

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

PRINTED: 02/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185122	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/06/2014
NAME OF PROVIDER OR SUPPLIER PARKWAY MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1155 EASTERN PARKWAY LOUISVILLE, KY 40217		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS A Standard Health Survey was initiated on 02/03/14 and concluded on 02/06/14 and a Life Safety Code survey was conducted on 02/04/14 through 02/05/14. Deficiencies were cited at the highest scope and severity of an "E" for the health survey with no deficiencies cited for the Life Safety Code survey.	F 000	The preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law. As part of the facilities' ongoing performance improvement program, all audit results will be reported to the Performance Improvement Team with additional education as necessary.		
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	The surveyors became aware of the alleged abuse regarding Resident O during a group interview with the residents of our facility during the survey. This resident was discharged to a psychiatric hospital five days after the survey (2/11/14). This was due to a behavior episode involving another resident. The facility reported this situation to the proper agencies on 2/11/14. Adult Protective Services conducted an investigation on 3/11/14 and determined it was unsubstantiated.		

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

X Joseph E. Drullman

TITLE Administrator

(X6) DATE

X 03/21/14/kt

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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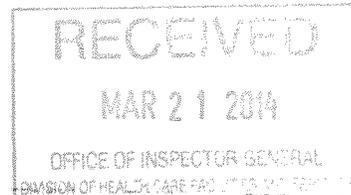
MAR 21 2014

OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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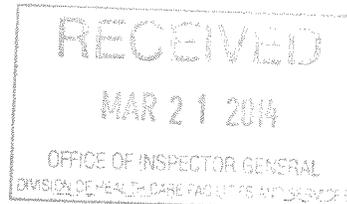
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F 225	<p>Continued From page 1</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) 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 interview, record review, and review of the facility's Abuse Prevention, Intervention, Data Collection policy, it was determined the facility failed to report an allegation of abuse for one (1) of fifteen (15) unsampled residents and thirty (30) sampled residents. (Unsampled Resident O). The facility failed to report to the State Agency an allegation of physical abuse by two CNAs as reported by Unsampled Resident O on 01/24/14.</p> <p>The finding include:</p> <p>Review of the facility's policy regarding Abuse Prevention, Intervention, Data Collection, revealed after consulting with Administration, the supervisor and reporting individual shall immediately report the concern to Adult Protective Services and any other regulatory agency or police, as instructed by administration.</p> <p>During the Group Interview with the residents of the facility, on 02/04/14 at 2:00 PM, it was reported Unsampled Resident O had been hit in the back by two CNAs and they were fired over the incident.</p> <p>An attempt to interview Unsampled Resident O,</p>	F 225	<p>F 225 Continued from page 1</p> <p>On 3/7/14, the Directors of Nursing conducted a Unit Manager's meeting to discuss if any other resident allegations of abuse had been reported on their units. From this meeting, two other allegations had been made, both of which were reported to all agencies on 3/4/14, and 3/5/14 per regulation.</p> <p>It is the policy of Parkway Rehabilitation and Nursing Center to report instances of alleged abuse in accordance with regulatory requirements. Administration revised our policy on 2/12/14 to reflect language - added "alleged" - in accordance with 483.13 (c) (1) (ii) - (iii), (c) (2) - (4). The Medical Director approved the revision on 2/28/14. Reporting of abuse is presented during orientation to newly-hired employees and during education programs throughout the year. In order to reinforce the knowledge of reporting alleged abuse and changes to the policy, the Staff Development Coordinator conducted inservices regarding this topic. The inservices were presented to all staff including nursing administration. The inservice sessions began on 2/7/14 and will be completed by 3/7/14. Any agency staff is required to sign a statement stating he/she is aware of the revised policy. The Director of Nursing, Staff Development Coordinator, and Social Service Director attended the Abuse & Neglect Prevention & Incident Reporting Seminar on February 26th, 2014.</p>		



