STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185289		C 05/22/2015

NAME OF PROVIDER OR SUPPLIER
HURSTBOURNE CARE CENTRE AT STONY BROOK

STREET ADDRESS, CITY, STATE, ZIP CODE
2200 STONY BROOK DR
LOUISVILLE, KY 40220

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F 000	INITIAL COMMENTS	F 000		

AMENDED 06/24/15

An Abbreviated Survey/Partial Extended survey was initiated on 04/14/15 and concluded on 05/06/15 to investigate KY23085, KY23140, KY23141, KY23142, and KY23143. After supervisory review the survey was re-opened on 05/08/15 and concluded on 05/22/15. The Division of Health Care unsubstantiated KY23085 with unrelated deficiencies cited. The Division of Health Care substantiated KY23140, KY23141, KY23142, and KY23143 and six (6) Immediate Jeopardy situations were identified.

Immediate Jeopardy was identified on 04/21/15 and determined to exist on 04/19/15 at 42 CFR 483.15 Quality of Life (F241) at a scope and severity of a K and at 42 CFR 483.70 Physical Environment (F469) at a scope and severity of an L. Substandard Quality of Care was identified at 42 CFR 483.15 Quality of Life. The facility was notified on 04/22/15.

Observations revealed ants in the facility. Observation and interview with Resident #24 on 04/21/15 revealed ants in the resident's room. Interview with Resident #24 revealed on 04/19/15 ants were in the bed and crawling all over his/her body. The resident was scared and had to scream out for staff to help him/her.

Immediate Jeopardy was identified on 04/22/15 and determined to exist on 02/25/15 at 42 CFR 483.10 Resident Right's (F157) at a scope and severity of a J; 42 CFR 483.20 Resident Assessment (F280) at a scope and severity of a K; 42 CFR 483.25 Quality of Care (F309) at a

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

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F 000	Continued From page 1 scope and severity of a J and (F323) at a scope and severity of a K; 42 CFR 483.30 Nursing Services (F353) at a scope and severity of an L; and, at 42 CFR 483.75 Administration (F490, F493, and F520) at a scope and severity of an L and (F514) at a scope of severity of a J. Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care. The facility was notified on 04/22/15. On 02/25/15 at approximately 12:30 AM, Resident #4 was found on the floor by a Certified Nursing Assistant (CNA) while performing rounds. Interview and record review revealed no documented evidence the resident's physician was notified at the time of the fall, there was no documented evidence the resident was assessed and monitored after the fall, and there was no evidence interventions were implemented to prevent recurrence. An x-ray was obtained at 4:30 PM (16 hours after the incident) and the resident was diagnosed with a right tibia fracture. Immediate Jeopardy and Substandard Quality of Care was also identified on 04/22/15 and determined to exist on 04/10/15 at 42 CFR 483.25 Quality of Care (F325) at a scope and severity of a "J". Resident #4 was nutritionally compromised and had an order dated 02/28/15 for weekly weights and staff was to monitor the resident's food intake. Interview and record review revealed the resident was not weighed weekly per the physician's order. The resident weighed 97.8 pounds on 03/20/15 and the next weight obtained on 04/10/15 revealed a weight of 88.6 pounds, a significant weight loss of 9.4% in less than one month. Review of the resident's meal intake	F 000		

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F 000	Continued From page 2 sheets revealed the resident's meal consumption was not recorded consistently. Immediate Jeopardy was also identified on 04/22/15 and determined to exist on 04/20/15 at 42 CFR 483.20 Resident Assessment (F279) at a scope and severity of a "J". Interview and record review revealed the facility failed to ensure a plan of care was developed to promote resident safety for Residents #14 and #15, whom the facility assessed to require supervision while smoking. Observation, on 04/20/15 at 10:00 AM, revealed Resident #14 and #15 were outside in the court yard smoking cigarettes without staff supervision and did not have smoking aprons applied. Immediate Jeopardy was identified on 05/12/15 and determined to exist on 03/25/15 at 42 CFR 483.13 Resident Behavior (F225 and F226) at a scope and severity of a J and 42 CFR 483.20 Resident Assessment (F282) at a scope and severity of a K. Substandard Quality of Care was identified at at 42 CFR 483.13 Resident Behavior. The facility was notified on 05/12/15. Record review and interview revealed on 03/25/15 during the 7:00 AM-3:00 PM shift, Registered Nurse (RN) #6 noted Resident #25's right eye was swollen and bruised on the side with a small cut. The resident had a history of wandering into other resident rooms, both male and female. Interview and record review revealed the resident's eye injury was not assessed or monitored. There was no documented assessment of the injury until 04/24/15, thirty (30) days after the bruising was identified. The facility could not provide any evidence the physician or	F 000		

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F 000	Continued From page 3	F 000		

responsible party were notified or that the incident was reported or investigated until 04/28/15 (thirty-four [34]days after the incident) after surveyor intervention.

Immediate Jeopardy was identified on 05/12/15 and determined to exist on 04/28/15 at 42 CFR 483.70 Physical Environment (F463) at a scope and severity of a K. The facility was notified on 05/12/15.

Observation, interview and record review revealed the facility failed to ensure the resident call system was functional for Residents #5, #7, #12 and Unsampled Residents M, T, Z, AA, CC, GG, HH, II, JJ, KK, and LL in order to notify staff of their needs. The facility failed to provide the residents with an alternate means of notifying staff. Additionally, the call system panel located at the nursing station had buttons missing and others that did not work.

The facility provided an acceptable Allegation of Compliance (AOC) on 05/19/15 which alleged removal of the Immediate Jeopardy on 05/16/15. The State Survey Agency verified Immediate Jeopardy was removed on 05/16/15 as alleged prior to exit on 05/22/15. The scope and severity was lowered to a D at F157, F225, F226, F279, F309, F325, F514; lowered to an E at F241, F280, F282, F323, F463; and, lowered to a F at F353, F469, F490, F493, and F520 while the facility implements and monitors the Plan of Correction for the effectiveness of systemic changes and quality assurance.

Substandard Quality of Care was also identified at 42 CFR 483.15 Quality of Life (F253 and F254) at a scope and severity of a F and actual harm

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F 000	Continued From page 4	F 000		
	was identified at 42 CFR 483.25 (F314) at a scope and severity of a G. Additional deficiencies were cited as a result of the Abbreviated Survey at 42 CFR 483.10 Resident Rights (F164) at a scope and severity of a F and (F166) at a scope and severity of an E; at 42 CFR 483.15 Quality of Life (F246) at a scope and severity of an E; at 42 CFR 483.25 Quality of Care (F312) and (F315) at a scope and severity of an E; at 42 CFR 483.30 Nursing Services (F356) at a scope and severity of a C; at 42 CFR 483.35 Dietary Services (F364) at a scope and severity of a D and (F371) at a scope and severity of an F; and, at 42 CFR 483.65 Infection Control (F441) at a scope and severity of an E.			
F 157 SS=J	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident	F 157		

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and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

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

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the facility's policies, it was determined the facility failed to have an effective system in place to ensure immediate notification of the attending physicians and resident representatives after a fall and/or injury for three (3) of forty-three (43) sampled residents (Resident's #4, #25, #30). (Refer to F309 and F323)

On 02/25/15 at approximately 12:30 AM, Resident #4 was found on the floor by a Certified Nursing Assistant (CNA) while performing rounds. Interview and record review revealed no documented evidence the resident's physician was notified at the time of the fall and there was no evidence interventions were implemented to prevent recurrence. An x-ray was obtained at 4:30 PM and the resident was diagnosed with a right tibia fracture.

On 03/25/15 during the 7:00 AM to 3:00 PM shift, Registered Nurse (RN) #6 noted the Resident #25's right eye was swollen and bruised on the

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side with a small cut. The facility could not produce any evidence of a physician or Responsible Party notification.

On 03/26/15 sometime during the 7:00 AM to 3:00 PM shift, the staff (not identified) and Resident #30 reported a fall at approximately 5:00 AM to 5:15 AM, in which the resident fell to his/her knees while using the commode per self. The facility could not produce any evidence the fall was reported to the physician or Responsible Party.

The facility's failure to have an effective system in place to ensure immediate notification of the attending physicians and resident representatives after a fall has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 04/22/15 and was determined to exist on 02/25/15.

An acceptable Allegation of Compliance (AOC) was received on 05/19/15 alleging the Immediate Jeopardy was removed on 05/16/15. The State Survey Agency validated the Immediate Jeopardy was removed on 05/16/15 as alleged, prior to exit on 05/22/15. The scope and severity was lowered to an "D" while the facility monitors the implementation of the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes.

The findings include:

Review of the facility's policy regarding Resident Incident/Accident Reports, dated 11/30/14, revealed any happening not consistent with routine operations of the facility or care of a resident may warrant the completion of an

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incident report. Following the nursing assessment, the physician would be notified of any noted or suspected injury, and would implement appropriate interventions. The event, along with the assessment, physician and other required notifications would be documented in the clinical record. Resident's family or legal representatives would be notified of the incident.

Review of the facility's policy regarding Resident Abuse-Injuries of Unknown Origin, dated 11/30/14, revealed bruises that had no known cause were considered an injury of unknown origin. The Executive Director (ED) and Director of Clinical Services (DCS) should be notified immediately and notification must be made to the Responsible Party and the physician.

1. Review of Resident #4's clinical record revealed the facility admitted the resident on 05/16/13 with diagnoses of Hypertension, Atrial Fibrillation, Chronic Obstructive Airway, Congestive Heart Failure, Macular Degeneration, Rheumatoid Arthritis, Osteoporosis and an Open Wound Site.

Review of the Accident/Incident Report Form, dated 02/25/15, revealed Resident #4 sustained a fall from the bed and was found on the floor at 12:30 AM. The report form stated the physician had not been contacted and the resident did not receive any treatment. Review of the Nursing Progress Note, dated 02/25/15 and timed at 6:00 AM, revealed Resident #4 was found on the floor by a Certified Nursing Assistant while performing rounds.

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Interview with Licensed Practical Nurse (LPN) #1, on 04/21/15 at 3:05 PM, revealed he was working on the 200 Unit when RN #1 notified him Resident #4 had fallen and RN #1 directed him to leave his assigned 200 Unit to go staff the 100 Unit. LPN #1 stated he documented he performed a head to toe assessment at 6:00 AM on 02/25/15; however, he did not immediately notify the resident's physician after the fall, due to the fall occurring during the night time hours and he did not want to bother the physician with what he believed to be a non-injury fall. He stated the physician or the nurse practitioner was in the facility early every morning, so he gave report to the first shift nurse, and believed the first shift staff notified the nurse practitioner after he left.

Interview with RN #1, on 04/21/15 at 11:20 PM, revealed he was not the nurse assigned to the 100 Unit and he did not document in Resident #4's medical record or contact the physician or family regarding the fall.

Interview with the Assistant Director of Clinical Services (ADCS), on 04/20/15 at 2:35 PM, revealed she was aware of Resident #4's fall and one of her responsibilities was to follow up on resident falls to ensure policies and procedures were followed. However, she was unable to complete her ADCS duties because she had been consistently working as a staff nurse or a nursing assistant due to recent staffing shortages.

Interview with the previous Executive Director

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F 157	Continued From page 9 (ED), on 04/22/15 at 8:34 AM, revealed RN #1 did not call her the night of Resident #4's fall and she was not aware the physician and Responsible Party had not been contacted immediately after the fall. She stated she knew the physician was in to see the resident the morning after the fall and had written orders for labs and x-rays. The ED stated the facility policy directed the physician and responsible party were to be notified immediately after a change in condition or an incident. Interview with Resident #4's Physician, on 04/24/15 at 10:55 AM, revealed he was informed of Resident #4's fall around 7:00 AM on 02/25/15. He stated he would have wanted to be contacted immediately after the fall so he could have directed staff at that time. Review of the Nursing Progress Note, dated 02/25/15 and timed at 4:30 PM, revealed X-ray results were positive for a right tibia fracture; the Nurse Practitioner was notified of the results; and, orders were received to transfer the resident to the hospital. 2. Review of the clinical record for Resident #25, revealed the facility admitted the resident on 12/30/14 with a diagnosis of Vascular Dementia. The facility care plan, dated 01/06/15, revealed the resident had impaired cognitive status with interventions that included to inform the responsible party of any changes. The care plan for risk of falls, dated 01/08/15, included an intervention to monitor the resident for change in condition that may warrant an increase in supervision or assistance, and notify the physician.	F 157		

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F 157	Continued From page 10 On 03/25/15 from 7:00 AM through the 3:00 PM shift, a nurse's note by Registered Nurse (RN) # 6 revealed the resident's right eye was swollen and bruised on the side with a small cut. Record review revealed no documented evidence the resident's physician or Responsible Party (RP) were notified to the injury. Review of a Social Service note, dated 04/20/15, revealed the Director of Social Services (DSS) and Unit Manager (UM) met with Resident #25's RP regarding the resident's injury. On 04/23/15 at 2:35 PM, interview with CNA #2 revealed she worked third shift and noticed a small cut over Resident #25's eye, and about an hour later the eye began to bruise. The aide further stated she reported to the third shift Charge Nurse when the eye started to bruise; however, she could not remember who the nurse was at the time. On 04/27/15 at 11:42 PM, interview with RN #1 revealed he worked with Resident #25 on the third shift. He stated he could not remember when the resident's eye injury had been brought to his attention; however, had been given the information in report but could not remember which nurse had given him report. The RN stated the nurse on duty at the time of the incident should have notified the physician and RP. On 04/24/15 at 1:24 PM, interview with RN #6 revealed she noticed Resident #25's eye when she came in to work that day, on 03/25/15 and she completed a nurse's note. However, she did not notify the resident's physician or RP. Interview with the UM, on 04/23/15 at 9:35 AM,	F 157		

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F 157	Continued From page 11 revealed she was on vacation at the time of Resident #25's injury that resulted in a black eye. The UM stated an incident report should have been completed, and the physician and RP notified immediately. The UM stated she became aware of the eye injury when she returned from vacation on 03/31/15. However, she did not know the resident's physician and RP had not been notified. Interview with Resident #25's Physician, on 04/27/15 at 1:05 PM, revealed he could not recall if the resident had a black eye, or if he had been notified of the resident's eye injury. He stated he or the Nurse Practitioner were always on call and either of them could be notified by the facility. On 04/28/15 at 8:35 AM, interview with the DCS revealed Resident #25's injury would require an investigation, a head to toe assessment, and notification to the physician and RP. However, she could not find any information about Resident #25's black eye. Interview, on 04/28/15 at 9:43 AM, with the Interim ED/Regional Vice President of Operations (RVPO) revealed she had been the Interim ED since 04/17/15, and had been the facility's RVPO since May 2014. She stated she first became aware of Resident #25's eye injury since the State Survey Agency (SSA) survey process had begun. She stated if the clinical record did not reflect the notifications were completed then the nurse did not follow the facility's policies and procedures. She further stated the facility could not locate any documentation about Resident #25's eye injury. 3. Review of the clinical record for Resident #30 revealed the facility admitted the resident on	F 157		

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F 157	Continued From page 12 03/20/15 with diagnoses of Dementia and history of Traumatic Brain Injury. The Admission Data Collection, dated 03/20/15, revealed the resident ambulated independently, was continent of bowel and bladder, and the facility assessed the resident as not at risk for falls with a fall risk score of six (6). The facility completed an initial MDS on 03/30/15 and assessed the resident with a BIMS score of twelve (12) of fifteen (15) which meant the resident was interviewable. A nurse's note, on 03/26/15 from the 7:00 AM to 3:00 PM shift, revealed staff (not identified) and the resident reported a fall at approximately 5:00 AM to 5:15 AM, in which the resident fell to his/her knees while using the commode. Record review revealed there was no documented evidence the resident's physician was notified of the fall. Post survey interview with RN #6, on 06/04/15 at 10:58 AM, revealed Resident #30 informed her of his/her fall as soon as she (RN #6) walked onto the unit. The nurse stated the resident reported that he/she had slipped in the bathroom. RN #6 stated she asked the previous nurse if they made notifications to the physician and RP and the previous shift nurse had reported to her that all the documents were completed and notifications were made. Post survey interview with the UM, on 06/04/15 at 11:12 AM, revealed she could not remember seeing any documents related to the fall, which included the SBAR with the notifications. Interview with the DCS, on 05/04/15 at 2:18 PM, revealed she could not locate an incident report, investigation, or any other documentation related	F 157		

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NAME OF PROVIDER OR SUPPLIER
HURSTBOURNE CARE CENTRE AT STONY BROOK

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F 157	Continued From page 13 to the fall for Resident #30. Post survey interview, on 06/04/15 at 2:15 PM, with Resident #30's RP revealed she was not notified by the facility about the resident's fall on 03/26/15. She stated the facility can fax, e-mail, or leave voice mail messages about the incident, and if the fall required an emergency room visit, the crisis hotline could give consent to treat. The RP stated the fall would be something that she should have been notified of. Post survey interview, on 06/03/15 at 2:11 PM, with the Medical Director revealed he could not recall if he had been notified of Resident #30's fall that occurred on 03/26/15. He stated the resident's fall to his/her knees would have been an incident that the facility's should have notified him or the NP. The Medical Director stated he would have been notified verbally by phone or in person when he was at the facility. The facility took the following actions to remove the Immediate Jeopardy on 05/16/15 as follows: 1. The facility notified Resident #4's physician, of a fall that occurred on 02/25/15 with new orders given to the nurse. The resident transferred to a local hospital on 02/25/15 for a tibia fracture and returned to the facility on 02/28/15 with new orders. The DCS assessed Resident #4 on 04/22/15 and was found in stable condition. 2. On 04/28/15, the facility reported to the SSA that Resident #25 was found to have a black eye on 03/25/15. The incident was investigated and with the assistance of the SSD and DCS the source of the black eye was determined as a result of a resident to resident altercation and	F 157		

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F 157	Continued From page 14 abuse was unsubstantiated. 3. On 04/22/15, one hundred twenty-six (126) residents were assessed by the ADCS, Nurse Manager, and Licensed Nurse to determine if any residents had an incident or accident or change in condition that would warrant physician notification and further intervention. One (1) resident was identified as having an incident, accident, or change of condition and the physician was notified by the nurse on 04/22/15. Additionally, the Nurse notified the RP and documented this in the clinical record. Nurses would additionally report incidents, accidents, or changes in condition to the clinical administrative team. 4. On 04/22/15 the Corporate Administrative Nurses educated twenty-three (23) of thirty-eight (38) Nurses regarding timely notification to the physician related to resident incidents, accidents, or change in condition; care plan policies, evidence of assessments and care planning with immediate falls preventions interventions to meet the resident's needs; and falls procedures, immediate assessment by the Nurse after a resident's fall, notifications to the physician and RP, implementation of an immediate intervention by the Nurse, documentation of the fall in the clinical record by the Nurse, fall root cause investigation report initiated by the Nurse and reviewed by the DCS, and follow up by the IDT in the weekly falls meeting. Nurses were also trained related to reporting an incident, accident, or change in condition, to the resident ' s RP and documentation in the medical record to include the incident, accident, or change in condition, notifications to the physician, RP, and clinical administrative team, nurse's assessment, and interventions; evidence of assessment would	F 157		

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F 157	Continued From page 15 include Situation, Background, Appearance, and Review (SBAR) sheet, Interdisciplinary Progress Note, and Neurological (neuro) checks sheet, and documentation of falls. Staff competencies were completed. Nursing staff not educated by midnight on 04/22/15 would not be allowed to work until they received training. Agency Nurses would be trained by the Corporate Administrative Nurses, DCS, Assistant DCS, or Nurse Manager prior to working their next shift. The DCS and ED would ensure staff that had not been educated were educated prior to working their next shift. The ED and DCS would monitor the daily schedule and highlight staff already trained. A department manager would stand by the time clock at shift change to direct staff that needed education to the training. The IDT would monitor daily incidents and accidents. Notifications of accidents, incidents, or changes of condition would be reviewed for completion by the DCS, ADCS, or Nurse Manager, who would make notifications if not done. 5. An Ad-Hoc Quality Assurance/ Performance Improvement (QAPI) meeting was conducted on 04/22/15 to discuss facility policy and procedure (P&P) for falls, and notifications of incidents, accidents, or changes of condition; care plans as related to immediate falls interventions and revision status post fall, nursing assessment and documentation for falls; with no changes made. Also discussed the facility protocol related to shift relief and report; and additional avenues to attract new staff and maintaining current staff with a plan for performance improvement. 6. The IDT would review in the daily meeting incidents and accidents reports and the 24 hour report for investigation reports, nursing	F 157		

