

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423	
(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 221	<p>Continued From page 6</p> <p>09/30/13 revealed Resident #1 had slid out of the soft foam belt and wheelchair onto the floor. However, review of Resident #1's medical record revealed no documented evidence the soft lap belt had been reassessed for necessity, or for the risk of injury after the resident's falls in which the lap belt was in use.</p> <p>Interview on 10/03/13 at 1:35 PM with Resident #1 revealed if he/she wanted to get out of the wheelchair, he/she would attempt to slide under the soft lap belt or try to untie the soft lap belt. The interview further revealed Resident #1 had the lap belt to prevent the resident from falling but the resident did not feel like the lap belt was effective because he/she was able to get out of the restraint and up from the wheelchair.</p> <p>Observations of Resident #1 on 10/01/13 at 12:45 PM, on 10/02/13 at 10:30 AM, 11:55 AM, and 4:15 PM, on 10/03/13 at 4:26 PM, and on 10/04/13 at 12:38 PM, revealed Resident #1 was sitting up in a wheelchair with a soft foam lap belt in place, tied behind the wheelchair back in a slipknot (a quick release knot). However, review of the manufacturer's application instructions revealed the soft lap belt should be tied in a crisscross manner with two quick-release knots.</p> <p>Interviews on 10/02/13 with State Registered Nurse Aide (SRNA) #3 at 10:45 AM, SRNA #4 at 11:23 AM, SRNA #5 at 11:41 AM, SRNA #1 at 4:55 PM, and SRNA #6 at 5:15 PM, revealed Resident #1 often removed the soft lap belt and/or attempted to slide under the soft lap belt. Further interview with direct care staff revealed the staff had been trained to tie the restraint behind the resident's wheelchair back in a slipknot. However, review of the manufacturer's</p>	F 221	<p>To identify other residents that may have the potential to be affected by the same deficient practice the facility conducted a Physical Restraint Assessment that was completed on 10/8/13 by Administrative LPN to determine the need for a physical restraint on the remaining Residents with physical restraints. The Physical Restraint Assessment will help to determine the continued need on all residents who already have physical restraints a weekly Restraint Assessment will continue as part of the facility Quality Assurance Program. All Restraint Assessments are submitted to the Restraint Committee that meets every day Monday through Friday. The Restraint Committee reports the results of all physical Restraint Assessments to the Quality Assurance Committee each week.</p> <p>Each Resident's MDS, Comprehensive Care Plan and SRNA Care plan is promptly updated to reflect any changes dictated by the Restraint Assessment</p>	

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423	
(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 221	Continued From page 7  guidelines revealed staff failed to apply the soft belt restraint in accordance with the guidelines to ensure the resident's safety.  Interview on 10/03/13 at 5:05 PM with Licensed Practical Nurse (LPN) #6 revealed Resident #1 often attempted to slide under the soft foam lap belt and/or to remove the soft belt restraint. The interview further revealed Resident #1 sustained a fall on 09/30/13 as a result of the resident sliding under the soft foam lap belt onto the floor.  Interview on 10/03/13 at 7:29 PM with LPN #7 revealed Resident #1 often removed the soft foam lap belt and/or would attempt to slide under the lap belt. The interview further revealed the resident sustained falls on 09/11/13 and 09/23/13 from the wheelchair after the resident removed the soft foam lap belt. Further interview revealed Resident #1 sustained a fall on 09/17/13 when the resident slid under the foam lap belt onto the floor while the soft lap belt was attached to the wheelchair.  Interview on 10/03/13 at 4:39 PM with Registered Nurse (RN) #1 revealed Resident #1 had experienced numerous falls that included sliding out of the lap belt when it was attached to the chair, removing the lap belt restraint from the chair, and from unassisted transfers. The interview further revealed RN #1 was not aware of the risks of the resident sliding out of the wheelchair under the soft lab belt until the fall on 09/30/13 and at that time "Dycem" (a no-slip rubber-like material) was placed on the seat of the wheelchair as an intervention to prevent the resident from sliding.  Interview on 10/03/13 at 7:15 PM with the	F 221	for each resident. On October 4-8, 2013, Administrative LPN conducted a Restraint Assessment for each Resident with a current physician order for a physical restraint. Each Restraint Assessment included review of the Resident's CCC related to use of physical restraint. The reviews validated that medical symptoms were present to support the use of a physical restraint, to validate that the existing restraint is the least restrictive restraint in use for the least amount of time and to validate whether the resident's environment or activities can be modified to reduce reliance on the restraint.  On October 4, 2013, the Facility's Director of Rehabilitation, Physical Therapist and Occupational Therapist, assessed all Residents with physical restraints to determine if a lesser restraint reduction is appropriate. The therapists also reviewed whether current physical restraints could be updated or modified to better ensure the	

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423		
(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 221	<p>Continued From page 8</p> <p>Director of Nursing (DON) revealed the DON had not read the soft belt application instructions and was not aware of the specific guidelines for tying the soft belt restraint. The DON acknowledged she was not aware the use of the belt was to be discontinued if a resident had a tendency to slide forward or down in the device or was able to self-release the device. According to the DON, nursing staff had not been trained on how to apply soft lap belt restraints in accordance with the manufacturer's application instructions. The interview further revealed the facility had not addressed the risk of Resident #1 sliding under the lap belt out of the wheelchair onto the floor until the fall on 09/30/13 and at that time "Dycem" was added as an intervention to prevent further falls.</p> <p>2. Record review revealed the facility admitted Resident #5 on 03/19/12, with diagnoses which included Alzheimer's, Anemia, Osteoporosis, and Dementia with Behavior.</p> <p>Review of a pre-restraining assessment conducted by the facility on 05/12/12 revealed the facility had initiated a foam lap belt restraint for Resident #5 on 05/12/12. Based on the assessment, the use of the restraint for Resident #5 was due to the resident's instability of his/her gait, a history of anemia, and a history of bilateral knee replacement.</p> <p>However, record review revealed no documented evidence the facility identified a medical symptom that warranted the use of the restraint. Review of the consent form for use of the resident's restraint revealed the resident's responsible party signed the consent on 03/19/12. However, the consent form failed to include a medical symptom or what</p>	F 221	<p>Resident's comfort and safety. The therapists also evaluated each Resident's environment to determine whether changes were appropriate.</p> <p>On October 7, 2013 the Facility's Assistant Medical Director audited the Restraint Assessment, for each Resident using a physical restraint. Each audit of Restraint Assessment included review of the Residents CCC related to use of physical restraint to validate that medical symptoms were present to support the use of a physical restraint, to validate that the existing restraint is the least restrictive restraint in use for the least amount of time and to validate whether the resident's environment or activities can be modified to reduce reliance on the restraint. Assistant Medical Director validated all use of current physical restraints on October 7, 2013. Assistant Medical Director will continue to audit each Resident with a physical restraint each week until all physical restraints are discontinued.</p>		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423		
(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 221	<p>Continued From page 9</p> <p>type of restraint was utilized for the resident.</p> <p>Review of the Physical Restraint Elimination Assessment conducted by facility staff revealed the resident was assessed for elimination of the restraint on 06/20/12, 09/19/12, 12/12/12, 03/13/13, 06/12/13, and 09/10/13. However, the facility documented Resident #5 was not a candidate for a restraint reduction or elimination program because the resident had not experienced negative outcomes, did not have skin breakdown, and tended "to be impulsive and is easily distracted."</p> <p>Review of Resident #5's Quarterly Minimum Data Set (MDS) assessment completed on 09/04/13 revealed the facility assessed the resident to be cognitively impaired and required extensive assistance of two staff persons with bed mobility, transferring, and toileting. The facility also documented Resident #5 utilized a walker and wheelchair for mobility and had not sustained any falls during the assessment period. The facility's assessment also revealed Resident #5 utilized a trunk restraint daily.</p> <p>Observations of Resident #5 on 10/07/13 at 11:04 AM, 12:00 PM, and 1:15 PM revealed the resident was alert, but did not respond appropriately to questions asked. The resident was sitting in a wheelchair with a foam lap belt restraint device. The lap belt restraint was observed to be tied to the back of the resident's wheelchair seat which, based on review of the application instructions in the manufacturer's guidelines, was contraindicated.</p> <p>Interview with the DON on 10/08/13 at 2:55 PM revealed Resident #5 had sustained falls in the</p>	F 221	<p>On October 7, 2013, the Facility's social service director and recreational coordinator assessed each Resident who uses a physical restraint to ensure personal preferences were updated and that the Facility is providing meaningful activities to each resident who uses a physical restraint.</p> <p>On October 8, 2013, Administrative, LPN, audited restorative care plans in cooperation with the Rehab Director, Physical Therapist, and Occupational Therapist for each resident using a physical restraint to ensure the Facility is providing restorative care to enhance Resident abilities to stand, transfer, and walk safely in attempt to decrease physical restraints.</p> <p>On October 9, 2013, Posey Company Representative conducted in-person training for all clinical staff regarding restraint programs, application and instruction for each Posey product in use at the Facility,</p>		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423	
(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 221	<p>Continued From page 10</p> <p>facility and was impulsive, and based on an assessment of the resident the soft lap belt restraint was initiated on 05/12/12 to prevent further falls. Further interview revealed the facility had not attempted to reduce or eliminate the resident's restraint since the restraint was initiated (a timeframe of 17 months).</p> <p>3. Record review revealed the facility admitted Resident #6 on 06/04/13 with diagnoses which included Muscle Weakness, Osteoarthritis, and a history of a Fractured Femur.</p> <p>Review of the resident's Quarterly MDS assessment dated 09/03/13 revealed the facility assessed the resident to be cognitively impaired and required extensive assistance of two staff persons with transferring, ambulation, and toileting. The facility also documented Resident #6 utilized a walker and wheelchair for mobility and had sustained three falls, without major injury, during the assessment period. The assessment revealed Resident #6 required a trunk restraint daily.</p> <p>Review of a pre-restraining assessment conducted by the facility on 09/05/13 revealed the facility had initiated a foam lap belt restraint for Resident #6 on 09/05/13. The facility had identified the restraint was necessary due to the resident's history of a Cerebrovascular Accident (CVA), weakness, and the resident's cognitive impairment that affected the resident's ability to make decisions related to safety issues. However, the facility had failed to identify a medical symptom that warranted the use of the restraint.</p> <p>Observations of Resident #6 on 10/03/13 at 6:00</p>	F 221	<p>as well as restraint reduction programs. The video of this presentation will be used in training for all new hires and annual training and review purposes. All clinical staff attended in-service training on October 9, 2013. Training required each clinical employee to demonstrate the correct application for each physical restraint currently used in the Facility. Posey Company Representative, Quality Assurance and Safety Administrative Assistant, and Compliance Director monitored training on the correct application of physical restraint. On October 7, 2013, instructions for the appropriate application of each Posey brand physical restraint in use were posted at each nurse's station and in the SRNA book.</p> <p>Quality Assurance and Safety Administrative Assistant educated all non-clinical laundry housekeeping and dietary to include all employees are trained on application and position of physical restraints starting on 10/22/13; all</p>	

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423		
(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 221	<p>Continued From page 11</p> <p>PM revealed the resident was sitting in a wheelchair holding his/her soft lap belt restraint in his/her hand. Continued observations revealed SRNA #1 reapplied the resident's restraint. The SRNA was observed to tie the resident's restraint to the back of the resident's wheelchair which was contraindicated based on review of the application instructions in the manufacturer's guidelines.</p> <p>Interview with the DON on 10/03/13 at 7:30 PM revealed Resident #6 had sustained falls in the facility and the soft lap belt restraint was initiated to prevent further falls from occurring. Further interview revealed staff had been trained to tie the restraints in the back or under the seating area of the wheelchair. The DON stated she was not aware, based on the manufacturer's guidelines, that the restraint should not be tied in the back or underneath the seating area of the resident's wheelchair.</p> <p>4. Record review revealed the facility admitted Resident #8 on 08/31/13 with diagnoses which included Muscle Weakness, Atrial Fibrillation, and Alzheimer's disease. Review of the facility's Minimum Data Set assessment completed on 09/10/13 revealed Resident #8 was cognitively impaired and required extensive assistance of two staff persons with bed mobility, transferring, and ambulation. The facility also documented Resident #8 utilized a walker and wheelchair for mobility and had sustained two or more falls in the facility since admission. Based on review of the assessment, Resident #8 did not utilize physical restraints.</p> <p>Review of a pre-restraining assessment conducted by the facility on 09/24/13 revealed the</p>	F 221	<p>non-clinical staff will be completely educated by 10/25/13. This education will ensure that all employees facility wide were educated on the proper application and positioning of all physical restraints. This will be used to continually monitor residents with physical restraints to ensure the Facility is using a systemic team approach to identify sliding, falling, or attempts of removal of the physical restraint. Non-clinical staff members are educated to communicate with charge nurses to provide communication assistance.</p> <p>On October 7, 2013, the Facility reviewed and updated policies and procedures regarding the safe and effective use of physical restraints. The updated policy clearly provides that physical restraint may not be used unless for the safety and well-being of the Patient and only after other alternatives have been evaluated.</p>		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423		
(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 221	<p>Continued From page 12</p> <p>facility had initiated a lap buddy restraint for Resident #8 on 09/24/13. The facility had identified that the necessity of the lap buddy for Resident #8 was due to poor cognition and his/her lack of safety awareness. However, the facility failed to identify a medical symptom that warranted the use of the restraint.</p> <p>Observations of Resident #8 on 10/07/13 at 11:00 AM and 1:39 PM revealed the resident sitting in a wheelchair with a lap buddy restraint device in place. Resident #8 was alert and would make eye contact, but would not respond when spoken to.</p> <p>Interview with the DON on 10/08/13 at 2:55 PM revealed Resident #8 had sustained falls in the facility and the lap buddy had been initiated to prevent further falls and injury.</p> <p>5. Record review revealed the facility admitted Resident #7 on 12/17/08 with diagnoses which included Dementia, Hypertension, and Anemia.</p> <p>Review of a pre-restraining assessment conducted by the facility on 01/10/13 revealed a torso restraint had been initiated for Resident #7 on 01/01/13. The facility documented the torso restraint was necessary due to the resident's history of anemia and a left hip fracture. However, the facility failed to identify a medical symptom that warranted the use of the restraint.</p> <p>Review of Resident #7's quarterly Minimum Data Set assessment completed on 08/12/13 revealed the resident was severely cognitively impaired, required extensive assistance of two staff persons with bed mobility and transferring, and was non-ambulatory and dependent on staff for</p>	F 221	<p>Following the incident, the Facility increased physical restraint monitoring to ensure the safety of Residents using physical restraints.</p> <p>On October 11, 2013, all clinical staff participated in training given by MDS Coordinator and Compliance Director on the new QA monitor tool for Resident's using physical restraints to ensure the restraints are applied safely and effectively and to identify any potential accidents before they occur. The Facility established this new Quality Assessment Tool on 10/11/13. Charge Nurses' will now document using required QA monitoring tool each shift for each resident with a physical restraint. All clinical staff was successful trained on 10/11/13 on the new QA monitoring tool for physical restraints. The Quality Assessment Tool requires charge nurses to observe whether the physical restraint is properly applied, confirm whether the restraint is being released and removed on schedule</p>		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423	
(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 221	Continued From page 13 mobility via wheelchair. According to the assessment, Resident #7 utilized a trunk restraint daily and had not sustained any falls since the facility's prior assessment.  Continued review of Resident #7's medical record revealed the facility completed a Physical Restraint Elimination Assessment for Resident #7 on 02/19/13, 05/20/13, and 08/15/13, and had determined on all three of the assessments that the resident was not a candidate for a restraint reduction or elimination program because the resident had not had any negative outcomes from the use of the torso restraint.  Observations of Resident #7 on 10/07/13 at 11:13 AM and 1:15 PM revealed the resident sitting in a wheelchair with a torso restraint in place. Resident #7 was alert but made no attempts at communication and talked in a mumble.  Interview with the DON on 10/08/13 at 2:55 PM revealed Resident #7's restraint had been initiated as a fall intervention. According to the DON, attempts to reduce the use of the restraint for Resident #7 had not been conducted because facility staff released the resident's restraint during meals and activities.  Interview with the Executive Director (ED) on 10/17/13 at 3:30 PM revealed resident restraint use was determined by the DON and RN #1 and administrative staff did not provide any oversight for any aspect of restraint use.	F 221	and confirm whether there is documentation of appropriate toileting. The tool will be reviewed each day by the Administrator and Executive Director. All information will also be submitted to the Quality Assurance Committee each day.  On October 15, 2013, the Facility's charge nurses began monitoring each resident that uses a physical restraint every two hours. Charge nurses document restraint monitoring in Point Click Care under Restraint Note. Nurses will be monitoring to identify if the restraint is in use, if restraint is applied correctly, if resident has any discomfort due to the application of the physical restraint. If any negative findings are discovered then charge nurses are to immediately call physician. A new assessment and revision to CCC, and SRNA Care Plan would follow. All nurses' were educated on physical restraints safety checks every two hours successfully on October 15, 2013. Compliance Director and Executive Director are	
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423	
(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 225	<p>Continued From page 14</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance 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,</p>	F 225	<p>monitoring nurses that complete safety checks every two hours with residents who have physical restraints daily on all shifts. The Restraint Note is part of the Residents clinical record. Compliance Director and Executive Director report all findings to Quality Assurance Committee daily.</p> <p>Charge nurses that encounter an incident involving the safety or security of a resident using physical restraints, including that a restraint is improperly applied, are required to secure the resident's safety of the resident and immediately report the incident to the Primary Care Physician, Nurse on Call and the Executive Director. Upon identifying the improper application of restraints, the charge nurse or superior will immediately remove applicable personnel from the floor and require reeducation before returning staff to resident care. The Nurse on Call and Executive Director are available to respond to restraint incident reports 24 hours</p>	

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423		
(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 225	<p>Continued From page 15</p> <p>and review of the facility's policy, it was determined the facility failed to ensure that allegations of neglect were reported to the appropriate state agencies and thoroughly investigated for three of eighteen sampled residents (Residents #4, #14, and #15). Interview and record review revealed Resident #4 exited the facility on 05/20/13 in his/her wheelchair, without supervision or assistance, and rolled down an embankment on facility grounds. Resident #4 sustained no injuries as a result of the incident. Continued interviews and record reviews revealed on 09/30/13 Resident #14 exited the facility, without supervision or assistance, went to the facility parking lot, and was observed by a State Registered Nurse Aide (SRNA) attempting to get into a truck. In addition, interview and record review revealed on 03/15/13 Resident #15 exited the back door of the facility, without supervision or assistance, walked around the building, and sat down under a tree. However, the facility was unable to provide documented evidence the incidents of the residents exiting the building, unassisted and unsupervised, had been investigated or reported to the appropriate state agencies.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Abuse Investigations," dated 10/12/11, revealed when an incident of neglect was reported to the Administrator or the designee, a member of management would be appointed to investigate the alleged incident. Further review of the policy revealed the investigation would include review of documentation, interviews with witnesses and residents, and a review of events leading to the alleged incident. The results of the investigation</p>	F 225	<p>per day, seven days per week. All information will be reported to the Quality Assurance Committee daily. Quality Assurance Committee will provide oversight.</p> <p>On Monday October 21, 2013 Director of Nursing began visually monitoring and overseeing all clinical nursing staff including SRNA's, KMA's, LPN's, and RN's on their performance of physical restraint application documentation can be found on DON restraint tool (please see attached). DON continues to check each resident Monday thru Friday on 7-3 shift and 3-11 during Monday through Friday DON is checking 7-3 shift once daily, and 3-11 once daily each shifts to ensure that each resident is positioned properly, restraint is applied properly, and resident is not showing signs of discomfort due to the use of the restraint. DON will continue this process until all physical restraints are successfully removed. Any negative findings will immediately</p>		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423	
(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 225	<p>Continued From page 16</p> <p>were to be recorded on the approved documentation forms.</p> <p>Review of the facility's policy titled "Reporting Abuse to State Agencies and Other Entities/Individuals," dated 10/12/11, revealed a suspected violation of neglect should be reported to the facility Administrator who would then promptly notify the state licensing/certification agency and Adult Protective Services.</p> <p>Review of the facility's policy titled "Recognizing Signs and Symptoms of Abuse/Neglect" defines neglect as failure to provide goods and services as necessary to avoid physical harm, mental anguish, or mental illness.</p> <p>1. Review of Resident #4's medical record revealed the facility admitted the resident on 02/03/12 with diagnoses which included Senile Dementia and a history of Falls. Review of the Quarterly Minimum Data Set (MDS) assessment dated 09/23/13 revealed Resident #4 required extensive assistance with transfers, dressing, and bathing, and utilized a wheelchair for mobility. Further review of the assessment revealed Resident #4 had behaviors of wandering which had occurred one to three days during the assessment period.</p> <p>Review of Resident #4's medical record revealed the facility assessed the resident on 04/25/12 to be an elopement risk and applied a Wanderguard bracelet to the resident's ankle at that time.</p> <p>Review of an incident report completed by Licensed Practical Nurse (LPN) #3, dated 05/20/13, entitled "Elopement," revealed Resident #4 exited the facility in a wheelchair and wheeled</p>	F 225	<p>be addressed. Staff will be retrained before continuing care. Information will be submitted to the Restraint Committee and the Quality Assurance Committee each day.</p> <p>Effective 10/11/13 MDS Coordinator will be re-accessing each physical restraint assessment after each incident, or change in condition. Assessments will be completed prior to any changes made to the resident's physical restraint. Rose McKenzie will additionally update the care plan and or MDS if needed accordingly. Rehab team Activity, Rehab, Social Services, Dietary, &amp; MDS will all be notified by DON and or Executive Director that re-assessment is necessary after each incident. After the re-assessment process is complete; Restraint Committee will discuss re-assessment findings and options for the resident finally getting physician approval.</p> <p>On Monday October 21, 2013 Ms. Olive Allen, L.N.H.A</p>	