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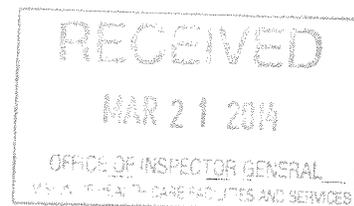
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F 225	Continued From page 2 on 02/06/14 at 10:45 AM, revealed he was sitting up in a chair with his eyes open. He did not respond to questions. Interview with LPN #2, on 02/06/14 at 10:55 AM, revealed approximately two weeks ago Unsampld Resident O reported to her he/she was brutally attacked. He/She told her his/her fingers had been bent back. LPN #2 examined the resident and found a bruised area on the ring finger of the left hand. She reported the allegation to LPN #3, (the Assistant Unit Manager). LPN #2 stated it was written up and an investigation was done. She stated she was not sure of the outcome of the investigation, but it was now required that two staff be there whenever care was rendered to Resident #1. She stated he/she was confused and had been verbally abusive with staff. Interview with LPN #3, Assistant Clinical Director on 3rd floor, on 02/06/14 at 11:05 AM, revealed she remembered the incident involving Unsampld Resident O. Unsampld Resident O stated a tall black man named Kelly, who was visiting another resident, came in his/her room and bent his/her fingers back. She completed an assessment on the resident and found bruises on two fingers and back of the hand on the right. LPN #3 notified MD and obtained an order for an x-ray, which was negative. She stated the resident had good range of motion and denied pain. LPN #3 stated she completed an unusual occurrence form and reported the incident to Director of Nursing #2 (DON #2) less than one half hour of the initial report. An investigation was conducted by DON #2. Both the Power of Attorney and Health Care Proxy were identified. She stated there were two CNAs who worked that	F 225	Continued from page 2 Presentations were done by representatives of the Office of Inspector General and Adult Protective Services. A process was put in place on 2/24/14, where the Directors of Nursing will inform the Administrator and Compliance Officer of any allegations of abuse. The Administrator will be responsible to ensure any allegations of abuse are reported per facility policy and regulations. The Administrator educated the Directors of Nursing to this process on 2/24/14. Nursing Administration will maintain a log to document suspected/alleged abuse which lists the date and who conducted the reporting. The Directors of Nursing will submit the log to the Performance Improvement Committee meeting quarterly. The log will be added as part of the routine agenda at each future Performance Improvement Committee meeting.	3/8/14	



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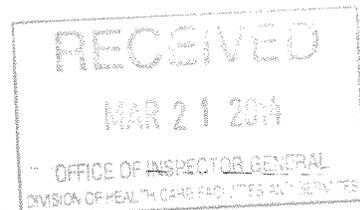
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F 225	<p>Continued From page 3</p> <p>floor that might have fit that description. LPN #3 also stated the resident gave two or three versions of what happened.</p> <p>A phone call to the Abuse Hotline, on 02/06/14 at 1:35 PM, revealed there was no evidence of a report of alleged abuse reported involving Unsampled Resident O.</p> <p>Interview with DON #2, on 02/06/14 at 1:40 PM, revealed she conducted the investigation on abuse for Unsampled Resident O. She stated the allegation of abuse was not reported to the Department of Community Based Services (DCBS) or the Office of Inspector General (OIG) because she determined through her investigation that it was not considered an allegation of abuse.</p> <p>Interview with DON #2, on 02/06/14 at 2:40 PM, revealed the incident was reported to her on 01/24/14. She initiated an investigation and interviewed the resident. Unsampled Resident O stated the incident occurred. DON #2 stated she did not suspect Unsampled Resident O had been abused. He/She did have an injury to their hand, but he/she had been throwing trays a few days earlier and that was probably how the injury occurred. She stated if you are hit, punched or slapped it was physical abuse. She stated the facility abuse policy required reporting for suspected abuse and after her investigation she did not suspect abuse. She further stated she would report allegations of abuse to DCBS or OIG only, if after her investigation of staff and residents involved she suspected abuse had occurred.</p> <p>Interview with Administrator, on 02/06/14 at 4:15</p>	F 225			