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F 157	Continued From page 16 documentation in the clinical record, an SBAR, notifications to the physician and RP, and care plans with appropriate interventions. 7. On 05/13/15, Corporate Administrative RNs educated facility Administrative Staff on the regulations and P&P for staffing, pest control, housekeeping, and maintenance, with competencies completed. The ED would monitor the facility's process for notification, abuse, hiring, dignity, care plan revision, professional standards, assessments, behavior and falls management, incidents and accidents, smoking, call lights, pest control, and staffing. 8. Review of the 24 hour report, incident/ accident reports, in the daily meeting with the IDT; documentation in the clinical record included notification to the physician and new orders, and to the RP. 9. The IDT would meet at least monthly to discuss facility action plan and ensure tasks were completed for the removal of the IJ, and QA monitoring completed according to the AOC during the IJ period, validated by the ED/RVPO/RDCS/Corporate Administrative RNs. 10. Per the Ad-Hoc QAPI meeting, on 05/15/15, QI monitoring would be done utilizing approved audit tool with oversight by the ED, beginning 05/16/15, review of the clinical record for timely notifications to the physician and RP. The State Survey Agency validated the removal of Immediate Jeopardy on 05/22/15 as follows: 1. Review of the facility's SBAR's, incident report, neuro checks, progress notes and physician	F 157		

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F 157	Continued From page 17 orders, all dated 02/25/15, revealed Resident #4 had a fall on 02/25/15, the physician was notified on 02/25/15 with new orders received. The resident was transferred to a local hospital on 02/25/15 for a tibia fracture on 02/25/15, and returned to the facility on 02/28/15 with new orders. The DCS assessed Resident #4 on 04/22/15 and found the resident was stable. 2. Review of the facility investigation, dated 04/28/15, for Resident #25's black eye noted on 03/25/15, revealed the SSA was notified on 04/28/15, investigated, and followed up on 05/04/15. The investigation resulted in the cause of the injury from a resident to resident altercation. Interview with the DCS, on 05/20/15 at 2:04 PM, revealed she investigated Resident #25's black eye and the cause was determined to be a resident to resident altercation. Observation, on 05/22/15 at 2:11 PM of Resident #25 revealed the resident was in his/her recliner with the TV on and staff sitting with him/her on a 1:1. 3. Review of one hundred twenty-six (126) resident assessments, completed by Assistant DCS/Nurse Manager/Licensed Nurse, on 04/22/15, revealed residents were assessed for any incident or accident, or change in condition that warranted notification to the physician. One (1) resident was identified as experienced a change in condition, accident, or incident and the physician was notified on 04/22/15. 4. Review of in-service records, revealed twenty-three (23) nurses were educated by Corporate Administrative Registered Nurses regarding: timely notification to the physician related to incidents, accidents, and changes in condition; care plan policies; resident	F 157		

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assessments, including SBAR, neuro checks; falls and immediate interventions; notification to the physician and RP; documentation of the fall in the clinical record; fall root cause investigation report. Staff competencies were completed. No staff had worked prior to them receiving the training. Review of staffing schedules revealed staff who had not yet been trained were not highlighted, which noted they required education. Review of facility records revealed notifications of incidents, accidents, and changes in condition were reviewed for completion by the DCS/ADCS/ Nurse Manager. Interview with the DCS and RDCS, on 05/04/15 at 4:18 PM, revealed twenty-three (23) nurses had been trained. Interview with RN #8, on 05/04/15 at 4:33 PM, with CNA #11, on 05/05/15 at 9:51 AM, with the UM, on 05/05/15 at 9:55 AM, CNA #14, on 05/05/15 at 10:03 AM, CNA #13, on 05/05/15 at 10:10 AM, revealed they had been educated on falls, notifications, Kardex and care plans. Interview, on 05/05/15 at 2:00 PM, with the DCS, ADCS, Nurse Manager, ED, Admissions Coordinator, DSS, MDS Director revealed they had all been trained on care plans, changes in condition, staff look at interventions for residents, the 24 hour report, falls, SBAR, incident reports, Kardex and care plans, notifications to the physician and family.

5. Review of a QAPI sign in sheet, dated 04/22/15, and agenda revealed the committee discussed the P&P for falls management, notifications of incidents, care plans, falls interventions, nursing assessments, shift to shift relief and report, with no changes made. Interview with the DCS, ADCS, Nurse Manager, ED, Admission Coordinator, DSS, MDS Director, on 05/05/15 at 2:00 PM, revealed QA would track

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and trend falls information to validate interventions and notifications were being completed.

6. Observation of the morning meeting, on 05/22/15 at 9:05 AM, revealed the IDT reviewed the 24 hour report, care plans, and specific resident concerns.

7. Review of in-service records, dated 05/13/15, revealed Administrative staff were trained on staffing, pest control, housekeeping and maintenance, and would be monitored by the ED. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, Assistant DCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS revealed they had been trained on staffing, pest control, housekeeping and maintenance, and any concerns of audits would be taken to the morning meeting. Interview with Resident #3 on 05/22/15 at 1:00 PM, revealed staffing had improved and were answering lights timely and the facility looked cleaner.

8. Observation of the daily morning meeting, on 05/22/15 at 9:05 AM, revealed review of the 24 hour report, notifications made and documented, new physician orders, maintenance concerns and books, pests, rounds and audits, call lights, care plans. Interview with the Maintenance Director, DCS, Assistant DCS, UM, Schedule Coordinator, MDS Coordinator, and DSS, on 05/22/15 at 2:52 PM, revealed they participate in the morning meeting and review the 24 hour report, notifications were made, maintenance books reviewed, physician orders, call lights, care plans, and audits/ round were reviewed in the morning meeting.

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	9. Review of sign in sheets, dated 04/22/15, 05/13/15, and 05/15/15, revealed QAPI meetings were held on those dates. Interview, with the Maintenance Director, DCS, Assistant DCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, Business Office Manager, Housekeeping Supervisor, and DSS revealed they attended the QAPI meetings. Interview with the RDCS, on 05/22/15 at 5:05 PM, revealed the next QAPI meeting was scheduled for 06/17/15. Interview with the Medical Director, on 05/22/15 at 8:00 AM, revealed he was informed by the Executive Director of the resident care issues, attended the QA meetings held by the facility and provided direction regarding corrective action plans that were developed to meet the needs of the residents.			
	10. Review of the QAPI sign in sheet, dated 05/15/15, and agenda revealed audit tools were approved for QA monitoring and discussed: resident interviews; resident/family concerns; morning meeting; new employee files; falls or behaviors reviewed; care plans and Kardexes update; review of the 24 hour report; notifications; maintenance rounds and book; supervised smoking; falls interventions in place; call lights; weekly falls; and, behavior management meetings.			
F 164 SS=F	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS	F 164		
	The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.			
	Personal privacy includes accommodations,			

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medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and review of the facility's policies, it was determined the facility failed to have an effective system in place to ensure the confidentiality of medical and billing records for seven (7) of forty-three (43) sampled residents (Residents #5, #7, #12, #16, #17, #25, #27) and thirteen (13) of thirty-nine (39) unsampled residents, (Unsampled Resident A, F, G, H, I, J, K, L M, T, U, V, X). The facility stored resident sensitive data in boxes in an unlocked room, marked Personal Items Closet on the Journey 2 Unit. The unlocked Personal Items

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F 164	Continued From page 22 Closet was located in the common area used as the residents' sitting, activity, and dining area. Four (4) Bankers' Boxes were stored on the floor of the closet. Observation revealed the boxes contained resident billing and medical information. One (1) box was uncovered and confidential resident information was visible. The findings include: Review of the facility's policy titled, "Release of Personal Information", effective 11/30/14, revealed the company guaranteed the residents' privacy regarding personal information. Review of the facility's policy regarding "Clinical/Medical Records", effective 11/30/14, revealed all information contained in the resident's clinical record, regardless of the form or storage method, would be considered confidential, and the resident had the protected right of information. Review of the facility's policy regrding "Resident Financial Records", effective 11/30/14, revealed the Business Office Manager and staff would maintain the accuracy and confidentiality of the resident's financial record. All resident financial files were to be kept in a secured cabinet located in the Business Office or locked in the Business Office during non-business office hours. Observation, on 04/17/15 at 12:46 PM, revealed an unlocked room marked Personal Items Closet	F 164		

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F 164	Continued From page 23 on the Journey 2 Unit. The unlocked Personal Items Closet was located in the common area used as the residents' sitting, activity, and dining area. Observation revealed four (4) Bankers' Boxes on the floor of the closet; these boxes contained resident billing and medical information. One (1) box was uncovered with confidential resident information visible. One (1) box was dated 09/10/11; and, three (3) boxes were not dated. Observation, on 04/22/15 at 11:25 AM, in the Journey 1 Unit (Rehabilitation) revealed unattended medical records for Unsampled Residents A, F, G, H, I, J, K, L M, T, U, V and X on top of a printer-copier machine and scattered on the floor around the machine. There were also unattended medical records for Residents #5, #7, #12, #16, #17, #25, #27, and #29 on top of a shredding box next to the printer-copier. The machine was located next to an exit door. Interview, on 04/17/15 at 3:30 PM, with the Business Office Manager revealed she had been in her current position for one and one half years. She related her job duties entailed Medicaid, Medicare, and commercial insurance billing. She stated Residents' billing records remained at the facility for two (2) years. According to the Business Office Manager, residents' billing records contained clinical information, patient agreements, identification information, Medicaid and Medicare cards, insurance cards, social security numbers, dates of birth, admission packages, Preadmission Screens and Resident Reviews, original assessments of residents upon admission, and level of care. She related	F 164		

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F 164	Continued From page 24 residents' billing records would be stored in her office in locked file cabinets, and some were stored in the Assistant Business Office Manager's office. During times when she was not in her office, the door would be locked, in addition to the outer door leading to her office. When her file cabinets became full, older records would be boxed and kept in her office. As her office space filled, the facility's contracted medical record storage vendor picked up the boxes and stored them. She stated the facility underwent renovations approximately one year ago and the boxes that had been stored in her office and her assistant's office should have gone to storage at the facility's contracted medical record storage service. She related resident records not properly stored resulted in a negative outcome as someone unauthorized could see a resident's personal information. Interview with the Medical Records and Staffing Coordinator, on 04/22/15 at 2:53 PM, revealed the facility had a written policy for maintaining the residents' private information and that medical records should never be left unattended because someone who was not authorized could obtain confidential information. She stated she had training in the Health Insurance Portability and Accountability Act (HIPAA) and resident confidentiality, and was aware HIPAA provided for the protection of residents' private health information. On 04/22/15 on the Journey 1 Unit at the printer-copier, she and CNA #11 had been updating elopement pictures. The Medical Records and Staffing Coordinator related the Executive Director called her away, and she left CNA #11 with the records. She related CNA #11 was supposed to have stayed with the medical	F 164		

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2200 STONY BROOK DR
LOUISVILLE, KY 40220

(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 164	Continued From page 25 records. Interview with CNA #11, on 05/15/15 at 2:20 PM, revealed she went on break and when she came back the elopement binder she used to conduct and document resident fifteen (15) minute checks was not on the unit. She stated she found out that the Staffing/Medical Records Coordinator had retrieved the book. She stated she determined the coordinator had taken the pages out of the book and was updating the resident information in the elopement binder. She stated she tried to help the Coordinator out by attaching the pictures to the pages, but was called back to the unit before they all were attached. She stated she took the binder and left the pictures on the printer and floor. She said she told the Coordinator, when she passed her in the hall, that she had to go back to the unit and she did not finish attaching all the pictures to the pages. Interview, on 05/05/15 at 3:55 PM, with the Vice President of Operations/Interim Executive Director, revealed the facility had several policies regarding residents' confidentiality. She related the facility had a policy for the confidentiality of medical records and the storage of medical records. However, she was uncertain if the facility had a policy related to the confidentiality of the residents' billing records, and would have to search and pull the policy. The Vice President of Operations/Interim Executive Director related it was the Medical Records Coordinator's responsibility to ensure medical records remained confidential and stored properly. Records no longer needed should have been forwarded to a medical record storage facility. She stated	F 164		

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F 164	Continued From page 26 medical records should not be left unattended as it could lead to unauthorized disclosure. Observation, on 04/23/15 at 8:10 AM, 04/23/15 at 8:42 AM, 04/23/15 at 2:47 PM, and 04/24/15 at 10:05 AM, of one (1) of two (2) of the 200 Unit nurse's station revealed Progress Notes, face up, on top of a treatment cart behind the nurse's station within reach and legible from the other side of the half wall. The notes were for Residents #16, #25, #27, #29, #43, and Unsampled Residents A, T, U, V, X, Y. Interview with Licensed Practical Nurse (LPN) #1, on 04/23/15 at 8:42 AM, revealed the Progress Notes on the treatment cart were copies of the clinical record. He stated he did not know who made the copies or left the papers there. The nurse stated the papers should have been turned over as some residents or family members could read the notes. The LPN further stated there were some residents who could take the records. On 04/24/15 at 10:05 AM, interview with the Unit Manager (UM) revealed the resident Progress Notes were still on the treatment cart behind the nurse's station and within reach from the other side of the half wall. She stated the papers were copies of original documents and was not sure why the papers were there. The UM stated having the records out for anyone to see was a HIPAA violation.	F 164		
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior	F 166		

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F 166	Continued From page 27 of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policies, Grievance Tracking Log and Concern Form, it was determined the facility failed to promptly resolve residents' grievances. These grievances included clothing not returned timely from laundry, lost clothing, clean clothes stored on the closet floor, closet door with hole in the bottom not repaired as requested, call lights not answered timely, and a shortage of linen along with not replacing torn, tattered, and thin linen for five (5) of forty-three (43) sampled residents (Residents #3, #7, #8, #9, and #10); and, one (1) of thirty-nine (39) unsampled residents (Unsampled Residents C). The findings include: Review of the facility's policy titled "Resident Related Concerns and Grievances", effective 11/30/14, revealed concerns should be investigated in an effort to provide follow-up of concerns expressed by residents, family members, and/or visitors, which may affect the quality of care delivered. Any employees who received a complaint from a resident, family member and/or visitor would initiate a Concerns Form. Review of the Contracted Vendor's policy regarding Resident Personal Clothing, dated	F 166		

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F 166	Continued From page 28 02/01/03, revealed residents, residents' families, Admissions, Social Services, Administration, and Nursing would all be involved with laundry in creating policies for getting residents' clothing collected, washed, dried, and returned on a timely basis. Per the policy, the keys to a successful Resident Personal Clothing System included labeling, tracking resident clothing through the facility, collection of soiled personal clothing, washing personal clothing, drying personal clothing, processing personal clothing, and delivery of personal clothing. The processing of personal clothing should be divided into clothing to be hung and clothing to be folded. A tracking system should be created to identify each article of clothing with the correct resident. Unmarked clothing should be brought up to the units for identification by CNAs who would be more familiar with the residents. Once unmarked clothing was identified, it should be labeled immediately. Review of the facility's policy, "Maintenance", effective 11/30/14, revealed the facility's physical plant and equipment would be maintained through a program of preventive maintenance and prompt action to identify areas/items in need of repair. 1. Review of the Grievance Tracking Log for April 2015 revealed an incident on 04/08/15 regarding the family member's concern for Resident #7's missing clothing. A Concerns Form, dated 04/08/15, stated family members of Resident #7 reported the resident was missing three (3) jogging suits, five (5) pairs of pajamas, six (6) T-shirts, six (6) pairs of underwear, and socks.	F 166		

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F 166	Continued From page 29 Review of the facility's investigation revealed the Head of Housekeeping and Laundry took Resident #7's sibling to the Laundry and searched for the resident's missing clothing. One (1) jogging jacket and one (1) pair of pants were located. The Head of Housekeeping and Laundry offered donated clothing to the resident. Review of the Concerns Form, dated 04/08/15, initiated by Resident #7's family members indicated a grievance was filed regarding the resident's clothing not being returned from the laundry. Review of Resident #7's clinical record revealed the facility admitted the resident on 03/17/15, with diagnoses of Vascular Dementia and Vascular Accident (stroke). Review of the Admission Minimum Data Set (MDS) assessment, completed on 03/25/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of ninety-nine (99) meaning the resident was rarely/never understood. Observation of Resident #7's room, on 04/16/15 at 11:07 AM, revealed no clothes in his/her closet and seven (7) pairs of briefs were stored on the top of the heating/air condition unit. Observation on 04/17/15 at 11:07 AM, revealed no clothes in the resident's closet. Further observation on 04/17/15 at 10:29 AM, revealed two (2) pairs of pants hanging in the closet and on 04/21/15 at 4:14 PM, there were no clothes in the closet. On 04/22/15 at 9:33 PM, observation revealed two (2) pairs of shorts in the closet. Additionally, in	F 166		

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F 166	Continued From page 30 the closet there was one (1) polo shirt marked with another resident's name. Observation on 04/28/15 at 1:35 PM, revealed the call light was not working; there were no sheets on the resident's bed and no clothes in the closet. On 04/30/15 at 3:00 PM, there was no clothing in the closet. Continued observation revealed the resident sat in a chair next to the bed and was dressed in shorts, and a polo shirt. Interview with Family Member #10 via telephone, on 04/16/15 at 10:22 AM, revealed the family brought new clothing for Resident #7 to the facility and ensured the clothes were marked with the resident's name. However, when the family visited the resident, there would be no clothing in the resident's closet. During a visit on 04/04/15, Family Member #10 found the resident's toilet was plugged and the room smelled badly. The family member made a request for staff to contact maintenance to repair the toilet and was informed the facility did not have a maintenance staff member in the building or on call. Upon visiting on 04/05/15, a family member found the toilet was still stopped up, the room had an odor, and the resident had no clothes in the closet. Further interview revealed that on more than one occasion, the family member found the resident lying wet in bed. When the family member addressed her concerns to the Executive Director, she stated the Executive Director told her the resident's brief was only changed once per day. Interview, on 04/16/15 at 2:45 PM, with Certified Nursing Assistant (CNA) #3, revealed there were times when the laundry lost Resident #7's	F 166		

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F 166	Continued From page 31 clothing. He stated third shift dressed the resident each morning around 5:30 AM to 6:00 AM. If the resident did not have clothing in his/her closet, the nursing aides would search the laundry room for clothing. He stated the resident's clothing should have been marked with the resident's name so that staff would be able to identify his/her clothing. He stated that today (04/16/15); the resident had two (2) sweatshirts, one (1) polo shirt, and one (1) pair of sweat pants in his/her closet. Additionally, CNA #3 stated the resident sometimes would put on more than one piece of clothing at a time and might go through half of their clothing in one (1) day. CNA #3 stated the facility was oftentimes short of linen for the residents' beds. At the start of shift there would be times when there would be no linen in the Linen Closet on the 200 Unit. When that happened, the aides would have to go to the Laundry Room or other units to search for sheets and pillow cases. Interview, on 04/22/15 at 9:50 AM, with the Director of Social Services revealed the grievance related to Resident #7's laundry not being returned to his/her room, was given to the Head of Housekeeping and Laundry. She stated then it was the Head of Housekeeping and Laundry's responsibility to resolve the issue. Interview with the Head of Housekeeping and Laundry, on 04/28/15 at 3:05 PM, revealed regarding Resident #7's clothing not being returned, he had obtained a list of the missing clothing from the family, and personally escorted the family member to the Laundry Room so the family member could search for Resident #7's	F 166		