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423		
(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 225	<p>Continued From page 17</p> <p>his/her self over an embankment located in back of the facility.</p> <p>Interview with LPN #3 on 10/15/13 at 2:03 PM revealed she had been assigned to provide care for Resident #4 when the resident eloped on 05/20/13. LPN #3 stated she heard the back door alarm and when she responded the resident had "rolled down the slight embankment" in his/her wheelchair. The LPN stated the resident's wheelchair had "anti-tippers" and had not overturned. LPN #3 also stated she had not investigated the elopement and stated staff nurses were not required to investigate incidents of elopement. The LPN stated she had not reported the incident to the Director of Nursing; however, she "passed" it on in report to the oncoming shift and put it on the 24-hour report.</p> <p>2. Review of the medical record for Resident #14 revealed the facility admitted the resident on 07/25/13 with diagnoses which included Dementia, Hypertension, and Depression. Review of the Nurse's Progress Notes dated 08/04/13 revealed Resident #14 began having exit-seeking behaviors on 08/04/13 and incidents of exiting the facility. Review of the facility's elopement incident report for Resident #14, dated 09/30/13, revealed the resident had exited the facility and was found by a State Registered Nurse Aide (SRNA) in the facility's parking lot attempting to get into a truck.</p> <p>Interview on 10/16/13 at 3:50 PM with SRNA #11 revealed on 09/30/13 someone informed her the resident was in the parking lot. She stated she found Resident #14 in the facility's parking lot attempting to get into a truck. The interview further revealed the SRNA was unaware how long</p>	F 225	<p>consultant educated the Executive Director, Administrator, administrative nurses, MDS Coordinator, DON, LPN's and RN's on care plans, assessments and MDS'. Ms. Allen advised clinical administrative staff on physical restraints &amp; regulatory requirements.</p> <p>On Monday, October 7, 2013, the Facility established a Restraint Committee consisting of the DON, MDS Coordinator, Director of Rehab and Executive Director. The Restraint Committee will meet daily, Monday through Friday to evaluate the safe and effective use of physical restraints at the Facility. The Restraint Committee will report all findings to the Facility Administrator and Quality Assurance Committee.</p> <p>The facility was completely restraint free On October 25, 2013. No physical restraints were in use for any resident.</p> <p>The Facility alleges that it was in substantial compliance on 11/8/13.</p>		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423	
(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 225	<p>Continued From page 18 the resident had been outside of the facility.</p> <p>3. Review of the medical record for Resident #15 revealed the facility admitted the resident on 10/03/12 with diagnoses which included Seizures, Hypertension, Anxiety, and Coronary Artery Disease. Review of a facility document titled "Risk of Elopement/Wandering Review" revealed on 10/11/12, the facility assessed Resident #15 to be at risk of wandering and/or an elopement risk. Documentation at that time revealed staff was unable to redirect the resident to come inside. A Wanderguard bracelet was placed on the resident and observations of the resident every hour for safety were implemented.</p> <p>Review of the facility's incident reports for Resident #15 revealed an incident report completed on 03/15/13 at 11:26 PM indicated Resident #15 had exited the back door of the facility, walked around the building, and sat down under a tree. According to the incident report, the resident got tired and sat down under the tree. Further review of the document revealed the resident complained of right knee pain and an x-ray was ordered. However, the incident report did not indicate the time the incident occurred.</p> <p>Interview with LPN #1 on 10/15/13 revealed that during shift change on 03/15/13 at approximately 3:00 PM, the LPN was going to take Resident #15 for a walk outside but was unable to locate the resident. LPN #1 stated a search for the resident was initiated and Resident #15 was found outside the building under a tree. The LPN stated the resident had apparently exited through the back door of the facility. Further interview revealed staff did not hear the alarm on the back door sounding prior to the resident exiting the</p>	F 225	<p><b>F225</b></p> <p>On October 31, 2013 a self-report was submitted to appropriate agencies regarding the incident with Residents #4, #14, and #15.</p> <p>Resident #4. MDS coordinator updated the care plan and SRNA care plan on October 23, 2013 to address high risk for elopement. Continued use of wander guard ankle bracelet is ongoing. Interventions including wander book identification were implemented to protect resident identified as high risk from exiting the facility unsupervised. The revision was a result in wandering/elopement assessments completed by MDS coordinator on 10/18/13 to identify if the resident was a risk for elopement, the resident scored a 14 and is a high risk. Safety employee checks resident for placement and safety in facility every 15 minutes started on Thursday October 17, 2013 and is ongoing. Interventions and diversions are listed in the front of each wandering book and all employees are educated on October 25, 2013. Social Service director will</p>	

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423	
(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 225	Continued From page 19 facility.	F 225	be continually updating resident's risk for elopement each week.	
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to promote care in a manner and in an environment that maintained or enhanced dignity and respect for one of eighteen sampled residents (Resident #6). Observations on 10/03/13 revealed Resident #6 requested assistance from facility staff to be toileted. Continued observations revealed staff failed to provide assistance with toileting timely and as a result the resident experienced an episode of urinary incontinence.</p> <p>The findings include:  Review of the facility's policy titled "Quality of Life-Dignity," not dated, revealed residents should</p>	F 241	<p>Resident #14 MDS coordinator updated the care plan and SRNA care plan on October 23, 2013 to address high risk for elopement. Continued use of wander guard ankle bracelet is ongoing. Interventions including wander book identification were implemented to protect resident identified as high risk from exiting the facility unsupervised. The revision was a result in wandering/elopement assessments completed by MDS coordinator on 10/18/13 to identify if the resident was a risk for elopement, the resident scored a 15 and is a high risk. Safety employee checks resident for placement and safety in facility every 15 minutes started on Thursday October 17, 2013 and is ongoing. Interventions and diversions are listed in the front of each wandering book and all employees are educated on October 25, 2013. Social Service director will be continually updating resident's risk for elopement each week.</p>	

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185264</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>10/17/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHARLESTON HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>203 BRUCE COURT DANVILLE, KY 40423</b>	
(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 241	<p>Continued From page 20</p> <p>be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality.</p> <p>Review of the facility's policy titled "Incontinent Management Policy/Program," not dated, revealed the policy had not addressed how staff was to assist residents with toileting when requested.</p> <p>Record review revealed the facility admitted Resident #6 on 06/04/13 with diagnoses which included Muscle Weakness and a history of a Fractured Right Femur. Review of the Quarterly Minimum Data Set (MDS) assessment dated 09/03/13 revealed the facility assessed the resident as being cognitively impaired, with a Brief Interview for Mental Status (BIMS) score of 6. The assessment revealed the resident required extensive assistance with transfers, toileting, and bathing. Further review revealed the facility assessed the resident to require the use of a trunk restraint on a daily basis when he/she was out of bed.</p> <p>Observations conducted on 10/03/13 at 6:00 PM revealed Resident #6 was holding a soft lap belt restraint in his/her hand. The resident requested assistance with toileting to State Registered Nurse Aide (SRNA) #1. Resident #6 stated, "I need to go pee." The SRNA called the resident by his/her first name and stated, "You have to leave this (referring to the restraint) on." The SRNA proceeded to reapply the resident's restraint, and tied it to the resident's wheelchair. The SRNA failed to provide assistance to the resident with toileting.</p> <p>Continued observations revealed on 10/03/13 at</p>	F 241	<p>Resident #15 MDS coordinator updated the care plan and SRNA care plan on October 23, 2013 to address high risk for elopement. Continued use of wander guard ankle bracelet is ongoing. Interventions including wander book identification were implemented to protect resident identified as high risk from exiting the facility unsupervised. The revision was a result in wandering/elopement assessments completed by MDS coordinator on 10/18/13 to identify if the resident was a risk for elopement, the resident scored a 13 and is a high risk. Safety employee checks resident for placement and safety in facility every 15 minutes started on Thursday October 17, 2013 and is ongoing. Interventions and diversions are listed in the front of each wandering book and all employees are educated on October 25, 2013. Social Service director will be continually updating resident's risk for elopement each week.</p>	

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423	
(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 241	Continued From page 21 6:15 PM Resident #6 stated to the surveyor, "I can't get waited on here." The resident was asked if the inability to get assistance with toileting happened often and the resident answered, "All the time."  An interview with SRNA #1 on 10/03/13 at 6:16 PM revealed Resident #6 had requested assistance with toileting at 6:00 PM. The SRNA acknowledged she had not assisted the resident, or told any other staff members of the resident's request to toilet. SRNA #6 stated she did not have time to assist the resident with toileting because she was assisting residents with meals in the dining room.  Additional observation and interview with Resident #6 on 10/03/13 at 6:21 PM revealed he/she stated, "I've already went on myself now," while pointing at his/her genital area.  An interview with Licensed Practical Nurse (LPN) #5 on 10/03/13 at 6:25 PM revealed Resident #6 should have received assistance with toileting as requested and should not have had to experience an incontinence episode. The LPN stated the SRNA had not informed her that the resident needed assistance with toileting.  An interview with the Director of Nursing (DON) on 10/03/13 at 7:30 PM revealed staff should have provided the resident with assistance with toileting when requested. The DON stated she randomly makes rounds in the facility to ensure resident care needs are met; however, she had not identified a concern with not assisting residents with toileting.	F 241	Administrator and Executive Director implemented a new wandering program on 10/17/13. For each resident identified as being high risk for wandering/and or elopement a picture and description of each resident is at each nurses' station and front office. Strategically placed these locations are closest to all exit doors. The binders are in alphabetic order of each resident in a purple binder. Training started on Thursday October 17, 2013 and was completed on Friday October 25, 2013. On Friday October 25, 2013 all Facility staff was educated on wandering books, new Policy of Residents Leaving the Facility, Sign in/out sheet, New Wandering/Elopement Precautions, Code Green Suggested Elopement Interventions, & Interventions Tools for the Wandering Resident. DON, Compliance Director, Quality Assurance/Safety Administrative Assistant, Executive Director, and Human Resources Coordinator are involved in training. All facility staff will be educated on all topics	
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	F 280		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423		
(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 280 SS=K	Continued From page 22 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 by: Based on observation, interview, record review, and review of the facility policy the facility failed to ensure staff periodically reviewed and revised the comprehensive care plan after each assessment for five of eighteen sampled residents (Residents #1, #2, #4, #14, and #15). Resident #1 experienced multiple falls as a result of removing or sliding under a soft lap belt (used as a physical restraint) out of the wheelchair onto the floor. However, the facility failed to ensure the resident's care plan included revisions related to these issues. Interview and record review revealed Resident #4 exited the facility on	F 280	before being allowed to continue employment. Each employee will complete a return demonstration; a hand on approach by going through the facility and finding new books, policy's, interventions that Administration and Quality Assurance has put into place On October 25, 2013. Quality Assurance/Safety Administrative Assistant, Social Service Director, and Quality Assurance Member #7 will be overseeing the wondering program daily. Social Service Director is responsible for monitoring and making any changes to high risk residents; updating assessments each week, updating Resident's picture, and Resident's description in wondering book. Quality Assurance/Safety Administrative Assistant is responsible for ensuring all documentation is complete on each shift and that all information is reported back to the Quality Assurance Committee daily, for oversight.		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423		
(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 280	<p>Continued From page 23</p> <p>05/20/13 in his/her wheelchair, without supervision or assistance, and rolled down an embankment on facility grounds. Review of Resident #4's care plan revealed the facility failed to develop or modify interventions related to the resident's unassisted/unsupervised exit from the facility. Interview and record review revealed on 03/15/13 Resident #15 exited the back door of the facility, without supervision or assistance, walked around the building, and sat down under a tree. Review of the resident's care plan revealed no documented evidence the facility implemented new interventions to prevent Resident #15 from exiting the facility without supervision. The facility conducted a Minimum Data Set (MDS) assessment (dated 07/28/13) of Resident #2 and noted the resident required the extensive assistance of two persons for transfers; however, review of the Plan of Care for Resident #2 revealed the facility failed to document the number of staff required to assist the resident with transfers. Review of the Nurse Aide's Information Sheet revealed Resident #2 required one to two persons to assist with transfers. Documentation revealed Resident #14 exited the facility multiple times without staff knowledge/assistance. Review of the Plan of Care revealed the facility failed to ensure the resident's Plan of Care addressed the resident's risk for elopement after each occurrence and failed to develop/modify interventions related to the resident's unsupervised/unassisted exit from the facility.</p> <p>The facility's failure to review and revise residents' plans of care when residents exited the facility without staff knowledge, and when residents removed and slid underneath/attempted to slide underneath a restraint, placed residents</p>	F 280	<p>MDS Coordinator completed wandering/elopement risk assessment for all residents on 10/18/13. Residents that were at high risk for wandering/elopement were placed in wandering program. New wandering policy was adapted on 10/21/13 by the Administrator and Executive Director that effective immediately no resident who has been assessed as cognitively impaired through the MDS assessment BIMS scoring process may leave the facility unsupervised even though may be their own responsible party. The resident's cognition is the primary consideration for safety and protection of the residents. All resident who leave the facility must sign out. Those assessed as cognitively impaired through the MDS assessment BIMS Scoring must be accompanied with a family or responsible person or there will be considered an elopement. Sign in/out log are located at each nurse's stations. All staff received education to the new policy on 10/21/13</p>		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423	
(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 280	<p>Continued From page 24</p> <p>in the facility at risk for serious injury, harm, impairment, or death. The Immediate Jeopardy with Substandard Quality of Care was determined to exist on 03/15/13 and is ongoing at 42 CFR 483.20 Resident Assessment. The facility was notified of the Immediate Jeopardy on 10/17/13 and was informed on 10/17/13 the Immediate Jeopardy was ongoing.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Care Plans-Comprehensive," revision date of October 2011, revealed assessments of residents were ongoing and care plans were to be revised as information about the residents and the residents' condition changed.</p> <p>Review of the application instructions for the Posey Soft Belt (soft foam lap belt) revealed the use of the Posey Soft Belt should be stopped at once if the resident has the tendency to slide forward or down in the device or is able to self-release the device. Further review of the application instructions revealed the resident should be monitored per facility policy to ensure the resident cannot slide down or fall off the chair and become suspended or entrapped. Review of the application instructions revealed the soft foam belt should be laid across the resident's thighs with the connecting straps down at a 45-degree angle between the seat and the wheelchair sides with the straps crisscrossed behind the chair and tied using a quick-release knot to the opposite side kick spurs. Observations revealed the application instructions were not followed.</p> <p>1. Review of the medical record for Resident #1 revealed the facility admitted the resident on</p>	F 280	<p>through 10/25/13 by the H/R Coordinator. The social service director will be reviewing the sign in/out log weekdays. The Executive Director directed the Maintenance Director to implement a new coding system for the facility. Code was changed on Sunday October 20, 2013.</p> <p>On Tuesday October 15, 2013, after surveyors brought forward concerns to DON and Executive Director an immediate QA meeting was conducted. That meeting resulted in locking all exit doors at all times. Staff were trained that night 10/15/13 on the opening and closing of all exit doors. . In the event of a fire alarm and or power failure, all doors would automatically be unlocked so each exit can be utilized as an emergency exit. Exit will still alarm if resident has secure care monitor in place. On Friday October 25, 2013 Compliance Coordinator will be educating all staff as a continued training on the Secure Care System, and the audio</p>	

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185264</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>10/17/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHARLESTON HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>203 BRUCE COURT</b> <b>DANVILLE, KY 40423</b>		
(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 280	<p>Continued From page 25</p> <p>09/21/10 with diagnoses which included Osteoarthritis, Macular Degeneration, and Progressive Supranuclear Palsy. Review of Resident #1's most recent Quarterly Minimum Data Set (MDS) assessment completed on 08/19/13 revealed the facility assessed the resident to require extensive assistance of one staff person with bed mobility, transferring, and ambulation. The facility also identified Resident #1 to utilize a walker and a wheelchair for mobility. The assessment revealed Resident #1 utilized a trunk physical restraint.</p> <p>Review of incident reports dated 09/11/13 and 09/23/13 revealed Resident #1 had sustained falls from the wheelchair related to the resident removing the soft lap belt. However, review of the Plan of Care, revision date of 10/01/13, revealed the facility failed to re-evaluate the use of the restraint for the resident and failed to revise the Plan of Care after each assessment. In addition, review of incident reports dated 09/17/13 and 09/30/13 revealed Resident #1 sustained falls as the result of sliding under the soft lap belt out of the wheelchair onto the floor. There was no documented evidence the safety of the use of the restraint was re-evaluated and revisions made to the resident's Plan of Care.</p> <p>Interview on 10/03/13 at 7:15 PM with the Director of Nursing (DON) revealed she was not aware the instructions for use of the Posey Soft Belt (soft lap belt) indicated the use of the device was to be stopped if the resident was able to self-remove the device or able to slide under the device. The interview further revealed the Safety Committee had looked at all of Resident #1's falls and the risk of the resident removing the soft lap belt had been addressed but the Committee had</p>	F 280	<p>enhancements we have implemented this week. All employees will be successfully educated On Friday October 25, 2013 to continue employment.</p> <p>On Wednesday October 16, 2013 Maintenance Director worked on the secure care monitoring system to increase volume of alarm. Power sounder was added to both C Hall doors to increased volume. That device was placed midway on A Hall. Compliance Director and or designee will check daily with floor staff to ensure all staff can hear alarm and are responding promptly. All volume levels are turned to the loudest position.</p> <p>On Thursday October 17, 2013 Compliance Coordinator began in servicing each employee currently in the facility in every department. The employees were in serviced on the volume of the alarms, employees were instructed that if they can't hear an alarm they are to immediately report to management, and in</p>		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423	
(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 280	<p>Continued From page 26</p> <p>not recommended discontinuing the use of the soft lap belt. The DON revealed that the Safety Committee met after the fall on 09/30/13 and put an intervention in place to apply "Dycem" (a non-slip rubber-like material) to the seat of the wheelchair to prevent the resident from sliding under the seat belt.</p> <p>Interview on 10/17/13 at 3:30 PM with the Executive Director (ED) revealed all of Resident #1's falls had been discussed in the Safety Committee meetings; however the Committee had not identified the risk of the resident sliding under the soft lap belt out of the wheelchair as a concern and had recommended continuing use of the soft lap belt.</p> <p>2. Review of Resident #15's medical record revealed the facility admitted the resident on 10/03/12. Further review revealed the facility assessed the resident to be at risk for elopement on 10/11/12 because the resident was difficult to redirect back into the building when he/she would go outside unsupervised.</p> <p>Review of the care plan the facility developed for Resident #15 on 10/11/12 revealed interventions for a Wanderguard bracelet. Further review revealed staff was required to check the resident's whereabouts every hour.</p> <p>Review of the facility's incident reports completed on 03/15/13 (time not specified) revealed Resident #15 went out the back door of the facility unsupervised and without staff knowledge. Licensed Practical Nurse (LPN) #1 found the Wanderguard system alarm sounding at the back door and went out and searched for the resident. The resident was found on the ground</p>	F 280	<p>addition write the problem in the maintenance book for repair. On Friday October 25, 2013 all Facility staff will be educated on wandering books, new Policy of Residents Leaving the Facility, Sign in/out sheet, New Wandering/Elopement Precautions, Suggested Elopement Interventions, Code Green &amp; Interventions Tools for the Wandering Resident. DON, Compliance Director, Quality Assurance/Safety Administrative Assistant, Executive Director, and Human Resources Coordinator are involved in training. All facility staff will be educated on all topics before being allowed to continue employment. Each employee will complete a return demonstration; a hand on approach by going through the facility and finding new books, policy's, interventions that Administration and Quality Assurance has put into place On October 25, 2013.</p> <p>On Friday October 25, 2013 Executive Director educated staff on</p>	