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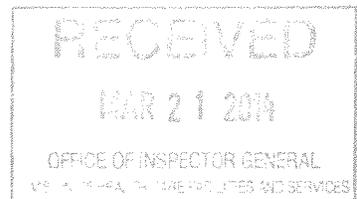
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F 225	Continued From page 4 PM, revealed the facility reported only suspected abuse to regulatory agencies.	F 225			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review 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 interview and record review it was determined the facility failed to develop a care plan of one (1) of thirty (30) sampled residents, (Resident #19). The staff documented incidents of suicidal ideation and verbal behaviors towards staff by Resident #19 which included accusing a staff member of physical abuse; however, failed to develop a care plan to address those behaviors.	F 279	Upon discovery that a care plan specific to behavior was lacking, nursing staff immediately developed a "behavior" care plan for Resident #19. This was done while the survey was in progress. Interventions related to behavior had been care planned under the "mood" section of the care plan and interventions were being implemented regarding her behaviors. The care plan for Resident #19 is routinely reviewed and revised by the Interdisciplinary Care Team as conditions change. The Directors of Nursing obtained a list for all residents to determine those with behavior problems. The Unit Managers and RAI staff are in the process of reviewing and revising the care plans of these residents to ensure they contain a "behavior" care plan. This will be completed by 3/21/14. The Directors of Nursing developed a schedule so that care plans will be audited for all residents by 3/21/14, to determine that behaviors and other key issues are addressed on the care plan. These will be conducted by administrative and licensed nursing staff. Care plans will then be audited during the quarterly, annual, and significant change MDS schedule. The Directors of Nursing will take remedial action as needed for any discrepancies. The Directors of Nursing established "Care Plan Guidelines" for nursing staff on 2/12/14. Residents will continue to be assessed by nursing staff for behaviors and other conditions upon admission, quarterly and as conditions change. Pertinent problems, including behaviors, will be addressed		



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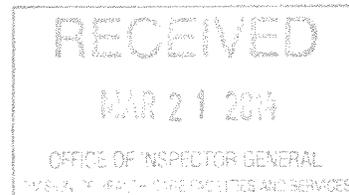
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F 279	Continued From page 5 The findings include: Review of the facility's Resident Assessment Instrument on 02/06/14 revealed in item number one (1) the purpose of the Comprehensive Care Plan was to support the resident to attain or maintain the highest practicable physical, mental, and psychosocial well being. Item four (4) stated the Care Plan was to identify the resident's individualized priority problems or strengths that were at risk. Review of the Nursing Notes for Resident #19 revealed the resident called 911 on 11/17/13 and reported he/she wanted to go home. On 12/26/12 the resident became angry thinking his/her son was his/her spouse and he/she wanted nothing to do with him/her. On 01/02/14 the resident reported to the nurse that a Certified Nursing Assistant (CNA) had been rough with her and pulled her arm. The facility notified the physician and a portable X-Ray of the left arm was done with negative results. On 01/22/14 the resident threatened to kill himself/herself and on 01/23/14 the resident threatened to harm staff. In response to the threat of suicidal ideation the resident was put on 1:1 checks on 01/22/14 which were advanced to every 15 minute checks on 01/23/14. Review of the medical record for Resident #19, revealed the facility admitted the resident on 02/01/13 with diagnoses of Nausea/Vomiting, Acute Kidney Failure, High Potassium, Reflux, Anemia, Pylonephritis, Encephalopathy, Diabetes II, Dementia, and High Blood Pressure. He/she had psychiatric diagnoses of Anxiety and Delusions.	F 279	F 279 Continued from page 5 on the care plan. The nurse who observes a change in condition is required to update the care plan accordingly. Staff nurses were instructed of this requirement by Nursing Administration and Unit Managers on 2/13/14. Upon completion of the house-wide audits, the Compliance Officer will audit 10 charts weekly x 4 weeks, monthly x 2 months, then quarterly x 3 quarters. The Compliance Officer will provide results to the Directors of Nursing. The Directors of Nursing will promptly review with the Unit Managers any discrepancies noted. The Unit Managers will return the audits with actions taken regarding the findings to the Directors of Nursing. The Directors of Nursing will review monthly chart audits in the weekly Unit Managers meeting x 3 months. The results of the audits will be submitted by the facility's Compliance Officer to the Performance Improvement Committee meetings quarterly for the next 3 quarters.	3/22/14	