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F 166	Continued From page 32 clothes. He then informed the Administrator that one (1) sweatshirt, one (1) pair of sweat pants, and one (1) shirt had been found. He stated the Executive Director nor the Social Services Director provided him with a copy of the written grievance form filed by Resident #7's family members. He was verbally informed of the family's concern. Interview with the Interim Executive Director/Vice President of Operations, on 05/05/15 at 3:55 PM revealed she did not recall a grievance that concerned Resident #7; however, she recalled other issues with residents' clothing and the previous Executive Director had mentioned to her clothing had not been getting back to the residents. She stated sometimes clothing was not marked with the resident's name. Interview, on 04/17/15 at 10:05 AM, with the Unit Manager for the 200 Unit, revealed the aides were responsible for putting clothing in the soiled linen rooms and shower rooms so that laundry staff could collect and take the clothing to the laundry room, and the laundry aides were responsible for washing, and delivering to the residents' rooms. Interview, on 04/22/15 at 11:11 AM, with Housekeeper/Laundry Aide #1, assigned to the 200 Unit, revealed her duties as a Laundry Aide included washing, drying, folding linen and clothing, and delivering clothing to the resident rooms. She checked clothing for a name marked in the clothing to ensure clothing was returned to the correct owner. She stated all clothing was	F 166		

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F 166	Continued From page 33 supposed to have the resident's name written inside the clothing for identification of the owner. Interview with Unsampled Resident C, on 04/21/15 at 5:20 PM, revealed he/she had missing clothing (three pairs of pants). The resident stated he/she was capable of advocating for himself/herself and therefore he/she did not report the missing items. Rather he/she wrote a signed note that informed staff not to steal, and taped the note to the bottom of his/her television. Interview, on 04/22/15 at 4:18 PM, with Family Member #1 revealed although she would personally wash and return Resident #33's clothing, the clothing still got lost. When she could not find the resident's clothing, she brought it to the attention of staff and staff would take her to the Laundry Room where she personally searched for the resident's clothes. 2. Review of the Resident Council Meeting minutes for 01/07/15, 02/04/15, 03/04/15, and 04/01/15, revealed residents expressed concerns about not getting clothing back from the laundry. There were also concerns that the CNAs were not picking up the dirty laundry from resident rooms, shower rooms, and soiled linen rooms. Interview, on 04/27/15 at 2:13 PM, with the Activity Assistant, revealed one of her responsibilities included recording the minutes at each Resident Council Meeting. She recalled recording in January, February, and March 2015	F 166		

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F 166	Continued From page 34 residents' concerns about personal laundry not being picked up and returned timely. She did not know whether the Laundry Department was short staffed. She stated the head of each department attended the meetings. Further interview revealed the department head responsible for a concern expressed during a resident council meeting would address the concern by talking to the resident and explaining how their concern was going to be handled. 3. Review of Resident #3's clinical record revealed the facility admitted the resident on 07/27/12, with diagnoses of Chronic Pain, Cerebral Vascular Accident, Anemia, Heart Failure, Hypertension, Anxiety, Depression, and Chronic Lung Disease. Review of Resident #3's Quarterly Minimum Data Set (MDS) assessment, completed on 02/17/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the resident was assessed with a score of thirteen (13), which meant the resident was cognitively intact and interviewable. Review of Resident #3's Comprehensive Care Plan revealed the facility developed a care plan on 07/18/13, with updated goals and a target date of 05/18/15. The problem on the care plan stated Resident #3, required assistance with activities of daily living due to multiple medical problems and left sided paralysis. The goal stated the resident would continue to be highly involved in their daily care needs within safety limits. The approaches included direction for staff to: provide assistance with activities of daily living as indicated; encourage the resident to be as independent as	F 166		

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F 166	Continued From page 35 possible; and anticipate toileting needs and assist to the toilet. Interview with Resident #3, on 04/14/15 at 1:15 PM, revealed the resident routinely attended the monthly Resident Council meeting and had made complaints regarding care, services and environmental issues. Resident #3 stated the facility had not resolved the issues discussed at the meetings. The resident stated he/she had an overactive bladder and recently had put on the call light for assistance in order to go to the toilet. The resident stated he/she had to wait over an hour for staff to answer the call light. Resident #3 stated while waiting he/she was incontinent of urine and this had upset him/her. Resident #3 stated he/she had complained to the facility staff about the laundry, staff throwing the roommate's (Resident #18) clean clothes on the floor in their closet; however, nothing had been done to rectify her complaint and the clothes were still on the floor. Resident #3 stated Resident #18 was blind and required total care by staff and he/she was advocating for Resident #18. Resident #3 stated he/she had made complaints to staff related to the preference of wanting to stay up until 9:00 PM. Resident #3 stated due to staffing shortages and the need for transfer assistance by staff, he/she had to go to bed between 6:00 PM and 8:30 PM and this was also upsetting. But he/she felt they did not have a choice and had to comply. Observation of Resident #3's shared closet space with Resident #18, on 04/14/15 at 1:15 PM, revealed the right side of the closet contained numerous folded and unfolded items of clothing on the closet floor.	F 166		

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F 166	Continued From page 36	F 166		

Interview with Maintenance, on 04/14/15 at 3:00 PM, revealed he was aware of Resident #3's request to fix the closet door. He stated he had forgotten about the request and would fix it immediately. He stated he was the only maintenance person in the building and did not have any assistance with completing all his tasks. He stated he had to prioritize his tasks and resident requests and not everything was completed timely. The Maintenance technician stated he was unable to locate a repair request for Resident #3's closet door.

Interview with the Housekeeping Director, on 05/15/15 at 1:45 PM, revealed the laundry staff was responsible for putting the resident's clean laundry in the resident's dressers and closets. He stated his laundry staff was trained not to put clean clothes on the floor and if resident's closets or dressers were full their families would be called to discuss storage or placement of all clean clothes. He stated he was unaware of Resident #3's grievance regarding Resident #18's clothes being thrown on the floor in the closet.

4. Review of Resident #8's clinical record revealed the facility admitted the resident on 04/18/14, with diagnoses of Hypoxia, Respiratory Failure, Stage Three Renal Disease, Cerebral Vascular Accident, Congestive Heart Failure, Hypertension, Decubitus, and Toxic Metabolic Encephalopathy.

Review of Resident #8's Quarterly Minimum Data Set (MDS) assessment, completed on 03/25/15, revealed a Brief Interview for Mental Status

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F 166	Continued From page 37 (BIMS) exam was conducted and the facility assessed the resident with a score of fifteen (15) meaning the resident was cognitively intact and interviewable. Interview with Resident #8, on 04/16/15 at 8:48 AM, revealed the resident had made complaints to nursing staff regarding the call light not being answered timely, bathing, nail care and that there was not a lift available to get him/her out of bed when requested. The resident stated he/she felt like the facility did not care and it did not do any good to complain. Observation, on 04/16/15 at 8:48 AM, revealed Resident #8's call light was not within reach, but was hanging on the wall behind and to the side of the resident's bed. Resident #8's fitted sheet for their bariatric bed was thin and torn in various areas. The resident's nails were long and had a black substance underneath them. 5. Review of Resident #9's clinical record revealed the facility admitted the resident on 08/14/14, with diagnoses of Anemia, Coronary Artery Disease, Hypertension, Peripheral Vascular Disease, Traumatic Brain Injury, Anxiety, Depression, and Chronic Obstructive Pulmonary Disease and Dementia. Review of Resident #9's Minimum Data Set (MDS) assessment, completed on 03/03/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of fifteen (15),	F 166		

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F 166	Continued From page 38 which meant the resident was cognitively intact and interviewable. Interview with Resident #9, on 04/16/15 at 8:41 AM, revealed the resident had put on the call light thirty (30) minutes ago and wanted help with getting some cranberry juice and his/her brief changed. The resident stated it had been two (2) weeks since he/she had taken a shower and received a shave. The resident stated he/she had made complaints to staff about the care and services; however, nothing had been done to resolve the issues. Observation of Resident #9, on 04/17/15 at 10:40 AM, revealed the resident was in the bed with no covering over his/her body, wearing a brief and a t-shirt. The resident's left leg was amputated above the knee, the resident's face was unshaven and the room had a strong odor of urine. Interview with Certified Nursing Assistant (CNA) #1, on 04/17/15 at 10:55 AM, revealed she was assigned to take care of Residents #8 and #9 and when her shift started today there were just two (2) aides and the third aide did not come in until 10:00 AM. She stated it was difficult to get residents up and ready for breakfast with only two aides on the unit. She stated she was also responsible for passing the breakfast trays and feeding the ten (10) residents that needed total assistance. She stated several residents needed the assistance of two (2) to get out of bed. She stated she changed the incontinent residents and dressed those that were gotten up, but due to	F 166		

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F 166	Continued From page 39 time constraints and staffing she was not able to shave, provide oral, or comb the hair of all her residents. She stated the residents had complained about care and services and she had forwarded the information to her supervisors; however, staffing was still a problem. Interview with Registered Nurse #8, on 04/16/15 at 3:45 PM, revealed the facility had a staffing shortage and when there were only two (2) Certified Nursing Assistants on for the unit; call lights did not always get answered timely. He stated the usual staffing pattern was for the 100 Unit to have only two (2) CNAs on duty. He stated the schedule would say there were four (4) CNAs on the unit, but that was not the reality. He called this scheduling process "Ghost Staffing". He also stated employees were chronically late to work. Further interview revealed if there were four (4) CNAs on the unit it would take five to six minutes to answer call lights; however, if there were only two CNAs then it could take twenty (25) to thirty (30) minutes to answer call lights. He stated management was aware of the residents' complaints; however, nothing had been done as far as he knew to correct the problems. He said they did the best they could with the staff on duty. 6. Review of Resident #10's clinical record revealed the facility admitted the resident on 05/01/14, with diagnoses of Hypertension, Chronic Atrial Fibrillation, Quadriplegic, Neuropathy, Muscle Spasms, Gastro-esophageal Disease, Proteus Urinary Tract Infection, and Chronic Ileus resolved.	F 166		

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Review of Resident #10's Annual Minimum Data Set (MDS) assessment, completed on 02/03/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of fifteen (15) which meant the resident was cognitively intact and interviewable.

Interview with Resident #10, on 04/14/15 at 9:25 AM, revealed the resident had many concerns with nursing care, food service and linens provided by the facility. Resident #10 stated he/she was unable to move and was totally dependent upon staff for care. The resident stated he/she was left wet all night long due to the facility not having enough staff. Resident #10 stated his/her food was cold most of the time due to not enough staff to deliver it timely and to assist with feeding him/her. The resident stated there were not enough sheets to change his/her bariatric bed and the few sheets available had holes in them and they were thin. Further interview revealed there were not enough pillow cases to cover the pillows so the staff would put them under the sheets when they positioned him/her. The resident stated he/she had spoken with the staff regarding the issues; however, they had yet to be resolved.

Interview, on 04/22/15 at 9:50 AM, with the Director of Social Services revealed the system for handling grievances was that all grievances reported on a Concerns Form would be forwarded to her and documented on the Grievance Tracking Log, which was maintained by her department. The investigation of the grievance would then be given to the department

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F 166	Continued From page 41 head who was responsible for the concern. Interview with the Assistant Director of Clinical Services (ADCS), on 04/20/15 at 2:35 PM, revealed the facility had a staffing shortage and due to the insufficient numbers of staff this prevented the facility from providing all the necessary care and services. She stated answering call lights was not always timely; especially when they were short staffed. She stated she was unable to complete her ADCS supervisory duties because she had been working as a floor nurse and aide due to staffing shortages. Interview, on 05/04/15 at 2/;20 PM, with the Interim Director of Clinical Services (DCS), revealed she expected staff to answer call lights timely and check on residents frequently to meet their needs. She stated she expected nursing to make rounds to ensure residents' activities of daily living were completed. Further interview revealed she expected staff to report issues if they were not able to complete their tasks. The DCS stated she expected the Nurse Managers to supervise the staff and the ADCS to supervise the Nurse Managers to ensure resident care needs were met. Interview with the Interim DCS, on 04/29/15 at 7:55 AM, revealed she was only employed by the facility for two (2) weeks and was not aware resident complaints or needs were not being met. Interview with the Interim Executive	F 166		

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F 166	Continued From page 42 Director/Regional Vice President of Operations, on 04/23/15 at 8:34 AM, revealed she did not remember specifics regarding resident grievances or complaints. She stated the Resident Council and other individual residents made complaints regarding lost clothing and clothing not being returned timely, linen shortages, along with call lights not being answered timely. She stated the facility's staffing shortage was the underlying issue to the problems in the facility. Further interview revealed she tried to address the resident's concerns with the contracted Housekeeping and Laundry Company the facility used and improvements occurred. However, it did not last and the issues would return again. Interview with Interim Executive Director/Regional Vice President of Operations, on 04/28/15 at 9:40 AM, revealed she was not aware of any complaints from residents not receiving care and services. She stated prior to becoming the Interim ED she visited the building and made rounds with the previous ED to discuss and identify opportunities for improvement. She stated she did not make notes of their findings or discussions for follow up and was unable to provide evidence of any corrections made from the rounds. Interview with the Interim Executive Director/Vice President of Operations, on 05/05/15 at 3:55 PM revealed grievances should be discussed in the morning meetings, addressed, resolved within five (5) days, and follow-up with the individual who initiated the grievance. She stated the Social Services Department was responsible for tracking	F 166		

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	the grievance process, and forwarded concerns to the respective Department Head. Depending on the grievance, the Department Head responsible assisted with the process until resolved, and then returned the form to Social Services, "who kept everything together". After the resolution of a grievance, it was brought back to the morning meeting. Interview with the Head of Housekeeping and Laundry, on 04/28/15 at 3:05 PM, revealed upon admission, residents, and their family should be informed to mark clothing with the resident's name for identification purposes. Nevertheless, his department always received lots of clothing that was not marked with the resident's name. He stated all unmarked and unclaimed clothing was donated. When his department received a grievance, he personally made contact with the individual who had the concern so the individual would know their concerns were not ignored. The Head of Housekeeping and Laundry explained the breakdown in the system was due to Admissions not informing resident/family that clothing had to be marked; CNAs not placing dirty clothing in the shower rooms and soiled linen rooms; having too many clothing to pick-up several times per day throughout the facility; and being under staffed.			
F 225 SS=J	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide	F 225		

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registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

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.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of the facility's policy and investigation, it was determined the facility failed to have an effective system to ensure incidents were reported and investigated when a resident

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F 225	Continued From page 45 received an injury of unknown origin for one (1) of forty-three (43) sampled residents (Resident #25). On 03/25/15 during the 7:00 AM-3:00 PM shift, Registered Nurse (RN) #6 noted the Resident #25's right eye was swollen and bruised on the side with a small cut. The resident had a history of wandering into other resident rooms, both male and female. The facility could not provide any evidence the incident was reported or investigated until 04/28/15 after surveyor intervention. The facility's failure to have an effective system in place to ensure all injuries of unknown origin were reported and investigated has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy and Substandard Quality of Care was identified on 05/12/15 and determined to exist on 03/25/15. An acceptable Allegation of Compliance (AOC) was received on 05/19/15 alleging the Immediate Jeopardy was removed on 05/16/15. The State Survey Agency (SSA) validated the Immediate Jeopardy was removed on 05/16/15 as alleged, prior to exit on 05/22/15. The scope and severity was lowered to a D while the facility monitors the implementation of the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes. The findings include: Review of the facility's policy regarding Resident Abuse, revised 01/01/12, revealed all reported events, including bruises, would be investigated by the Director of Clinical Services (DCS), and	F 225		

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forwarded to the Executive Director (ED) who was also the facility's Abuse Coordinator. All incidents of abuse should be reported immediately to the Clinical Nurse in Charge, DCS, and ED. The Abuse Coordinator was responsible to report the incident to the appropriate officials. The facility should investigate all reports of suspected abuse. The Abuse Coordinator should be notified and the Clinical Nurse in Charge or DCS should perform and document a thorough nursing assessment and notify the physician. The facility investigation should include statements from the victim, suspects, and all possible witnesses that included other employees.

Review of the facility's policy regarding Resident Abuse-Injuries of Unknown Origin, dated 11/30/14, revealed injuries of unknown origin also included bruises with no known cause. The Executive Director (ED) and Director of Clinical Services (DCS) should be notified immediately, and the responsible party (RP) and physician should also be notified. The ED, DCS, or designee should begin a documented investigation of the cause of the injury and that would include interviews with the resident, all staff involved, or anyone who may help with the investigation. All injuries of unknown origin should be reported to the state agencies.

Review of the facility's policy regarding Accident and Incident Investigations, dated 11/30/14, revealed certain accidents and incidents, which included injuries of unknown origin, would be investigated to determine root cause and provide an opportunity to decrease future occurrence of the event. Injuries of unknown origin included bruises with no known cause. Any occurrence not

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F 225	Continued From page 47 part of routine care of a resident would need an incident report completed. Bruises required the completion of the Bruise Root Cause Investigation form. Injuries of unknown origin required the appropriate investigative form. The Executive Director (ED) and the Director of Clinical Services (DCS) should be immediately notified of injuries of unknown origin. Notification must be made to the resident's responsible party and the physician. The ED or DCS should begin a documented investigation of the cause of injury. The investigation would include interviews with the resident, all staff involved, who may have had contact with the resident and/or may help with the investigation. All injuries of unknown origin should be reported to the appropriate agencies per State protocols. Review of the facility's Bruise Root Cause Investigation Report, revised September 2014, revealed the form would document a description of the bruise, environmental contributing factors, resident contributing factors, and the details of the injury. Review of the facility's blank Situation, Background, Appearance, Review (SBAR) Communication Form, dated 2014, revealed the Situation of the incident, Background of the resident's care, Resident's Evaluation, the Appearance of the resident, and Review and Notification to the physician, and also to the responsible party (RP) was to be documented. On 04/23/15, surveyor requested evidence of the investigation of Resident #25's black eye around the date of 03/25/15 from the DCS. It was determined the facility staff working at the time of the incident had not reported to the DCS or ED,	F 225		

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investigated, made notifications to the physician, RP, completed an SBAR, or a nursing assessment.

Review of Resident #25's clinical record revealed a nurse's note by Registered Nurse (RN) #6, on 03/25/15 from 7:00 AM to 3:00 PM, stating the resident had wandered in and around the dayroom. The resident's right eye was swollen and bruised on the side with a small cut. The resident had often wandered into other resident rooms, both male and female. Continued review of the record revealed a skin assessment was completed on 03/25/15 by RN #6; however, review of the skin assessment revealed no documentation of the right eye bruising or the small cut. Review of the Skin Assessment form, dated 03/24/15, revealed the right eye bruising and cut were not documented until 04/24/15, thirty-one (31) days later.

Interview with RN #6, on 04/23/15 at 1:15 PM, revealed she could not recall what occurred to cause Resident #25's black eye. She stated with an injury to the head, a SBAR and neuro-checks should have been completed, and the incident should have been documented on the twenty-four (24) hour report. However, there was no documented evidence this process was followed when the bruising was identified on 03/25/15.

Continued review of the clinical record for Resident #25 revealed a psychiatric note, dated 03/30/15, that indicated the resident had right eye bruising. The note further indicated per nursing staff notes the resident wandered the unit day and night, often into other resident rooms. The resident was recently punched by another resident whose room Resident #25 had wandered

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into.

Review of a Social Service note, dated 04/20/15, revealed the Director of Social Services (DSS) and Unit Manager (UM) met with Resident #25's responsible party (RP) to discuss the resident's eye injury and the facility's failure to notify the RP of the injury. Further review revealed the UM documented she would investigate the RP's concern regarding the eye injury.

Observation of Resident #25, on 04/22/15 at 10:50 AM, revealed the resident had yellowed discoloration of the skin around the outside of the right eye, from the forehead to cheekbone. Interview, on 04/22/15 at 10:59 PM with Resident #25, whom the facility assessed with impaired cognitive status, revealed he/she did not know what happened to his/her eye.