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185264</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/17/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHARLESTON HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>203 BRUCE COURT</b> <b>DANVILLE, KY 40423</b>		
(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 280	<p>Continued From page 27</p> <p>underneath a tree. Further record review revealed the incident report did not give a time period for how long the resident was outside unsupervised and there was no evidence the facility investigated the incident to determine how the resident was able to leave the facility without staff knowledge while wearing a Wanderguard bracelet.</p> <p>Review of the Safety Committee Note for Resident #15 dated 03/21/13 revealed after the incident on 03/15/13 when the resident left the facility without staff knowledge, an x-ray of the resident's right knee was obtained on 03/15/13; a new mattress was placed on the resident's bed; and the resident's physician was consulted because the Committee believed the resident's elopement was attention-seeking behavior. There was no evidence the resident's Plan of Care was revised when the Wanderguard system and the hourly checks were not effective in preventing Resident #15 from exiting the facility without staff knowledge.</p> <p>Interview with the DON on 10/16/13 at 12:40 PM revealed she was responsible for updating the resident's care plan. The DON indicated she had not considered that the Wanderguard and hourly checks were not effective, and she had not considered additional interventions because the Wanderguard system was checked and was functioning properly.</p> <p>3. Review of the medical record for Resident #4 revealed the facility admitted the resident on 02/03/12 with diagnoses which included Hypertension, Senile Dementia, and History of Falls. Review of a Quarterly Minimum Data Set (MDS) assessment dated 09/23/13 revealed the</p>	F 280	<p>Abuse, Neglect, Resident Rights, Dignity and New Policies. Each employee had to take a quiz to demonstrate knowledge of covered material.</p> <p>Abuse, Neglect, and Dignity Policies were updated on October 24, 2013.</p> <p>On October 21, 2013 David Storm and Associates dealer and installer for secure care products performed an Audit of Secure Care monitoring system and auditable devices in the facility. The audit showed the system was installed and working to manufactory specifications. Additional sounders for enhanced auditory were recommended and ordered on 10/21/13. Equipment was overnigheted in freight and was delivered to the facility on 10/23/13. Maintenance installed on 10/24/13 to complete to audio enhancement of the secure care monitoring system. A loiter feature was programmed to all doors on 10/21/13 by Compliance</p>		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423		
(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 280	<p>Continued From page 28</p> <p>resident required extensive assistance with transfers, dressing, and bathing. Continued review of the assessment revealed staff assessed the resident to have a behavior of wandering, which occurred one to three days during the assessment period.</p> <p>Review of an incident report dated 03/17/13 revealed Resident #4 had sustained a skin tear when he/she attempted to exit the facility "out the front door." Further review of the resident's incident reports revealed the resident exited the facility and rolled over an embankment in his/her wheelchair on 05/20/13. Continued review revealed the resident's fingers "were stuck" in the front lobby door of the facility on 08/31/13, which resulted in no injury to the resident.</p> <p>Review of Resident #4's Plan of Care, with a revision date of 09/26/13, revealed the facility assessed the resident to be at risk for wandering and injury. However, the facility failed to address the resident's risk for elopement, or the resident's exit-seeking behaviors; and failed to revise the Plan of Care after the resident attempted to exit the building unsupervised.</p> <p>Interview with the DON on 10/15/13 at 4:20 PM revealed she reviewed all incident reports daily and was responsible for updating the residents' care plans. The DON acknowledged reviewing the incidents related to Resident #4's exit-seeking behaviors and the elopement incident on 05/20/13. The DON stated she had not updated the resident's care plan or implemented any new interventions related to Resident #4's exit-seeking behaviors.</p> <p>4. Review of the medical record for Resident #14</p>	F 280	<p>Officer. Loiter feature is designed to alarm staff when a resident wearing a Wanderguard is approximately 4-5 feet from an exit for 60 consecutive seconds. The alarm will sound so staff can re-direct resident and prevent elopement.</p> <p>Daily monitoring of secure care equipment system is being completed by maintenance department to ensure all equipment is working properly and functioning with no problems. Compliance Director and or designee audit's review inspection daily and reports all information to the Quality Assurance Committee weekly. Immediate action will be taken to address any negative findings. Please see attached audit tool.</p> <p>Daily monitoring of secure care bracelets started on October 25, 2013 and is being recorded by SRNA's in Cerner Software System. On 7-3 and 3-11 shifts wonder guards are being tested to validate</p>		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423	
(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 280	<p>Continued From page 29</p> <p>revealed the facility admitted the resident on 07/25/13 with diagnoses which included Depression, Dementia, and Hypertension. Further review of the Nurse's Progress Notes, dated 07/25/13 through 10/17/13, revealed on 08/04/13, Resident #14 began exhibiting exit-seeking behaviors. Review of the Admission MDS assessment, dated 08/01/13, revealed the facility assessed Resident #14 to require one-person assistance with supervision for ambulation. Review of Resident #14's Plan of Care, revised 08/05/13, revealed the facility implemented the use of a Wanderguard bracelet to the resident's ankle at all times due to the resident's exit-seeking behaviors. Further review of the Plan of Care revealed no documented evidence the Plan of Care was reviewed and revised after the elopement incident on 09/30/13.</p> <p>Review of the facility's elopement incident report for Resident #14, dated 09/30/13, revealed the resident had exited the facility and was found by a State Registered Nurse Aide (SRNA) in the facility parking lot attempting to get into a truck.</p> <p>Interview on 10/17/13 at 1:51 PM with the DON revealed she was responsible for updating the residents' care plans but had not considered the intervention of the Wanderguard as ineffective and had not considered additional interventions due to the Wanderguard system functioning properly, even though the resident was able to exit the facility without staff's knowledge.</p> <p>5. Review of the medical record for Resident #2 revealed the facility admitted the resident on 08/13/12 with diagnoses which included Syncope, Anemia, a history of Frequent Falls, and Dementia. Review of Resident #2's Nurse Aide's</p>	F 280	<p>proper function. All clinical staff was educated on October 25, 2013 on the new documentation required in the Cerner Software System to document on residents with Wonder guards. All clinical staff was successfully trained on October 25, 2013 before being allowed to continue employment.</p> <p>Under the direction of the Administrator, Arnold Glass was contacted and in the facility on 10/21/13 to help with the assistance of the redesign of the glass doors on B Hall. Redesign started on 10/21/13 and will was finished on 10/23/13. Glass doors were relocated to ensure staff can hear Secure Care System alarm.</p> <p>The facility was in substantial compliance on 11/8/13.</p> <p><b><u>F241</u></b></p> <p>On November 1, 2013 the facility developed a staffing policy that reviewed work assignments of the caregivers. An audit of resident</p>	

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423		
(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 280	Continued From page 30 Information Sheet, dated 02/11/13, revealed the resident required the assistance of one to two persons with transfers. Review of the annual MDS assessment dated 07/28/13 revealed the facility assessed the resident to need the extensive assistance of two persons for ambulation, transfers, and bed mobility. Review of Resident #2's Plan of Care, revised 10/01/13, revealed no documented evidence of the number of staff persons needed by the resident for transfers.  Review of the facility's final investigation report of a fall on 09/19/13, dated 09/25/13, revealed SRNA #9 failed to use a gait belt when transferring Resident #2 which resulted in a fall; however, the investigation did not address that the resident was assessed to need two-person extensive assistance for transfers, and the SRNA transferred the resident without another staff person to assist. Further review of the facility's investigation revealed Resident #2 was transferred to the hospital Emergency Room for an evaluation and diagnosed with a right tibia and fibula fracture.  Interview on 10/02/13 at 4:38 PM with the DON revealed she was responsible for updating and making changes to the resident's Plan of Care as needed Monday through Friday. The interview further revealed the DON was not aware Resident #2's Plan of Care and Nurse Aide's Information Sheet had not been updated with the information related to Resident #2 requiring the assistance of two staff persons for transfers.	F 280	satisfaction was conducted on October 31, 2013. Facility began inservicing all staff on November 5, 2013 all staff will be educated by November 8, 2013. All staff will be in serviced on the new policy and notifying a supervisor if they are unable to complete care timely. All residents have the potential to be effected by the deficient practice please see systemic changes below. Resident #6 is having his needs met.  SRNA was counseled and re-educated on October 10/03/14, 10/04/13 and 11/4/13.  Systemic Changes include Management staff will interview each resident each day Monday thru Friday to assure that their needs are being met. Interview will be completed with legal Representative if the resident is not interview-able. All information will be submitted to the Quality Assurance Committee daily.  Quality Assurance Committee will discuss weekly to		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282			

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423	
(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 282	<p>Continued From page 31</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy it was determined the facility failed to ensure care was provided in accordance with each resident's written plan of care for one of eighteen sampled residents (Resident #5). Record review revealed the facility implemented a soft lap belt restraint for Resident #5 on 05/12/12. Review of Resident #5's care plan revealed the resident had a physical restraint and staff was to document the results of the restraint reduction periods. Interviews with facility staff revealed a restraint reduction had not been attempted for Resident #5 since 05/12/12 when it was implemented.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Care Plans-Comprehensive," revised October 2011, revealed an individualized comprehensive care plan that included measurable objectives and timetable to meet the resident's needs would be developed for each resident. The policy stated the resident's care plan was designed to incorporate risk factors associated with identified problems and should reflect recognized standards of practice for problem areas and conditions.</p> <p>Review of Resident #5's Quarterly Minimum Data Set (MDS) assessment completed on 09/04/13</p>	F 282	<p>assure that compliance recommendations and follow-up is sustained pertaining to F353.</p> <p>Under the direction of the Administrator the Consultant assisted with developing a staffing policy and compliance is sustained pertaining to F353. Consultant will continue to work with facility to ensure that recommendations, appropriate follow-up and sustained practices are being met daily.</p> <p>All employees were successfully in-serviced about resident rights, dignity, abuse &amp; neglect on October 25, 2013.</p> <p>Additional Clinical Staff will be supporting SRNA's in the dining room to prevent future occurrences.</p> <p>The facility was in substantial compliance on 11/8/13.</p>	

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423	
(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 282	<p>Continued From page 32</p> <p>revealed the facility assessed the resident to be cognitively impaired and required extensive assistance of two staff persons with transferring, bed mobility, and toileting. The MDS also revealed Resident #5 utilized a walker and wheelchair for mobility and had not sustained any falls during the assessment period. The facility's assessment also revealed Resident #5 utilized a trunk restraint daily.</p> <p>Observations of Resident #5 on 10/07/13 at 11:04 AM, 12:00 PM, and 1:15 PM revealed the resident was alert, but did not respond appropriately to questions asked. The resident was sitting in a wheelchair with a foam lap belt restraint device.</p> <p>Review of a pre-restraining assessment conducted on 05/12/12 revealed the facility had initiated a foam lap belt restraint for Resident #5. Based on the assessment, the use of the restraint for Resident #5 was due to the resident's history of anemia, instability of his/her gait, and a history of bilateral knee replacement.</p> <p>Review of Resident #5's Comprehensive Care Plan with a revision date of 06/11/13 revealed the facility had identified a focus area of a Physical Restraint for the resident. The care plan directed staff to conduct and document quarterly restraint reviews for possible reduction of the restraint.</p> <p>Review of the Physical Restraint Elimination Assessment conducted by facility staff revealed the resident was assessed on 06/20/12, 09/19/12, 12/12/12, 03/13/13, 06/12/13, and 09/10/13, for elimination of the restraint. However, the facility documented Resident #5 was not a candidate for a restraint reduction or elimination program</p>	F 282	<p><b>F280</b></p> <p>Care Plan and SRNA Care Plan for resident #1 was revised on October 23, 2013 by MDS Coordinator. The updated care plans address addresses the risk for falls. The physical restraint has been removed. Restorative &amp; activity plans were also updated on October 23, 2013.</p> <p>Resident #2. MDS coordinator updated the care plan, and SRNA care plan on October 23, 2013. The new plan of care defines the resident to be a transfer of two with care.</p> <p>Resident #4. MDS coordinator updated the care plan and SRNA care plan on October 23, 2013 to address high risk for elopement. Continued use of wander guard ankle bracelet is ongoing. Interventions including wander book identification were implemented to protect resident identified as high risk from exiting the facility unsupervised. The revision was a</p>	

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423	
(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 282	Continued From page 33 because the resident did not have skin breakdown, had not experienced negative outcomes, and tended "to be impulsive and is easily distracted."  Interview with the Director of Nursing (DON) on 10/08/13 at 2:55 PM revealed Resident #5 was impulsive and had sustained falls in the facility. Based on the assessment of the resident, the soft lap belt restraint was initiated on 05/12/12 to prevent further falls. Further interview revealed since the restraint was initiated (a timeframe of 17 months) staff had not attempted to reduce or eliminate the resident's restraint as outlined in the resident's plan of care.	F 282	result in wandering/elopement assessments completed by MDS coordinator on 10/18/13 to identify if the resident was a risk for elopement, the resident scored a 14 and is a high risk. Safety employee checks resident for placement and safety in facility every 15 minutes started on Thursday October 17, 2013 and is ongoing. Interventions and diversions are listed in the front of each wandering book and all employees are educated on October 25, 2013. Social Service director will be continually updating resident's risk for elopement each week.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  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.  This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure one of eighteen sampled residents (Resident #6), who was unable to carry out activities of daily living, received necessary services to maintain personal hygiene. Observations conducted on 10/03/13 revealed Resident #6 requested staff to assist him/her with toileting. Continued observations revealed staff failed to provide the resident assistance with toileting and the resident had an incontinence episode.	F 312	Resident #14 MDS coordinator updated the care plan and SRNA care plan on October 23, 2013 to address high risk for elopement. Continued use of wander guard ankle bracelet is ongoing. Interventions including wander book identification were implemented to protect resident identified as high risk from exiting the facility unsupervised. The revision was a result in wandering/elopement	

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423		
(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 312	Continued From page 34  The findings include:  Review of the facility's policy titled "Quality of Life-Dignity," not dated, revealed residents should be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality.  Review of the facility's policy titled "Incontinent Management Policy/Program," not dated, revealed the policy had not addressed how staff was to assist residents with toileting when requested.  Record review revealed the facility admitted Resident #6 on 06/04/13 with diagnoses which included Muscle Weakness and a history of a Fractured Right Femur. Review of the Quarterly Minimum Data Set (MDS) assessment dated 09/03/13 revealed the facility assessed the resident to be cognitively impaired. The facility assessed the resident to require extensive assistance with transfers, toileting, and bathing. Further review revealed Resident #6 had sustained three falls during this assessment period.  Observations conducted on 10/03/13 at 6:00 PM revealed Resident #6 requested State Registered Nurse Aide (SRNA) #1 to assist him/her with toileting. Resident #6 stated, "I need to go pee." Observation revealed the SRNA did not assist the resident with toileting.  Continued observation of Resident #6 on 10/03/13 at 6:15 PM revealed the resident stated to the surveyor, "I can't get waited on here." The resident was asked if the inability to get	F 312	assessments completed by MDS coordinator on 10/18/13 to identify if the resident was a risk for elopement, the resident scored a 15 and is a high risk. Safety employee checks resident for placement and safety in facility every 15 minutes started on Thursday October 17, 2013 and is ongoing. Interventions and diversions are listed in the front of each wandering book and all employees are educated on October 25, 2013. Social Service director will be continually updating resident's risk for elopement each week.  Resident #15 MDS coordinator updated the care plan and SRNA care plan on October 23, 2013 to address high risk for elopement. Continued use of wander guard ankle bracelet is ongoing. Interventions including wander book identification were implemented to protect resident identified as high risk from exiting the facility unsupervised. The revision was a result in wandering/elopement assessments completed by MDS		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423	
(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 312	Continued From page 35 assistance with toileting happened often and the resident answered, "All the time."  Interview with SRNA #1 on 6:16 PM on 10/03/13 revealed Resident #6 requested her to assist him/her with toileting at 6:00 PM. The SRNA acknowledged she had not assisted the resident or told any other staff members of the resident's request to be toileted.  During further interview with Resident #6 on 10/03/13 at 6:21 PM, the resident stated, "I've already went on myself now," while pointing at his/her genital area.  Interview with Licensed Practical Nurse (LPN) #5 on 10/03/13 at 6:25 PM revealed Resident #6 should have received assistance with toileting as requested. The LPN stated the SRNA had not informed her that the resident had requested assistance with toileting.  Interview with the Director of Nursing (DON) on 10/03/13 at 7:30 PM revealed staff should have provided the resident with assistance with toileting when requested.	F 312	coordinator on 10/18/13 to identify if the resident was a risk for elopement, the resident scored a 13 and is a high risk. Safety employee checks resident for placement and safety in facility every 15 minutes started on Thursday October 17, 2013 and is ongoing. Interventions and diversions are listed in the front of each wandering book and all employees are educated on October 25, 2013. Social Service director will be continually updating resident's risk for elopement each week.  On Friday October 25, 2013 all Facility staff was educated on wandering books, new Policy of Residents Leaving the Facility, Sign in/out sheet, New Wandering/Elopement Precautions, Suggested Elopement Interventions, Code Green & Interventions Tools for the Wandering Resident. DON, Compliance Director, Quality Assurance/Safety Administrative Assistant, Executive Director, and Human Resources Coordinator are involved in training. All facility	
F 323 SS=K	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.	F 323		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423		
(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 323	Continued From page 36 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 adequate supervision and assistive devices for five of eighteen sampled residents (Residents #1, #2, #4, #14, and #15) to prevent accident hazards; Residents #4, #14, and #15 related to exiting the facility unsupervised, and Residents #1 and #2 related to falls. Based on interviews conducted with facility staff, Resident #4 had a history of exiting the facility unassisted and had exited the facility without staff knowledge sometime in March or April of 2013 (exact date unknown). Resident #4 exited the facility on 05/20/13 in his/her wheelchair and was found over an embankment behind the facility without injury. Observations conducted on 10/08/13 revealed Resident #4 pushed an exit door open, without staff present, and an alarm sounded; however, observation revealed facility staff was not in the immediate area and failed to respond to the alarm for three minutes. On 09/30/13, Resident #14 exited the facility, went to the facility parking lot without supervision or assistance, and was observed by a State Registered Nurse Aide (SRNA) attempting to get into a truck. In addition, Resident #15, on 03/15/13, exited out the back door of the facility, without supervision or assistance, walked around the building, and sat down under a tree. Continued interviews and record reviews revealed on 09/19/13, SRNA #9 was assisting Resident #2 to the bed and the resident sustained a fall with injury. SRNA #9 failed to use a gait belt for the transfer and attempted to transfer the resident without other staff to assist even though the resident was assessed to require the extensive assistance of	F 323	staff will be educated on all topics before being allowed to continue employment. Each employee will complete a return demonstration; a hand on approach by going through the facility and finding new books, policy's, interventions that Administration and Quality Assurance has put into place On October 25, 2013.  On Monday October 21, 2013 consultant Olive Allen trained and educated DON, Cooperate RN, MDS Coordinator, MDS Nurse, and Administrative LPN on care plans. Ms. Allen educated staff pertaining to F280. Consultant educated on developing and completion of care plans and SRNA care plans as well as examples of revision of all care plans and SRNA care plans to ensure revisions are made when a change occurs in a resident.  On Monday October 21, 2013 Administrator and Executive Director, directed DON, Corporate RN, MDS Coordinator, MDS Nurse		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185264</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>10/17/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHARLESTON HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>203 BRUCE COURT</b> <b>DANVILLE, KY 40423</b>		
(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 323	<p>Continued From page 37</p> <p>two persons for transfers. Continued interviews and record reviews revealed Resident #1 sustained a fall with injury and was assisted back into a wheelchair by SRNA #10; however, the SRNA failed to report the fall to the nurse.</p> <p>The facility's failure to provide adequate supervision and assistive devices placed residents at risk for serious injury, harm, impairment, or death. The Immediate Jeopardy with Substandard Quality of Care was determined to exist on 10/16/13 and is ongoing at 42 CFR 483.25 Quality of Care. The facility was notified of the Immediate Jeopardy on 10/16/13 and was informed on 10/17/13 the Immediate Jeopardy was ongoing.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Eloperments," not dated, revealed staff should investigate and report all cases of missing residents. The policy did not provide staff with guidance related to what actions to take, to prevent further elopements, when an elopement occurred.</p> <p>Review of the facility's policy titled "Fall Procedure," not dated, revealed when staff observes a resident fall, staff should allow the resident to lie on the floor and examine carefully. The policy review further revealed if a resident was found on the floor, staff was not to move the resident until the resident could be assessed by the Charge Nurse.</p> <p>Review of the facility's policy titled "Transfer of Residents (Use of Gait Belts)," not dated, revealed a gait belt should be used in the transfer or ambulation of any resident that required the</p>	F 323	<p>and Administrative LPN for a complete review on every care plan, MDS, and SRNA care plan for each resident. All revisions are to be completed by Friday October 25, 2013. The audit is being led by MDS Coordinator and assisted by Administrative LPN. Final audit will be reviewed by Cooperate RN and DON. Audit is overseen by Administrator and Executive Director.</p> <p>On Tuesday October 22, 2013 Administrator and Executive Director directed weekly revisions of care plans and SRNA care plans pertaining to physical restraints, falls, and elopement. Care plans and SRNA care plans will be completed on a daily basis and reviewed each week by MDS Coordinator and or designee. Administrator and Executive will oversee to ensure compliance is achieved each week.</p> <p>IPOC (interdisciplinary plan of care) meeting will be held each weekday morning with</p>		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423	
(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 323	<p>Continued From page 38 assistance of a staff member.</p> <p>1. Review of Resident #15's medical record revealed the facility admitted the resident on 10/03/12 with diagnoses which included Seizure Disorder, Coronary Artery Disease, Hypertension, and Anxiety.</p> <p>Review of Resident #15's Admission Minimum Data Set (MDS) assessment dated 10/12/13 revealed Resident #15 required supervision/oversight with ambulation and was cognitively intact.</p> <p>Review of the Risk of Elopement/Wandering Review for Resident #15 dated 10/11/12 revealed the facility assessed the resident and determined the resident was an elopement risk due to facility staff being unable to redirect the resident from going outside unsupervised. Review of the resident's care plan dated 10/11/12 revealed a Wanderguard bracelet (placed on the resident's person and triggers an alarm at the exit door if the resident attempts to exit the facility without staff knowledge) was placed on the resident and every hour checks were initiated at that time. Further review of Resident #15's care plan (not dated when revised) revealed the resident had removed the Wanderguard bracelet and the bracelet was replaced. Review of Social Services Notes dated 01/02/13 revealed the resident was not allowed to move into a community setting because the resident was considered to be an elopement risk by the resident's State Guardian.</p> <p>Further review of Resident #15's care plan revealed the resident utilized a rolling walker for ambulation in the hallway and could ambulate outdoors when the weather permitted. Although</p>	F 323	<p>Administrator, Executive Director, Social Service Director, Rehab Coordinator, MDS Coordinator, Administrative LPN, Dietary Director, Activity Coordinator, Director of Nursing to review intervention from prior day. The DON (Director of Nursing) will start the meeting with review of the 24 hour report from the previous day and any new physician orders including changes in DNR status, new occurrences including falls any action related to wandering that have occurred the team discusses pertinent issues and reviews the MDS Coordinator revises the care plan and SRNA care plan at that time if needed.</p> <p>The Administrative LPN audits the records of newly admitted resident to validate that their care plan addresses fall risk, elopement risk, and physical restraints. The DON reviews these audits to verify care plan revisions and development are completed. MD Coordinators complete care plan revisions daily</p>	