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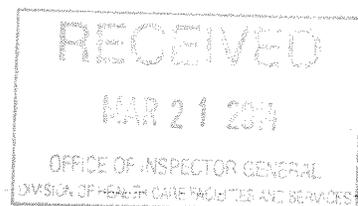
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F 279	Continued From page 6 Further review of the medical record revealed a care plan had not been developed to address socially inappropriate behaviors such as accusing staff of harming him/her, spitting at staff, and making 911 phone calls. Interview with Licensed Practical Nurse #5, on 02/06/14 at 1:14PM, revealed a care plan should have been developed to reflected the behavioral needs of Resident #19 and specific interventions and goals to meet the residents psychological needs should have been addressed on the care plan.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and review of the facility's Resident Assessment Instrument (RAI) Policy, it was determined the facility failed to follow the comprehensive care plan for one (1) of thirty (30) sampled residents. (Resident #1). The facility staff assessed and care planned Resident #1 as requiring supervision during any po intake; however, staff left Resident #1 unsupervised while Resident #1 ate his/her meals in the room. The findings include:	F 282	F 282 Upon learning of this situation, the Directors of Nursing and the Unit Manager informed the CNA caring for Resident #1 to provide supervision during meals as listed on the CNA's care card. An investigation found that the CNA involved in this situation was aware of the facility's system to use care cards for information regarding individual residents' specific needs. We feel that this was an isolated occurrence and the CNA was counseled on her failure to follow facility's standards. Resident #1 is now receiving supervision during meals. It is to be noted that this resident has had no problems with eating and the last episode of aspiration occurred in 2010. All residents have the potential for being affected by not providing care in accordance with the comprehensive assessment and plan of care. The CNAs are educated in orientation and during skills days (the last being 1/28/14 and 1/29/14) on the requirement to use resident care cards for information to provide care for the residents. In	



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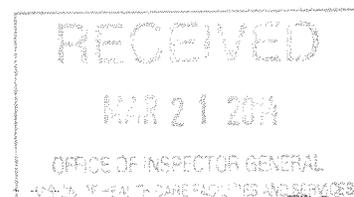
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F 282	<p>Continued From page 7</p> <p>Review of the facility, RAI Policy, identified as 10-99/6-04/10/10, revealed the RAI was utilized to develop an interdisciplinary plan of care that enhanced communication, coordinated efforts, establish priorities and practical level of functioning.</p> <p>Observation of Resident #1, on 02/04/14 at 12:55 PM, revealed the lunch meal tray sat on the over the bed table and he/she was eating independently. Staff were not present in the room. A staff member later entered the room and washed her hands and then left the room without checking on the resident. Staff returned, at 1:00 PM, checked in with Resident #1 and then left the resident's room.</p> <p>Observation of Resident #1, on 02/05/14 at 9:13 AM, revealed the breakfast meal tray sat on the over the bed table and he/she was eating independently. No staff were in the room.</p> <p>Review of the medical record for Resident #1, revealed the facility admitted the resident on 06/14/10, with diagnoses of Vascular Dementia, Aspiration Pneumonia, Aphasia, Dysphgia and Left Middle Cardiovascular Accident (CVA). The facility assessed Resident #1 on the Quarterly Minimum Data Set (MDS), dated 11/09/13, with severely impaired cognitive skills for daily decision making.</p> <p>Review of the physician orders, dated February 2014, included assist with all by mouth (po) intake.</p> <p>Review of the Speech Therapy notes, dated 08/13/13, revealed staff education was completed with the first shift certified nurse aide (CNA) about</p>	F 282	<p>F 282 Continued from page 7</p> <p>order to reinforce their knowledge, nursing administration staff provided education for all CNAs on this topic. The education began on 2/13/14 and ended on 2/24/14. CNAs were required to document their signatures to demonstrate their understanding of the material presented. The content of this education will continue on an as needed basis and during skills days throughout the year.</p> <p>In order to provide an additional alert to staff, the facility has implemented a new system on 2/12/14 whereby a magnet depicting a fork and spoon is placed on the door frame of residents' rooms to indicate that a resident in that room requires supervision with meals. Detailed information is listed on the resident's CNA care card. "Supervision" has been added to resident dietary tray cards for those needing supervision while eating. This will alert staff to those residents in the dining room who need supervision during meals. Nursing administration staff provided education for nursing staff on the new systems. The education began on 2/13/14 and ended on 2/24/14. Education will continue on an as needed basis and during skills days throughout the year. The Unit Managers on each floor were instructed by the Directors of Nursing on 2/13/14 of their responsibility to supervise staff to ensure residents are being cared for in accordance with physician's orders, assessment, care plan and instructions listed on the CNAs care card. They will observe meal service to ensure that residents who require supervision during meals are being supervised.</p>		