Review of the facility's investigation of physical abuse for Resident #25, dated 04/28/15 after surveyor intervention, revealed the resident was noted to have a bruise to his/her right eye on 03/25/15. Statements given by Certified Nurse Assistant (CNA) #2, dated 04/28/15, revealed she worked at 11:00 PM on 03/23/15 and noted immediately that Resident #25 had a small cut above the right eye; however, there was no bruising, and had not received a report about an injury. The aide stated toward the end of the shift, the resident began to bruise and she reported to RN #1 about the black eye. The CNA further indicated she informed LPN #1 and the Director of Clinical Services (DCS) at the time, that Unsampled Resident A had stated to her that Resident #29 had hit Resident #25. The facility investigation further revealed the Director of Social Services (DSS) interviewed Resident #29

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F 225	Continued From page 50 and Unsampled Resident A on 04/28/15 and both residents denied any knowledge of what happened to Resident #25's eye. Interview with Resident #29, on 05/01/15, by the DCS, revealed he/she stated that he/she did hit Resident #25 in the eye as Resident #25 had come into the room at night while dark and tried to get into bed with him/her. Resident #29 stated he/she did not mean to hurt Resident #25; however, it had scared him/her. On 04/23/15 at 2:35 PM, interview with CNA #2 revealed Resident #25 had at times wandered in and out of resident rooms. She stated the resident had a black eye because he/she wandered into another resident's room about a month ago. The aide stated she did not witness the incident; however, was told about it from Resident #2's roommate, Unsampled Resident A and the incident occurred on the second shift. She stated she had worked third shift and noticed a small cut over Resident #25's eye, and about an hour later the eye began to bruise. The CNA further stated she reported to the charge nurse on third shift when the eye started to bruise; however, she could not remember who the nurse was at the time. Interview, on 04/27/15 at 11:42 PM, with RN #1 revealed he worked with Resident #25 on third shift. He stated he could not remember when the resident's eye injury had been brought to his attention; however, he had been given the information in report. RN #1 stated the nurse who gave him report was unsure what had occurred and he was unsure which nurse had given him the report. The RN stated the nurse on duty at the time of the incident (including injury of unknown origin) should have assessed the resident,	F 225		

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F 225	Continued From page 51 completed a SBAR, notified the physician and RP, and completed neuro checks for 24 hours. On 04/24/15 at 1:24 PM, continued interview with the RN #6 revealed she noticed Resident #25's eye when she came in to work the day of 03/25/15. The nurse stated she was informed by staff they heard a loud yell and found the resident in his/her bed with blood all over the pillow, and staff thought Resident #25 had been hit. She further stated she was not sure which nurse had reported the incident to her, was uncertain if the incident occurred on second or third shift, and could not recall if she had notified a supervisor about the incident. She stated Resident #25 had a noticeably big black eye and she completed a nurse's note. The RN stated one of the Social Workers talked to Resident #29 and Unsampled Resident A. She further stated Unsampled Resident A had reported that Resident #29 hit Resident #25. She could not recall if she notified anyone in management about the incident. Interview, on 04/27/15 at 11:15 AM, with LPN #1 revealed he was not Resident #25's nurse at the time; however, he and RN #6 were working first shift when they both saw Resident #25's eye. He stated he did not know when or how the resident received the injury. The nurse stated he could not remember who the nurse on duty was on the previous shift. Interview with the DSS, on 04/27/15 at 2:05 PM, revealed RN #6 had reported to her (the DSS) when she had came on duty on the first shift on 03/25/15 and discovered Resident #25 with an injury to the eye and that Unsampled Resident A had been irritable with Resident #25. The DSS stated she spoke to Resident #29 and	F 225		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HURSTBOURNE CARE CENTRE AT STONY BROOK	2200 STONY BROOK DR LOUISVILLE, KY 40220

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F 225	Continued From page 52 Unsampled Resident A who both said they did not know anything about the incident. She stated she talked to Resident #25 who was not able to answer reliably or sensibly and saw his/her black eye. The DSS further stated she did not document the instance as both Resident #29 and Unsampled Resident A said they did not know anything. She stated she could not recall if the black eye was discussed in the morning meeting or if it was on the 24 hour report. The DSS stated no one at the facility asked her to further investigate Resident #25's black eye and nursing was responsible to conduct the investigation. She further stated the facility was now conducting an investigation into Resident #25's eye injury. She stated with this injury the DCS and ED should have been notified. Interview with the UM, on 04/24/15 at 9:35 AM, revealed she was on vacation at the time of Resident #25's injury that resulted in a black eye. She stated the nurse's note by RN #6 for first shift on 03/25/15 stated the resident had bruising to his/her right eye. The UM stated the DCS at the time of the incident would be responsible to investigate the injury. She stated an incident report should be completed, and the physician and RP notified immediately. The UM stated the nurse should have also completed a SBAR, which would also include notification the physician and RP. She stated the injury was documented on the twenty-four (24) hour report; however, those reports were only kept by the facility for a few weeks and the facility no longer had it for the time of Resident #25's eye injury. She further stated she assessed 03/31/15 Resident #25 and saw bruising; however, she did not document her assessment because it had been so long since the incident occurred.	F 225		

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F 225	Continued From page 53 On 04/28/15 at 8:35 AM, interview with the DCS revealed she had just begun as the DCS on 04/20/15. She stated the UM had informed her Resident #25 had a fall that resulted in the eye bruising, and the UM had been on vacation. However, she could not find any information about Resident #25's black eye. The DCS stated Resident #25's injury would require an investigation, a head to toe assessment, and notification to the physician and RP. She stated the purpose of the investigation was to try and determine what happened. The DCS stated she would expect to find a SBAR, incident report, neuro checks since the injury occurred on the head, and notifications. She stated if those items were not completed, the resident could have an injury the facility was not aware of, which could cause harm to the resident. She stated the incident report was the root cause analysis form that should be completed by the nurse that discovered the injury. The DCS further stated if the incident report was not completed, there would not be any follow up with the resident, the facility would not know if the resident was injured, and the facility would not know how the incident occurred. She stated the purpose of the root cause analysis was to try and determine how the incident occurred in order to try to prevent the incident from occurring again. The DCS stated the 24 hour reports were reviewed in the morning clinical meeting and any change of a resident's condition should be documented on the 24 hour report. She further stated the 24 hour reports were kept for thirty (30) days and then shredded. She stated the facility had already discarded the 24 hour reports from the time of Resident #25's black eye.	F 225		

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F 225	Continued From page 54 Interview with the Interim ED/Regional VP of Operations, on 04/28/15 at 9:43 AM, revealed she had been the Interim ED since 04/17/15, and had been the facility Regional VP of Operations since May 2014. She stated she first became of aware of Resident #25's eye injury when the State Survey Agency (SSA) survey process began on 04/14/15. She stated the facility did not conduct an investigation into the black eye at the time the injury occurred. The Interim ED further stated the purpose of the root cause analysis was to prevent other injuries. She stated the incident report should have been completed by the nurse and given to the UM, who would take the information to the morning meeting. She stated the facility no longer had the morning meeting notes for March as they were only kept for thirty (30) days. The Interim ED stated if the investigation was not completed the facility would not know what the cause of the incident was and could place the resident at risk of re-injury. Continued interview with the DCS, on 05/05/15 at 2:52 PM, revealed the facility should report abuse to the SSA immediately and begin an investigation. She stated the investigation should be conducted timely to protect the residents and try to prevent the incident from happening again. The DCS stated she had been trained to report abuse immediately. She further stated she monitored that allegations of abuse were reported during the morning clinical meeting, and used the twenty-four (24) hour report, and the nurse's notes. She stated if the incident was not documented in those records, she would not be aware of an allegation of abuse. Continued interview, on 05/05/15 at 3:05 PM, with the Interim ED revealed she was the facility's	F 225		

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F 225	Continued From page 55 Abuse Coordinator and any incident that required an investigation and notification to the SSA would be reported to her. She stated the facility needed to know the root cause of Resident #25's black eye to prevent the injury from occurring again. The Interim ED stated as the Regional Vice President of Operations she was unaware of the resident's black eye, and only discussed with the ED at the time the number of reportable incidents, and not specific residents. Continued interview with the DCS, on 05/20/15 at 2:04 PM, revealed she was first aware of Resident #25's black eye by the SSA on 04/28/15. She stated she initially thought the black eye was a current issue and assessed the resident with no noted injury. She stated she began to investigate and interview staff and residents to try and figure out how the resident received a black eye in March. The DCS stated Social Services was responsible to initiate the investigation. She further stated if an investigation was not conducted then abuse could continue or other residents could be injured. She stated if the interviews conducted during the investigation were not documented, then the facility could not prove an investigation was conducted, or who felt safe in the facility. Continued interview with the Interim ED, on 05/21/15 at 8:23 AM, revealed Resident #25's black eye should have been reported to the SSA and investigated at the time it occurred. She stated whoever reported the black eye should have also reported to the next level of supervision. The Interim ED further stated the investigation should have been conducted jointly by Social Services, the ED, and the DCS. She stated if an investigation was not conducted, the	F 225		

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facility would not have put anything in place to prevent the incident from occurring again.

The facility took the following actions to remove the Immediate Jeopardy on 05/16/15 as follows:

1. On 04/28/15, the facility reported to the SSA that Resident #25 was found to have a black eye on 03/25/15. The incident was investigated and with the assistance of the SSD and DCS the source of the black eye was determined as a result of a resident to resident altercation and abuse was unsubstantiated.

2. One hundred twenty-one (121) residents were assessed by a nurse for suspicious injuries on 05/12/15 and 05/13/15. No suspicious injuries were found.

3. Current residents with BIMS Scores of twelve (12) or higher were interviewed by the ED, on 05/12/15 and 05/13/15, about their safety.

4. Staff in Nursing, Dietary, Housekeeping and Laundry, and Therapy were interviewed by the ED/Assistant ED on 05/12/15, 05/13/15, and 05/14/15. Two (2) new allegations of abuse/neglect that required reporting to the SSA were reported on 05/14/15.

5. The Corporate Administrative RNs educated 107 of 149 staff and fourteen (14) agency staff on abuse and neglect and injuries of unknown origin from 05/09/15 through 05/14/15 with competency. Forty-two (42) staff not educated as of 05/14/15 will not be allowed to work without having been educated prior to the start of their shift. Agency staff will be educated prior to working their next shift. Staff, through the use of a Performance

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F 225	Continued From page 57 Improvement tool, staff were aware of the types of abuse, injuries of unknown origin, and when and whom to report to. Forty- two (42) staff not educated as of 05/14/15 6. One hundred twelve (112) of 112 employee personnel files were reviewed by the Regional Director of HR (RDHR), facility HR, and BOM to ensure files were complete with criminal background checks, nurse aide abuse registry checks, and abuse training. The RDHR corrected discrepancies on 05/13/15. Ongoing reviews of five (5) new employee files would occur twice weekly. 7. The ED or DCS would review all allegations of abuse, complete the 24 hour report, investigation, and five (5) day report. 8. The QAPI Committee met on 05/13/15 and reviewed the Policy and Procedures (P&P) for abuse with no changes made. 9. The Regional Director of Clinical Services (RDCS) reviewed potential reportable events were completed on 04/21/15 through 04/24/15, 04/26/15 through 04/29/15, 05/01/15, 05/04/15, 05/06/15, 05/09/15, and on 05/11/15 with no issues identified. On 05/14/15 the RDCS reviewed abuse allegations and investigations for the last ninety (90) days for timely reporting, investigation, and resolution. 10. An Ad-Hoc QAPI Committee meeting on 05/15/15 discussed ongoing quality improvement monitoring for abuse and neglect reporting beginning 05/16/15 using an approved audit tool and included:	F 225		

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F 225	Continued From page 58 a. Five (5) resident interviews on 05/12/15 and ongoing five (5) times weekly. b. Skins sweeps on 05/08/15, 05/12/15, 05/13/15 completed by a nurse and reviewed by RDCS, Corporate Administrative RNs, DCS, ADCS, or Nurse Manager for any suspicious injuries, of five (5) residents, five (5) times a week. c. Beginning 04/21/15 and ongoing the RDCS, RVPO, RDHR will review new allegations of abuse and neglect for timely reporting, investigation, and resolution once a week. d. On 05/15/15 and ongoing new resident and family concerns would be reviewed by the ED, RDCS, RCPO, RDHR, or Corporate Administrative RNs for resolution five (5) times a week. e. On 05/12/15 an ongoing Daily Department Head Meeting led by the ED and DCS would be attended by Corporate Administrative RN, RDCS, RVPO, or RDHR to ensure new resident injuries or concerns were discussed five (5) times weekly. 11. An Ad-Hoc QAPI meeting held on 05/15/15 for ongoing QI monitoring of the facility process for abuse and neglect reporting is done, and call lights, beginning 05/16/15 using an approved audit tool. Any issues identified in audits were addressed and ongoing plans developed. 12. On 05/13/15, Corporate Administrative RNs educated facility Administrative Staff on the regulations and P&P for staffing, pest control, housekeeping, and maintenance, with competencies completed. The ED would monitor the facility's process for notification, abuse, hiring,	F 225		

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dignity, care plan revision, professional standards, assessments, behavior and falls management, incidents and accidents, smoking, call lights, pest control, and staffing.

13. New employee files would be reviewed by the ED or Corporate Administrative Nurses for completeness two (2) times weekly.

14. Daily oversight since 04/22/15 on all shifts to ensure residents were safe and the plan of care was followed to meet resident needs, by the ED/ DCS/ RVPO/RDCS/Corporate Administrative Nurses.

15. The IDT would meet at least monthly to discuss facility action plan and ensure tasks were completed for the removal of the IJ, and QA monitoring completed according to the AOC during the IJ period, validated by the ED/RVPO/RDCS/Corporate Administrative RNs.

16. Per the Ad-Hoc QAPI meeting, on 05/16/15, QI monitoring would be done utilizing approved audit tool with oversight by the ED, beginning 05/16/15, five (5) resident interview; new resident/ family concerns; daily department head meeting to ensure new resident injuries or concerns were discussed; five (5) new employee files reviewed two (2) times weekly;

The State Survey Agency validated the removal of Immediate Jeopardy on 05/22/15 as follows:

1. Review of the facility investigation, dated 04/28/15, for Resident #25's black eye noted on 03/25/15, revealed the SSA was notified on 04/28/15, investigated, and followed up on 05/04/15. The investigation resulted in the cause

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of the injury from a resident to resident altercation. Interview with the DCS, on 05/20/15 at 2:04 PM, revealed she investigated Resident #25's black eye and the cause was determined to be a resident to resident altercation. Observation, on 05/22/15 at 2:11 PM of Resident #25 revealed the resident was in his/her recliner with the TV on and staff sitting with him/her on a 1:1.

2. Review of skin sweeps, dated 05/12/15 and 05/13/15, for one hundred twenty-one (121) residents revealed no suspicious injuries were identified. Interview with the RDCS, on 05/22/15 at 8:59 AM, revealed all residents skin were assessed for any injuries that did not have reasonable cause. Observation of Resident #25, on 05/05/15 at 2:11 PM, Unsampled Resident KK, on 05/05/15 at 2:11 PM, Resident #8, on 05/22/15 at 4:20 PM, Resident #6, on 05/05/15 at 2:26 PM, revealed no concerns with new or unknown injuries.

3. Review of resident interview questionnaire, dated 05/12/15 and 05/13/15, revealed residents with a BIMS Score of twelve (12) or more were interviewed by the Executive Director about their safety, no concerns identified. Interview with the DCS, on 05/22/15 at 2:52 PM, revealed residents were interviewed about their safety with no concerns identified. Interview with Resident #8, on 05/22/15 at 4:20 PM, revealed the resident felt safe in the facility.

4. Review of staff questionnaires, dated 05/12/15 and 05/13/15, revealed staff were interviewed by the ED to determine if any staff member had witnessed abuse or neglect. Review of two (2) facility reports to the SSA revealed the reports were made on 05/14/15. Interview with the DCS,

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F 225	Continued From page 61 on 05/22/15 at 2:52 PM, revealed staff were interviewed about abuse. She stated two (2) new additional reports were made and investigations were begun. 5. Review of in-service records, dated 05/09/15 through 05/14/15, revealed one hundred one (107) staff and fourteen (14) agency staff were educated on abuse and neglect and injury of unknown origin, with staff competencies completed. Interview with CNA #7, on 05/22/15 at 8:05 AM, RN #6, on 05/22/15 at 8:13 AM, with Housekeeper, on 05/22/15 at 8:20 AM, with LPN #1, on 05/22/15 at 8:25 AM, CNA #8, on 05/22/15 at 8:37 AM, had been trained on abuse and neglect, could name the types of abuse, and who and when to report. Interview, on 05/22/15 at 2:52 PM, with the DCS, Maintenance Director, ADCS, UM, Staffing Coordinator, Medical Records, MDS Coordinator, Housekeeping Supervisor, revealed they had been trained on abuse. 6. Review of one hundred twelve (112) employee file audits, dated 05/13/15, revealed employee files were audited by the Regional Director of Human Resources by the Regional Director of Clinical Services for criminal background checks, nurse aide abuse registry, OIG checks, and telephone reference checks with no discrepancies corrected. Review of the QAPI meeting, held on 05/15/15, five (5) new employee files would be reviewed for completeness, twice a week. Review of five (5) new employee files, dated 05/15/15 and 05/20/15, revealed they were complete with criminal checks, nurse aide abuse registry, OIG checks, and reference checks. 7. Review of the facility abuse allegation investigations, revealed complete investigations	F 225		

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and five day follow up. Interview with the RDCS, on 05/22/15 at 12:07 PM, revealed allegations were reviewed for investigation and follow up.

8. Review of a QAPI sign in sheet, dated 05/13/15, revealed review of the P&P for abuse with no changes made. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, ADCS, UM, Staffing Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS had all been trained on abuse, and staff trained on abuse.

9. Review of facility investigations , dated 04/21/15 through 04/24/15, 04/26/15 through 04/29/15, 05/01/15, 05/04/15, 05/06/15, 05/09/15, 05/11/15, revealed incidents were reviewed by the RDCS for regulatory compliance and timeliness with no issues identified. Review of the investigations audit for the last thirty (30) days, dated 05/14/15, revealed the investigations were reviewed for timely reporting, investigation, and resolution. Interview with the RDCS, on 05/22/15 at 12:07 PM, revealed she completed the review of investigations with no concerns.

10. Review of the sign in sheet and agenda for QAPI meeting, dated 05/15/15, revealed monitoring of abuse and neglect reporting: resident interviews, dated 05/12/15, 05/13/15, 05/15/15, 05/16/15, 05/18/15, 05/19/15, would be completed for five (5) residents five (5) times weekly; skin sweeps, dated 05/08/15, 05/12/15, 05/13/15, and would be conducted for five (5) residents five (5) times a week; beginning 05/15/15 resident and family concerns would be reviewed five (5) times weekly; beginning 05/12/15 and on 05/15/15, 05/18/15, 05/19/15, 05/20/15, daily meeting would discuss new

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resident injuries or concerns five (5) times weekly; and use of an abuse audit tool for abuse reporting beginning on 05/15/15. Observation of the daily meeting, on 05/22/15 at 9:05 AM, revealed specific residents were discussed in regard to specific resident concerns. Interview with the DCS, on 05/22/15 at 2:52 PM, revealed residents were discussed in the morning meeting for specific concerns and plan.

11. Review of the sign in sheet for an Ad-Hoc QAPI meeting, dated 05/15/15, and audit tools revealed abuse and neglect reporting was monitored by the QA.

12. Review of in-service records, dated 05/13/15, revealed Administrative staff were trained on staffing, pest control, housekeeping and maintenance, and would be monitored by the ED. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS revealed they had been trained on staffing, pest control, housekeeping and maintenance, and any concerns of audits would be taken to the morning meeting. Interview with Resident #3 on 05/22/15 at 1:00 PM, revealed staffing had improved and were answering lights timely and the facility looked cleaner.

13. Review of audits for employee files revealed they were audited twice per week by the Executive Director/RDHR/RVPO/RDCS or Corporate Administrative Nurse.