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423		
(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 323	<p>Continued From page 39</p> <p>the resident's MDS assessment revealed the resident required supervision/oversight with ambulation, the care plan did not specify the level of supervision required outdoors.</p> <p>Review of the facility's incident reports completed for Resident #15 on 03/15/13 (time not specified) revealed Resident #15 was agitated and wanted to go outside the facility and walk around the parking lot. Licensed Practical Nurse (LPN) #1 told the resident she would take the resident for a walk but, for safety reasons, the resident had to wait for the LPN to go with him/her. According to the incident report, Resident #15 went past the nurses' station, down the hallway into the break room, and out the back door. The incident report revealed the resident left his/her rolling walker inside the facility at the back door. The incident report stated Resident #15 walked around the facility, up an embankment, and was found seated under a tree. According to the incident report, the resident stated he/she got tired and sat down. The incident report did not address how long the resident was outside the facility without staff supervision. Further review of the incident report revealed the resident complained of right knee pain and was assessed to have no injury. According to the incident report, the resident stated he/she was going for a walk and got lost.</p> <p>Interview with LPN #1 on 10/15/13 at 1:50 PM revealed Resident #15 wanted to go outside for a walk on 03/15/13 at approximately 3:00 PM. LPN #1 told the resident he/she had to wait for her to complete a task before she could take the resident for a walk. According to LPN #1, she left Resident #15, completed a task, and approximately 15 minutes later went to find the</p>	F 323	<p>per the information obtained from the physician orders, and 24 hour nursing report to other occurrences addressed during the IPOC meeting. On a daily basis the Administrative LPN audits resident care plans to validate that these updates are completed. Please see attached audit form. All information will be submitted to the Quality Assurance Committee daily.</p> <p>The facility was in substantial compliance on 11/1/13.</p> <p><b><u>F282</u></b></p> <p>Resident #5. On October 10, 2013, Rehab department screened resident for occupational therapy to evaluate and assess safety with current wheel chair positioning system. On October 16 and October 23 Assistant Medical Director made rounds checking to validate if restraint was applied properly, if the resident showed distress, if there was any skin irritation due to the use of the physical restraint, and if the</p>		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423		
(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 323	<p>Continued From page 40</p> <p>resident to take the resident for a walk. LPN #1 stated she could not locate the resident and asked facility staff to assist her in searching for the resident. Further interview revealed the LPN went to the back door of the facility and the Wanderguard system alarm was sounding; however, she did not hear the alarm until she had almost reached the back door. According to the LPN, she went out the door, around the building, and Resident #15 was found under a tree beside a facility office building. According to the LPN, Resident #15 had traveled about 500 feet from the building.</p> <p>On 10/16/13 at 9:40 AM, observations were conducted of the area outside the back door of the facility where Resident #15 was located after he/she exited the building unsupervised. Observations revealed the area just outside the back door of the facility was within 100 feet of a retaining basin that was approximately 7 feet deep and a ditch that was approximately 12 feet deep. Further observation revealed the back door of the facility was within 8 feet of a hill with a sloping grade of approximately 25 degrees. According to the facility's Executive Director, the total property consisted of five acres.</p> <p>Interview with the Director of Nursing (DON) on 10/15/13 at 4:20 PM revealed that elopement incidents were discussed during the facility's weekly safety meeting. According to the DON, Resident #15's elopement had been discussed; however, the facility did not conduct a thorough investigation to determine how the resident was able to leave the facility without staff knowledge and be gone for an undetermined amount of time or revise the resident's care plan to prevent further potential elopements. The DON stated</p>	F 323	<p>restraint was being released properly for Resident #5. Physical restraint assessment was completed on 10-08-13 for Resident #5. On October 7 Social Service and Activity Directors assessed Resident #5 assessment included how they could continue to help reduce the physical restraint, and ensure the facility was providing meaningful activities to benefit Resident #5. Restorative Program was evaluated on October 8, 2013 for Resident #5. On October 9, 2013 MDS Coordinator audited the MDS to validate documentation. On October 23, 2013 every 15 minute checks were conducted to validate the resident's safety. On October 22 Resident #5's restraint reduction was updated. On October 23, 2013 the Resident #5's physical restraint was discontinued per doctor's order Sensor Pad was added to Resident #5 wheelchair. On October 23, Resident #5 CCC was revised and on October 25, 2013 Resident #5's SRNA Care Plan was revised.</p>		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185264</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>10/17/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHARLESTON HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>203 BRUCE COURT</b> <b>DANVILLE, KY 40423</b>		
(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 323	<p>Continued From page 41</p> <p>the facility's Wanderguard system had not been considered to be ineffective because the system was checked and working. Further interview revealed the incident was not reported to state agencies because the facility's administrative staff felt that because the resident had not left the facility property it was not an allegation of neglect.</p> <p>Interview with the Executive Director on 10/16/13 at 12:40 PM revealed she reviewed the incident reports and conducted investigations regarding elopements. According to the Executive Director, Resident #15 exiting the building was not considered an elopement because the resident had not left the facility's property; the allegation was not reported to the required state agencies because neglect was not considered. Further interview revealed the Executive Director had reviewed the incident, but had not considered that the facility's Wanderguard system may not be effective because the system was functioning, even though Resident #15 was able to exit the building without staff knowledge.</p> <p>2. Review of the medical record for Resident #4 revealed the facility admitted the resident on 02/03/12 with diagnoses which included Senile Dementia, Hypertension, and History of Falls. Review of a Quarterly Minimum Data Set (MDS) assessment dated 09/23/13 revealed the resident required extensive assistance with transfers, dressing, and bathing, and utilized a wheelchair for mobility. Further review of the assessment revealed staff identified Resident #4 had behaviors of wandering, which had occurred one to three days during the assessment period.</p> <p>Review of documentation in Resident #4's medical record revealed the facility assessed the</p>	F 323	<p>The Facility's Restraint Assessment was completed on 10/8/13 by Administrative LPN to determine the need for a physical restraint. To determine the continued need on all residents who already have physical restraints a weekly Restraint Assessment will continue as part of the facility Quality Assurance Program. All Restraint Assessments are submitted to the Restraint Committee that meets every day Monday through Friday. The Restrain Committee reports the results of all physical Restraint Assessments to the Quality Assurance Committee each week.</p> <p>Each Resident's MDS, Comprehensive Care Plan and SRNA Care plan is promptly updated to reflect any changes dictated by the Restraint Assessment for each resident. On October 4-8, 2013, Administrative LPN conducted a Restraint Assessment for each Resident with a current physician order for a physical restraint. Each Restraint Assessment included</p>		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423	
(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 323	<p>Continued From page 42</p> <p>resident on 04/25/12 to be an elopement risk and applied a Wanderguard bracelet to the resident's ankle at that time.</p> <p>Observations conducted on 10/08/13 at 3:41 PM revealed Resident #4 was on the back hallway of the facility; Resident #4 was wearing a "Wanderguard bracelet" on his/her right ankle. Continued observation revealed Resident #4 pushed open an exit door located on the back hallway of the facility and an alarm sounded. However, facility staff was not in the immediate area when the resident pushed the door open and staff failed to respond to the alarm for three minutes. The resident opened the door but did not go out the door.</p> <p>Interview conducted with Licensed Practical Nurse (LPN) #1 on 10/16/13 at 11:40 AM revealed Resident #4 had been "missing" from the facility but was unable to remember when the incident occurred. The LPN stated that at the time of the incident she realized that she had not seen the resident in a while and tried to locate the resident. Continued interview revealed she was unable to locate the resident and notified other staff the resident was "missing." The LPN stated the search continued outside the facility and Resident #4's wheelchair, with a lap belt restraint attached, was located in a graveled parking area at the back of the facility. LPN #1 stated another nurse located the resident beside a bush on a hill that was located approximately 100 feet away from the resident's wheelchair. The LPN stated the Wanderguard bracelet was still attached to Resident #4's right ankle. According to LPN #1, she had not heard an alarm sound prior to being unable to locate Resident #4 at the time of the incident. The LPN stated the door alarms were</p>	F 323	<p>review of the Resident's CCC related to use of physical restraint. The reviews validated that medical symptoms were present to support the use of a physical restraint, to validate that the existing restraint is the least restrictive restraint in use for the least amount of time and to validate whether the resident's environment or activities can be modified to reduce reliance on the restraint.</p> <p>On October 4, 2013, the Facility's Director of Rehabilitation, Physical Therapist and Occupational Therapist, assessed all Residents with physical restraints to determine if a lesser restraint reduction is appropriate. The therapists also reviewed whether current physical restraints could be updated or modified to better ensure the Resident's comfort and safety. The therapists also evaluated each Resident's environment to determine whether changes were appropriate.</p>	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423		
(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 323	<p>Continued From page 43</p> <p>supposed to sound when a resident attempted to exit the doors; she stated she could not always hear the facility's door alarms because the alarm was not loud enough to be heard at times. The LPN stated the resident was assessed to have no injuries as a result of the incident. In addition, according to LPN #1, she had not documented the incident in the medical record or notified administrative staff of the incident because that was the responsibility of the Charge Nurse; however, the LPN could not recall who the Charge Nurse was at the time of the incident. LPN #1 stated that, although she could not recall the date, she had notified the Director of Nursing (DON) and the Executive Director (ED) of the inability to hear the door alarms from all areas of the facility.</p> <p>LPN #2 confirmed in interview on 10/16/13 at 3:50 PM that, although she did not recall the date, Resident #4 had been missing from the facility possibly in March 2013. The LPN stated she was notified Resident #4 was missing and assisted in the search for the resident; however, LPN #2 stated she had not heard any door alarms sound prior to the search for the resident. LPN #2 stated she located Resident #4 at the "bottom of the hill, at the gated area, located in back of the facility." The LPN stated she was unable to recall if she documented the incident, or notified administrative staff. The LPN continued to state the facility's exit door alarms do not work "half the time" and administrative staff "know they don't work."</p> <p>Continued review of Resident #4's medical record revealed facility staff had not documented that Resident #4 had left the facility without staff knowledge in March 2013.</p>	F 323	<p>On October 7, 2013 the Facility's Assistant Medical Director audited the Restraint Assessment, for each Resident using a physical restraint. Each audit of Restraint Assessment included review of the Residents CCC related to use of physical restraint to validate that medical symptoms were present to support the use of a physical restraint, to validate that the existing restraint is the least restrictive restraint in use for the least amount of time and to validate whether the resident's environment or activities can be modified to reduce reliance on the restraint. Assistant Medical Director validated all use of current physical restraints on October 7, 2013. Assistant Medical Director will continue to audit each Resident with a physical restraint each week until all physical restraints are discontinued.</p> <p>On October 7, 2013, the Facility's social service director and recreational coordinator assessed each Resident who uses a physical</p>		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423		
(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 323	Continued From page 44  However, a review of an incident report entitled "Elopement," dated 05/20/13, revealed Resident #4 had exited the facility in a wheelchair and wheeled his/her self over an embankment located in back of the facility. Resident #4 did not sustain any injuries.  Interview with LPN #3 on 10/15/13 at 2:03 PM revealed she had been assigned to care for Resident #4 when the elopement occurred on 05/20/13. LPN #3 stated she heard the back door alarm and when she responded, the resident had "rolled down the slight embankment" in his/her wheelchair. LPN #3 also stated she had not implemented any interventions after the incident occurred and stated staff nurses "don't update care plans." The LPN stated, although she had not reported the incident to administrative staff, she "passed" the information to the oncoming shift and documented the incident on the 24-hour report. Continued interview revealed, "If a resident's sock is pulled up over their Wanderguard bracelet, or if the bracelet is turned a certain way, it will not work properly to sound the exit alarms." The LPN further stated she had not reported the concern related to the exit alarm system to Administration, but "should have."  Interview with State Registered Nurse Aide (SRNA) #14 on 10/16/13 at 10:00 AM revealed she was working at the time the elopement occurred on 05/20/13. The SRNA stated she never heard an exit alarm sounding, and was only aware of the resident's elopement when notified by the nurse after the incident had occurred. The SRNA stated the exit door alarms, on the back hall where Resident #4 exited the facility, "never	F 323	restraint to ensure personal preferences were updated and that the Facility is providing meaningful activities to each resident who uses a physical restraint.  On October 8, 2013, Administrative, LPN, audited restorative care plans in cooperation with the Rehab Director, Physical Therapist, and Occupational Therapist for each resident using a physical restraint to ensure the Facility is providing restorative care to enhance Resident abilities to stand, transfer, and walk safely in attempt to decrease physical restraints.  On October 9, 2013, Posey Company Representative conducted in-person training for all clinical staff regarding restraint programs, application and instruction for each Posey product in use at the Facility, as well as restraint reduction programs. The video of this presentation will be used in training for all new hires and annual training		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185264</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>10/17/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHARLESTON HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>203 BRUCE COURT</b> <b>DANVILLE, KY 40423</b>	
(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 323	<p>Continued From page 45</p> <p>worked." The SRNA also stated facility staffing was "horrible" and staff was not able to answer fall alarms or exit door alarms timely.</p> <p>Interview with SRNA #15 on 10/15/13 at 3:50 PM revealed the facility was short-staffed most of the time. The SRNA stated the facility had a lot of "wanderers," alarms, and falls, and with all the other work required to be completed during their shift, it was "hard to do things timely."</p> <p>Observations and interviews on 10/16/13 at 9:40 AM conducted with Maintenance Staff Person #1 and Human Resources (HR) Staff Person #1, who assisted in transporting the resident back into the facility on 05/20/13, revealed the resident had gone down an approximate 25 to 30-degree sloped, grassy area in a wheelchair. Further observations and interview with the HR staff revealed the resident was approximately 100 feet from the facility.</p> <p>Interview with the DON on 10/15/13 at 4:20 PM revealed she had not been notified of an elopement incident, which involved Resident #4, any time before the documented elopement that occurred on 05/20/13. The DON stated staff had not notified her, and she had not been made aware that Resident #4 had ever been missing from the facility. However, she had reviewed an elopement incident sometime in May 2013 for Resident #4. She acknowledged she had not investigated the incident or implemented any new interventions to prevent further elopements for the resident. The DON further stated she had not considered the incident a true elopement, because she had been trained that if residents remained on facility property they had not eloped.</p>	F 323	<p>and review purposes. All clinical staff attended in-service training on October 9, 2013. Training required each clinical employee to demonstrate the correct application for each physical restraint currently used in the Facility. Posey Company Representative, Quality Assurance and Safety Administrative Assistant, and Compliance Director monitored training on the correct application of physical restraint. On October 7, 2013, instructions for the appropriate application of each Posey brand physical restraint in use were posted at each nurse's station and in the SRNA book.</p> <p>Quality Assurance and Safety Administrative Assistant educated all non-clinical laundry housekeeping and dietary to include all employees are trained on application and position of physical restraints starting on 10/22/13; all non-clinical staff will be completely educated by 10/25/13. This education will ensure that all employees facility wide were</p>	

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423		
(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 323	<p>Continued From page 46</p> <p>The DON stated staff had never notified her that the door alarms could not be heard at times. However, she stated Maintenance had adjusted the alarms, but could not recall when or why the alarms were adjusted.</p> <p>Interview with the Executive Director (ED) on 10/16/13 at 12:40 PM revealed she was responsible for investigating incidents of elopement. The ED stated she had not been notified of an elopement that occurred around March 2013. She acknowledged Resident #4 had exit-seeking behaviors, and had exited the facility in May 2013. However, no evidence was provided to ensure Resident #4's elopement had been investigated, or that new interventions had been implemented to prevent further elopements from occurring. She stated she was not aware of concerns related to the exit doors' alarms.</p> <p>3. Review of the medical record for Resident #14 revealed the facility admitted the resident on 07/25/13 with diagnoses which included Dementia, Hypertension, and Depression. Further review of the medical record revealed Nurse's Progress Notes dated 07/25/13 through 10/17/13 that revealed Resident #14 began having exit-seeking behaviors on 08/04/13.</p> <p>Review of the Admission Minimum Data Set assessment dated 08/01/13 revealed the facility assessed Resident #14 as being cognitively impaired and required supervision with the assistance of one person for ambulation.</p> <p>Review of the Plan of Care revealed the facility revised the Plan of Care on 08/05/13 and documented the resident had exit-seeking behaviors. Based on the Plan of Care, facility</p>	F 323	<p>educated on the proper application and positioning of all physical restraints. This will be used to continually monitor residents with physical restraints to ensure the Facility is using a systemic team approach to identify sliding, falling, or attempts of removal of the physical restraint. Non-clinical staff members are educated to communicate with charge nurses to provide communication assistance.</p> <p>On October 7, 2013, the Facility reviewed and updated policies and procedures regarding the safe and effective use of physical restraints. The updated policy clearly provides that physical restraint may not be used unless for the safety and well-being of the Patient and only after other alternatives have been evaluated.</p>		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185264</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>10/17/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHARLESTON HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>203 BRUCE COURT</b> <b>DANVILLE, KY 40423</b>		
(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 323	<p>Continued From page 47</p> <p>staff was to implement and place a Wanderguard bracelet on the resident's ankle at all times as an intervention for staff to be alerted if the resident attempted to exit the facility without staff knowledge unassisted.</p> <p>Review of an incident report dated 09/30/13 revealed SRNA #11 found Resident #14 outside the facility in the parking lot attempting to get into a truck. There was no documented evidence of how long the resident was outside of the facility or how staff was made aware the resident was outside of the facility.</p> <p>Interview on 10/16/13 at 3:50 PM with SRNA #11 revealed on 09/30/13, between 6:30 and 7:00 PM, she was informed by someone (unable to remember who) that Resident #14 was outside of the facility. The interview further revealed the SRNA found the resident in the facility's parking lot attempting to get into a truck. SRNA #11 stated she assisted Resident #14 back into the facility and a nurse was informed of the incident. The SRNA stated Resident #14 exits the facility "all the time" without staff knowledge or assistance.</p> <p>During an interview on 10/17/13 at 1:15 PM, LPN #8 revealed she was on a break when Resident #14 exited the facility on 09/30/13, and was not made aware of the incident until the resident was assisted back inside the building by facility staff. The interview further revealed the LPN was not aware how long the resident was outside of the facility or who identified and/or reported Resident #14 was outside of the facility. According to LPN #8, Resident #14 often attempted to leave the facility unassisted, but staff usually witnessed Resident #14's efforts to exit the building and</p>	F 323	<p>Following the Incident, the Facility increased physical restraint monitoring to ensure the safety of Residents using physical restraints.</p> <p>On October 11, 2013, all clinical staff participated in training given by MDS Coordinator and Compliance Director on the new QA monitor tool for Resident's using physical restraints to ensure the restraints are applied safely and effectively and to identify any potential accidents before they occur. The Facility established this new Quality Assessment Tool on 10/11/13. Charge Nurses' will now document using required QA monitoring tool each shift for each resident with a physical restraint. All clinical staff was successful trained on 10/11/13 on the new QA monitoring tool for physical restraints. The Quality Assessment Tool requires charge nurses to observe whether the physical restraint is properly applied, confirm whether the restraint is being released and removed on schedule</p>		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423		
(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 323	<p>Continued From page 48</p> <p>redirected him/her back inside the building.</p> <p>Interview on 10/17/13 at 1:30 PM with Registered Nurse (RN) #2 revealed the RN was aware Resident #14 got outside of the facility into the parking lot on 09/30/13 but was not aware of how long the resident was outside of the facility or who discovered the resident outside the facility. The interview further revealed Resident #14 exited the facility, unassisted, on numerous occasions but staff usually observed the resident and assisted the resident back inside the building.</p> <p>Interviews on 10/17/13 with SRNA #13 at 2:04 PM, and SRNA #6 at 2:09 PM, revealed Resident #14 often made attempts to exit and/or had exited the facility; however, according to SRNA #13 and SRNA #6, staff usually witnessed the resident's attempts and redirected and/or assisted the resident back into the facility.</p> <p>Interview on 10/17/13 at 1:51 PM with the DON revealed she was aware Resident #14 had exited the facility on 09/30/13 but was unaware of how long Resident #14 was outside of the facility. The DON was unable to find documented evidence of the facility's hourly safety checks for Resident #14 for 09/30/13.</p> <p>An interview with the ED on 10/16/13 at 12:40 PM revealed she was responsible to investigate incidents of elopement. She acknowledged Resident #14 had exit-seeking behaviors and had exited the facility on 09/30/13. However, the ED failed to provide documentation that the incident of Resident #14 exiting the facility had been investigated, or that new interventions had been implemented to prevent further elopements from occurring.</p>	F 323	<p>and confirm whether there is documentation of appropriate toileting. The tool will be reviewed each day by the Administrator and Executive Director. All information will also be submitted to the Quality Assurance Committee each day.</p> <p>On October 15, 2013, the Facility's charge nurses began monitoring each resident that uses a physical restraint every two hours. Charge nurses document restraint monitoring in Point Click Care under Restraint Note. Nurses will be monitoring to identify if the restraint is in use, if restraint is applied correctly, if resident has any discomfort due to the application of the physical restraint. If any negative findings are discovered then charge nurses are to immediately call physician. A new assessment and revision to CCC, and SRNA Care Plan would follow. All nurses' were educated on physical restraints safety checks every two hours successfully on October 15, 2013. Compliance Director and Executive Director are</p>		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423	
(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 323	<p>Continued From page 49</p> <p>4. Review of the medical record for Resident #2 revealed the facility admitted the resident on 08/13/12 with diagnoses which included Dementia, Syncope, Anemia, and a history of Frequent Falls.</p> <p>A review of Resident #2's Nurse Aide's Information Sheet dated 02/11/13 revealed the resident required assistance of one to two persons with transfers.</p> <p>A review of the annual Minimum Data Set assessment dated 07/28/13 revealed Resident #2 required extensive assistance of two persons for bed mobility, transfers, and ambulation.</p> <p>However, review of Resident #1's Plan of Care, revision date of 10/01/13, revealed staff had failed to document the assistance required by the resident for transfers.</p> <p>A review of an incident report dated 09/19/13 revealed SRNA #9 was assisting Resident #2 by herself to bed and the resident fell to the floor. Documentation revealed at the time of the incident Resident #2 stated he/she heard his/her ankle pop and complained of ankle pain. LPN #5 assessed Resident #2 and made arrangements for Resident #2 to be transferred to the hospital Emergency Room for examination. Review of the facility's investigation revealed that as a result of the examination performed by the staff in the Emergency Room, Resident #2 was diagnosed with a tibia and fibula fracture of the right leg. A review of the facility's investigation of the incident dated 09/25/13 revealed SRNA #9 failed to use a gait belt for the transfer of Resident #2 and the resident had fallen. However, the facility's</p>	F 323	<p>monitoring nurses that complete safety checks every two hours with residents who have physical restraints daily on all shifts. The Restraint Note is part of the Residents clinical record. Compliance Director and Executive Director report all findings to Quality Assurance Committee daily.</p> <p>On Thursday October 24, 2013 Facility began monitoring every resident with a physical restraint every 15 minutes. H/R Coordinator will be assigning a clinical staff member each day each shift. Clinical staff member will be monitoring the time, the location of the resident, the status of the resident and initialing of the monitoring process on each resident with a physical restraint. As safety monitoring is being conducted any negative findings would be immediately communicated to the charge nurse.</p> <p>Charge nurses that encounter an incident involving the safety or</p>	