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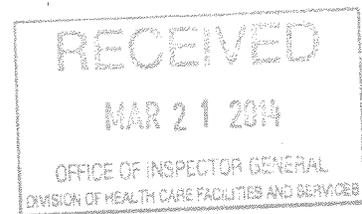
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F 282	Continued From page 8 the need for supervision with mechanical soft foods and compensatory strategies needed for safe intake. Speech Therapy notes, dated 08/14/13, revealed Speech Therapy changed Resident #1's diet to a mechanical soft with ground meat and thin liquids with supervision for all PO intake. Staff education was completed with the second shift nurse. Speech Therapy notes, dated 08/21/13, revealed staff education was completed with the certified nurse aides, the unit manager and the nurse about safety with the PO diet.	F 282	F 282 Continued from page 8 Nursing staff is present in the dining room to supervise meal service conducted there. In addition, the facility's Compliance Officer will conduct an audit of residents who need supervision at meal times to determine if supervision is being done and the "fork and spoon" magnets are in place. These audits consist of observing five meals weekly x 4 weeks, then two meals monthly for 2 months, and then three meals quarterly for 3 quarters. The Compliance Officer will report any infractions immediately to the Unit Manager for correction. The results of the audit will be submitted to the Performance Improvement committee meetings by the Compliance Officer quarterly for the next three quarters, after which time the members will decide the need and time frames for continued auditing.	2/26/2014	
	Review of the facility's care plan, for Resident #1, onset date 08/26/13, revealed a problem listed for risk of aspiration related to the diet. The care plan approaches included the resident must have supervision with all meals to be sure the resident takes small bites at a slow rate and using tongue sweeps. Review of the CNA's care plan included staff to stay with the resident during meals. Supervision was written on the CNA care plan in the diet section. The bottom of the care plan, dated 08/16/13, included a large lettered statement of CNA/Staff must supervise resident with all by mouth intake per Speech. Interview with CNA #2, on 02/06/14 at 9:25 AM, revealed Resident #1 required someone to stay with him/her while he/she ate or drank. He/she might get choked if unsupervised. Interview with CNA #1, on 02/06/14 at 2:35 PM, revealed Resident #1 was supposed to have someone with him/her when they ate. The resident feeds him/herself, but staff are suppose to stay with the resident during that time. She stated she guessed they think he/she will choke, if he/she eats to fast. She stated the tray was left				



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

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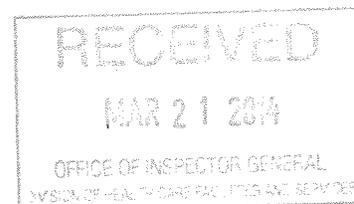
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F 282	Continued From page 9 with the resident in the room unattended; however, it was her responsibility to make sure the tray was not left unattended. Interview with Licensed Practical Nurse (LPN) #1, on 02/06/14 at 2:15 PM, revealed Resident #1 was supposed to be supervised at all times during meals, but she had not seen this done everyday. It was everybody's responsibility. The resident was supposed to be observed during his meals to make sure the resident did not get choked while eating. She reported, she had seen the resident cough during meals and his/her face got real red while coughing.	F 282			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to provide supervision of a resident during meals as	F 309	F 309 Upon learning of this situation, the Directors of Nursing and the Unit Manager informed the CNA caring for Resident #1 to provide supervision during meals as listed on the CNA's care card. An investigation found that the CNA involved in this situation was aware of the facility's system to use care cards for information regarding individual residents' specific needs. We feel that this was an isolated occurrence and the CNA was counseled on her failure to follow facility's standards. All residents have the potential for being affected by not providing care in accordance with the comprehensive assessment and plan of care.		