14. Interview, on 05/22/15 at 2:52 PM, with the DCS revealed facility concerns were reviewed in the morning meeting, including audits and

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F 225	Continued From page 64 rounding results, for department heads to address. She stated she (the DCS) or the ED would initial when concerns were resolved. Observation, on 05/22/15 at 9:05 AM, of the morning meeting revealed the DCS provided direction and asked clarifying questions related to information discussed with follow up items determined. 15. Review of sign in sheets, dated 04/22/15, 05/13/15, and 05/15/15, revealed QAPI meetings were held on those dates. Interview, with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS revealed they attended the QAPI meetings. Interview with the RDCS, on 05/22/15 at 5:05 PM, revealed the next QAPI meeting was scheduled for 06/17/15. Interview with the Medical Director, on 05/22/15 at 8:00 AM, revealed he was informed by the Executive Director of the resident care issues, attended the QA meetings held by the facility and provided direction regarding corrective action plans that were developed to meet the needs of the residents. 16. Review of the QAPI sign in sheet, dated 05/15/15, and agenda revealed audit tools were approved for QA monitoring and discussed: resident interviews; resident/family concerns; morning meeting; new employee files; falls or behaviors reviewed; care plans and Kardexes update; review of the 24 hour report; notifications; maintenance rounds and book; supervised smoking; falls interventions in place; call lights; weekly falls; and, behavior management meetings.	F 225		

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F 226 SS=J	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to have a system in place to ensure staff followed the policy to report and investigate an incident when a resident received an injury of unknown origin for one (1) of forty-three (43) sampled residents (Resident #25). (Refer to F225) During the 7:00 AM-3:00 PM shift on 03/25/15, Registered Nurse (RN) #6 noted Resident #25's right eye was swollen and bruised with a small cut. The resident was noted wandering around within the dayroom. The resident had a history of wandering into other resident rooms, both male and female. The facility could not provide any evidence the incident was reported or investigated until 04/28/15 after surveyor intervention. The facility's failure to have an effective system in place to ensure staff followed the policy regarding reporting and investigating injuries of unknown origin has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy and Substandard Quality of Care was identified on 05/12/15 and determined	F 226		

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F 226	Continued From page 66 to exist on 03/25/15. An acceptable Allegation of Compliance (AOC) was received on 05/19/15 alleging the Immediate Jeopardy was removed on 05/16/15. The State Survey Agency (SSA) validated the Immediate Jeopardy was removed on 05/16/15 as alleged, prior to exit on 05/22/15. The scope and severity was lowered to a D while the facility monitors the implementation of the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes. The findings include: Review of the facility's policy regarding Resident Abuse, revised 01/01/12, revealed all reported events, including bruises, would be investigated by the Director of Clinical Services (DCS), and forwarded to the Executive Director (ED) who was also the facility's Abuse Coordinator. All incidents of abuse should be reported immediately to the Clinical Nurse in Charge, DCS, and ED. The Abuse Coordinator was responsible to report the incident to the appropriate officials. The facility should investigate all reports of suspected abuse. The Abuse Coordinator should be notified and the Clinical Nurse in Charge or DCS should perform and document a thorough nursing assessment and notify the physician. The facility investigation should include statements from the victim, suspects, and all possible witnesses that included other employees. Review of the facility's policy regarding Accident and Incident Investigation, dated 11/30/14, revealed certain accidents and incidents would be investigated to determine root cause and provide	F 226		

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an opportunity to decrease future occurrence of the event. Injuries of unknown origin for example bruises with no known cause were included. Occurrences that were not part of the routine care of a resident required an incident report be completed. The Bruise Root Cause Investigation form was required for bruises with no known cause. Injuries of unknown origin required the appropriate investigative form. Notification must be made immediately to the resident's responsible party (RP) and physician as well as the Executive Director (ED) and the Director of Clinical Services (DCS). The ED or DCS should begin a documented investigation of the cause of injury and should include interviews with the residents and staff. All injuries of unknown origin should be reported to the appropriate agencies per State protocols.

Review of the facility's policy regarding Resident Abuse-Injuries of Unknown Origin, dated 11/30/14, revealed injuries of unknown origin also included bruises with no known cause. The RP, physician, DCS, and ED should be immediately notified. The ED, DCS, or designee should begin a documented investigation of the cause of the injury and would include interviews with the resident, staff, or anyone who may help with the investigation. Injuries of unknown origin should also be reported to the State agencies.

Review of Resident #25's clinical record revealed a nurse's note by Registered Nurse (RN) #6, on 03/25/15 from 7:00 AM to 3:00 PM, stating the resident's right eye was swollen and bruised on the side with a small cut. Record review revealed a skin assessment was completed on 03/25/15 by RN #6; however, review of the skin assessment revealed no documentation of the

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right eye bruising or the small cut. Record review revealed the right eye bruising and cut were not documented until 04/24/15, thirty-one (31) days later.

On 04/23/15, surveyor requested evidence of the investigation of Resident #25's black eye to the Director of Clinical Services (DCS) and the Executive Director (ED). The facility was unable to provide evidence that it had investigated the incident, notified the physician or the responsible party (RP) of the eye injury, or completed a nursing assessment of Resident #25's eye injury per the facility's policy and procedures. Interview with the DCS, on 04/24/15 at 2:20 PM, revealed she was not able to locate a facility investigation of Resident #25's black eye.

Interview with the RN #6, on 04/24/15 at 1:24 PM, revealed when she came in to work, on 03/25/15, she noticed Resident #25 had a noticeably big black eye and she completed a nurse's note. She stated no one completed an assessment or any other documentation for the incident, all which should have been completed by the shift on which the incident occurred. The nurse stated she did not complete any of the required forms nor could she recall if she notified anyone in management about the incident per the facility's policy and procedures.

On 04/27/15 at 2:05 PM, interview with the Director of Social Services (DSS) revealed RN #6 had reported to her (the DSS) that she had discovered Resident #25 with an injury to the eye when she reported to work on 03/25/15. The DSS reported nursing was responsible to conduct the investigation and no one at the facility asked her to further investigate Resident #25's black

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eye. However, review of the facility's policy and procedures revealed the ED or DCS should begin a documented investigation of the cause of injury. Per interview, the type of injury Resident #25 sustained to his/her eye required the DCS and ED to be notified. Clinical record review and review of facility provided materials revealed there was no documented evidence the DSS notified either the DCS or the ED.

Interview with the UM, on 04/24/15 at 9:35 AM, revealed the investigation of the black eye would have been the responsibility of the DCS at the time of the incident. She stated an incident report should be completed, and the physician and RP notified immediately. However, there was no evidence this was done per the facility's policy and procedures.

On 04/28/15 at 8:35 AM, interview with the DCS revealed the nature of Resident #25's injury, a black eye, would require an investigation, a head to toe assessment, and notification to the physician and RP. However, this procedure was not followed per the facility's policy.

Continued interview, on 05/05/15 at 2:52 PM, with the DCS revealed the facility should report abuse to the SSA immediately and begin an investigation, per the facility policy, to protect the residents and try to prevent the incident from happening again. Continued interview, on 05/20/15 at 2:04 PM, revealed the facility did not follow its policy to document, investigate, and report the incident.

Interview, on 04/28/15 at 9:43 AM, with the Interim ED/Regional Vice President of Operations (RVPO), revealed she had been the Interim ED

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F 226	Continued From page 70 since 04/17/15, and had been the facility Regional VP of Operations since May 2014. She stated she was not aware of Resident #25's eye injury until the State Survey Agency (SSA) survey process had begun. She stated the facility did not conduct an investigation into the black eye at the time the injury occurred as required by facility policy. Further interview with the Interim ED/Regional Vice President of Operations (RVPO), on 05/05/15 at 3:05 PM, revealed she was the facility's Abuse Coordinator as the ED and any incident should be reported to her that required an investigation and then reported to the SSA. She further stated, per the facility's policy, an investigation should have been initiated and appropriate agencies notified immediately. However, there was no documented evidence this was process was completed at the time Resident #25's injury was identified. Continued interview, on 05/21/15 at 8:23 AM, revealed the facility's policy was not followed and an investigation was not conducted. Per interview, due to the process not being followed, the facility would not have put anything in place to prevent the incident from occurring again and there could be another resident to resident altercation. Interview with the DCS, on 05/20/15 at 2:04 PM, and record review revealed the facility initiated their investigation on 04/28/15 after the DCS was notified of Resident #25's black eye by the SSA. The facility took the following actions to remove the Immediate Jeopardy on 05/16/15 as follows: 1. On 04/28/15, the facility reported to the SSA that Resident #25 was found to have a black eye on 03/25/15. The incident was investigated and	F 226		

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F 226	Continued From page 71 with the assistance of the SSD and DCS the source of the black eye was determined as a result of a resident to resident altercation and abuse was unsubstantiated. 2. One hundred twenty-one (121) residents were assessed by a nurse for suspicious injuries on 05/12/15 and 05/13/15. No suspicious injuries were found. 3. Current residents with BIMS Scores of twelve (12) or higher were interviewed by the ED, on 05/12/15 and 05/13/15, about their safety. 4. Staff in Nursing, Dietary, Housekeeping and Laundry, and Therapy were interviewed by the ED/Assistant ED on 05/12/15, 05/13/15, and 05/14/15. Two (2) new allegations of abuse/neglect that required reporting to the SSA were reported on 05/14/15. 5. The Corporate Administrative RNs educated 107 of 149 staff and fourteen (14) agency staff on abuse and neglect and injuries of unknown origin from 05/09/15 through 05/14/15 with competency. Forty-two (42) staff not educated as of 05/14/15 will not be allowed to work without having been educated prior to the start of their shift. Agency staff will be educated prior to working their next shift. Staff, through the use of a Performance Improvement tool, staff were aware of the types of abuse, injuries of unknown origin, and when and whom to report to. Forty- two (42) staff not educated as of 05/14/15 6. One hundred twelve (112) of 112 employee personnel files were reviewed by the Regional Director of HR (RDHR), facility HR, and BOM to ensure files were complete with criminal	F 226		

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F 226	Continued From page 72 background checks, nurse aide abuse registry checks, and abuse training. The RDHR corrected discrepancies on 05/13/15. Ongoing reviews of five (5) new employee files would occur twice weekly. 7. The ED or DCS would review all allegations of abuse, complete the 24 hour report, investigation, and five (5) day report. 8. The QAPI Committee met on 05/13/15 and reviewed the Policy and Procedures (P&P) for abuse with no changes made. 9. The Regional Director of Clinical Services (RDCS) reviewed potential reportable events were completed on 04/21/15 through 04/24/15, 04/26/15 through 04/29/15, 05/01/15, 05/04/15, 05/06/15, 05/09/15, and on 05/11/15 with no issues identified. On 05/14/15 the RDCS reviewed abuse allegations and investigations for the last ninety (90) days for timely reporting, investigation, and resolution. 10. An Ad-Hoc QAPI Committee meeting on 05/15/15 discussed ongoing quality improvement monitoring for abuse and neglect reporting beginning 05/16/15 using an approved audit tool and included: a. Five (5) resident interviews on 05/12/15 and ongoing five (5) times weekly. b. Skins sweeps on 05/08/15, 05/12/15, 05/13/15 completed by a nurse and reviewed by RDCS, Corporate Administrative RNs, DCS, ADCS, or Nurse Manager for any suspicious injuries, of five (5) residents, five (5) times a week.	F 226		

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F 226	Continued From page 73 c. Beginning 04/21/15 and ongoing the RDCS, RVPO, RDHR will review new allegations of abuse and neglect for timely reporting, investigation, and resolution once a week. d. On 05/15/15 and ongoing new resident and family concerns would be reviewed by the ED, RDCS, RCPO, RDHR, or Corporate Administrative RNs for resolution five (5) times a week. e. On 05/12/15 an ongoing Daily Department Head Meeting led by the ED and DCS would be attended by Corporate Administrative RN, RDCS, RVPO, or RDHR to ensure new resident injuries or concerns were discussed five (5) times weekly. 11. An Ad-Hoc QAPI meeting held on 05/15/15 for ongoing QI monitoring of the facility process for abuse and neglect reporting is done, and call lights, beginning 05/16/15 using an approved audit tool. Any issues identified in audits were addressed and ongoing plans developed. 12. On 05/13/15, Corporate Administrative RNs educated facility Administrative Staff on the regulations and P&P for staffing, pest control, housekeeping, and maintenance, with competencies completed. The ED would monitor the facility's process for notification, abuse, hiring, dignity, care plan revision, professional standards, assessments, behavior and falls management, incidents and accidents, smoking, call lights, pest control, and staffing. 13. New employee files would be reviewed by the ED or Corporate Administrative Nurses for completeness two (2) times weekly.	F 226		

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F 226	Continued From page 74 14. Daily oversight since 04/22/15 on all shifts to ensure residents were safe and the plan of care was followed to meet resident needs, by the ED/ DCS/ RVPO/RDCS/Corporate Administrative Nurses. 15. The IDT would meet at least monthly to discuss facility action plan and ensure tasks were completed for the removal of the IJ, and QA monitoring completed according to the AOC during the IJ period, validated by the ED/RVPO/RDCS/Corporate Administrative RNs. 16. Per the Ad-Hoc QAPI meeting, on 05/15/15, QI monitoring would be done utilizing approved audit tool with oversight by the ED, beginning 05/16/15, five (5) resident interview; new resident/ family concerns; daily department head meeting to ensure new resident injuries or concerns were discussed; five (5) new employee files reviewed two (2) times weekly; The State Survey Agency validated the removal of Immediate Jeopardy on 05/22/15 as follows: 1. Review of the facility investigation, dated 04/28/15, for Resident #25's black eye noted on 03/25/15, revealed the SSA was notified on 04/28/15, investigated, and followed up on 05/04/15. The investigation resulted in the cause of the injury from a resident to resident altercation. Interview with the DCS, on 05/20/15 at 2:04 PM, revealed she investigated Resident #25's black eye and the cause was determined to be a resident to resident altercation. Observation, on 05/22/15 at 2:11 PM of Resident #25 revealed the resident was in his/her recliner with the TV on and staff sitting with him/her on a 1:1.	F 226		

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F 226	Continued From page 75 2. Review of skin sweeps, dated 05/12/15 and 05/13/15, for one hundred twenty-one (121) residents revealed no suspicious injuries were identified. Interview with the RDCS, on 05/22/15 at 8:59 AM, revealed all residents skin were assessed for any injuries that did not have reasonable cause. Observation of Resident #25, on 05/05/15 at 2:11 PM, Unsampled Resident KK, on 05/05/15 at 2:11 PM, Resident #8, on 05/22/15 at 4:20 PM, Resident #6, on 05/05/15 at 2:26 PM, revealed no concerns with new or unknown injuries. 3. Review of resident interview questionnaire, dated 05/12/15 and 05/13/15, revealed residents with a BIMS Score of twelve (12) or more were interviewed by the Executive Director about their safety, no concerns identified. Interview with the DCS, on 05/22/15 at 2:52 PM, revealed residents were interviewed about their safety with no concerns identified. Interview with Resident #8, on 05/22/15 at 4:20 PM, revealed the resident felt safe in the facility. 4. Review of staff questionnaires, dated 05/12/15 and 05/13/15, revealed staff were interviewed by the ED to determine if any staff member had witnessed abuse or neglect. Review of two (2) facility reports to the SSA revealed the reports were made on 05/14/15. Interview with the DCS, on 05/22/15 at 2:52 PM, revealed staff were interviewed about abuse. She stated two (2) new additional reports were made and investigations were begun. 5. Review of in-service records, dated 05/09/15 through 05/14/15, revealed one hundred one (107) staff and fourteen (14) agency staff were educated on abuse and neglect and injury of	F 226		

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F 226	Continued From page 76 unknown origin, with staff competencies completed. Interview with CNA #7, on 05/22/15 at 8:05 AM, RN #6, on 05/22/15 at 8:13 AM, with Housekeeper, on 05/22/15 at 8:20 AM, with LPN #1, on 05/22/15 at 8:25 AM, CNA #8, on 05/22/15 at 8:37 AM, had been trained on abuse and neglect, could name the types of abuse, and who and when to report. Interview, on 05/22/15 at 2:52 PM, with the DCS, Maintenance Director, ADCS, UM, Staffing Coordinator, Medical Records, MDS Coordinator, Housekeeping Supervisor, revealed they had been trained on abuse. 6. Review of one hundred twelve (112) employee file audits, dated 05/13/15, revealed employee files were audited by the Regional Director of Human Resources by the Regional Director of Clinical Services for criminal background checks, nurse aide abuse registry, OIG checks, and telephone reference checks with no discrepancies corrected. Review of the QAPI meeting, held on 05/15/15, five (5) new employee files would be reviewed for completeness, twice a week. Review of five (5) new employee files, dated 05/15/15 and 05/20/15, revealed they were complete with criminal checks, nurse aide abuse registry, OIG checks, and reference checks. 7. Review of the facility abuse allegation investigations, revealed complete investigations and five day follow up. Interview with the RDCS, on 05/22/15 at 12:07 PM, revealed allegations were reviewed for investigation and follow up. 8. Review of a QAPI sign in sheet, dated 05/13/15, revealed review of the P&P for abuse with no changes made. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, ADCS, UM, Staffing Coordinator, Medical	F 226		

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F 226	Continued From page 77 Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS had all been trained on abuse, and staff trained on abuse. 9. Review of facility investigations , dated 04/21/15 through 04/24/15, 04/26/15 through 04/29/15, 05/01/15, 05/04/15, 05/06/15, 05/09/15, 05/11/15, revealed incidents were reviewed by the RDCS for regulatory compliance and timeliness with no issues identified. Review of the investigations audit for the last thirty (30) days, dated 05/14/15, revealed the investigations were reviewed for timely reporting, investigation, and resolution. Interview with the RDCS, on 05/22/15 at 12:07 PM, revealed she completed the review of investigations with no concerns. 10. Review of the sign in sheet and agenda for QAPI meeting, dated 05/15/15, revealed monitoring of abuse and neglect reporting: resident interviews, dated 05/12/15, 05/13/15, 05/15/15, 05/16/15, 05/18/15, 05/19/15, would be completed for five (5) residents five (5) times weekly; skin sweeps, dated 05/08/15, 05/12/15, 05/13/15, and would be conducted for five (5) residents five (5) times a week; beginning 05/15/15 resident and family concerns would be reviewed five (5) times weekly; beginning 05/12/15 and on 05/15/15, 05/18/15, 05/19/15, 05/20/15, daily meeting would discuss new resident injuries or concerns five (5) times weekly; and use of an abuse audit tool for abuse reporting beginning on 05/15/15. Observation of the daily meeting, on 05/22/15 at 9:05 AM, revealed specific residents were discussed in regard to specific resident concerns. Interview with the DCS, on 05/22/15 at 2:52 PM, revealed residents were discussed in the morning meeting for specific concerns and plan.	F 226		

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F 226	Continued From page 78 11. Review of the sign in sheet for an Ad-Hoc QAPI meeting, dated 05/15/15, and audit tools revealed abuse and neglect reporting was monitored by the QA. 12. Review of in-service records, dated 05/13/15, revealed Administrative staff were trained on staffing, pest control, housekeeping and maintenance, and would be monitored by the ED. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS revealed they had been trained on staffing, pest control, housekeeping and maintenance, and any concerns of audits would be taken to the morning meeting. Interview with Resident #3 on 05/22/15 at 1:00 PM, revealed staffing had improved and were answering lights timely and the facility looked cleaner. 13. Review of audits for employee files revealed they were audited twice per week by the Executive Director/RDHR/RVPO/RDCS or Corporate Administrative Nurse. 14. Interview, on 05/22/15 at 2:52 PM, with the DCS revealed facility concerns were reviewed in the morning meeting, including audits and rounding results, for department heads to address. She stated she (the DCS) or the ED would initial when concerns were resolved. Observation, on 05/22/15 at 9:05 AM, of the morning meeting revealed the DCS provided direction and asked clarifying questions related to information discussed with follow up items determined.	F 226		

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F 226	Continued From page 79 15. Review of sign in sheets, dated 04/22/15, 05/13/15, and 05/15/15, revealed QAPI meetings were held on those dates. Interview, with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS revealed they attended the QAPI meetings. Interview with the RDCS, on 05/22/15 at 5:05 PM, revealed the next QAPI meeting was scheduled for 06/17/15. Interview with the Medical Director, on 05/22/15 at 8:00 AM, revealed he was informed by the Executive Director of the resident care issues, attended the QA meetings held by the facility and provided direction regarding corrective action plans that were developed to meet the needs of the residents. 16. Review of the QAPI sign in sheet, dated 05/15/15, and agenda revealed audit tools were approved for QA monitoring and discussed: resident interviews; resident/family concerns; morning meeting; new employee files; falls or behaviors reviewed; care plans and Kardexes update; review of the 24 hour report; notifications; maintenance rounds and book; supervised smoking; falls interventions in place; call lights; weekly falls; and, behavior management meetings.	F 226		
F 241 SS=K	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241		

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F 241	Continued From page 80 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 have an effective system in place to ensure resident dignity for nine (9) of forty-three (43) sampled residents (Residents #5, #6, #8, #9, #10, #20, #24, #36, and #39) and three (3) of thirty-nine (39) unsampled residents, (Unsampled Residents D, N and LL). Observations revealed ants in the facility and Interviews with Resident #24 and Resident #8 revealed they had ants in their beds and crawling on their bodies. Interviews with Resident #8 revealed he/she was mad and felt the staff did not care and Resident #24 was scared and had to scream out for staff to help him/her. In addition, the facility failed to toilet residents timely as to not cause embarrassment from urinary accidents, provide incontinent care and check/change to ensure residents did not remain in wet briefs for extended periods or in urine stained sheets. The facility failed to ensure food debris on residents clothing and pests were removed promptly and residents were afforded the right to privacy in semi-private rooms. The facility's failure to have an effective system in place to promote resident care in a manner and in an environment free of pest that enhanced the resident's dignity and respect has caused or is likely to cause serious injury, harm, impairment or death to resident. Immediate Jeopardy and Substandard Quality of Care was identified on 04/21/15 and determined to exist 04/19/15.	F 241		

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F 241	Continued From page 81 An acceptable Allegation of Compliance (AOC) was received on 05/19/15 alleging the Immediate Jeopardy was removed on 05/16/15. The State Survey Agency validated the Immediate Jeopardy was removed on 05/16/15 as alleged, prior to exit on 05/22/15. The scope and severity was lowered to an E while the facility monitors the implementation of the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes. The findings include: Review of the facility's policy regarding Incontinent Resident Care, dated 11/30/14, revealed incontinent residents would be cared for by nursing personnel to ensure adequate skin care, odor control, and provide personnel hygiene. Review of the facility's policy regarding Activities of Daily Living, dated 11/30/14, revealed all residents would remain at their highest level of self-help or independence. The role of the Clinical Services staff was to teach, support and supervise the resident in regaining and maintaining these functions. Review of the facility's policy regarding AM Care, dated 11/30/14, revealed Clinical Services personnel would offer AM care each day to ensure resident's overall comfort, cleanliness, good grooming, and general well-being.	F 241		

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F 241	Continued From page 82	F 241		

Residents who were capable of performing their own personal care would be encouraged to do so. Showers, baths, and shampoos would be scheduled at least weekly and more often if needed.