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423		
(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 323	<p>Continued From page 50</p> <p>investigation failed to address that the resident had been assessed to need the extensive assistance of two persons for transfers and that the SRNA had transferred the resident without another staff person to assist. Further review of the facility's investigation of the fall revealed the facility substantiated caretaker neglect and terminated SRNA #9's employment due to failure to use a gait belt when she had transferred Resident #2 on 09/25/13.</p> <p>Interview on 10/02/13 at 4:25 PM with LPN #5 revealed SRNA #9 had informed the LPN that she had attempted to transfer Resident #2 from the wheelchair to the bed by herself without a gait belt, the resident's legs "gave out," and the resident fell and complained of pain. The interview confirmed facility staff assessed Resident #2 after the fall and transferred the resident to the hospital Emergency Room for an evaluation.</p> <p>Interview on 10/02/13 at 4:38 PM with the DON revealed the DON was responsible to update each resident's Plan of Care, Monday through Friday, and to make changes as needed. The interview further revealed the DON was not aware Resident #2's Plan of Care and the Nurse Aide's Information Sheet failed to contain the updated information related to the requirement of two staff persons to assist Resident #2 with transfers.</p> <p>Interview on 10/02/13 at 3:25 PM with the ED revealed the facility had investigated Resident #2's fall and had determined the fall was the result of SRNA #9's failure to use a gait belt when attempting to transfer Resident #2 from the wheelchair to the bed. The ED stated she was not aware Resident #2 had been assessed to</p>	F 323	<p>security of a resident using physical restraints, including that a restraint is improperly applied, are required to secure the resident's safety of the resident and immediately report the incident to the Primary Care Physician, Nurse on Call and the Executive Director. Upon identifying the improper application of restraints, the charge nurse or superior will immediately remove applicable personnel from the floor and require reeducation before returning staff to resident care. The Nurse on Call and Executive Director are available to respond to restraint incident reports 24 hours per day, seven days per week. All information will be reported to the Quality Assurance Committee daily. Quality Assurance Committee will provide oversight.</p> <p>On Monday October 21, 2013 Director of Nursing began visually monitoring and overseeing all clinical nursing staff including SRNA's, KMA's, LPN's, and RN's on their performance of physical</p>		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423	
(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 323	<p>Continued From page 51</p> <p>require two staff persons for transfers. The interview further revealed that based on the facility's investigation the facility had determined SRNA #9 had failed to transfer the resident with the gait belt and had terminated the SRNA's employment at the facility.</p> <p>5. A review of the medical record of Resident #1 revealed the facility admitted the resident on 09/21/10, with diagnoses which included Osteoarthritis, Macular Degeneration, and Progressive Supranuclear Palsy.</p> <p>A review of the most recent quarterly Minimum Data Set assessment, completed on 08/19/13, revealed the facility assessed Resident #1 to require the extensive assistance of one staff person with bed mobility, transfers, and ambulation. The facility also noted Resident #1 utilized a walker and a wheelchair for mobility. In addition, based on the assessment, facility staff was to utilize a trunk physical restraint for Resident #1 when he/she was up in the wheelchair.</p> <p>Review of a fall incident report dated 09/09/13 revealed a family member of Resident #1's roommate informed a nurse that Resident #1 had fallen to the floor, and an SRNA had assisted the resident back into a wheelchair. Further review of the incident report revealed facility staff assessed Resident #1 after being informed of the fall and noted the resident had a laceration on the left side of the head. The incident report revealed Resident #1 was assessed and transferred to the hospital Emergency Room for further evaluation and treatment at which time the resident received staples to the laceration on the left side of the head.</p>	F 323	<p>restraint application documentation can be found on DON restraint tool (please see attached). DON continues to check each resident Monday thru Friday on 7-3 shift and 3-11 during Monday through Friday DON is checking 7-3 shift once daily, and 3-11 once daily each shifts to ensure that each resident is positioned properly, restraint is applied properly, and resident is not showing signs of discomfort due to the use of the restraint. DON will continue this process until all physical restraints are successfully removed. Any negative findings will immediately be addressed. Staff will be retrained before continuing care. Information will be submitted to the Restraint Committee and the Quality Assurance Committee each day.</p> <p>Effective 10/11/13 MDS Coordinator will be re-accessing each physical restraint assessment after each incident, or change in condition. Assessments will be completed prior to any</p>	

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185264</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>10/17/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHARLESTON HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>203 BRUCE COURT DANVILLE, KY 40423</b>	
(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 323	<p>Continued From page 52</p> <p>A review of the facility's investigation of the fall, dated 09/10/13, revealed on 09/09/13 SRNA #10 assisted Resident #1 back into his/her wheelchair after the resident had fallen and failed to inform the nurse of the resident's fall. Further review of the investigation revealed after the resident's fall SRNA took a break and never reported the resident's fall to anyone. Continued review of the investigation revealed staff arranged for Resident #1 to be transferred to the hospital Emergency Room for evaluation and treatment; and based on the report, Resident #1 returned to the facility with staples intact to a head wound. The investigation further revealed SRNA #10 was sent home, not allowed further contact with the residents on 09/09/13, the day of the incident, and was terminated from employment on 09/10/13.</p> <p>Review of Resident #1's Plan of Care, revision date of 09/24/13, revealed the facility assessed the resident to have a history of multiple falls, with minor injuries, since his/her admission to the facility. The facility had assessed the resident to require the use of a soft lap belt, fall mats at the bedside, a bed alarm, and hipster briefs as an intervention to prevent falls/injuries.</p> <p>Interview on 10/02/13 at 3:00 PM with SRNA #8 revealed the SRNA was in orientation with SRNA #10 on 09/09/13, the day Resident #1 had the fall that resulted in the laceration. The interview further revealed SRNAs #8 and #10 were walking down the hall to go on break and overheard someone yell for help. SRNA #8 stated she and SRNA #10 walked into Resident #1's room and observed the resident attempting to get up from the floor. Based on interviews, SRNA #10 assisted the resident into the wheelchair,</p>	F 323	<p>changes made to the resident's physical restraint. Rose McKenzie will additionally update the care plan and or MDS if needed accordingly. Rehab team Activity, Rehab, Social Services, Dietary, &amp; MDS will all be notified by DON and or Executive Director that re-assessment is necessary after each incident. After the re-assessment process is complete; Restraint Committee will discuss re-assessment findings and options for the resident finally getting physician approval.</p> <p>On Monday October 21, 2013 Ms. Olive Allen, L.N.H.A consultant educated the Executive Director, Administrator, administrative nurses, MDS Coordinator, DON, LPN's and RN's on care plans, assessments and MDS'. Ms. Allen advised clinical administrative staff on physical restraints &amp; regulatory requirements.</p> <p>On Monday, October 7, 2013, the Facility established a Restraint Committee consisting of</p>	

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423	
(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 323	<p>Continued From page 53</p> <p>attached the resident's restraint, and then SRNAs #8 and #10 continued to go outside the facility for a break. SRNA #8 stated she was not aware Resident #1 had an injury. SRNA #8 revealed when she was hired she was trained to not move a resident that had fallen and to report all falls immediately to the nurse; however, SRNA #8 stated since she was in orientation she thought SRNA #10 would report the incident.</p> <p>Interview on 10/02/13 at 11:23 AM with SRNA #4 revealed she had been assigned to assist and provide care to Resident #1 on 09/09/13 when the fall occurred but she did not witness the fall. SRNA #4 stated after her break she was assessing the residents, noticed the cut on Resident #1's head, and immediately informed the nurse.</p> <p>Interview on 10/02/13 at 11:41 AM with SRNA #5 revealed the SRNA was making a round with SRNA #4 and noticed Resident #1 sitting in the wheelchair with a laceration on his/her head. The interview further revealed Resident #1's roommate's family member informed SRNA #5 that SRNAs #8 and #10 had assisted the resident back into the resident's wheelchair after the resident had fallen and was concerned that they had failed to report the resident's fall to the nurse. The interview further revealed the nurse immediately came to the room to assess the resident and the resident was sent to the hospital for an evaluation.</p> <p>Interview on 10/02/13 at 12:20 PM with LPN #4 revealed the LPN was informed of Resident #1's fall on 09/09/13 by SRNAs #4 and #5. The interview further revealed the SRNAs had reported to the LPN they had been informed by a</p>	F 323	<p>the DON, MDS Coordinator, Director of Rehab and Executive Director. The Restraint Committee will meet daily, Monday through Friday to evaluate the safe and effective use of physical restraints at the Facility. The Restraint Committee will report all findings to the Facility Administrator and Quality Assurance Committee.</p> <p>The facility was completely restraint free On October 25, 2013. No physical restraints were in use for any resident.</p> <p>The facility was in substantial compliance on 11/8/13.</p> <p><b><u>F312</u></b></p> <p>On November 1, 2013 the facility developed a staffing policy that reviewed work assignments of the caregivers. An audit of resident satisfaction was conducted on October 31, 2013. Facility began inservicing all staff on November 5, 2013 all staff will be educated by November 8, 2013. All staff will be</p>	

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423		
(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 323	Continued From page 54 family member that SRNAs #8 and #10 had assisted Resident #1 back into a wheelchair after the resident had fallen. The LPN stated neither SRNA #8 nor SRNA #10 had informed her of the resident's fall and stated she immediately assessed Resident #1 and sent the resident to the hospital for an evaluation. The interview further revealed LPN #4 immediately reported the incident to the ED and SRNA #10 was immediately removed from resident care.  Interview on 10/02/13 at 3:25 PM with the ED revealed the incident involving Resident #1's fall on 09/09/13 was investigated immediately. According to the ED, SRNA #10 was removed from care and then terminated for failure to report a resident's fall. The interview further revealed SRNA #10 admitted to finding Resident #1 on the floor, assisting the resident back into the resident's wheelchair, and reapplying the resident's restraint. The ED further revealed SRNA #10 denied being aware the resident was injured. The interview further revealed SRNA #8 was still in orientation with SRNA #10 at the time of the incident so SRNA #8 was restrained on proper fall procedures.	F 323	in serviced on the new policy and notifying a supervisor if they are unable to complete care timely. All residents have the potential to be effected by the deficient practice please see systemic changes below. Resident #6 is having his needs met.  SRNA was counseled and re-educated on October 10/03/14, 10/04/13 and 11/4/13.  Systemic Changes include Management staff will interview each resident each day Monday thru Friday to assure that their needs are being met. Interview will be completed with legal Representative if the resident is not interview-able. All information will be submitted to the Quality Assurance Committee daily.		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS  The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.  The facility must provide services by sufficient numbers of each of the following types of	F 353	Quality Assurance Committee will discuss weekly to assure that compliance recommendations and follow-up is sustained pertaining to F353.		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185264</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>10/17/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHARLESTON HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>203 BRUCE COURT</b> <b>DANVILLE, KY 40423</b>		
(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 353	<p>Continued From page 55</p> <p>personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview it was determined the facility failed to provide sufficient personnel to provide services to maintain the highest practicable wellbeing related to toileting for one of eighteen sampled residents (Resident #6).</p> <p>The findings include:</p> <p>Review of the facility's staffing policy titled "Staffing for Charleston Health Care Center," not dated, revealed the facility's staffing for day shift (7:00 AM-3:00 PM) would be three or four Nurses, three Medication Aides, and eight, nine, or ten Certified Nurse Aides. On the evening shift (3:00 PM-11:00 PM) the planned staffing was three Nurses, three Medication Aides, and six, seven, or eight Certified Nurse Aides. Further review revealed for night shift (11:00 PM-7:00 AM) the facility's staffing would include two Nurses and four or five CNAs. The policy revealed in the event of "call-ins" staff was to ask if someone was interested in staying over. In</p>	F 353	<p>Under the direction of the Administrator the Consultant assisted with developing a staffing policy and compliance is sustained pertaining to F353. Consultant will continue to work with facility to ensure that recommendations, appropriate follow-up and sustained practices are being met daily.</p> <p>The facility was in substantial compliance on 11/8/13.</p> <p><b>F323</b></p> <p>Resident #1. The care plan and SRNA care plan was revised on October 23, 2013 by the MDS coordinator to include cushion in wheelchair, sensor pad in wheelchair, and the termination of the physical restraint. Resident was evaluated from rehab for wheelchair position and safety.</p> <p>Resident #2. The SRNA that assisted with care the night of the incident was terminated on September 20, 2013. The care plan and SRNA care plan has been</p>		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423	
(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 353	<p>Continued From page 56</p> <p>addition, the facility required staff members that had a "distinguished mark" next to their name on the schedule to "stay over" on a shift or to "come in" four hours early. Review of the policy also revealed Human Resources staff and a nurse that was "on call 24/7" would help with attempts to get staff to come in when needed.</p> <p>Review of the medical record for Resident #6 revealed the facility admitted the resident on 06/04/13 with diagnoses which included Muscle Weakness, Osteoarthritis, and a history of a Fractured Right Femur. Review of a Quarterly Minimum Data Set (MDS) assessment dated 09/03/13 revealed the facility assessed the resident to be cognitively impaired and to require extensive assistance with transfers, toileting, and bathing. Facility staff documented the resident had experienced three falls during the assessment period and staff was to utilize a trunk restraint when the resident was out of bed, on a daily basis.</p> <p>Observations conducted on 10/03/13 at 6:00 PM revealed Resident #6 was sitting up in a wheelchair and was holding a soft lap belt restraint in his/her hand. The resident was observed to tell State Registered Nurse Aide (SRNA) #1, "I need to go pee." The SRNA was observed to call the resident by his/her first name and stated, "You have to leave this (referring to the restraint) on." The SRNA proceeded to reapply the resident's restraint and tied it to the resident's wheelchair.</p> <p>Observations of Resident #6 continued and at 6:15 PM, the resident stated, "I can't get waited on here." The resident was asked if the inability to get assistance with toileting happened often</p>	F 353	<p>updated by MDS Coordinator on October 23, 2013. Resident is working with therapy.</p> <p>Resident #4. MDS coordinator updated the care plan and SRNA care plan on October 23, 2013 to address high risk for elopement. Continued use of wander guard ankle bracelet is ongoing. Interventions including wander book identification were implemented to protect resident identified as high risk from exiting the facility unsupervised. The revision was a result in wandering/elopement assessments completed by MDS coordinator on 10/18/13 to identify if the resident was a risk for elopement, the resident scored a 14 and is a high risk. Safety employee checks resident for placement and safety in facility every 15 minutes started on Thursday October 17, 2013 and is ongoing. Interventions and diversions are listed in the front of each wandering book and all</p>	

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423		
(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 353	<p>Continued From page 57 and the resident answered, "All the time."</p> <p>An interview was conducted with SRNA #1 at 6:16 PM on 10/03/13. The SRNA acknowledged Resident #6 had requested assistance with toileting at 6:00 PM. The SRNA stated she had not assisted the resident, or told any other staff members of the resident's request to toilet. The SRNA stated she had to assist with feeding residents in the dining room and did not have time, and could not find anyone to help the resident at the time of the resident's request for assistance. SRNA #1, who was observed to be feeding a resident in the dining room at the time of the interview, stated two SRNAs (which included her) were assisting and passing trays in the dining room and another CNA was passing trays and assisting residents with their meals in their rooms on B Hall.</p> <p>An interview with Licensed Practical Nurse (LPN) #5 on 10/03/13 at 6:25 PM confirmed three SRNAs were providing care on B Hall for the 3:00 PM-11:00 PM shift on 10/03/13. LPN #5 stated SRNA #1 should have notified her that Resident #6 had requested assistance for toileting. The LPN stated she had just completed a medication pass, and that "especially during mealtimes" it was almost impossible with three SRNAs to "feed the residents a hot meal, answer the call lights, attend to falls, door alarms, and assist the residents to the bathroom." The LPN stated she assisted with resident care after she provided physician ordered medications to the residents.</p> <p>Interview with SRNA #15 on 10/15/13 at 3:50 PM revealed the facility was short-staffed most of the time. The SRNA stated the facility had a lot of "wanderers," alarms, and falls, and with all the</p>	F 353	<p>employees are educated on October 25, 2013. Social Service director will be continually updating resident's risk for elopement each week.</p> <p>Resident #14 MDS coordinator updated the care plan and SRNA care plan on October 23, 2013 to address high risk for elopement. Continued use of wander guard ankle bracelet is ongoing. Interventions including wander book identification were implemented to protect resident identified as high risk from exiting the facility unsupervised. The revision was a result in wandering/elopement assessments completed by MDS coordinator on 10/18/13 to identify if the resident was a risk for elopement, the resident scored a 15 and is a high risk. Safety employee checks resident for placement and safety in facility every 15 minutes started on Thursday October 17, 2013 and is ongoing. Interventions and diversions are listed in the front of each wandering book and all employees are educated on October</p>		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423	
(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 353	Continued From page 58 other work required to be completed during their shift, it was "hard to do things timely."  Interview with SRNA #14 on 10/16/13 at 10:00 AM revealed facility staffing was "horrible." The SRNA stated the alarms were unable to be answered timely, and staff was not able to assist the residents when they needed it due to "not enough help."  An interview with LPN #2 on 10/16/13 at 3:50 PM revealed facility staffing was "awful." The LPN stated the residents "don't receive quality care." Continued interview revealed the workload was "too much," and the facility had a lot of wanderers, call bells, and door alarms, and it was hard to monitor/answer them all timely.  An interview conducted on 10/17/13 at 1:15 PM with LPN #8 revealed it was difficult to provide care during meal times. The LPN stated staffing concerns had been discussed with administrative staff; however, staff continues to work "short" and residents "don't get the care they deserve."  An interview with the Executive Director (ED) on 10/16/13 at 12:40 PM revealed she was aware that a few staff members had resigned from employment at the facility. However, the ED was unaware of how many SRNAs were required to staff the facility each shift. She stated she had placed advertisements with various employment agencies and was awaiting applicants.	F 353	25, 2013. Social Service director will be continually updating resident's risk for elopement each week.  Resident #15 MDS coordinator updated the care plan and SRNA care plan on October 23, 2013 to address high risk for elopement. Continued use of wander guard ankle bracelet is ongoing. Interventions including wander book identification were implemented to protect resident identified as high risk from exiting the facility unsupervised. The revision was a result in wandering/elopement assessments completed by MDS coordinator on 10/18/13 to identify if the resident was a risk for elopement, the resident scored a 13 and is a high risk. Safety employee checks resident for placement and safety in facility every 15 minutes started on Thursday October 17, 2013 and is ongoing. Interventions and diversions are listed in the front of each wandering book and all employees are educated on October 25, 2013. Social Service director will	
F 490 SS=K	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING  A facility must be administered in a manner that enables it to use its resources effectively and	F 490		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423	
(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 490	Continued From page 59 efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of facility policy it was determined the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility Administration failed to ensure Residents #4, #14, and #15, who were assessed to be an elopement risk and were utilizing a Wanderguard bracelet, received adequate supervision and assistive devices to prevent accidents. Residents #4 and #15 exited out the back door of the facility without staff knowledge. On 03/15/13, Resident #15 was gone for an undetermined amount of time and was found under a tree approximately 500 feet from where the resident exited the facility. Resident #4 exited the facility on 05/20/13, was gone for an undetermined amount of time, and was located approximately 100 feet from the facility. The resident was found on the ground approximately 50 feet from his/her wheelchair. On 09/30/13, Resident #14 exited the facility and was found in the parking lot attempting to get into a vehicle. The facility Administration failed to ensure the incidents were documented, failed to thoroughly investigate how the residents were able to exit the building without staff knowledge, and failed to implement corrective action in an attempt to prevent further resident elopement (Refer to F280 and F323).	F 490	be continually updating resident's risk for elopement each week.  Administrator and Executive Director implemented a new wandering program on 10/17/13. Each resident identified as being high risk for wandering/and or elopement are monitored every 15 minutes for safety. A picture and description of each resident is at each nurses' station and front office. Strategically placed these locations are closest to all exit doors. The binders are in alphabetic order of each resident in a purple binder. Training started on Thursday October 17, 2013 and will be complete on Friday October 25, 2013. On Friday October 25, 2013 all Facility staff will be educated on wandering books, new Policy of Residents Leaving the Facility, Sign in/out sheet, New Wandering/Elopement Precautions, Code Green Suggested Elopement Interventions, & Interventions Tools for the Wandering Resident. DON, Compliance Director, Quality	