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

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F 309	Continued From page 10 assessed and care planned for one (1) of thirty (30) sampled residents, (Resident #1). The staff left Resident #1 unsupervised during two meals eaten in room after they assessed the resident to need supervision during all po intake and compensatory strategies to be used by the resident. The findings include: There was no policy provided regarding providing supervision to residents at meal times. Observation of Resident #1, on 02/04/14 at 12:55 PM, revealed the lunch meal tray sat on the over-the-bed table and he/she was eating independently. The head of the bed was an approximate 90 degree angle. The resident had consumed approximately 50% of the meal and staff were not present in the room. A staff member entered the room and washed her hands and then left the room without checking on the resident. Observation of Resident #1, on 02/05/14 at 9:13 AM, revealed the breakfast meal tray sat on the over-the-bed table and he/she was eating independently. The head of the bed was at an approximate 90 degree angle. The resident had consumed approximately 75% of the meal. No staff were in the room at the time. Review of the clinical record for Resident #1, revealed the facility admitted the resident on 06/14/10, with diagnoses of Vascular Dementia, Aspiration Pneumonia, Aphasia, Dysphgia and Left Middle Cardiovascular Accident (CVA). Review of the physician orders, dated December	F 309	F 309 Continued from page 10 The CNAs are educated in orientation and during skills days (the last being 1/28/14 and 1/29/14) on the requirement to use resident care cards for information to provide care for the residents. In order to reinforce their knowledge, Nursing Administration provided education for all CNAs on this topic. The education began on 2/13/14 and ended on 2/24/14. CNAs were required to document their signatures to demonstrate their understanding of the material presented. The content of this education will continue on an as needed basis and during skills days throughout the year. In order to provide an additional alert to staff, the facility has implemented a new system on 2/12/14, whereby a magnet depicting a fork and spoon is placed on the door frame of residents' rooms to indicate that a resident in that room requires supervision with meals. Detailed information is listed on the resident's CNA care card. "Supervision" has been added to resident dietary tray cards for those needing supervision while eating. This will alert staff to those residents in the dining room who need supervision during meals. Nursing staff is present in the dining room to supervise meal service conducted there. Nursing Administration provided education for nursing staff on the new system. The education began on 2/13/14 and ended on 2/24/14. Education will continue on an as needed basis and during skills days throughout the year. The Meal Service Policy was updated 2/25/14 by the Director(s) of Nursing to include information regarding supervision during meals. "Supervision" will be listed on individual resident tray cards as		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

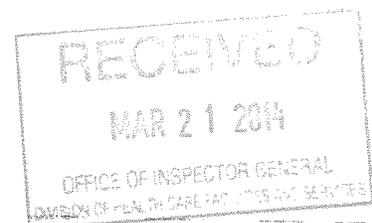
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F 309	<p>Continued From page 11</p> <p>2013 and February 2014, with an original order date of 08/14/13, included assist with all by mouth (po) intake.</p> <p>Review of the Speech Therapy notes, dated 08/13/13, revealed staff education was completed on this day with the first shift certified nurse aide (CNA) about the need for supervision with mechanical soft foods and the compenstory strategies needed for safe intake. Speech Therapy notes, dated 08/14/13, revealed the Speech Therapist changed Resident #1's diet to a mechanical soft with ground meat and thin liquids with supervision for all PO intake. Staff education was completed with the second shift nurse. Speech Therapy notes, dated 08/21/13, revealed staff education was completed with the certified nurse aides, the unit manager and the nurse about safety with the po diet.</p> <p>Interview with CNA #2, on 02/06/14 at 9:25 AM, revealed Resident #1 required someone to stay with him/her while he/she ate or drank. He/she might get choked if unsupervised.</p> <p>Interview with CNA #1, on 02/06/14 at 2:35 PM, revealed Resident #1 was supposed to have someone with him/her when the Resident ate. She reported, the resident feeds him/herself, but staff are supposed to stay with the resident. She stated, she guessed they think he/she would choke and he/she eats to fast. She stated the tray was left with the resident in the room unattended and it was her responsibility to make sure the tray was not left unattended.</p> <p>Interview with Licensed Practical Nurse #1, on 02/06/14 at 2:15 PM, revealed Resident #1 was supposed to be supervised at all times during</p>	F 309	<p>F 309 Continued from page 11</p> <p>appropriate. The Unit Managers on each floor were instructed by the Directors of Nursing on 2/13/14 of their responsibility to supervise staff to ensure residents are being cared for in accordance with physician's orders, assessment, care plan and instructions listed on the CNAs care cards. They will observe meal service to ensure that residents who require supervision during meals are being supervised.</p> <p>In addition, the facility's Compliance Officer will conduct an audit of residents who need supervision at meal times to determine if supervision is being done and the "fork and spoon" magnets are in place. These audits consist of observing five meals weekly x 4 weeks, then two meals monthly for 2 months, and then three meals quarterly for 3 quarters.. The Compliance Officer will report any infractions immediately to the Unit Manager for correction. The results of the audit will be submitted to the Performance Improvement committee meetings by the Compliance Officer quarterly for the next three quarters, after which time the members will decide the need and time frames for continued auditing.</p>	2/26/14	