Review of the facility's policy regarding Pest Control, dated 11/30/14, revealed the facility would maintain a pest control program.

Tour of the 100 Unit, on 04/14/15 at 1:00 PM, revealed a strong odor of urine permeated throughout the unit.

Tour of the 200 Unit, on 04/16/15 at 1:45 PM, revealed a strong odor of urine permeated throughout the unit and was stronger by rooms 211 and 212.

Observation of the 200 Unit, on 04/16/15 at 3:16 PM, revealed the odor of urine remained strong and was stronger by room 206 and going down that hallway.

1. Review of Resident #24's Annual Minimum Data Set (MDS) assessment, completed on 05/10/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a fifteen (15) meaning the resident was cognitively intact and interviewable.

Review of the Comprehensive Care Plan for Resident #24 revealed the facility developed a

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F 241	Continued From page 83 care plan on 12/01/14, with updated goals and target date for 08/10/15. The problem on the care plan stated the resident required staff assistance for all activities of daily living. The goal stated the resident would be clean, neat and appropriately dressed daily through the next review. The approaches listed directed staff to provide assistance with activities of daily living as needed, anticipate needs and wants and provide necessary care. Observation of Resident #24's room, on 04/21/15 at 4:45 PM, revealed ants were crawling on the bedside table and inside packaging that contained supplies to change Resident #24's dressings. Spiders and spider webs were observed above the closet doors and behind the head of the resident's bed on the walls close to the floor. Observation of a denture cup on Resident #24's night stand revealed the inside of the cup contained dentures, a clear liquid and the sides of the container contained an unknown black substance. Interview with Certified Nursing Assistant (CNA) #7, 04/15/15 at 9:10 AM, revealed staff heard Resident #39 screaming for help from their room. The CNA stated when staff went into the resident's room they found ants crawling on the resident and in the resident's bed. The CNA stated the resident was a quadriplegic and staff had to use the lift to remove the resident from the bed in order to remove the ants from the resident's body and the bed. Interview with Certified Nursing Assistant (CNA)	F 241		

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F 241	Continued From page 84 #9, 04/22/15 at 9:15 AM, revealed she did not know what the black substance in Resident #24's denture cup was; however she stated it was due to staff not changing the water in the cup often enough. Interview with Resident #24, on 04/21/15 at 4:45 PM, revealed the resident had an ant crawling on their pillow this morning. Resident #24 stated ants had been crawling on him/her last week and that was when he/she was screaming for help. The resident stated staff had to get him/her out of the bed using the lift equipment in order to remove the ants from the bed and his/her body. The resident stated then again on 04/19/15 ants were crawling on his/her face. Resident #24 said he/she was afraid the ants would crawl up into their nose and ears or even get into their wounds and private area. The resident continued to state they were deathly afraid of spiders. Resident #24 stated he/she did see someone outside his/her window spraying for bugs, but no one had been into the resident's room to address the ant issue. Resident #24 stated the ants were every where in the room and they were all over and inside the denture cup that contained his/her dentures. Interview with Licensed Practical Nurse (LPN) #24, on 04/22/15 at 3:25 PM, revealed she had found ants on Resident #24 this morning and was on duty last week when the resident was found with numerous ants in the bed and all over the body. She stated she had not seen pest control in the building for some time now. She stated the facility leadership had been made aware of the pest infestation.	F 241		

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F 241	Continued From page 85 Interview with Unit Manager (UM), on 04/21/15 at 3:25 PM, revealed Resident #24 was found with ants on them and in their bed. She said the resident was cleaned up, and pest control called; however, she was unaware there were additional incidents and residents with pests in their bed and on their bodies. 2. Review of Resident #39's Annual Minimum Data Set (MDS) assessment, completed on 03/31/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a fifteen (15) which meant the resident was cognitively intact and interviewable. Review of the Comprehensive Care Plan for Resident #39 revealed the facility developed a care plan on 04/01/15, with updated goals and target date for 06/30/15. The problem on the care plan stated the resident had a decline in strength and endurance related to recent hospital stay and was now receiving assistance with activities of daily living. The goal stated the resident would have an increase in at least some of the activities of daily living and return to the highest level of function as possible and return home. The approaches stated the staff would provide assistance with activities of daily living as indicated, encourage the resident to be as independent as possible, and to be an assist of two with bed mobility, and transfers would be with a mechanical lift. In addition, the facility developed a plan of care on 04/01/15, with updated goals and target date for 06/30/15. The problem on the care plan stated the resident was	F 241		

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F 241	Continued From page 86 occasionally incontinent of urine due to stress incontinence. The goal stated the resident would not experience any infections or skin conditions from incontinence. The approach stated staff would assist the resident to the bathroom or commode as needed. Observation on, 04/29/15 at 2:12 PM, revealed Resident #39's call light was illuminated and at 2:15 PM the Activity Assistant entered and immediately exited the room and the light was no longer illuminated. Interview with Resident #39, on 04/29/15 at 2:15 PM, revealed the Activity Assistant said she was going to find someone to help the resident. Resident #39 said routinely it took a long time for staff to answer his/her call light and because the resident had waited so long for assistance he/she had urinated on themselves. The resident could not specify a time frame. The resident said he/she had held their urine as long as they could and it was very embarrassing to talk about wetting on themselves with this surveyor. The resident stated he/she was heavy and it took two (2) people to assist with toileting and because staff was not fast enough he/she had wet on himself/herself on many nights. The resident also said they were admitted in March and because of her impaired mobility and staffing issues he/she had only had their hair washed one time. Interview with Certified Nursing Assistant (CNA) #7, on 04/29/15 at 2:25 PM, revealed she was in Resident #10's room providing incontinent care when the activity assistant told her that Resident	F 241		

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F 241	Continued From page 87 #39 needed her assistance. She stated she was the only aide working on the Journey two (2) Unit and would be back to take care of Resident #39 when she finished with Resident #10. 3. Review of Resident #6's Quarterly Minimum Data Set (MDS) assessment, completed on 01/08/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of fourteen (14), which meant the resident was cognitively intact and interviewable. Review of the Comprehensive Care Plan for Resident #6 revealed the facility developed a care plan on 11/03/13, with updated goals and target date for 07/09/15. The problem on the care plan stated Resident #6 was incontinent of bowel and bladder related to a Urinary Tract Infection, and obesity as evidence by activities of daily living care tracker. The approaches included direction for staff to assist with toileting needs as needed and on a consistent schedule to promote continence, and check frequently for incontinence. Observation of Resident #6, on 04/16/15 at 10:45 AM, revealed the resident was lying in a bariatric bed. The sheet underneath the resident was thin, frayed and contained holes. The resident's hair appeared uncombed and greasy. Interview with Resident #6, on 04/16/15 at 10:45 AM, revealed he/she was left wet for seventeen hours (17) due to the facility not having enough staff to meet his/her needs. However, the resident could not specify a date or time frame. The	F 241		

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F 241	Continued From page 88 resident stated he/she did not want to be a "pain in the ass because it would just get worse and I do not want to throw anyone under the bus". The resident stated he/she weighed 332 pounds and due to this it took at least two (2) staff members to get him/her cleaned up after an incontinent episode. Resident #6 stated due to his/her weight the staff had to use a lift to get him/her out of bed and using the lift required the assistance of two (2) staff also. Resident #6 said he/she would be wet during the night shift and would have to wait till the day shift staff came on to get cleaned up. The resident stated there were times when he/she wanted to get out of bed to attend activities; however, there was not enough staff to accommodate the request. Resident #6 stated staff did not want to get him/her up out of bed and did not want to put him/her back to bed because of the lack of staffing assistance. The resident stated this made them feel upset. Resident #6 stated if he/she had an incontinent episode while up in the wheelchair, and requested to be changed, he/she had to wait until there was adequate staff available to change his/her brief, which at times took over an hour for there to be enough staff. The resident stated the staff would have to put him/her back to bed to change the brief and then due to time constraints and staffing shortages; would then encouraged the resident not to get back into the wheelchair so the resident felt like he/she had to comply. The resident stated this upset him/her, but what was he/she going to do? Resident #6 stated he/she had to take a bed bath routinely. Resident #6 stated the shower bed was	F 241		

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unsafe and was afraid he/she would fall on the floor because the rails would not stay up. The resident stated this preference prevented him/her from getting their hair washed as often as preferred. The resident said he/she was angry and scared.

Continued interview with Resident #6 revealed there were times the facility did not have full size bariatric fitted bed sheets to change his/her bed linens. The resident stated that if the staff removed the full size sheet it would take two (2) or three (3) days to get one back. The resident also stated he/she would get cold and there were never any blankets available when he/she needed one for warmth. The resident stated this made them feel mad and like the staff did not care about their needs.

Observation of Resident #6, on 04/17/15 at 11:10 AM, revealed the resident's hair appeared uncombed and greasy.

Continued interview with Resident #6, on 04/17/15 at 11:10 AM, revealed staff did not help the resident wash up prior to breakfast. The resident stated that type of assistance only happens on shower day. Resident #6 stated the staff had not provided repositioning help either. The resident stated it took two (2) staff to reposition him/her and due to staffing issues it was hard for staff to find assistance.

Further interviews with Resident #6 and interview with Unsampled Resident D, on 04/17/15 at 4:00 PM, revealed they had trouble getting urine pads for their bariatric beds. Instead of using urine pads, the CNAs used rolled up sheets to place underneath them. Unsampled Resident D stated

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F 241	Continued From page 90 the sheets on his/her bed on 04/17/15 were ripped and he/she did not even get a folded sheet to use as a urine pad. Resident #6 related that on 04/17/15 a folded sheet was placed in the center of his/her bed to be used as a urine pad. Resident #6 and Unsampled Resident D stated they did not feel good about not having urine pads, as the folded sheets did not work as well. The resident stated, well this did not make him/her feel good. Interview with Certified Nursing Assistant (CNA) #6, on 04/16/15 at 11:00 AM, revealed he was not able to complete all his assigned duties for twenty three residents that needed assistance with activities of daily living. He stated he had several residents that required total care. He stated the facility was short staffed and due to this those residents that required the assistance of two (2) to get up, turn and reposition or check and change, did not always have their needs met or if they were it was not timely. He stated if he was the only one working and he was giving a bath or assisting a resident he could not tend to his other assigned residents' needs. 4. Review of Resident #8's Quarterly Minimum Data Set (MDS) assessment, completed on 03/25/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of fifteen (15) which meant the resident was cognitively intact and interviewable. Review of the Comprehensive Care Plan for Resident #8 revealed the facility developed a care plan on 08/11/14, with updated goals and a target date for 05/24/15. The problem on the care plan	F 241		

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F 241	Continued From page 91 stated Resident #8 had impaired ability to perform own activities of daily living and self-mobility related to weakness, immobilization and chronic obstructive pulmonary disease. The goal stated the resident would improve self-care skills in at least one area of activities of daily living and mobility by next review on 05/24/15. The approaches listed stated staff was to provide assistance with activities of daily living, while promoting independence, promote dignity by assuring privacy and organize supplies by how or when they should be used and place within reach. Interview with Resident #8, on 04/16/15 at 8:48 AM, revealed the resident had urinated on him/herself during the night. The resident said he/she was unable to reach the call light to ring for assistance and instead hollered for staff to come help him/her. The resident stated staff walked by and did not come into his/her room. The resident stated this behavior made him/her feel like the staff did not care about them. Observation, on 04/16/15 at 8:48 AM, revealed Resident #8's call light was not within reach, but was hanging on the wall behind and to the side of the resident's bed and the room had a strong odor of urine. Resident #8's fitted sheet for the bariatric bed was thin and torn in various areas. The resident nails were long and had a black substance underneath them. The resident's mouth was full of unknown debris. Observation of Resident #8, on 04/22/15 at 9:15 AM, revealed the resident was sitting in their wheelchair beside the bed in the middle of the room. Observation of the wall beside the bed revealed ants were crawling on the wall and inside the baskets and bin that was on the floor	F 241		

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F 241	Continued From page 92 next to the bed. Interview with Resident #8, on 04/22/15 at 9:20 AM, revealed he/she had ants crawling in the bed with him/her and the staff cleaned them off of his/her body and removed the sheets from the bed. Resident #8 stated he/she felt like the management staff did not care and that it did not do any good to complain. Further interview revealed the resident put on their call light again last night because he/she was wet and wanted to be pulled up in the bed and the staff answered the light and said they would be back because they needed help. The resident said he/she fell back to sleep, woke up again and pushed the call light again and they turned if off again and did not come back for a while and remained wet until the change of the shift. Interview with Certified Nursing Assistant (CNA) #9, 04/22/15 at 9:15 AM, revealed she had seen ants in the bed with Resident #8 this morning during incontinent care. She stated she got the resident out of the bed and removed the sheets. She said she had not informed her supervisor yet, but the process was for her to write her findings in the maintenance book for management to address. 5. Review of Resident #9's Sixty-day (60) scheduled Minimum Data Set (MDS) assessment, completed on 03/03/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of fifteen (15) meaning the resident was cognitively intact and interviewable. Review of the Comprehensive Care Plan for	F 241		

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F 241	Continued From page 93 Resident #9 revealed the facility developed a care plan on 04/17/14, with updated goals and target date for 06/03/15. The problem on the care plan stated Resident #9 had urinary incontinence related to impaired physical mobility, a right above the knee amputation, neurogenic bladder and evidence of being incontinent of urine. The goal stated the resident would have no unrecognized urinary tract infections or skin breakdown related to incontinence. The approaches listed for staff to implement were to place the call light within reach at all times and to provide incontinence device of resident's choice for dignity. Observation of Resident #9, on 04/16/15 at 8:41 AM, revealed the resident was lying in the bed with an unshaven face and the room had a strong odor of urine. The resident's bed, floor, privacy curtain and wall beside the bed contained food debris. Interview with Resident #9, on 04/16/15 at 8:41 AM, revealed the resident had put on the call light thirty (30) minutes ago and wanted help with getting some cranberry juice and the brief changed. The resident stated it had been two weeks since he/she had taken a shower in the shower room. The resident stated this made him/her feel like the staff did not care about them. Further observation of Resident #9, on 04/17/15 at 10:40 AM, revealed the resident was in the bed with no covering over their body, wearing a brief and a t-shirt. The resident's left leg was amputated above the knee, the resident's face	F 241		

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F 241	Continued From page 94 was unshaven and the room had a strong odor of urine. Interview with Certified Nursing Assistant (CNA) #1, on 04/17/15 at 10:55 AM, revealed she was assigned to take care of Resident #4, #8 and #9 and when her shift started today there were just two (2) aides and the third aide did not come in until 10:00 AM. She stated it was difficult to get residents up and ready for breakfast with only two aides on the unit. She stated she was also responsible for passing the breakfast trays and feeding the ten (10) residents that needed total assistance. She stated several residents needed the assistance of two (2) to get out of bed. She stated she changed the incontinent residents and dressed those that were gotten up, but due to time constraints and staffing she was not able to shave, provide oral, or comb the hair of all her residents. 6. Review of Resident #10's Annual Minimum Data Set (MDS) assessment, completed on 02/03/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of fifteen (15) meaning the resident was cognitively intact and interviewable. Review of the Comprehensive Care Plan for Resident #10 revealed the facility developed a care plan on 03/31/14, with updated goals and target date for 05/03/15. The problem on the care plan stated Resident #10 was incontinent of bowel and bladder related to Quadriplegia. The goal stated the resident would show no evidence	F 241		

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F 241	Continued From page 95 of skin breakdown related to incontinence through next review. The approaches listed for staff to implement stated staff would assist with toileting needs as needed and on a consistent schedule to promote continence and to check frequently for incontinence. Interview with Resident #10, on 04/15/15 at 9:25 AM, revealed the resident had many concerns with nursing care and was left wet all night long due to the facility not having enough staff. Interview with Certified Nursing Assistant (CNA) #7, on 04/15/15 at 9:10 AM, revealed she was normally assigned to Resident #10. She stated she worked by herself most of the time. She stated even though the schedule listed another aide as working the unit with her the aide actually left and said they were not coming back and no replacement was provided. CNA #7 stated she was now responsible for sixteen residents and Resident #10 was totally dependent on staff due to being quadriplegic. She stated there were several other residents that also required the assistance of two staff to check and change, toilet and transfer and she could not do that by herself. She stated the nurses were not always available to assist her when needed. 7. Review of Resident #20's Annual Minimum Data Set (MDS) assessment, completed on 02/24/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of fifteen (15) meaning the resident was cognitively intact and interviewable.	F 241		

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Review of the Comprehensive Care Plan for Resident #20 revealed the facility developed a care plan on 02/27/15, with updated goals and target date for 05/27/15. The problem on the care plan stated the resident required total/extensive assistance with activities of daily living secondary to medical problems. The goal stated the resident would continue to be highly involved with daily care and make his/her wishes known through the next review. The approach for staff to implement stated staff would provide assistance with activities of daily living as indicated. The facility also developed a care plan on 02/27/15 with a Problem that stated Resident #20 was incontinent of bowel related to functional abilities. The approaches listed stated staff would offer and provide the bedpan upon request and assess for environmental factors that may contribute to the resident's incontinence.

Observation of Resident #20, on 04/16/15 at 9:11 AM, revealed the resident was sitting up in a bariatric bed.

Interview with Resident #20, on 04/16/15 at 9:11 AM, revealed the resident was wet from urinary incontinence and had requested to be changed, but was told by staff that he/she would have to wait until staff picked up the morning breakfast trays. The resident stated it was uncomfortable sitting in a wet bed.