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423		
(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 490	<p>Continued From page 60</p> <p>In addition, the facility Administration failed to ensure there was an effective system to assess the necessary and safe use of physical restraints for Residents #1, #5, #6, #7, and #8. Resident #1 utilized a lap belt restraint that the resident was able to remove and sustained falls. The facility revised the resident's care plan to tie the physical restraint underneath the wheelchair so the resident could not remove the device, which was not in accordance with the manufacturer's guidelines. Resident #1 then attempted to remove the restraint and slid under the restraint which was contraindications for use per the manufacturer's guidelines; however, the facility failed to assess the resident's risk factors for injury, and Resident #1 continued to utilize the lap belt restraint (Refer to F221 and F280).</p> <p>The facility Administration's failure to ensure residents received adequate supervision and assistive devices to prevent accidents and failure to ensure residents were free from physical restraints placed residents in the facility at risk for serious injury, harm, impairment, or death. The Immediate Jeopardy was determined to exist on 03/15/13 and is ongoing at 42 CFR 483.75 Administration. The facility was notified of the Immediate Jeopardy on 10/17/13 and was informed on 10/17/13 the Immediate Jeopardy was ongoing.</p> <p>The findings include:</p> <p>An interview conducted with the facility Executive Director on 10/17/13 at 3:30 PM revealed the facility administration policy consisted of an Organizational Chart. Additional interview revealed the Executive Director and the Administrator met as needed to discuss incidents</p>	F 490	<p>Assurance/Safety Administrative Assistant, Executive Director, and Human Resources Coordinator are involved in training. All facility staff will be educated on all topics before being allowed to continue employment. Each employee will complete a return demonstration; a hand on approach by going through the facility and finding new books, policy's, interventions that Administration and Quality Assurance has put into place On October 25, 2013. Quality Assurance/Safety Administrative Assistant, Social Service Director, and Quality Assurance Member #7 will be overseeing the wondering program daily. Quality Assurance Member #7 is responsible for staffing the Safety Employee each shift daily. Social Service Director is responsible for monitoring and making any changes to high risk residents; updating assessments each week, updating Resident's picture, and Resident's description in wondering book. Quality Assurance/Safety Administrative</p>		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423		
(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 490	<p>Continued From page 61</p> <p>in the facility and to evaluate the facility systems for improvement.</p> <p>A review of the facility's policy titled "Restraint Policy," not dated, revealed the facility limited the use of restraints to circumstances in which the resident had medical symptoms that warranted the use of restraints, and the resident was to be fully informed of the potential risks and benefits of use of the restraint. Further review of the restraint policy revealed the facility would use a systematic and gradual process toward reducing the restraints. A review of the manufacturer's instructions for the application of the Soft Belt restraint revealed the use of the Soft Belt should be stopped at once if the resident has the tendency to slide forward or down in the device or is able to self-release the device. Further review of the application instructions revealed the resident should be monitored per facility policy to ensure the resident cannot slide down or fall off of the chair and become suspended or entrapped.</p> <p>Observations, interviews, and record reviews completed during the abbreviated survey revealed a soft lap belt restraint was not utilized in accordance with manufacturer's guidelines for Resident #1 when the resident exhibited behaviors of trying to remove/slide under the physical restraint. Further investigation revealed Residents #1, #5, #6, #7, and #8 had no evidence of a medical symptom that required the use of a physical restraint. In addition, the facility failed to evaluate/assess Residents #5, #7 and #8's physical restraint in order to reduce/eliminate the restraint.</p> <p>A review of the facility policy titled "Eloperments," not dated, revealed staff should investigate and</p>	F 490	<p>Assistant is responsible for ensuring all documentation is complete on each shift and that Safety Employee is making rounds. Executive Director, Social Service Coordinator, Quality Assurance/Safety Administration Assistant and Quality Assurance Member #7 are all responsible for validating rounds are being completed throughout the day on all shifts. All information is reported back to the Quality Assurance Committee daily, for oversight.</p> <p>MDS Coordinator completed wandering/elopement risk assessment for all residents on 10/18/13. Residents that were at high risk for wandering/elopement were placed in wandering program. New wandering policy was adapted on 10/21/13 by the Administrator and Executive Director that effective immediately no resident who has been assessed as cognitively impaired through the MDS assessment BIMS scoring process may leave the facility unsupervised</p>		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423		
(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 490	<p>Continued From page 62</p> <p>report all cases of missing residents. The policy did not provide staff with guidance related to what actions to take to prevent further elopements when an elopement occurred.</p> <p>Observations, interviews, and record review completed for residents who were identified by the facility as elopement risk revealed Residents #4, #14, and #15 had exited the building without staff knowledge. There was no evidence the facility conducted thorough investigations to identify causative factors to prevent residents from exiting the building without staff knowledge. The facility failed to evaluate the effectiveness of interventions that were in place for these residents and review/revise the residents' plan of care with interventions to meet the needs of these residents.</p> <p>An interview conducted with the Executive Director (ED) on 10/16/13 at 12:40 PM and on 10/17/13 at 3:30 PM revealed administrative staff had discussed the resident elopement incidents, but failed to evaluate the interventions in place to prevent residents from eloping without staff knowledge, and did not implement any other actions. The ED stated the facility checked to see that the alarm system was functioning properly when the residents eloped, and since the alarms were functioning properly administrative staff felt no other action was needed. Further interview revealed that all incidents were discussed in the weekly safety meeting, which was attended by the Executive Director, and the facility Wanderguard system was not identified as a concern. The ED revealed administrative staff did not consider residents leaving the facility without staff knowledge as an "elopement" because the residents were found on facility</p>	F 490	<p>even though may be their own responsible party. The resident's cognition is the primary consideration for safety and protection of the residents. All resident who leave the facility must sign out. Those assessed as cognitively impaired through the MDS assessment BIMS Scoring must be accompanied with a family or responsible person or there will be considered an elopement. Sign in/out log are located at each nurse's stations. All staff received education to the new policy on 10/21/13 through 10/25/13 by the H/R Coordinator. The social service director will be reviewing the sign in/out log weekdays. The Executive Director directed the Maintenance Director to implement a new coding system for the facility. Code was changed on Sunday October 20, 2013.</p> <p>On Tuesday October 15, 2013, after surveyors brought forward concerns to DON and Executive Director an immediate QA</p>		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185264</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>10/17/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHARLESTON HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>203 BRUCE COURT</b> <b>DANVILLE, KY 40423</b>		
(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 490	Continued From page 63 property. Further interview with the ED revealed administrative staff did not provide any oversight for any aspect of restraint use, and restraint use was determined by the Director of Nursing and Registered Nurse #1.  Interview with the Director of Nursing (DON) on 10/08/13 at 2:55 PM revealed the facility did not attempt physical restraint reductions/eliminations as long as the resident had no negative outcome, for example, no pressure sores. The DON stated she was aware Resident #1 had slid under the restraint and sustained a fall, but did not consider the risks of the resident sliding under the restraint, thus, failed to re-evaluate the continued usage of the restraint.	F 490	meeting was conducted. That meeting resulted in locking all exit doors at all times. Staff were trained that night 10/15/13 on the opening and closing of all exit doors. . In the event of a fire alarm and or power failure, all doors would automatically be unlocked so each exit can be utilized as an emergency exit. Exit will still alarm if resident has secure care monitor in place. On Friday October 25, 2013 Compliance Coordinator will be educating all staff as a continued training on the Secure Care System, and the audio enhancements we have implemented this week. All employees will be successfully educated On Friday October 25, 2013 to continue employment.		
F 520 SS=K	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.  The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.  A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the	F 520	On Wednesday October 16, 2013 Maintenance Director worked on the secure care monitoring system to increase volume of alarm. Power sounder was added to both C Hall doors to increased volume. That device was placed midway on A Hall. Compliance Director and or		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423		
(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 520	<p>Continued From page 64 requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to have an effective quality assessment and assurance program to identify quality deficiencies, and to develop and implement appropriate plans of action to correct identified quality deficiencies. There was no evidence the facility Quality Assurance Committee identified accident hazards and unnecessary restraints as quality concerns in the facility.</p> <p>The facility failed to ensure that utilized physical restraints were necessary to treat a medical symptom for Residents #1, #5, #6, #7, and #8. In addition, the facility failed to ensure restraint reduction and/or elimination attempts were completed for Residents #5, #7, and #8. The facility further failed to ensure a lap belt restraint was utilized in accordance with manufacturer's guidelines for Resident #1. Resident #1 untied/attempted to untie the restraint and attempted to slide under the restraint. According to the manufacturer's warnings, when these behaviors were exhibited restraint use should be discontinued. However, the facility was unaware the manufacturer's warnings existed, failed to identify the risk factors for Resident #1, and failed to reassess the continued usage of the restraint. Interviews with staff revealed restraint use was not part of the facility's Quality Assurance</p>	F 520	<p>designee will check daily with floor staff to ensure all staff can hear alarm and are responding promptly. All volume levels are turned to the loudest position.</p> <p>On Thursday October 17, 2013 Chris Brown Compliance Coordinator began in servicing each employee currently in the facility in every department. The employees were in serviced on the volume of the alarms, employees were instructed that if they can't hear an alarm they are to immediately report to management, and in addition write the problem in the maintenance book for repair. On Friday October 25, 2013 all Facility staff will be educated on wandering books, new Policy of Residents Leaving the Facility, Sign in/out sheet, New Wandering/Elopement Precautions, Suggested Elopement Interventions, Code Green &amp; Interventions Tools for the Wandering Resident. DON, Compliance Director, Quality Assurance/Safety Administrative Assistant, Executive Director, and</p>		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423		
(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 520	<p>Continued From page 65 Program.</p> <p>In addition, the facility was aware Residents #4, #14, and #15 had eloped from the facility without staff knowledge but failed to develop and implement actions to prevent further elopement. The facility failed to identify that the Wanderguard system alarm was not audible throughout the facility, and failed to identify that residents were exiting the facility by pushing on the doors for 30 seconds which released the door lock. (Refer to F221, F280, F323 and F490).</p> <p>The facility's failure to ensure a Quality Assurance Committee was in place, which identified quality concerns in the facility, and implemented action plans to correct the concerns placed residents at risk for serious injury, harm, impairment, or death. The Immediate Jeopardy was determined to exist on 03/15/13 and is ongoing at 42 CFR 483.75 Administration. The facility was notified of the Immediate Jeopardy on 10/17/13 and was informed on 10/17/13 the Immediate Jeopardy was ongoing.</p> <p>The findings include:</p> <p>A review of the facility's policy titled "Quality Assessment and Assurance (QA) Plan," with a revision date of October 2012, revealed the purpose of QA was to provide a means to identify and resolve present and potential negative outcomes related to resident care and safety. Additional review of the policy revealed the QA Coordinator would attend and review minutes of meetings or other committees as needed. According to the policy, the focus of the committee was to monitor areas of resident behavior and facility practices, physical</p>	F 520	<p>Human Resources Coordinator are involved in training. All facility staff will be educated on all topics before being allowed to continue employment. Each employee will complete a return demonstration; a hand on approach by going through the facility and finding new books, policy's, interventions that Administration and Quality Assurance has put into place On October 25, 2013.</p> <p>On October 21, 2013 David Storm and Associates dealer and installer for secure care products performed an Audit of Secure Care monitoring system and auditable devices in the facility. The audit showed the system was installed and working to manufactory specifications. Additional sounders for enhanced auditory were recommended and ordered on 10/21/13. Equipment was overnighted in freight and was delivered to the facility on 10/23/13. Maintenance installed on 10/24/13 to complete to audio enhancement of</p>		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423		
(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 520	<p>Continued From page 66</p> <p>environment, and safety for quality and appropriateness of resident care and any trends in performance and outcomes. In addition, the QA Committee was to help define issues, plan and implement actions, and ensure monitoring and follow-up.</p> <p>Record review revealed Residents #1, #5, #6, #7, and #8 utilized physical restraints. The facility failed to attempt restraint reductions/elimination for Resident #5, #7, and #8, and failed to ensure Residents #1, #5, #6, #7, and #8 had a medical symptom that necessitated the use of a physical restraint. Resident #1 utilized a lap belt restraint that the resident was able to remove. Because the resident was able to remove the restraint, the facility revised the resident's care plan to tie the restraint underneath the wheelchair, which was not in accordance with the manufacturer's guidelines. There was no evidence the facility was aware of the manufacturer's guidelines/warnings and did not identify and reassess Resident #1's risk factors of continuing to remove/attempt to remove the restraint and sliding/attempting to slide underneath the restraint. According to the manufacturer's warnings, the restraint should have been discontinued when this behavior occurred; however, the facility continued to apply the restraint on Resident #1.</p> <p>Residents #4, #14, and #15 were assessed to be an elopement risk and were utilizing a Wanderguard bracelet. Residents #4 and #15 exited out the back door of the facility without staff knowledge. Resident #15 was gone for an undetermined amount of time and was found under a tree approximately 500 feet from where the resident exited the facility. The Wanderguard</p>	F 520	<p>the secure care monitoring system. A loiter feature was programmed to all doors on 10/21/13 by Compliance Officer. Loiter feature is designed to alarm staff when a resident wearing a Wanderguard is approximately 4-5 feet from an exit for 60 consecutive seconds. The alarm will sound so staff can re-direct resident and prevent elopement.</p> <p>Daily monitoring of secure care equipment system is being completed by maintenance department to ensure all equipment is working properly and functioning with no problems. Compliance Director and or designee audit's review inspection daily and reports all information to the Quality Assurance Committee weekly. Immediate action will be taken to address any negative findings. Please see attached audit tool.</p> <p>Daily monitoring of secure care bracelets started on October 25, 2013 and is being recorded by</p>		

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

PRINTED: 10/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/17/2013
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423	
(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 520	<p>Continued From page 67</p> <p>alarm was sounding; however, interviews with staff revealed the alarm was not audible throughout the facility. Further interviews with staff revealed staff was aware that the residents were exiting the facility because the exit doors would open after a resident pushed on the door for 15 seconds (observation of the facility doors revealed the door would open in 30 seconds). Resident #4 exited the facility on one occasion, was gone for an undetermined amount of time, and was located approximately 100 feet from the facility. The resident was found on the ground approximately 50 feet from his/her wheelchair. Resident #14 exited the facility and was found in the parking lot attempting to get into a vehicle.</p> <p>An interview conducted with the Executive Director (ED) on 10/17/13 at 3:30 PM, revealed the ED was the Quality Assurance Coordinator and chaired the QA Committee. Additional interview revealed meetings were conducted weekly and monthly in the facility to review concerns and the full QA Committee met quarterly to review all concerns monitored by QA. According to documentation provided by the facility, the facility tracked the number of elopements but never investigated/trended the elopements, had not identified that the Wanderguard alarm was not audible throughout the facility, or that residents were exiting the facility after pushing on exit doors for 30 seconds. However, the facility's policy stated the QA Committee was to help define issues, plan and implement actions, and ensure monitoring and follow-up. Further interview with the ED revealed the facility had not identified a concern with restraints and restraints were not reviewed as part of the facility's QA program.</p>	F 520	<p>SRNA's in Cerner Software System. On 7-3 and 3-11 shifts wonder guards are being tested to validate proper function. All clinical staff was educated on October 25, 2013 on the new documentation required in the Cerner Software System to document on residents with Wonder guards. All clinical staff was successfully trained on October 25, 2013 before being allowed to continue employment.</p> <p>Under the direction of the Administrator, Arnold Glass was contacted and in the facility on 10/21/13 to help with the assistance of the redesign of the glass doors on B Hall. Redesign started on 10/21/13 and will was finished on 10/23/13. Glass doors were relocated to ensure staff can hear Secure Care System alarm.</p> <p>The facility was in substantial compliance on 11/8/13.</p>	

**F353**

On November 1, 2013 the facility developed a staffing policy that reviewed work assignments of the caregivers. An audit of resident satisfaction was conducted on October 31, 2013. Facility began inservicing all staff on November 5, 2013 all staff will be educated by November 8, 2013. All staff will be in serviced on the new policy and notifying a supervisor if they are unable to complete care timely. All residents have the potential to be effected by the deficient practice please see systemic changes below. Resident #6 is having his needs met.

SRNA was counseled and re-educated on October 10/03/14, 10/04/13 and 11/4/13.

Systemic Changes include Management staff will interview each resident each day Monday thru Friday to assure that their needs are being met. Interview will be

completed with legal Representative if the resident is not interview-able. All information will be submitted to the Quality Assurance Committee daily.

Quality Assurance Committee will discuss weekly to assure that compliance recommendations and follow-up is sustained pertaining to F353.

Under the direction of the Administrator the Consultant assisted with developing a staffing policy and compliance is sustained pertaining to F353. Consultant will continue to work with facility to ensure that recommendations, appropriate follow-up and sustained practices are being met daily.

The facility was in substantial compliance on 11/8/13.

**F490**

On Friday October 18, 2013 Administrator hired a consultant to

immediately help facility put systematic changes in place to enhance facility to use resources effectively and efficiently to attain and maintain the highest well-being for each resident.

On Sunday October 20, 2013 consultant educated Executive Director and Administrator. Education consisted of physical restraints, elopement, required reporting, incidents reports and investigations, & quality assurance and regulatory compliance. Day to day operations were discussed and modified to achieve compliance and promote well-being for all residents.

Consultant reviewed campus property and facility to help Administrator and Executive Director identify additional concerns and help rectify regulatory concerns on 10/20/13. Consultant is overseeing all abatement and regulatory issues, consulting Executive Director and Administrator on a daily basis.

On 10/21/13 Consultant continued education training to Administrator and Executive Director. Consultant helped revise policies, assisted with staff meetings and assignments. Trained Clinical Administrative nursing staff. Consultant provided extensive training with DON pertaining to care plans, reeducation of restraints, and operations.

On 10/20/13 at the request of the Administrator the Consultant began providing monitoring. Consultant will work daily with Administrator to validate monitoring of all new systems and ensure all components are working and immediate jeopardy is removed. Administrator is monitoring to oversee systematic changes with regards but not limited to Secure Care System, Elopement, physical restraints, incidents, and documentation then reports daily to the Quality Assurance Committee.

The facility was in substantial compliance on 11/8/13.

**F520**

On Sunday October 20, 2013 consultant educated Executive Director and Administrator. Education consisted of physical restraints, elopement, required reporting, incidents reports and investigations, & quality assurance and regulatory compliance. Day to day operations were discussed and modified to achieve compliance and promote well-being for all residents.

Consultant reviewed campus property and facility to help Administrator and Executive Director identify additional concerns and help rectify regulatory concerns on 10/20/13. Consultant is overseeing all abatement and regulatory issues, consulting Executive Director and Administrator on a daily basis.

Consultant help restructure Facility Quality Assurance Committee members. Facility has significantly decreased the number of committee members to become more effective. Quality Assurance Committee will be meeting daily to monitor status and evaluate any changes. Quality Assurance training has been conducted by consultant on 10/20-10/21-13 to all new Quality Assurance Committee members. Quality Assurance Committee met on 10/21/13 while consultant was present to validate committee was capable and had knowledge of monitoring by implementing recommendations that the consultant suggested.

Non-Committee members were trained on 10/25/13 using a CQI Assessment tool to help identify continuous quality improvement areas. Paper will be pink in color and at each nurse's station and in all offices for staff convenience.

Quality Assurance  
Committee will continue to monitor but not limited to the following: 15 minute monitoring log, sign in/out sheet, CQI assessment tool, Risk records audit, wander guard system, wandering risk/elopement risk assessment, review of clinical documentation, new policy's pertain to elopement when residents leave the facility, wandering elopement precautions, elopement interventions, wandering book, immediate intervention tools for the wandering resident, physical restraints, physical restraint assessments, physical restraint QA tool, restraint reduction on a daily basis. Quality Assurance will immediately address any negative findings. Quality Assurance will re-train, order more audits, and modify as needed to validate any regulatory concerns.

The facility was in substantial compliance on 11/8/13.

F353

Resident #6 was immediately toileted, provided proper peri care, and clothes were changes. Additional Resident #6's wheelchair was sanitized. Resident #6 is having his needs met. Resident #6 is being interviewed by a member of the quality assurance committee members. The members ask each resident Monday through Friday questions to monitor and identify things the facility can do to improve continue quality improvement. The questions also identify if staff treats the resident with dignity, if the resident is having problems the staff can address to improve quality of care. All information is reported daily to the quality assurance committee; quality assurance members are educated rectifying any negative findings immediately.

The facility acknowledges that all residents have the potential to be effected by the deficient practice.

To ensure compliance is achieved facility continues to interview all residents conducted by quality assurance committee members. The members ask each resident daily Monday through Friday questions to identify things the facility can do to improve continue quality improvement. The questions also identify if staff treats the resident with dignity, if the resident is having problems the staff can address to improve quality of care. All information is reported daily to the quality assurance committee; quality assurance members are educated rectifying any negative findings immediately. In addition quality assurance members make rounds to ensure sufficient nursing staff is achieved each day to continually ensure the facility is maintaining physical, mental, and psychosocial well-being for each resident as determined by resident assessment and the comprehensive care plan. Examples of observations include but are not limited to ensuring staff is responding to residents promptly,

call bells are being answered timely, resident are well kept, resident are toileted in a timely manner, residents needs are being met while in the dining room, alarms are being answered, door alarms are responded to immediately.

On November 1, 2013 the facility developed a staffing policy that reviewed work assignments of the caregivers. Additional clinical staff were assigned and utilized to ensure residents were receiving care and needs were being met while in the dining room at meal times.

An audit of resident satisfaction was conducted on October 31, 2013. The audit is ongoing and conducted by quality assurance committee members. The members ask each resident Monday through Friday questions to identify things the facility can do to improve continue quality improvement. The

questions also identify if staff treats the resident with dignity, if the resident is having problems the staff can address to improve quality of care. All information is reported daily to the quality assurance committee; quality assurance members are educated rectifying any negative findings immediately.

Facility began in- servicing all staff on November 5, 2013 by Executive Director all staff was educated on November 8, 2013. All staff was in serviced on the new policy staffing policy, notifying a supervisor if they are unable to complete care timely, continued education on neglect, dignity, communication and quality assurance program were also discussed. All employees successfully completed a quiz to confirm knowledge of covered topics during in service education. Education was led by Administrator, Executive Director, and Compliance Coordinator.

SRNA was counseled and re-educated on October 10/03/14, 10/04/13 and 11/4/13.

Systemic Changes include Quality assurance committee members. The members ask each resident Monday through Friday questions to identify things the facility can do to improve continue quality improvement. The questions also identify if staff treats the resident with dignity, if the resident is having problems the staff can address to improve quality of care. All information is reported daily to the quality assurance committee; quality assurance members are educated rectifying any negative findings immediately. Quality assurance committee members interview each resident Monday through Friday questions to identify things the facility can do to improve continue quality improvement. The questions also identify if staff treats the resident with dignity, if the resident is having problems the staff can address to improve quality of

care. All information is reported daily to the quality assurance committee; quality assurance members are educated rectifying any negative findings immediately.

Quality Assurance Committee will discuss daily to assure that compliance recommendations and follow-up is sustained pertaining to F353.

Under the direction of the Administrator the Consultant assisted with developing a staffing policy and compliance is sustained pertaining to F353. Consultant will continue to work and monitor facility to ensure that recommendations, appropriate follow-up and sustained practices are being met daily.

The facility was in substantial compliance on 11/8/13.

**F490**

On Friday October 18, 2013 Administrator hired a consultant to

immediately help facility put systematic changes in place to enhance facility to use resources effectively and efficiently to attain and maintain the highest well-being for each resident.

On Sunday October 20, 2013 consultant educated Executive Director and Administrator. Education consisted of physical restraints, elopement, required reporting, incidents reports and investigations, & quality assurance and regulatory compliance. Day to day operations were discussed and modified to achieve compliance and promote well-being for all residents.

Consultant reviewed campus property and facility to help Administrator and Executive Director identify additional concerns and help rectify regulatory concerns on 10/20/13. Consultant is overseeing all abatement and regulatory issues, consulting Executive Director and Administrator on a daily basis.