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

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F 309	Continued From page 12 meals, but had not seen this done everyday. It was everybody's responsibility. The resident was supposed to be observed during his/her meals to make sure the resident did not get choked while eating. She reported, she had seen the resident cough during meals and his/her face got real red while coughing. Interview with the Director of Nursing #2, on 02/06/14 at 3:15 PM, revealed it was the expectation for the staff to supervise Resident #1 during his/her meals and with all PO intake.	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain an environment as free of accidents/hazards as possible for one (1) of one (1) service elevator. The facility utilized an unsecured service elevator on each unit that went to the basement with access to an outside exit that was not alarmed and access to stored biohazard materials. The findings include: The facility provided no policy regarding the use	F 323	F 323 No specific resident was cited. All residents, except those who are unable to get out of bed have the potential to be affected. The Director of Facility Management contracted with a local elevator company who installed a code panel system on the service elevator. This was done on 2/7/2014. This system prevents the service elevator from going to the basement until the code is entered and the basement light button is pushed. This is the only elevator that goes to the basement. The Facility Management Director will provide inservices by 3/7/2014, to staff in all departments regarding the operation of the secure service elevator. The Facility Management Director developed a policy regarding elevator use and safety. This policy developed on 2/25/2014 included information regarding the residents not having access to the basement via the service elevator. The Facility Management Director added monthly inspections of the service elevator on the preventive maintenance log.	



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

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F 323	Continued From page 13 of the service elevator. Observation, on 02/03/14 at 2:15 PM, revealed a service elevator which opened onto the fifth (5 th) floor living unit with no keypad device or roam alert monitoring device. In addition, observation on 02/04/14 from 9:00 AM to 10:00 AM, revealed the service elevator doors opened to the basement and the first (1st.), second (2nd.), third (3rd.), fourth (4 th.), sixth (6 th.) and seventh (7 th.) floors.	F 323	F 323 Continued from page 13 The Facility Management Director will inspect the code panel system weekly x 4 weeks, monthly x 2 months, and then quarterly for three quarters. Any issues found will be corrected immediately. She will submit a written report regarding the results of the inspection to the Performance Improvement Committee each quarter for three quarters. The members of this committee will review the results of the inspections and determine the need and time frames for further monitoring.	3/8/14	
	Observation of the basement room, on 02/04/14 at 10:12 AM, revealed: a hazardous waste room (signified by sign on door) unlocked and containing ten (10) full sharps containers and eight (8) large red bags containing hazardous waste; electrical panels with approximately two (2) to three(3) inches of water standing at the base of the panels; and an exit door from the basement room with no roam alert alarm monitoring system. Interview with the Facilities Management Director, on 02/05/14 at 10:08 AM, revealed the service elevator that was accessible to residents came all the way to the basement and the basement was a dangerous place. She stated there was a roam alert monitoring device outside the service elevator on the first (1st) floor, but it would not alarm every time a resident with a roam alert device was on the elevator. The Facilities Management Director further stated she was not aware of any resident having been discovered in the basement and the elevator door was locked every night from 9:00 PM until 5:30 AM.				
	Interview with the Director of Nursing (DON), on				

