	Continued From page 7  2. Record review revealed Unsampled Resident A was admitted by the facility on 02/24/10 with diagnoses which included Hypertension, Coronary Artery Disease, Alzheimer's Dementia with Behaviors, Anxiety, Depression and Mood Disorder. Review of the BIMS, dated 05/27/14, revealed Unsampled Resident A scored a nine (9), which indicated the resident was moderately cognitively impaired.  Record review of Social Services Progress Notes for Resident #6 and Unsampled Resident A revealed, on 05/27/14, Unsampled Resident A struck Resident #6. Review of the Nursing Progress Notes revealed the altercation occurred on 05/26/14 at 3:00 PM, and was related to Resident #6 having Unsampled Resident A's shirt on.  Interview with the Social Services Director, on 07/09/14 at 4:00 PM, revealed he conducts the investigations on abuse and reports his findings to the Administrator, who uses the findings to determine whether the incident should be reported to the State Agency. Subsequent interview, on 07/10/14 at 5:32 PM, revealed the Social Services Director could not recall who the unknown resident involved in the altercation with Resident #6 on 04/23/14 was.  Interview with the Administrator-in-Training, on 07/11/14 at 11:43 AM, revealed he had just started his training approximately three weeks ago and had not yet been trained on abuse, but it was his expectation for staff to follow the facility's Abuse Policy. He stated the two (2) altercations involving Resident #6 should have been reported to the State Agency.	F 226	by the Social Service Director on Abuse, Neglect and Misappropriation. Also included was who to report suspected or actual abuse, neglect and misappropriation. Effective 8/12/2014 the Social Service Director will include the resident's BIM score in any investigation of abuse, neglect or misappropriation. The BIM's score will help determine if the intent of the act was "willful" toward the other person. 4. The Quality Assurance Nurse will check the investigations of abuse, neglect or misappropriation weekly for four (4) weeks to ensure compliance. Results of the Audits will		

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F 226	<p>Continued From page 8</p> <p>Interview with the Regional Director/Interim Administrator, on 07/11/14 at 2:54 PM, revealed he had been trained on abuse and had provided abuse training to others. He reported he had been made aware of the resident to resident altercations, and acknowledged both incidents should have been reported to the State Agency within twenty-four (24) hours, according to the facility's policy. He further stated once the investigations were completed and a final conclusion was made, the final reports should have been sent to the State Agency within five (5) days.</p>	F 226	<p>be reviewed with the Quality Assurance committee for any trends or needed follow up. If no trends are present after 3 months the committee will designate a proper schedule to continue to ensure compliance. Administrator will ensure compliance by August 22, 2014.</p>	8/22/14

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K 000	<p><b>INITIAL COMMENTS</b></p> <p>An Abbreviated Survey, investigating KY00021958, was initiated and concluded on 07/14/14. KY00021958 was unsubstantiated with no deficiencies cited.</p>	K 000		
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