On 10/21/13 Consultant continued education training to Administrator and Executive Director. Consultant helped revise policies, assisted with staff meetings and assignments. Trained Clinical Administrative nursing staff. Consultant provided extensive training with DON pertaining to care plans, reeducation of restraints, and operations.

On 10/20/13 at the request of the Administrator the Consultant began providing monitoring. Consultant will work daily with Administrator to validate monitoring of all new systems and ensure all components are working and immediate jeopardy is removed. Administrator is monitoring to oversee systematic changes with regards but not limited to Secure Care System, Elopement, physical restraints, incidents, and documentation then reports daily to the Quality Assurance Committee.

Resident #1. The care plan and SRNA care plan was revised on October 23, 2013 by the MDS coordinator to include cushion in wheelchair, sensor pad in wheelchair, and the termination of the physical restraint. Resident was evaluated from rehab for wheelchair position and safety.

Resident #2. The SRNA that assisted with care the night of the incident was terminated on September 20, 2013. The care plan and SRNA care plan has been updated by MDS Coordinator on October 23, 2013. Resident is working with therapy.

Resident #4. MDS coordinator updated the care plan and SRNA care plan on October 23, 2013 to address high risk for elopement. Continued use of wander guard ankle bracelet is ongoing. Interventions including wander book identification were implemented to protect resident identified as high risk from exiting the facility

unsupervised. The revision was a result in wandering/elopement assessments completed by MDS coordinator on 10/18/13 to identify if the resident was a risk for elopement, the resident scored a 14 and is a high risk. Safety employee checks resident for placement and safety in facility every 15 minutes started on Thursday October 17, 2013 and is ongoing. Interventions and diversions are listed in the front of each wandering book and all employees are educated on October 25, 2013. Social Service director will be continually updating resident's risk for elopement each week.

Resident #14 MDS coordinator updated the care plan and SRNA care plan on October 23, 2013 to address high risk for elopement. Continued use of wander guard ankle bracelet is ongoing. Interventions including wander book identification were implemented to protect resident identified as high risk from exiting the facility unsupervised. The revision was a

result in wandering/elopement assessments completed by MDS coordinator on 10/18/13 to identify if the resident was a risk for elopement, the resident scored a 15 and is a high risk. Safety employee checks resident for placement and safety in facility every 15 minutes started on Thursday October 17, 2013 and is ongoing. Interventions and diversions are listed in the front of each wandering book and all employees are educated on October 25, 2013. Social Service director will be continually updating resident's risk for elopement each week.

Resident #15 MDS coordinator updated the care plan and SRNA care plan on October 23, 2013 to address high risk for elopement. Continued use of wander guard ankle bracelet is ongoing. Interventions including wander book identification were implemented to protect resident identified as high risk from exiting the facility unsupervised. The revision was a result in wandering/elopement

assessments completed by MDS coordinator on 10/18/13 to identify if the resident was a risk for elopement, the resident scored a 13 and is a high risk. Safety employee checks resident for placement and safety in facility every 15 minutes started on Thursday October 17, 2013 and is ongoing. Interventions and diversions are listed in the front of each wandering book and all employees are educated on October 25, 2013. Social Service director will be continually updating resident's risk for elopement each week.

Administrator and Executive Director implemented a new wandering program on 10/17/13. Each resident identified as being high risk for wandering/and or elopement are monitored every 15 minutes for safety. A picture and description of each resident is at each nurses' station and front office. Strategically placed these locations are closest to all exit doors. The binders are in alphabetic order of each resident in a purple binder.

Training started on Thursday October 17, 2013 and was completed on Friday October 25, 2013. On Friday October 25, 2013 all Facility staff will be educated on wandering books, new Policy of Residents Leaving the Facility, Sign in/out sheet, New Wandering/Elopement Precautions, Code Green Suggested Elopement Interventions, & Interventions Tools for the Wandering Resident. DON, Compliance Director, Quality Assurance/Safety Administrative Assistant, Executive Director, and Human Resources Coordinator are involved in training. All facility staff will be educated on all topics before being allowed to continue employment. Each employee successfully completed a return demonstration; a hand on approach by going through the facility and finding new books, policy's, interventions that Administration and Quality Assurance has put into place On October 25, 2013. Quality Assurance/Safety Administrative Assistant, Social Service Director,

and Quality Assurance Member #7 will be overseeing the wondering program daily. Quality Assurance Member #7 is responsible for staffing the Safety Employee each shift daily. MDS Coordinator is responsible for monitoring and making any changes to high risk residents; updating assessments each week. Quality Assurance Committee Member #7 and Social Services Director are responsible for updating Resident's picture, and Resident's description in wondering book. Quality Assurance/Safety Administrative Assistant is responsible for ensuring all documentation is complete on each shift and that Safety Employee is making rounds. Executive Director, Social Service Coordinator, Quality Assurance/Safety Administration Assistant and Quality Assurance Member #7 are all responsible for validating rounds are being completed throughout the day on all shifts. All information is reported back to the Quality Assurance Committee daily, for oversight.

MDS Coordinator completed wandering/elopement risk assessment for all residents on 10/18/13. Residents that were at high risk for wandering/elopement were placed in wandering program. New wandering policy was adapted on 10/21/13 by the Administrator and Executive Director that effective immediately no resident who has been assessed as cognitively impaired through the MDS assessment BIMS scoring process may leave the facility unsupervised even though may be their own responsible party. The resident's cognition is the primary consideration for safety and protection of the residents. All resident who leave the facility must sign out. Those assessed as cognitively impaired through the MDS assessment BIMS Scoring must be accompanied with a family or responsible person or there will be considered an elopement. Sign in/out log are located at each nurse's stations. All staff received education to the new policy on 10/21/13

through 10/25/13 by the H/R Coordinator. The social service director will be reviewing the sign in/out log weekdays. The Executive Director directed the Maintenance Director to implement a new coding system for the facility. Code was changed on Sunday October 20, 2013.

On Tuesday October 15, 2013, after surveyors brought forward concerns to DON and Executive Director an immediate QA meeting was conducted. That meeting resulted in locking all exit doors at all times. Staff were trained that night 10/15/13 on the opening and closing of all exit doors. . In the event of a fire alarm and or power failure, all doors would automatically be unlocked so each exit can be utilized as an emergency exit. Exit will still alarm if resident has secure care monitor in place. On Friday October 25, 2013 Compliance Coordinator will be educating all staff as a continued training on the Secure Care System, and the audio

enhancements we have implemented this week. All employees will be successfully educated On Friday October 25, 2013 to continue employment.

On Wednesday October 16, 2013 Maintenance Director worked on the secure care monitoring system to increase volume of alarm. Power sounder was added to both C Hall doors to increased volume. That device was placed midway on A Hall. Compliance Director and or designee will check daily with floor staff to ensure all staff can hear alarm and are responding promptly. All volume levels are turned to the loudest position.

On Thursday October 17, 2013 Chris Brown Compliance Coordinator began in servicing each employee currently in the facility in every department. The employees were in serviced on the volume of the alarms, employees were instructed that if they can't hear an alarm they are to immediately report

to management, and in addition write the problem in the maintenance book for repair. On Friday October 25, 2013 all Facility staff will be educated on wandering books, new Policy of Residents Leaving the Facility, Sign in/out sheet, New Wandering/Elopement Precautions, Suggested Elopement Interventions, Code Green & Interventions Tools for the Wandering Resident. DON, Compliance Director, Quality Assurance/Safety Administrative Assistant, Executive Director, and Human Resources Coordinator are involved in training. All facility staff will be educated on all topics before being allowed to continue employment. Each employee will complete a return demonstration; a hand on approach by going through the facility and finding new books, policy's, interventions that Administration and Quality Assurance has put into place On October 25, 2013.

On October 21, 2013 David Storm and Associates dealer and

installer for secure care products performed an Audit of Secure Care monitoring system and auditable devices in the facility. The audit showed the system was installed and working to manufactory specifications. Additional sounders for enhanced auditory were recommended and ordered on 10/21/13. Equipment was overnighted in freight and was delivered to the facility on 10/23/13. Maintenance installed on 10/24/13 to complete to audio enhancement of the secure care monitoring system. A loiter feature was programmed to all doors on 10/21/13 by Compliance Officer. Loiter feature is designed to alarm staff when a resident wearing a Wanderguard is approximately 4-5 feet from an exit for 60 consecutive seconds. The alarm will sound so staff can re-direct resident and prevent elopement.

Daily monitoring of secure care equipment system is being completed by maintenance

department to ensure all equipment is working properly and functioning with no problems. Compliance Director and or designee audit's review inspection daily and reports all information to the Quality Assurance Committee weekly. Immediate action will be taken to address any negative findings. Please see attached audit tool.

Daily monitoring of secure care bracelets started on October 25, 2013 and is being recorded by SRNA's in Cerner Software System. On 7-3 and 3-11 shifts wonder guards are being tested to validate proper function. All clinical staff was educated on October 25, 2013 on the new documentation required in the Cerner Software System to document on residents with Wonder guards. All clinical staff was successfully trained on October 25, 2013 before being allowed to continue employment.

Under the direction of the Administrator, Arnold Glass was

contacted and in the facility on 10/21/13 to help with the assistance of the redesign of the glass doors on B Hall. Redesign started on 10/21/13 and will was finished on 10/23/13. Glass doors were relocated to ensure staff can hear Secure Care System alarm.

On Friday October 25, 2013 all Facility staff was educated on wandering books, new Policy of Residents Leaving the Facility, Sign in/out sheet, New Wandering/Elopement Precautions, Suggested Elopement Interventions, Code Green & Interventions Tools for the Wandering Resident. DON, Compliance Director, Quality Assurance/Safety Administrative Assistant, Executive Director, and Human Resources Coordinator are involved in training. All facility staff will be educated on all topics before being allowed to continue employment. Each employee will complete a return demonstration; a hand on approach by going through the facility and finding new books,

policy's, interventions that Administration and Quality Assurance has put into place On October 25, 2013.

On Monday October 21, 2013 consultant Olive Allen trained and educated DON, Cooperate RN, MDS Coordinator, MDS Nurse, and Administrative LPN on care plans. Ms. Allen educated staff pertaining to F280. Consultant educated on developing and completion of care plans and SRNA care plans as well as examples of revision of all care plans and SRNA care plans to ensure revisions are made when a change occurs in a resident.

On Monday October 21, 2013 Administrator and Executive Director, directed DON, Corporate RN, MDS Coordinator, MDS Nurse and Administrative LPN for a complete review on every care plan, MDS, and SRNA care plan for each resident. All revisions are to be completed by Friday October 25, 2013. The audit is being led by

MDS Coordinator and assisted by Administrative LPN. Final audit will be reviewed by Cooperate RN and DON. Audit is overseen by Administrator and Executive Director.

On Tuesday October 22, 2013 Administrator and Executive Director directed weekly revisions of care plans and SRNA care plans pertaining to physical restraints, falls, and elopement. Care plans and SRNA care plans will be completed on a daily basis and reviewed each week by MDS Coordinator and or designee. Administrator and Executive will oversee to ensure compliance is achieved each week.

IPOC (interdisciplinary plan of care) meeting will be held each weekday morning with Administrator, Executive Director, Social Service Director, Rehab Coordinator, MDS Coordinator, Administrative LPN, Dietary Director, Activity Coordinator, Director of Nursing to review

intervention from prior day. The DON (Director of Nursing) will start the meeting with review of the 24 hour report from the previous day and any new physician orders including changes in DNR status, new occurrences including falls any action related to wandering that have occurred the team discusses pertinent issues and reviews the MDS Coordinator revises the care plan and SRNA care plan at that time if needed.

The Administrative LPN audits the records of newly admitted resident to validate that their care plan addresses fall risk, elopement risk, and physical restraints. The DON reviews these audits to verify care plan revisions and development are completed. MD Coordinators complete care plan revisions daily per the information obtained from the physician orders, and 24 hour nursing report to other occurrences addressed during the IPOC meeting. On a daily basis the Administrative LPN audits resident care plans to

validate that these updates are completed. Please see attached audit form. All information will be submitted to the Quality Assurance Committee daily.

The facility was in substantial compliance on 11/8/13.

**F520**

On Friday October 4, 2013 Resident #1's physical restraint was discontinued due to resident sliding under the device which presents a safety concern. Resident was assessed by Rehab Department on October 4, 2013 for wheelchair management, positioning and safety. On October 8, 2013 rehab applied an anti-thrust cushion to resident's wheelchair and the MDS, Comprehensive Care Plan (CCC) and SRNA Care Plan were reviewed and revised by the MDS Coordinator and reviewed by the Director of Nursing. Effective October 8, 2013 Resident #1 received a physician order to discontinue the use of a physical restraint.

Resident #5. On October 10, 2013, Rehab department screened resident for occupational therapy to evaluate and assess safety with current wheel chair positioning system. On October 16 and October 23 Assistant Medical Director made rounds checking to validate if restraint was applied properly, if the resident showed distress, if there was any skin irritation due to the use of the physical restraint, and if the restraint was being released properly for Resident #5. Physical restraint assessment was completed on 10-08-13 for Resident #5. On October 7 Social Service and Activity Directors assessed Resident #5 assessment included how they could continue to help reduce the physical restraint, and ensure the facility was providing meaningful activities to benefit Resident #5. Restorative Program was evaluated on October 8, 2013 for Resident #5. On October 9, 2013 MDS Coordinator audited the MDS to validate documentation. On October 23, 2013 every 15 minute checks were conducted to validate

the resident's safety. On October 22 Resident #5's restraint reduction was updated. On October 23, 2013 the Resident #5's physical restraint was discontinued per doctor's order Sensor Pad was added to Resident #5 wheelchair. On October 23, Resident #5 CCC was revised and on October 25, 2013 Resident #5's SRNA Care Plan was revised.

Resident #6. On October 8, 2013 MDS Coordinator completed a physical restraint assessment to validate the use of the physical restraint. On October 9, 2013 MDS Coordinator audited the MDS. On October 11, 2013 Rehab department screened resident for physical therapy to observe resident's seating system while in wheelchair to identify any interventions. On October 14, 2013 physical restraint was discontinued per doctor's order due to the resident being able to remove the physical restraint. On October 22, 2013 the SRNA Care Plans were updated for Resident #6 by MDS Coordinator. On October

22, 2013 the CCC plan was revised and updated by MDS Coordinator.

Resident #7. On October 4, 2013 Occupational therapy began wheelchair management on Resident #7 to assess current seating system and identify appropriate modifications. Trials with pommel cushion to decrease risk for falls and increase sitting posture were started. On October 7, 2013 Social Service and Activity Directors assessed Resident #7 with how they could continue to help reduce the physical restraint, and ensure the facility was providing meaningful activities to benefit Resident #7. On October 8, 2013 MDS Coordinator completed a physical restraint assessment to validate the physical restraint. Restorative Program was evaluated on October 8, 2013 for Resident #7. On October 9, 2013 MDS Coordinator audited MDS to validate clinical information. On October 16, 2013 Assistant Medical Director assessed resident #7 to identify if the restraint was properly applied, if the

resident had any signs or system of distress due to the physical restraint, if there was any skin irritation due to the physical restraint, if the physical restraint was being released properly, and if the restraint was the least restrictive at that time. On October 21, MDS Coordinator updated physical restraint assessment. On October 21, 2013 SRNA Care Plan was updated. On October 23, 2013 Resident #7 CCC was updated. On October 21, 2013 per physician order physical restraint was discontinued on Resident #7.

Resident #8. On October 8, 2013 MDS Coordinator completed a physical restraint assessment to validate the use of the physical restraint. On October 8, 2013 Social Service reviewed resident #8 to identify how to help with the decrease of the physical restraint. On October 7, 2013 Activity Coordinator reviewed resident to ensure the facility was providing meaningful activities to benefit Resident #8. On October 8, 2013

Restorative addressed current plan and made any changes to help reduce the use of physical restraint. On October 9, 2013 MDS Coordinator audit the MDS. On October 10, 2013 Occupational therapy addressed wheel chair positioning under the direction of the Administrator. Resident was already on current caseload. On October 16, 2013 Assistant Medical Director evaluated resident to ensure properly placed, checked resident to identify any sign of distress, skin irritation due to the physical restraint, checking that the restraint is being released properly, and that the restraint is the least restrictive at the present time. On October 21, 2013 SRNA Care Plan was update by MDS Coordinator. On October 22, 2013 physical restraint assessment was updated by MDS Coordinator. On October 23, 2013 every 15 minute safety checks were completed on Resident #8. On October 24, 2013 Resident #8 CCC was revised by MDS Coordinator. On October 25, 2013 Physical restraint assessment

was updated. On October 25, 2013 per physician order physical restraint was discontinued sensor pad added to wheelchair, and one hour safety checks.

To identify other residents that may have the potential to be affected by the same deficient practice the facility conducted a Physical Restraint Assessment that was completed on 10/8/13 by Administrative LPN to determine the need for a physical restraint on the remaining Residents with physical restraints. The Physical Restraint Assessment will help to determine the continued need on all residents who already have physical restraints a weekly Restraint Assessment will continue as part of the facility Quality Assurance Program. All Restraint Assessments are submitted to the Restraint Committee that meets every day Monday through Friday. The Restraint Committee reports the results of all physical Restraint Assessments to the Quality Assurance Committee each week.

Each Resident's MDS, Comprehensive Care Plan and SRNA Care plan is promptly updated to reflect any changes dictated by the Restraint Assessment for each resident. On October 4-8, 2013, Administrative LPN conducted a Restraint Assessment for each Resident with a current physician order for a physical restraint. Each Restraint Assessment included review of the Resident's CCC related to use of physical restraint. The reviews validated that medical symptoms were present to support the use of a physical restraint, to validate that the existing restraint is the least restrictive restraint in use for the least amount of time and to validate whether the resident's environment or activities can be modified to reduce reliance on the restraint.

On October 4, 2013, the Facility's Director of Rehabilitation, Physical Therapist and Occupational Therapist, assessed all Residents with physical restraints to determine

if a lesser restraint reduction is appropriate. The therapists also reviewed whether current physical restraints could be updated or modified to better ensure the Resident's comfort and safety. The therapists also evaluated each Resident's environment to determine whether changes were appropriate.

On October 7, 2013 the Facility's Assistant Medical Director audited the Restraint Assessment, for each Resident using a physical restraint. Each audit of Restraint Assessment included review of the Residents CCC related to use of physical restraint to validate that medical symptoms were present to support the use of a physical restraint, to validate that the existing restraint is the least restrictive restraint in use for the least amount of time and to validate whether the resident's environment or activities can be modified to reduce reliance on the restraint. Assistant Medical Director validated all use of current physical restraints on October 7,

2013. Assistant Medical Director will continue to audit each Resident with a physical restraint each week until all physical restraints are discontinued.

On October 7, 2013, the Facility's social service director and recreational coordinator assessed each Resident who uses a physical restraint to ensure personal preferences were updated and that the Facility is providing meaningful activities to each resident who uses a physical restraint.

On October 8, 2013, Administrative, LPN, audited restorative care plans in cooperation with the Rehab Director, Physical Therapist, and Occupational Therapist for each resident using a physical restraint to ensure the Facility is providing restorative care to enhance Resident abilities to stand, transfer, and walk safely in attempt to decrease physical restraints.

On October 9, 2013, Posey Company Representative conducted in-person training for all clinical staff regarding restraint programs, application and instruction for each Posey product in use at the Facility, as well as restraint reduction programs. The video of this presentation will be used in training for all new hires and annual training and review purposes. All clinical staff attended in-service training on October 9, 2013. Training required each clinical employee to demonstrate the correct application for each physical restraint currently used in the Facility. Posey Company Representative, Quality Assurance and Safety Administrative Assistant, and Compliance Director monitored training on the correct application of physical restraint. On October 7, 2013, instructions for the appropriate application of each Posey brand physical restraint in use were posted at each nurse's station and in the SRNA book.

Quality Assurance and Safety Administrative Assistant educated all non-clinical laundry housekeeping and dietary to include all employees are trained on application and position of physical restraints starting on 10/22/13; all non-clinical staff will be completely educated by 10/25/13. This education will ensure that all employees facility wide were educated on the proper application and positioning of all physical restraints. This will be used to continually monitor residents with physical restraints to ensure the Facility is using a systemic team approach to identify sliding, falling, or attempts of removal of the physical restraint. Non-clinical staff members are educated to communicate with charge nurses to provide communication assistance.

On October 7, 2013, the Facility reviewed and updated policies and procedures regarding the safe and effective use of physical restraints. The updated policy

clearly provides that physical restraint may not be used unless for the safety and well-being of the Patient and only after other alternatives have been evaluated.

Following the Incident, the Facility increased physical restraint monitoring to ensure the safety of Residents using physical restraints.

On October 11, 2013, all clinical staff participated in training given by MDS Coordinator and Compliance Director on the new QA monitor tool for Resident's using physical restraints to ensure the restraints are applied safely and effectively and to identify any potential accidents before they occur. The Facility established this new Quality Assessment Tool on 10/11/13. Charge Nurses' will now document using required QA monitoring tool each shift for each resident with a physical restraint. All clinical staff was successful trained on 10/11/13 on the new QA monitoring tool for physical

restraints. The Quality Assessment Tool requires charge nurses to observe whether the physical restraint is properly applied, confirm whether the restraint is being released and removed on schedule and confirm whether there is documentation of appropriate toileting. The tool will be reviewed each day by the Administrator and Executive Director. All information will also be submitted to the Quality Assurance Committee each day.

On October 15, 2013, the Facility's charge nurses began monitoring each resident that uses a physical restraint every two hours. Charge nurses document restraint monitoring in Point Click Care under Restraint Note. Nurses will be monitoring to identify if the restraint is in use, if restraint is applied correctly, if resident has any discomfort due to the application of the physical restraint. If any negative findings are discovered then charge nurses are to immediately call physician. A new assessment and

revision to CCC, and SRNA Care Plan would follow. All nurses' were educated on physical restraints safety checks every two hours successfully on October 15, 2013. Compliance Director and Executive Director are monitoring nurses that complete safety checks every two hours with residents who have physical restraints daily on all shifts. The Restraint Note is part of the Residents clinical record. Compliance Director and Executive Director report all findings to Quality Assurance Committee daily.