Continued interview with Resident #20, on 04/16/15 at 10:00 AM, revealed the resident was

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still wet and staff had not been into change his/her brief or linens that were now wet with urine.

Interview with Resident #20, on 04/16/15 at 3:20 PM, revealed staff came into change his/her brief and sheets at noon. The resident stated it felt like forever to get cleaned up and changed. The resident said staff told him/her that it took them a while to find a sheet for the bed.

Interview with Certified Nursing Assistant #1, 04/17/15 at 10:55, revealed she had help CNA #34 change Resident #20 on 04/16/15 and said the unit was out of sheets and they had to wait until laundry came to the unit to change the resident.

8. Review of Resident #5's Significant Change Minimum Data Set (MDS) assessment, completed on 04/25/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of ninety-nine (99), which meant the resident was rarely/never understood.

Observation of Resident #5, on 04/15/15 at 1:05 PM, revealed the resident was in a recliner wearing a white t-shirt and gray pants with no shoes or socks on his/her feet.

Observation of Resident #5, on 04/16/15 at 3:30 PM, revealed Resident #5's mattress was lying directly on the floor and the resident was lying on

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top of the mattress. Next to the mattress was a blue vinyl matt with two (2) torn areas. The resident had food debris on his/her clothes and on the mattress. The resident's room did not have a privacy curtain available to curtain off each resident's living space in order to afford them the right to privacy if they desired.

Interview with Certified Nursing Assistants #2, #3, #4, on 04/17/15 at 2:50 PM, revealed

Observation of Resident #5, on 05/13/15 at 9:41AM, revealed residents were sitting and moving about the common area on the 200 Unit. Resident #5 was in a recliner in the common area close to the window and the resident's pants were down around their ankles, exposing their brief. Continued observation, on 05/13/15 at 9:41AM, revealed Licensed Practical Nurse #2 was sitting at the nursing station and got up and then walked over to the resident and pushed the resident into their semi-private room and then left the room. Further observation revealed the resident remained in the recliner and was next to a dresser and continued to have his/her pants down around the ankles.

Interview with Certified Nursing Assistant (CNA) #3, on 05/13/15 at 10:10 AM, revealed the CNA was walking out of Resident #7's room and stated he was in Resident #7's room providing care. He stated Licensed Practical Nurse #2 informed that Resident #5 needed his assistance, but he was busy taking care of Resident #7 and could not leave to address the request. He stated Resident #5 pulled the privacy curtain, and the

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F 241	Continued From page 99 track on the ceiling that held the curtain in place, down more than once. He stated it was important to provide the resident privacy in order to promote their dignity; however, this could not be done with out a curtain. Interview with License Practical Nurse #2, on 05/13/15 at 10:10 AM, revealed Resident #5 should be provided privacy but there were no curtains on the resident's side of the room. She stated the ceiling did not have a track for a curtain to be placed and believed the resident had pulled it down with the curtain. She stated without the curtain you would not be able to afford the resident privacy or maintain their dignity. Interview with Certified Nursing Assistant (CNA) #3, on 04/15/15 at 2:50 PM, revealed Resident #5 rolled out of the bed so many times that the decision was made to put the mattress on the floor to prevent falls. He stated a fall mat was placed next to the bed; now the resident rolls over onto the mat and sometimes onto the floor. He also said the resident frequently disrobes and staff had to assist the resident to remain clothed. The CNA stated he was very busy today and was not aware the resident did not have socks or shoes in place. He stated it was important to maintain resident dignity. Interview with Licensed Practical Nurse (LPN) #1, on 04/15/15 at 3:10 PM revealed Resident #5 disrobes and rolls out of the bed frequently and needed frequent reminding to leave clothes on and supervision to promote safety and dignity.	F 241		

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Interview with 200 Unit Manager, on 04/28/15 at 10:40 AM, revealed the resident had behaviors and pulled the privacy curtain down on several occasions causing it to break at the top where it connected to the track on the ceiling. She stated she had reported this to the Maintenance Director verbally and was unable to provide a date of the last occurence but said it occured sometime prior to 04/14/15. She stated she was unsure but believed the curtain was not going to be replaced since the resident continually pulled the curtain down.

Interview with Maintenance Director, on 04/30/15 at 3:00 PM, revealed he was putting a privacy curtain up in Resident #5's room; however, not on the resident's side of the room but on bed A's side. He stated they still needed the track for the ceiling for Resident #5's side of the room and was not sure when that was going to arrive. The Maintence Director did not provide documented evidence of when he was notified of the missing track/curtains or of when he placed the order for the track and curtains.

9. Review of Resident #36's Quarterly Minimum Data Set (MDS) assessment, completed on 03/21/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of fourteen (14) which meant the resident was cognitively intact and interviewable. Continued review of the MDS revealed the resident required extensive physical assistance of two (2) staff for bed mobility, transfers, and toileting. The MDS

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F 241	Continued From page 101 assessment also indicated the resident needed the assistance of one (1) with dressing and bathing. The resident required set up assistance for meals and staff to provide oversight, encouragement and cueing while eating. The MDS also stated the resident was frequently incontinent of bowel and bladder. Observation of Resident #36, on 04/29/15 at 9:55 AM, revealed the resident was sitting in a wheelchair beside the bed with food debris on his/her face and clothing. Observation of the resident's bed sheet revealed a yellow/brown circular stain and the bottom of the sheet was torn. A urinal containing a yellow liquid was observed on the night stand beside the bed. The opening of the urinal had an unknown food substance adhered to it which had several small black bugs stuck in the unknown substance. The resident's room had a strong odor of urine. Observation of the night stand on the right side of the resident's bed revealed a small rectangular storage container filled with a dark brown liquid. The resident's call light cord was observed to be on the floor and out of the resident's reach. Further observation of Resident #36, on 04/29/15 at 10:35 AM, revealed the resident's bed was made; however, there was a light brown circular stain on the pillow case and with loose hairs. The urinal containing a yellow liquid previously observed on the night stand beside the bed remained. The opening of the urinal still contained the unknown food substance with the several small black bugs stuck in the unknown substance. Observation of night stand on the right side of the resident's bed revealed a small	F 241		

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F 241	Continued From page 102 rectangular storage container filled with a dark brown liquid. The resident's room still had a strong odor of urine. Observation of Resident #36, on 04/29/15 at 12:53 PM, revealed the urinal containing a yellow liquid previously observed on the night stand beside the bed remained. The opening of the urinal still contained the unknown food substance with the several small black bugs stuck in the unknown substance. The resident's room still had a strong odor of urine. Further observation revealed small insects were flying around the resident's lunch tray and urinal. Food debris was observed on the floor. Observation revealed the resident had entered the bathroom and was trying to self toilet without assistance; surveyor obtained staff assistance. Continued observation, on 04/29/15 at 3:00 PM, of Resident #36's room, revealed a sticky liquid substance on the floor behind the head of the bed, a torn bed sheet, and a plastic Tupperware like container sitting on the nightstand filled to the top with a dark brown liquid that when opened had a strong urine odor. Interview with Resident #36, on 04/29/15 at 9:55 AM and 12:55 PM, revealed the resident wanted assistance with clothing and getting cleaned up. The resident was upset that staff had not been into assist with getting clothing from closet and helping him/her get cleaned up. Interview with Certified Nursing Assistant (CNA)	F 241		

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NAME OF PROVIDER OR SUPPLIER
HURSTBOURNE CARE CENTRE AT STONY BROOK

STREET ADDRESS, CITY, STATE, ZIP CODE
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F 241	Continued From page 103 #33 on 04/29/15 at 3:00 PM, revealed the she had not provided care to the resident prior to coming into the room upon surveyors request. She stated the CNA assigned to the resident had left. The surveyor questioned the CNA about the container with the brown liquid and she said she did not know what was inside the container. She removed the lid and a strong odor escaped and she stated the liquid was urine. 10. Review of Unsampled Resident LL's Quarterly Minimum Data Set (MDS) assessment, completed on 04/13/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of nine (9), which meant the resident was interviewable. Further review revealed the resident required oversight, cueing and encouragement with the needed assistance of one (1) person when eating meals. Review of Unsampled Resident N's Quarterly Minimum Data Set (MDS) assessment, completed on 04/08/15, revealed a Brief Interview for Mental Status (BIMS) exam was not conducted due to the resident was rarely/never understood. Further review revealed the resident required the assistance of one (1) person when eating meals. Observations of Unsampled Resident's LL and N, on 04/28/15 at 1:35 PM, revealed the residents were sitting in the common area during the lunch meal. The meal consisted of spaghetti and meat sauce. The residents were sitting at tables with food debris all down the front of their shirts,	F 241		

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F 241	Continued From page 104 pants, and shoes. The floor beside their feet had spaghetti noodles and sauce. Staff were observed in the common area; however, were not addressing the resident's need for assistance with eating or cleaning. Interview attempted with Unsampled Residents LL and N, on 04/28/15 at 1:35 PM, revealed Resident LL only said "good" when asked about the lunch meal and Resident N only made eye contact with this surveyor and made no attempt to answer, but continued to try and feed him/her self. Interview with Certified Nursing Assistants (CNAs) #2 and #3, on 04/28/15 at 1:50 PM, revealed the two CNAs were providing incontinent care and feeding other residents and did not notice Resident's LL and N with food all over their clothes and the floor. They both stated the residents required assistance from staff with meals. Interview with Licensed Practical Nurse (LPN) #5, on 04/22/15 at 3:25 PM, revealed that staffing was an issue and not all activities of daily living could be completed when only two (2) or three (3) aides were on the unit. She said the assigned aides were not on the unit, all at the same time, because they were allowed to come and go as they pleased. She stated when she came into work most mornings, the night shift aides were already gone, and usually there was only one Certified Medication Technician (CMT) and one Licensed Nurse on the floor.	F 241		

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F 241	Continued From page 105 She stated the unit had about thirty-six (36) to thirty-seven (37) residents and most needed the assistance of two (2) staff for activities of daily living. She said most of the time they would only have two (2) to (3) aides and she would be the only nurse working with a CMT that passed medications on one hall while she passed medications on the other hall. She stated she had treatments, dressing changes and assessments to complete and said she could not always complete all the required tasks and this included supervising the certified nursing assistants. She stated on the night shift, the 100 Unit would only have two (2) aides and one nurse and one CMT most of the time. She also stated she was aware of the ants in the resident's room, but was not sure where they were coming from and said management was aware of the pest issue, but nothing had been done to resolve it as far as she knew. Interview with the Unit Manager, on 04/20/15 at 12:10 PM, revealed she was not able to conduct routine rounds to ensure residents dignity was promoted related to activities of daily living. She stated the facility had a staffing shortage and due to the shortage she had to fill in and provide direct resident care as a floor nurse. Interview with the Assistant Director of Clinical Services (ADCS), on 04/20/15 at 2:35 PM, revealed the facility had a staffing shortage that prevented the facility from providing all the necessary activities of daily living to meet the needs of the residents. She stated washing resident faces, shaving and bathing were just a	F 241		

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F 241	Continued From page 106 few of the tasks that were unable to be completed on a daily basis. She stated she was unable to complete her ADCS duties in order to ensure resident's dignity was promoted, due to staffing issues. Interview with the Interim Director of Clinical Services (DCS), on 05/04/15 at 2:20 PM, revealed she expected residents rooms to be kept neat and clean and staff should check on residents frequently to meet their needs. The DCS stated "obviously someone was not doing their job". She stated she expected nursing to make rounds to ensure activities of daily living were completed in order to promote resident dignity. Interview with the former Executive Director in charge of the facility during the survey dates of 04/14/15 through 04/14/15, on 04/23/15 at 8:35 AM, revealed she had notified upper management of the staffing issues and her concerns of not meeting the residents' needs and was told to make sure everyone including management was out on the floor providing care. However, even though management and others were helping out it still was not enough to meet the needs of the residents. She further stated no audits of the care and service provided were completed. She stated staffing concerns were discussed at the Quality Assurance Committee meetings. However, they did not discuss their inability to meet the residents' needs or maintain dignity and no action plans were developed related to improving services.	F 241		

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Interview with the Medical Director, on 04/24/15 at 10:55 AM, revealed he had concerns regarding the care and services the facility was providing. He stated he was aware there was a staffing shortage and had discussed his concerns with the previous Executive Director. He stated the ED made the corporation aware of the staffing issues and they were waiting for approval for agency staff to be hired.

Interview with Interim Executive Director (ED)/Regional Vice President of Operations (RVPO), on 04/28/15 at 9:40 AM, revealed she stated prior to becoming the Interim ED she visited the building and made rounds with the previous ED to discuss and identify opportunities for improvement; however, she was not aware of any complaints from residents not receiving care and services.

The facility took the following actions to remove the Immediate Jeopardy on 05/16/15 as follows:

1. On 04/22/15, 126 residents were assessed by Nurses using a visual and/or verbal nursing assessment that included vital signs to ensure there were no current physical or emotional distress or needs that were not met as related to inadequate staffing. One (1) resident was identified in physical distress and the Nurse timely notified the physician.

2. Resident #39's hair was washed and combed, shaved and care provided, sheets changed, privacy curtain provided.

3. QAPI meeting was held on 05/13/15 to review

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F 241	Continued From page 108 the P&P for care plans and behavior management, resident weights, skin assessments, ADLs, smoking, assistive devices related to lifts and shower bed, facility maintenance, pest control, housekeeping/ laundry, and staffing, falls, incidents/accidents, grievances, with no changes made. The facility's action plan for removal of the IJ was reviewed and tasks assigned, with department managers assigned to provide daily oversight along with the RDCS/ RVPO/ RDHC/ RCMC/Corporate Administrative RNs. 4. On 05/13/15 and 05/14/15 twenty-two (22) nurses were educated by the Corporate Administrative RNS to complete skin sweeps weekly and PRN, and complete residents' weights per physician order. 5. Walking rounds were conducted by Corporate Administrative Nurses, on 05/12/15, to look for pests, with none seen. One hundred twenty-one (121) residents were assessed by skin sweeps, with no pest bites evident. No pests were observed in resident beds or rooms. 6. On 05/12/15 and 05/13/15, housekeeping rounds were completed by the ED and Housekeeping Supervisor for facility cleanliness and odors, with areas needing cleaning were cleaned on 05/12/15 through 05/15/15. 7. On 05/13/15, Corporate Administrative RNs educated facility Administrative Staff on the regulations and P&P for staffing, pest control, housekeeping, and maintenance, with competencies completed. The ED would monitor the facility's process for notification, abuse, hiring, dignity, care plan revision, professional	F 241		

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F 241	Continued From page 109 standards, assessments, behavior and falls management, incidents and accidents, smoking, call lights, pest control, and staffing. 8. Review of the 24 hour report, incident/ accident reports, in the daily meeting with the IDT; documentation in the clinical record included notification to the physician and new orders, and to the RP; the IDT made rounds in five (5) resident care areas to observe for maintenance and safety concerns; observations of five (5) residents during supervised smoking by the IDT; room rounds for five (5) residents to search for incendiary items by a member of the IDT, maintenance concerns were written in the maintenance books and taken to the daily meeting and prioritized for repair; observations of five (5) residents to ensure falls interventions were in place per the care plan by the IDT; call lights checked in resident rooms and bathrooms to ensure lights and sound; five (5) staff educated what to do if call light inoperable; resident care areas checked for no live pests; were validated five (5) times weekly. 9. Daily oversight since 04/22/15 on all shifts to ensure residents were safe and the plan of care was followed to meet resident needs, by the ED/ DCS/ RVPO/RDCS/Corporate Administrative Nurses. 10. The IDT would meet at least monthly to discuss facility action plan and ensure tasks were completed for the removal of the IJ, and QA monitoring completed according to the AOC during the IJ period, validated by the ED/RVPO/RDCS/Corporate Administrative RNs. 11. Per the Ad-Hoc QAPI meeting, on 05/15/15,	F 241		

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F 241	Continued From page 110 QI monitoring would be done utilizing approved audit tool with oversight by the ED, beginning 05/16/15, five (5) resident interview; new resident/ family concerns; the IDT rounds in five (5) resident care areas to observe the environment for safety and maintenance concerns; room rounds of five (5) residents for incendiary items; maintenance concerns listed in the maintenance book and taken to the daily meeting to discuss and prioritize repairs. 12. Linen rounds were completed, on 05/13/15, by the ED/ Housekeeping Supervisor/Department Managers to ensure PAR levels and available resident laundry, with areas of concern addressed by the Housekeeping Supervisor at that time. 13. The RVPO/RDCS/Corporate Administrative RNs would provide daily oversight of the ED and DCS in areas of sufficient staffing to meet resident needs, housekeeping and laundry, and pest control during the IJ period until removal. 14. Grievances were reviewed, on 05/13/15, by the ED/SSD/DCS back to 05/1/15 for any areas requiring additional follow up, which was handled by 05/15/15. 15. On 05/12/15 rounds were completed by the DCS/ADCS/ Nurse Managers, and Corporate Administrative Nurses to identify residents who needed additional grooming or incontinent care; bed linens checked to ensure they were clean and pest free; call lights checked to ensure they were within resident reach and answered timely; resident's skin observed to ensure free from pests; and privacy curtains in place. Additional grooming was provided to residents requiring it,	F 241		

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F 241	Continued From page 111 and one (1) resident room was identified to need a privacy curtain on 05/13/15. 16. On 05/13/15 and 05/14/15, nursing staff and ten (10) agency staff were educated on incontinent care, bathing, shaving, washing resident's hair, with those not trained would not allowed to work until trained prior to the start of their shift. 17. On 05/13/15 and 05/14/15, 101 of 149 staff and ten (10) agency staff were educated to notify housekeeping when privacy curtains were needed; report pest sightings in the pest sightings book; any pests noticed on residents should be reported immediately to the nurse supervisor/DCS/ADCS for completion of a skin assessment; resident privacy. Forty-eight (48) staff not educated will be trained prior to working their next scheduled shift. 18. A QAPI meeting was held, on 05/13/15, to discuss the facility's P&P for incontinent care, resident privacy, shaving, AM care, with no changes made. 19. Daily rounds were conducted by department managers and corporate administration Monday through Friday to identify any issues with resident incontinent care, privacy, shaving and AM care, with any issues identified discussed in the daily IDT meeting and resolved with further Ad-Hoc education. 20. An Ad-Hoc QAPI meeting, on 05/15/15, discussed QI monitoring would be completed beginning 05/16/15 for: beginning 05/12/15 observations of five (5) residents to ensure they were shaven, hair combed, provided incontinent	F 241		

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care, privacy curtains were clean, bed linens were clean, rooms/bed/residents were free from pests, privacy provided for care, call lights in reach and answered timely, would be conducted five (5) times weekly.

The State Survey Agency validated the removal of Immediate Jeopardy on 05/22/15 as follows:

1. Review of assessments for one hundred twenty-six (126) residents, dated 04/22/15, revealed residents were assessed by the DCS, with vital signs taken. One (1) resident was identified in distress and the physician was notified at that time.

2. Review of rounds , dated 05/12/15, revealed Resident #39 was groomed and had clean linens.

3. Review of a QAPI sign in sheet, dated 05/13/15, and agenda revealed the P&P for care plans and behavior management were discussed with no changes made. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Staff Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS attended the QA meetings.