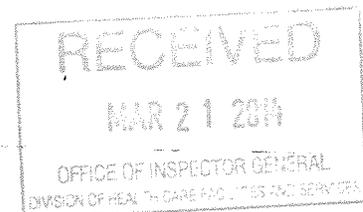
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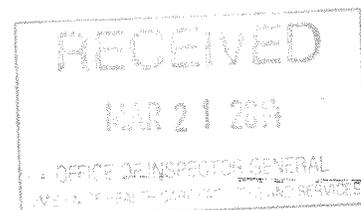
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F 323	Continued From page 14 02/06/14 at 2:30 PM, revealed there was a security guard at the facility every night from 7:00 PM to 7:00 AM who made rounds of the facility. She stated there was video surveillance of the exit door from the basement and when the security guard was not making rounds he sat at the reception desk in the lobby and could watch the video surveillance. She further stated the facility residents were checked at least every two hours and she was assured the staff knew where their residents were. The DON indicated there was a Nursing House Supervisor in the facility in the evenings, nights and weekends and that nurse made rounds also to check on the residents.	F 323		
F 463 SS=E	Interview with the Administrator, on 02/06/14 at 11:00 AM, revealed a resident had never been in the basement room to his knowledge and the service elevator had not been a problem. 483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a resident emergency call system in eight (8) of eight (8) unlocked staff and visitor restrooms accessible to residents.	F 463	F 463 No specific resident was cited. All residents, except those who are unable to get out of bed have the potential to be affected. The Facility Management Director has contracted with local call light system companies to install emergency pull stations accessible to residents in public restrooms from 1st to 7th floors. The installation of these is in progress and will be completed no later than 3/21/2014. Facility Management Director will inservice all staff on the new emergency pull stations and these will be completed by 3/21/2014. The Call Light Policy was updated by the Administrator on 2/27/14 to include emergency call lights in restrooms accessible to residents. The Facility Management Director added monthly inspections of the call light system on the	
	The findings include:			



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

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F 463	Continued From page 15 The facility did not provide a policy on an emergency call system. Observation, on 02/03/14 at 3:00 PM, during the initial tour revealed an unlocked staff and visitor restroom on the back hall of the fifth (5th) floor living unit accessible to residents. Further observation of the restroom at that time revealed no emergency pull cord or other means for a resident to communicate with nursing staff in the event of an emergency. Observation of living units on floor's two (2), three (3), four (4), six (6) and seven (7), on 02/04/14 at 9:30 AM, revealed an unlocked staff and visitor restroom (accessible to residents) without an emergency pull cord or other means for a resident to communicate with nursing staff in the event of an emergency on each of those living units. Observation of the facility's first (1st) floor, on 02/04/14 at 10:00 AM, revealed two (2) unlocked staff and visitor restrooms (accessible to residents) without emergency pull cords or other means for a resident to communicate with nursing staff in the event of an emergency. Interview with Licensed Practical Nurse (LPN) #6, on 02/06/14 at 9:42 AM, revealed there was an unlocked restroom on every resident floor for staff and visitors. LPN #6 stated she had seen residents go into some of those restrooms over the twenty-three (23) years she had worked at the facility. Interview with Certified Nursing Assistant (CNA) #4, on 02/06/14 at 9:49 AM, revealed there was a	F 463	F 463 Continued from page 15 preventive maintenance log. The Facility Management Director will inspect the emergency call cords weekly x 4 weeks, monthly x 2 months, and then quarterly for three quarters. Any issues found will be corrected immediately. The Facility Management Director will submit a written report regarding the results of the inspection to the Performance Improvement Committee each quarter for three quarters. The members of this committee will review the results of the inspections and determine the need and time frames for further monitoring.	3/22/14



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F 463	<p>Continued From page 16</p> <p>restroom on each resident floor which was not identified, but was used by staff and visitors. CNA #4 stated it was possible for residents to use those restrooms.</p> <p>Interview with Registered Nurse (RN) #2, on 02/06/14 at 10:05 AM, revealed the unlocked restrooms on each floor of the facility were for visitors and staff. RN #2 stated she had seen residents use those restrooms, but not often while she had worked at the facility. RN #2 further stated if a resident needed assistance while in one of those restrooms they had no emergency pull cord or other device for communication with staff.</p> <p>Interview with the Director of Facility Management and the Administrator, on 02/06/14 at 11:00 AM, during the environmental tour revealed they were not aware residents should have an emergency pull cord or other means to communicate with nursing staff in the event of an emergency when in an accessible restroom in the facility. The Administrator stated the residents would usually use their own room restrooms, but they could access the staff/visitor restrooms in the living unit hallways.</p>	F 463		