Charge nurses that encounter an incident involving the safety or security of a resident using physical restraints, including that a restraint is improperly applied, are required to secure the resident's safety of the resident and immediately report the incident to the Primary Care Physician, Nurse on Call and the Executive Director. Upon identifying the improper application of restraints, the charge nurse or superior will immediately remove

applicable personnel from the floor and require reeducation before returning staff to resident care. The Nurse on Call and Executive Director are available to respond to restraint incident reports 24 hours per day, seven days per week. All information will be reported to the Quality Assurance Committee daily. Quality Assurance Committee will provide oversight.

On Monday October 21, 2013 Director of Nursing began visually monitoring and overseeing all clinical nursing staff including SRNA's, KMA's, LPN's, and RN's on their performance of physical restraint application documentation can be found on DON restraint tool (please see attached). DON continues to check each resident Monday thru Friday on 7-3 shift and 3-11 during **Monday through Friday DON is checking 7-3 shift once daily, and 3-11 once daily each** shifts to ensure that each resident is positioned properly, restraint is applied properly, and

resident is not showing signs of discomfort due to the use of the restraint. DON will continue this process until all physical restraints are successfully removed. Any negative findings will immediately be addressed. Staff will be retrained before continuing care. Information will be submitted to the Restraint Committee and the Quality Assurance Committee each day.

Effective 10/11/13  
MDS Coordinator will be re-accessing each physical restraint assessment after each incident, or change in condition. Assessments will be completed prior to any changes made to the resident's physical restraint. Rose McKenzie will additionally update the care plan and or MDS if needed accordingly. Rehab team Activity, Rehab, Social Services, Dietary, & MDS will all be notified by DON and or Executive Director that re-assessment is necessary after each incident. After the re-assessment process is complete; Restraint Committee will

discuss re-assessment findings and options for the resident finally getting physician approval.

On Monday October 21, 2013 Ms. Olive Allen, L.N.H.A consultant educated the Executive Director, Administrator, administrative nurses, MDS Coordinator, DON, LPN's and RN's on care plans, assessments and MDS'. Ms. Allen advised clinical administrative staff on physical restraints & regulatory requirements.

On Monday, October 7, 2013, the Facility established a Restraint Committee consisting of the DON, MDS Coordinator, Director of Rehab and Executive Director. The Restraint Committee will meet daily, Monday through Friday to evaluate the safe and effective use of physical restraints at the Facility. The Restraint Committee will report all findings to the Facility Administrator and Quality Assurance Committee.

The facility was completely restraint free On October 25, 2013. No physical restraints were in use for any resident.

Care Plan and SRNA Care Plan for resident #1 was revised on October 23, 2013 by MDS Coordinator. The updated care plans address addresses the risk for falls. The physical restraint has been removed. Restorative & activity plans were also updated on October 23, 2013.

Resident #2. MDS coordinator updated the care plan, and SRNA care plan on October 23, 2013. The new plan of care defines the resident to be a transfer of two with care.

Resident #4. MDS coordinator updated the care plan and SRNA care plan on October 23, 2013 to address high risk for elopement. Continued use of wander guard ankle bracelet is ongoing. Interventions including wander book identification were implemented to

protect resident identified as high risk from exiting the facility unsupervised. The revision was a result in wandering/elopement assessments completed by MDS coordinator on 10/18/13 to identify if the resident was a risk for elopement, the resident scored a 14 and is a high risk. Safety employee checks resident for placement and safety in facility every 15 minutes started on Thursday October 17, 2013 and is ongoing. Interventions and diversions are listed in the front of each wandering book and all employees are educated on October 25, 2013. Social Service director will be continually updating resident's risk for elopement each week.

Resident #14 MDS coordinator updated the care plan and SRNA care plan on October 23, 2013 to address high risk for elopement. Continued use of wander guard ankle bracelet is ongoing. Interventions including wander book identification were implemented to protect resident identified as high

risk from exiting the facility unsupervised. The revision was a result in wandering/elopement assessments completed by MDS coordinator on 10/18/13 to identify if the resident was a risk for elopement, the resident scored a 15 and is a high risk. Safety employee checks resident for placement and safety in facility every 15 minutes started on Thursday October 17, 2013 and is ongoing. Interventions and diversions are listed in the front of each wandering book and all employees are educated on October 25, 2013. Social Service director will be continually updating resident's risk for elopement each week.

Resident #15 MDS coordinator updated the care plan and SRNA care plan on October 23, 2013 to address high risk for elopement. Continued use of wander guard ankle bracelet is ongoing. Interventions including wander book identification were implemented to protect resident identified as high risk from exiting the facility

unsupervised. The revision was a result in wandering/elopement assessments completed by MDS coordinator on 10/18/13 to identify if the resident was a risk for elopement, the resident scored a 13 and is a high risk. Safety employee checks resident for placement and safety in facility every 15 minutes started on Thursday October 17, 2013 and is ongoing. Interventions and diversions are listed in the front of each wandering book and all employees are educated on October 25, 2013. Social Service director will be continually updating resident's risk for elopement each week.

On Friday October 25, 2013 all Facility staff was educated on wandering books, new Policy of Residents Leaving the Facility, Sign in/out sheet, New Wandering/Elopement Precautions, Suggested Elopement Interventions, Code Green & Interventions Tools for the Wandering Resident. DON, Compliance Director, Quality Assurance/Safety Administrative

Assistant, Executive Director, and Human Resources Coordinator are involved in training. All facility staff will be educated on all topics before being allowed to continue employment. Each employee will complete a return demonstration; a hand on approach by going through the facility and finding new books, policy's, interventions that Administration and Quality Assurance has put into place On October 25, 2013.

On Monday October 21, 2013 consultant Olive Allen trained and educated DON, Cooperate RN, MDS Coordinator, MDS Nurse, and Administrative LPN on care plans. Ms. Allen educated staff pertaining to F280. Consultant educated on developing and completion of care plans and SRNA care plans as well as examples of revision of all care plans and SRNA care plans to ensure revisions are made when a change occurs in a resident.

On Monday October 21, 2013 Administrator and Executive Director, directed DON, Corporate RN, MDS Coordinator, MDS Nurse and Administrative LPN for a complete review on every care plan, MDS, and SRNA care plan for each resident. All revisions are to be completed by Friday October 25, 2013. The audit is being led by MDS Coordinator and assisted by Administrative LPN. Final audit will be reviewed by Cooperate RN and DON. Audit is overseen by Administrator and Executive Director.

On Tuesday October 22, 2013 Administrator and Executive Director directed weekly revisions of care plans and SRNA care plans pertaining to physical restraints, falls, and elopement. Care plans and SRNA care plans will be completed on a daily basis and reviewed each week by MDS Coordinator and or designee. Administrator and Executive will oversee to ensure compliance is achieved each week.

IPOC (interdisciplinary plan of care) meeting will be held each weekday morning with Administrator, Executive Director, Social Service Director, Rehab Coordinator, MDS Coordinator, Administrative LPN, Dietary Director, Activity Coordinator, Director of Nursing to review intervention from prior day. The DON (Director of Nursing) will start the meeting with review of the 24 hour report from the previous day and any new physician orders including changes in DNR status, new occurrences including falls any action related to wandering that have occurred the team discusses pertinent issues and reviews the MDS Coordinator revises the care plan and SRNA care plan at that time if needed.

The Administrative LPN audits the records of newly admitted resident to validate that their care plan addresses fall risk, elopement risk, and physical restraints. The DON reviews these audits to verify

care plan revisions and development are completed. MD Coordinators complete care plan revisions daily per the information obtained from the physician orders, and 24 hour nursing report to other occurrences addressed during the IPOC meeting. On a daily basis the Administrative LPN audits resident care plans to validate that these updates are completed. Please see attached audit form. All information will be submitted to the Quality Assurance Committee daily.

On Sunday October 20, 2013 consultant educated Executive Director and Administrator. Education consisted of physical restraints, elopement, required reporting, incidents reports and investigations, & quality assurance and regulatory compliance. Day to day operations were discussed and modified to achieve compliance and promote well-being for all residents.

Consultant reviewed campus property and facility to help

Administrator and Executive Director identify additional concerns and help rectify regulatory concerns on 10/20/13. Consultant is overseeing all abatement and regulatory issues, consulting Executive Director and Administrator on a daily basis.

Consultant help restructure Facility Quality Assurance Committee members. Facility has significantly decreased the number of committee members to become more effective. Quality Assurance Committee will be meeting daily to monitor status and evaluate any changes. Quality Assurance training has been conducted by consultant on 10/20-10/21-13 to all new Quality Assurance Committee members. Quality Assurance Committee met on 10/21/13 while consultant was present to validate committee was capable and had knowledge of monitoring by implementing recommendations that the consultant suggested.

Non-Committee members were trained on 10/25/13 using a CQI Assessment tool to help identify continuous quality improvement areas. Paper will be pink in color and at each nurse's station and in all offices for staff convenience.

Quality Assurance Committee will continue to monitor but not limited to the following: 15 minute monitoring log, sign in/out sheet, CQI assessment tool, Risk records audit, wander guard system, wandering risk/elopement risk assessment, review of clinical documentation, new policy's pertain to elopement when residents leave the facility, wandering elopement precautions, elopement interventions, wandering book, immediate intervention tools for the wandering resident, physical restraints, physical restraint assessments, physical restraint QA tool, restraint reduction on a daily basis. Quality Assurance will immediately address any negative findings. Quality Assurance will re-train, order more

audits, and modify as needed to validate any regulatory concerns.

On Friday October 25, 2013 all Facility staff was educated on wandering books, new Policy of Residents Leaving the Facility, Sign in/out sheet, New Wandering/Elopement Precautions, Suggested Elopement Interventions, Code Green & Interventions Tools for the Wandering Resident. DON, Compliance Director, Quality Assurance/Safety Administrative Assistant, Executive Director, and Human Resources Coordinator are involved in training. All facility staff will be educated on all topics before being allowed to continue employment. Each employee will complete a return demonstration; a hand on approach by going through the facility and finding new books, policy's, interventions that Administration and Quality Assurance has put into place On October 25, 2013.

Resident #1. The care plan and SRNA care plan was revised on October 23, 2013 by the MDS coordinator to include cushion in wheelchair, sensor pad in wheelchair, and the termination of the physical restraint. Resident was evaluated from rehab for wheelchair position and safety.

Resident #2. The SRNA that assisted with care the night of the incident was terminated on September 20, 2013. The care plan and SRNA care plan has been updated by MDS Coordinator on October 23, 2013. Resident is working with therapy.

Resident #4. MDS coordinator updated the care plan and SRNA care plan on October 23, 2013 to address high risk for elopement. Continued use of wander guard ankle bracelet is ongoing. Interventions including wander book identification were implemented to protect resident identified as high

risk from exiting the facility unsupervised. The revision was a result in wandering/elopement assessments completed by MDS coordinator on 10/18/13 to identify if the resident was a risk for elopement, the resident scored a 14 and is a high risk. Safety employee checks resident for placement and safety in facility every 15 minutes started on Thursday October 17, 2013 and is ongoing. Interventions and diversions are listed in the front of each wandering book and all employees are educated on October 25, 2013. Social Service director will be continually updating resident's risk for elopement each week.

Resident #14 MDS coordinator updated the care plan and SRNA care plan on October 23, 2013 to address high risk for elopement. Continued use of wander guard ankle bracelet is ongoing. Interventions including wander book identification were implemented to protect resident identified as high risk from exiting the facility

unsupervised. The revision was a result in wandering/elopement assessments completed by MDS coordinator on 10/18/13 to identify if the resident was a risk for elopement, the resident scored a 15 and is a high risk. Safety employee checks resident for placement and safety in facility every 15 minutes started on Thursday October 17, 2013 and is ongoing. Interventions and diversions are listed in the front of each wandering book and all employees are educated on October 25, 2013. Social Service director will be continually updating resident's risk for elopement each week.

Resident #15 MDS coordinator updated the care plan and SRNA care plan on October 23, 2013 to address high risk for elopement. Continued use of wander guard ankle bracelet is ongoing. Interventions including wander book identification were implemented to protect resident identified as high risk from exiting the facility unsupervised. The revision was a

result in wandering/elopement assessments completed by MDS coordinator on 10/18/13 to identify if the resident was a risk for elopement, the resident scored a 13 and is a high risk. Safety employee checks resident for placement and safety in facility every 15 minutes started on Thursday October 17, 2013 and is ongoing. Interventions and diversions are listed in the front of each wandering book and all employees are educated on October 25, 2013. Social Service director will be continually updating resident's risk for elopement each week.

Administrator and Executive Director implemented a new wandering program on 10/17/13. Each resident identified as being high risk for wandering/and or elopement are monitored every 15 minutes for safety. A picture and description of each resident is at each nurses' station and front office. Strategically placed these locations are closest to all exit doors. The binders are in alphabetic order of

each resident in a purple binder. Training started on Thursday October 17, 2013 and will be complete on Friday October 25, 2013. On Friday October 25, 2013 all Facility staff will be educated on wandering books, new Policy of Residents Leaving the Facility, Sign in/out sheet, New Wandering/Elopement Precautions, Code Green Suggested Elopement Interventions, & Interventions Tools for the Wandering Resident. DON, Compliance Director, Quality Assurance/Safety Administrative Assistant, Executive Director, and Human Resources Coordinator are involved in training. All facility staff will be educated on all topics before being allowed to continue employment. Each employee will complete a return demonstration; a hand on approach by going through the facility and finding new books, policy's, interventions that Administration and Quality Assurance has put into place On October 25, 2013. Quality Assurance/Safety Administrative

Assistant, Social Service Director, and Quality Assurance Member #7 will be overseeing the wondering program daily. Quality Assurance Member #7 is responsible for staffing the Safety Employee each shift daily. Social Service Director is responsible for monitoring and making any changes to high risk residents; updating assessments each week, updating Resident's picture, and Resident's description in wondering book. Quality Assurance/Safety Administrative Assistant is responsible for ensuring all documentation is complete on each shift and that Safety Employee is making rounds. Executive Director, Social Service Coordinator, Quality Assurance/Safety Administration Assistant and Quality Assurance Member #7 are all responsible for validating rounds are being completed throughout the day on all shifts. All information is reported back to the Quality Assurance Committee daily, for oversight.

MDS Coordinator completed wandering/elopement risk assessment for all residents on 10/18/13. Residents that were at high risk for wandering/elopement were placed in wandering program. New wandering policy was adapted on 10/21/13 by the Administrator and Executive Director that effective immediately no resident who has been assessed as cognitively impaired through the MDS assessment BIMS scoring process may leave the facility unsupervised even though may be their own responsible party. The resident's cognition is the primary consideration for safety and protection of the residents. All resident who leave the facility must sign out. Those assessed as cognitively impaired through the MDS assessment BIMS Scoring must be accompanied with a family or responsible person or there will be considered an elopement. Sign in/out log are located at each nurse's stations. All staff received education to the new policy on 10/21/13

through 10/25/13 by the H/R Coordinator. The social service director will be reviewing the sign in/out log weekdays. The Executive Director directed the Maintenance Director to implement a new coding system for the facility. Code was changed on Sunday October 20, 2013.

On Tuesday October 15, 2013, after surveyors brought forward concerns to DON and Executive Director an immediate QA meeting was conducted. That meeting resulted in locking all exit doors at all times. Staff were trained that night 10/15/13 on the opening and closing of all exit doors. . In the event of a fire alarm and or power failure, all doors would automatically be unlocked so each exit can be utilized as an emergency exit. Exit will still alarm if resident has secure care monitor in place. On Friday October 25, 2013 Compliance Coordinator will be educating all staff as a continued training on the Secure Care System, and the audio

enhancements we have implemented this week. All employees will be successfully educated On Friday October 25, 2013 to continue employment.

On Wednesday October 16, 2013 Maintenance Director worked on the secure care monitoring system to increase volume of alarm. Power sounder was added to both C Hall doors to increased volume. That device was placed midway on A Hall. Compliance Director and or designee will check daily with floor staff to ensure all staff can hear alarm and are responding promptly. All volume levels are turned to the loudest position.

On Thursday October 17, 2013 Chris Brown Compliance Coordinator began in servicing each employee currently in the facility in every department. The employees were in serviced on the volume of the alarms, employees were instructed that if they can't hear an alarm they are to immediately report

to management, and in addition write the problem in the maintenance book for repair. On Friday October 25, 2013 all Facility staff will be educated on wandering books, new Policy of Residents Leaving the Facility, Sign in/out sheet, New Wandering/Elopement Precautions, Suggested Elopement Interventions, Code Green & Interventions Tools for the Wandering Resident. DON, Compliance Director, Quality Assurance/Safety Administrative Assistant, Executive Director, and Human Resources Coordinator are involved in training. All facility staff will be educated on all topics before being allowed to continue employment. Each employee will complete a return demonstration; a hand on approach by going through the facility and finding new books, policy's, interventions that Administration and Quality Assurance has put into place On October 25, 2013.

On October 21, 2013 David Storm and Associates dealer and

installer for secure care products performed an Audit of Secure Care monitoring system and auditable devices in the facility. The audit showed the system was installed and working to manufactory specifications. Additional sounders for enhanced auditory were recommended and ordered on 10/21/13. Equipment was overnighted in freight and was delivered to the facility on 10/23/13. Maintenance installed on 10/24/13 to complete to audio enhancement of the secure care monitoring system. A loiter feature was programmed to all doors on 10/21/13 by Compliance Officer. Loiter feature is designed to alarm staff when a resident wearing a Wanderguard is approximately 4-5 feet from an exit for 60 consecutive seconds. The alarm will sound so staff can re-direct resident and prevent elopement.

Daily monitoring of secure care equipment system is being completed by maintenance

department to ensure all equipment is working properly and functioning with no problems. Compliance Director and or designee audit's review inspection daily and reports all information to the Quality Assurance Committee weekly. Immediate action will be taken to address any negative findings. Please see attached audit tool.

Daily monitoring of secure care bracelets started on October 25, 2013 and is being recorded by SRNA's in Cerner Software System. On 7-3 and 3-11 shifts wonder guards are being tested to validate proper function. All clinical staff was educated on October 25, 2013 on the new documentation required in the Cerner Software System to document on residents with Wonder guards. All clinical staff was successfully trained on October 25, 2013 before being allowed to continue employment.

Under the direction of the Administrator, Arnold Glass was

contacted and in the facility on 10/21/13 to help with the assistance of the redesign of the glass doors on B Hall. Redesign started on 10/21/13 and will was finished on 10/23/13. Glass doors were relocated to ensure staff can hear Secure Care System alarm.

On Monday October 21, 2013 consultant Olive Allen trained and educated DON, Cooperate RN, MDS Coordinator, MDS Nurse, and Administrative LPN on care plans. Ms. Allen educated staff pertaining to F280. Consultant educated on developing and completion of care plans and SRNA care plans as well as examples of revision of all care plans and SRNA care plans to ensure revisions are made when a change occurs in a resident.

On Friday October 18, 2013 Administrator hired a consultant to immediately help facility put systematic changes in place to enhance facility to use resources

effectively and efficiently to attain and maintain the highest well-being for each resident.

On Sunday October 20, 2013 consultant educated Executive Director and Administrator. Education consisted of physical restraints, elopement, required reporting, incidents reports and investigations, & quality assurance and regulatory compliance. Day to day operations were discussed and modified to achieve compliance and promote well-being for all residents.

Consultant reviewed campus property and facility to help Administrator and Executive Director identify additional concerns and help rectify regulatory concerns on 10/20/13. Consultant is overseeing all abatement and regulatory issues, consulting Executive Director and Administrator on a daily basis.

On 10/21/13 Consultant continued education training to Administrator and Executive Director. Consultant helped revise

policies, assisted with staff meetings and assignments. Trained Clinical Administrative nursing staff. Consultant provided extensive training with DON pertaining to care plans, reeducation of restraints, and operations.

On 10/20/13 at the request of the Administrator the Consultant began providing monitoring. Consultant will work daily with Administrator to validate monitoring of all new systems and ensure all components are working and immediate jeopardy is removed. Administrator is monitoring to oversee systematic changes with regards but not limited to Secure Care System, Elopement, physical restraints, incidents, and documentation then reports daily to the Quality Assurance Committee.

On Monday October 21, 2013 Administrator and Executive Director, directed DON, Corporate RN, MDS Coordinator, MDS Nurse

and Administrative LPN for a complete review on every care plan, MDS, and SRNA care plan for each resident. All revisions are to be completed by Friday October 25, 2013. The audit is being led by MDS Coordinator and assisted by Administrative LPN. Final audit will be reviewed by Cooperate RN and DON. Audit is overseen by Administrator and Executive Director.

On Tuesday October 22, 2013 Administrator and Executive Director directed weekly revisions of care plans and SRNA care plans pertaining to physical restraints, falls, and elopement. Care plans and SRNA care plans will be completed on a daily basis and reviewed each week by MDS Coordinator and or designee. Administrator and Executive will oversee to ensure compliance is achieved each week.

IPOC (interdisciplinary plan of care) meeting will be held each weekday morning with

Administrator, Executive Director, Social Service Director, Rehab Coordinator, MDS Coordinator, Administrative LPN, Dietary Director, Activity Coordinator, Director of Nursing to review intervention from prior day. The DON (Director of Nursing) will start the meeting with review of the 24 hour report from the previous day and any new physician orders including changes in DNR status, new occurrences including falls any action related to wandering that have occurred the team discusses pertinent issues and reviews the MDS Coordinator revises the care plan and SRNA care plan at that time if needed.

The Administrative LPN audits the records of newly admitted resident to validate that their care plan addresses fall risk, elopement risk, and physical restraints. The DON reviews these audits to verify care plan revisions and development are completed. MD Coordinators complete care plan revisions daily

per the information obtained from the physician orders, and 24 hour nursing report to other occurrences addressed during the IPOC meeting. On a daily basis the Administrative LPN audits resident care plans to validate that these updates are completed. Please see attached audit form. All information will be submitted to the Quality Assurance Committee daily.

The facility was in substantial compliance on 11/8/13.