4. Record review of in-services conducted on 05/13/15 and 05/14/15 revealed education provided for skin assessments, resident weights. Interview with CNA #7, on 05/22/15 at 8:05 AM, with RN #1, on 05/22/15 at 8:13 AM, with LPN #1, on 05/22/15 at 8:25 AM, with CNA #8, on 05/22/15 at 8:37 AM, revealed they had been trained on resident weights and skin assessments. Observation, on 05/22/15 at 3:30 PM, revealed Resident #34 skin assessment was performed by Registered Nurse #11 and no new

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F 241	Continued From page 113 skin issues were identified and the documentation was completed as required. 5. Review of facility rounding sheets, dated 05/12/15, revealed no pests were observed. One hundred twenty-one (121) residents were assessed via skin sweeps on 05/12/15 and 05/13/15 with no pest bites evident, and no pests documented in resident beds or rooms. Interview with the DCS, ADCS, UM, MDS Director, on 05/22/15 at 2:52 PM, revealed residents were assessed via skin sweeps, and no concerns. Interview with Resident #24 on 05/22/15 at 4:30 PM, revealed no pests were in his/her room. 6. Review of rounding sheets, dated 05/12/15 and 05/13/15, revealed the ED and Housekeeping Supervisor observed the facility for cleanliness. Interview with the Housekeeping Supervisor, on 05/22/15 at 2:52 PM, revealed he conducted rounds for cleanliness of the facility, including linens, resident rooms, shower rooms, trash, webs and pests, and privacy curtains. Interview with Resident #10 on 05/22/15 at 12:30 PM, revealed no concerns with linens. 7. Review of in-service records, dated 05/13/15, revealed Administrative staff were trained on staffing, pest control, housekeeping and maintenance, and would be monitored by the ED. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS revealed they had been trained on staffing, pest control, housekeeping and maintenance, and any concerns of audits would be taken to the morning meeting. Interview with Resident #3 on 05/22/15 at 1:00 PM, revealed	F 241		

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F 241	Continued From page 114 staffing had improved and were answering lights timely and the facility looked cleaner. 8. Observation of the daily morning meeting, on 05/22/15 at 9:05 AM, revealed review of the 24 hour report, notifications made and documented, new physician orders, maintenance concerns and books, pests, rounds and audits, call lights, care plans. Interview with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, MDS Coordinator, and DSS, on 05/22/15 at 2:52 PM, revealed they participate in the morning meeting and review the 24 hour report, notifications were made, maintenance books reviewed, physician orders, call lights, care plans, and audits/ round were reviewed in the morning meeting. 9. Interview, on 05/22/15 at 2:52 PM, with the DCS revealed facility concerns were reviewed in the morning meeting, including audits and rounding results, for department heads to address. She stated she (the DCS) or the ED would initial when concerns were resolved. Observation, on 05/22/15 at 9:05 AM, of the morning meeting revealed the DCS provided direction and asked clarifying questions related to information discussed with follow up items determined. 10. Review of sign in sheets, dated 04/22/15, 05/13/15, and 05/15/15, revealed QAPI meetings were held on those dates. Interview, with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS revealed they attended the QAPI meetings. Interview with the RDCS, on 05/22/15 at 5:05 PM, revealed the next QAPI meeting was scheduled for 06/17/15. Interview with the	F 241		

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F 241	Continued From page 115 Medical Director, on 05/22/15 at 8:00 AM, revealed he was informed by the Executive Director of the resident care issues, attended the QA meetings held by the facility and provided direction regarding corrective action plans that were developed to meet the needs of the residents. 11. Review of the QAPI sign in sheet, dated 05/15/15, and agenda revealed audit tools were approved for QA monitoring and discussed: resident interviews; resident/family concerns; morning meeting; new employee files; falls or behaviors reviewed; care plans and Kardexes update; review of the 24 hour report; notifications; maintenance rounds and book; supervised smoking; falls interventions in place; call lights; weekly falls; and, behavior management meetings. 12. Review of facility linen rounds, dated 05/13/15, revealed resident laundry available for use and linen PAR levels were observed. Observation, on 05/22/15 at 2:05 PM, of the linen closet on Journey Home 1 revealed adequate numbers of linens, wash cloths and towels, pillows, and gowns. Observation of the linen closet on the 200 Unit, on 05/22/15 at 2:15 PM, revealed adequate linens, gowns, towels, washcloths, pillows, blankets and clothing protectors. Interview with the Housekeeping Supervisor, on 05/22/15 at 2:52 PM, revealed he completed rounds three (3) times a day and checked the linen closets for adequate supplies. Observation, on 05/22/15 at 2:00 PM, revealed Resident #4's linens on the bed were clean, neat and were not torn, tattered or frayed. 13. Review of the sign in sheet for QAPI, dated	F 241		

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F 241	Continued From page 116 05/13/15, revealed the ED and DCS presented and reviewed falls, changes in condition, staffing, housekeeping, and laundry, and pest control, and would provide daily oversight. 14. Review of grievance audit, dated 05/13/15, revealed grievances were reviewed since 05/01/15 and resolved by 05/15/15. Interviews on 05/22/15 with Resident #3 at 2:10 PM, Resident #8 at 2:00 PM, and Resident #10 at 12:30 PM, revealed the issues and concerns they had regarding linens, pests, environment repairs and answering call lights were resolved. 15. Review of the facility rounds, dated 05/12/15, revealed residents were observed to identify residents grooming, incontinent care, bed linens, pests, call lights in reach, and privacy curtains in place. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Staffing Coordinator, BOM, Central Supply, Housekeeping Supervisor, and DSS revealed daily rounds were completed to identify resident grooming needs and care, linens, pests, call lights in reach, and privacy curtains in place. Interviews with Resident #3, #8 and #10 on 05/22/15, revealed the issues and concerns they had regarding linens, pests, environment repairs and answering call lights had improved. 16. Review of in-service records, dated 05/13/15 and 05/14/15, revealed nursing staff and ten (10) agency staff were educated on incontinent care, bathing, shaving, and hair care. Interview, on 05/22/15 at 2:52 PM, with the DCS, ADCS, UM, and Staffing Coordinator revealed staff were trained on grooming, incontinent care, shaving, and bathing. Interview with CNA #31, on 05/22/15 at 8:10 AM, revealed she received training on	F 241		

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F 241	Continued From page 117 incontinent care, bathing, shaving, hair care, reporting pest, broken equipment, fall prevention, lifts, reporting change in condition, and answering call lights, abuse, resident laundry and linens. 17. Review of in-service records, dated 05/13/15 and 05/14/15, revealed one hundred one (101) staff and ten (10) agency staff were educated on privacy curtains; using the pest sightings book; resident privacy. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, Staffing Coordinator, Central Supply and Housekeeping Supervisor revealed they were trained on privacy curtains, resident privacy, and pests. Interview with Housekeeper #1, on 05/22/15 at 8:20 AM, revealed she received training on cleaning resident rooms, privacy curtains, reporting pests and broken equipment. Interview with Registered Nurse #11, on 05/22/15 at 8:10 AM, revealed she was educated on abuse, falls, physician orders, dignity, grievances, infection control, call lights, and reporting pests and maintenance issues. 18. Review of QAPI sign in sheet, dated 05/13/15, revealed incontinent care, resident privacy, shaving and AM care P&P were reviewed. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Staffing Coordinator, MDS Director, Housekeeping Supervisor, and DSS attended the QA meetings. 19. Review of rounding sheets revealed residents were observed by staff to identify any issues with grooming, incontinent care, privacy, shaving and AM care. Interview, on 05/22/15 at 2:52 PM with the DCS, ADCS, UM, Staffing Coordinator, Medical Records, BOM, MDS Director, Central Supply, Housekeeping Supervisor, and DSS	F 241		

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F 241	Continued From page 118 revealed they conducted rounds to assess residents grooming, privacy, shaved, and care. 20. Review of a QAPI sign in sheet, dated 05/15/15, revealed residents would be observed to ensure they were shaved, hair combed, incontinent care, privacy curtains and bed linens in place and clean, residents and environment free from pests, resident privacy, and call lights. On 05/22/15 at 2:52 PM, interview with the Maintenance Director, DCS, ADCS, UM, Staffing Coordinator, MDS Director, Housekeeping Supervisor, and DSS attended the QA meetings. Interview with Resident #8, on 05/22/15 at 4:20 PM, Resident #6, on 05/05/15 at 2:26 PM, Resident #24, on 05/22/15 at 8:07 AM, revealed the issues they had with not getting shaved, hair washed and combed, incontinent care provided, bed linens without tears, an environment free from pests, and call lights answered timely had improved. Observation of Resident #43, on 05/22/15 at 8:00 AM, revealed two staff were using a lift to transfer the resident into a wheelchair and then proceeded to shave the resident.	F 241		
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	F 246		

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F 246	Continued From page 119 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 have an effective system in place to ensure residents call lights were accessible in order for residents to alert staff of their needs related to incontinence, toileting, and repositioning for four (4) of forty-three (43) sampled residents (Residents #1, #8, #9 and #36) and five (5) of thirty-nine (39) unsampled residents. (Unsampled Residents O, U, Q, P and W). The findings include: Review of the facility's policy regarding Call Lights, dated 11/30/14, revealed all lights would be answered promptly by all staff regardless of assignment. 1. Review of Resident #1's clinical record revealed the facility admitted the resident on 01/10/13, with diagnoses of Quadriplegia, Neurogenic Bladder, Anxiety, Anemia, Gastro-Esophageal Reflux, Respiratory Failure, and Urinary Tract Infection. Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment, completed on 03/23/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of fifteen (15) meaning the resident was cognitively intact and interviewable.	F 246		

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Review of the Comprehensive Care Plan for Resident #1 revealed the facility developed a care plan on 07/08/14, with updated goals and a target date for 06/25/15. The problem on the care plan stated Resident #1 had a self-care deficit and was dependent on staff for all care due to Quadriplegia. The goal state the resident would remain clean, neat dressed appropriately for the season and free of odor and staff would continuously meet residents' needs through staff anticipation and assistance. The approaches directed staff to answer call light promptly and anticipate resident's needs and wants and provide necessary care.

Observation of Resident #1, on 04/15/15 at 8:20 AM, revealed the resident was laying on the bed with the cover over his/her head. Observation of the call light revealed it was above the resident's head and not with in reach.

Interview with Resident #1, on 04/15/15 at 10:00 AM, revealed staff would forget to put the call light within reach and he/she would have to yell out several times to get the attention of staff.

Interview with Certified Nursing Assistant (CNA) #34, on 04/15/15 at 10:30 AM, revealed she was unaware Resident #1 did not have the call light within reach. She stated she was very busy because the unit was short staffed that day and probably forgot to put the call light close to the resident. She stated it was important for residents to have call lights in reach so they could alert staff

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F 246	Continued From page 121 of a need. Interview with Licensed Practical Nurse (LPN) #5, on 04/15/15 at 3:10 PM, revealed she was the only nurse on the unit working with a Certified Medication Technician (CMT) and three (3) Certified Nursing Assistants. She stated it was hard for her to supervise the staff with all her other duties, to know if they completed all their tasks, and met the needs of the resident today. She was unaware that Resident #1's call light was not within reach at 8:20 AM. 2. Review of Resident #8's clinical record revealed the facility admitted the resident on 04/18/14, with diagnoses of Hypoxia, Respiratory Failure, Stage Three Renal Disease, Cerebral Vascular Accident, Congestive Heart Failure, Hypertension, Decubitus, and Toxic Metabolic Encephalopathy. Review of Resident #8's Quarterly MDS assessment, completed on 03/25/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of fifteen (15) indicating the resident was cognitively intact and interviewable. Review of the Comprehensive Care Plan for Resident #8 revealed the facility developed a care plan on 08/11/14, with updated goals and a target date for 05/24/15. The problem on the care plan stated Resident #8 had impaired ability to perform own activities of daily living and self-mobility related to weakness, immobilization and chronic	F 246		

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obstructive pulmonary disease. The goal stated the resident would improve self-care skills in at least one area of activities of daily living and mobility by next review on 05/24/15. The approaches listed stated staff was to provide assistance with activities of daily living, while promoting independence, promote dignity by assuring privacy and organize supplies by how or when they should be used and place within reach.

Interview with Resident #8, on 04/16/15 at 8:48 AM, revealed the resident had urinated on him/herself during the night. The resident said he/she was unable to reach the call light to ring for assistance and instead hollered for staff to come help him/her. The resident stated staff walked by and did not come into his/her room.

Observation, on 04/16/15 at 8:48 AM, revealed Resident #8's call light was not within reach, but was hanging on the wall behind and to the side of the resident's bed.

Interview with Resident #8, on 04/22/15 at 9:20 AM, revealed he/she put on their call light again last night because he/she was wet and wanted to be pulled up in the bed and the staff answered the light and said they would be back because they needed help. The resident said he/she fell back to sleep, woke up again and pushed the call light again and they turned if off again and did not come back for a while.

Interview with Certified Nursing Assistant (CNA) #15, 04/22/15 at 12:12 AM, revealed it was hard to meet the needs of residents during the night shift when there was only one aide for twenty (20) residents. She stated most of the residents required the assistance of two (2) for incontinent

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F 246	Continued From page 123 care or toileting and if they were short staffed it was difficult to meet their needs timely. She stated the facility was aware of the issue but nothing had been done to resolve it. Interview with Licensed Practical Nurse (LPN) #5, on 04/22/15 at 3:25 PM, revealed staffing was an issue and not all activities of daily living could be completed when only two (2) or three (3) aides were on the unit. She said the assigned aides were not on the unit all at the same time either because they were allowed to come and go as they pleased. She stated when she came into work most mornings the night shift aides were already gone and usually there was only one Certified Medication Technician (CMT) and one Nurse on the floor. She stated the unit had about thirty-six (36) to thirty-seven (37) residents and most of the time they would only have two (2) to three (3) aides and she would be the only nurse working with a CMT that passed medications on one hall while she passed medications on the other hall. She stated the night shift would only have two (2) aides and one (1) nurse and one (1) CMT most of the time. 3. Review of Resident #9's clinical record revealed the facility admitted the resident on 08/14/14, with diagnoses of Anemia, Coronary Artery Disease, Hypertension, Peripheral Vascular Disease, Traumatic Brain Injury, Anxiety, Depression, and Chronic Obstructive Pulmonary Disease and Dementia. Review of Resident #9's Sixty-day (60) scheduled MDS assessment, completed on 03/03/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of	F 246		

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F 246	Continued From page 124 fifteen (15) meaning the resident was cognitively intact and interviewable. Review of the Comprehensive Care Plan for Resident #9 revealed the facility developed a care plan on 04/17/14, with updated goals and a target date for 06/03/15. The problem on the care plan stated Resident #9 had urinary incontinence related to impaired physical mobility, Right Above the Knee Amputation, Neurogenic Bladder and evidence of being incontinent of urine. The goal stated the resident would have no unrecognized urinary tract infections or skin breakdown related to incontinence. The approaches listed were to place call light within reach at all times and to provide incontinence device of resident's choice for dignity. Observation of Resident #9, on 04/16/15 at 8:41 AM, revealed the resident was laying in the bed with an unshaven face and the room had a strong odor of urine. The resident's bed, floor, privacy curtain and wall beside the bed contained food debris. Interview with Resident #9, on 04/16/15 at 8:41 AM, revealed the resident had put on the call light thirty (30) minutes ago and wanted help with getting some cranberry juice and a brief changed. Interview with CNA #1, on 04/17/15 at 10:55 AM, revealed she was assigned to take care of Resident #8 and #9 and when her shift started today there were just two (2) aides and the third aide did not come in until 10:00 AM. She stated it	F 246		

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was difficult to get residents up and ready for breakfast with only two (2) aides on the unit. She stated she was also responsible for passing the breakfast trays and feeding the ten (10) residents that needed total assistance. She stated several residents needed the assistance of two (2) to get out of bed. She stated she changed the incontinent residents and dressed those that were gotten up, but due to time constraints and staffing she was not able to shave, provide oral, or comb the hair of all her residents.

Interview with Registered Nurse (RN) #8, on 04/16/15 at 3:45 PM, revealed the facility had a staffing shortage and when there were only two (2) Certified Nursing Assistants for the unit, call lights did not always get answered timely. He stated the usual staffing pattern was for the 100 Unit to have only two (2) CNAs on duty. He said if there were four (4) CNAs on the unit it would take five (5) to six (6) minutes to answer call lights; however, if there were only two (2) CNAs then it could take twenty-five (25) to thirty (30) minutes to answer call lights.

4. Review of Resident #36's Quarterly MDS assessment, completed on 03/21/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of fourteen (14) meaning the resident was cognitively intact and interviewable. Continued review of the MDS revealed the resident required extensive physical assistance of two (2) staff for bed mobility, transfers, and toileting. The MDS assessed the resident as needing the assistance of one (1) with dressing and bathing. The resident required set up assistance for meals and staff to provide

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F 246	Continued From page 126 oversight, encouragement and cueing while eating. The MDS also assessed the resident as frequently incontinent of bowel and bladder. Observation of Resident #36, on 04/29/15 at 9:55 AM, revealed the resident was sitting in a wheelchair beside the bed with food debris on his/her face and clothing. The resident's call light cord was observed to be on the floor and out of the resident's reach. Interview with CNA #33, on 04/29/15 at 3:00 PM, revealed she had not provided care to the resident prior to coming into the room upon surveyors request. She stated the CNA assigned to the resident had left. 5. Review of Unsampled Resident O's clinical record revealed the facility admitted the resident on 05/01/12, with diagnoses of Dementia, Malnutrition and Depression. Review of Unsampled Resident O's Annual MDS assessment, completed on 03/23/15, revealed a BIMS exam was not conducted due to the resident rarely being understood. Continued review of the MDS revealed the resident required extensive physical assistance of two (2) staff for bed mobility, transfers, and toileting. The MDS assessment also revealed the resident needed the assistance of one (1) with dressing and bathing. The resident required extensive assistance of one (1) with eating. The MDS also assessed the resident was always incontinent of bowel and bladder.	F 246		

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Observation, on 04/16/15 at 11:23 AM, revealed the call button for Unsampled Resident O was on the floor.

6. Review of Unsampled Resident P's clinical record revealed the facility admitted the resident on 07/28/06, with diagnoses of Dementia, Anemia, Diabetes, Anxiety, Peripheral Vascular Disease, and Depression.

Review of Unsampled Resident #P's Quarterly MDS assessment, completed on 02/25/15, revealed a BIMS exam was not conducted due to the resident rarely being understood. Continued review of the MDS revealed the resident required extensive physical assistance of two (2) staff for bed mobility, transfers, and toileting. The MDS assessment also assessed the resident as needing the assistance of one (1) with dressing and bathing. The resident required extensive assistance of one (1) with eating. The MDS assessed the resident as always incontinent of bowel and bladder.

Observation, on 04/28/15 at 1:35 PM, revealed Unsampled Resident P's call light button was at the foot of his/her bed, out of the reach of the resident.

7. Review of Unsampled Resident Q's clinical record revealed the facility admitted the resident on 11/19/14, with diagnoses of Dementia, Hypertension, Anemia, Hyperlipidemia, Anxiety,

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STREET ADDRESS, CITY, STATE, ZIP CODE
2200 STONY BROOK DR
LOUISVILLE, KY 40220

(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 246	Continued From page 128 Urinary Tract Infection, and Depression. Review of Unsampled Resident Q's Quarterly MDS assessment, completed on 04/25/15, revealed a BIMS exam was not conducted due to the resident rarely being understood. Continued review of the MDS revealed the resident required extensive physical assistance of one (1) staff for bed mobility, transfers, and toileting. The MDS assessment also assessed the resident as needing the assistance of one (1) with dressing and bathing. The resident required set up assistance for meals and staff to provide oversight, encouragement and cueing while eating. The MDS assessed the resident as always incontinent of bowel and frequently incontinent of bladder. Observation, on 04/28/15 at 1:35 PM, revealed the call light button for Unsampled Resident Q was under the resident's recliner, out of reach of the resident. 8. Review of Unsampled Resident U's clinical record revealed the facility admitted the resident on 04/28/14, with diagnoses of Dementia, Hypertension, Anemia, Hyperlipidemia, Anxiety and Depression. Review of Unsampled Resident U's Quarterly MDS assessment, completed on 03/4/15, revealed a BIMS exam was not conducted due to the resident rarely being understood. Continued review of the MDS revealed the resident required extensive physical assistance of two (2) staff for	F 246		

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	185289		C 05/22/2015

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F 246	Continued From page 129 bed mobility, transfers, and toileting. The MDS assessment also assessed the resident as needing the assistance of one (1) with dressing and bathing. The resident required set up assistance for meals and staff to provide oversight, encouragement and cueing while eating. The MDS assessed the resident as always incontinent of bowel and bladder. Observation, on 04/28/15 at 2:09 PM, revealed Unsampled Resident U's call light was located behind the wardrobe/dresser located between the two beds in the room. The piece of furniture had to be moved in order for the call light to be retrieved and available for use by the resident. 9. Review of Unsampled Resident W's clinical record revealed the facility admitted the resident on 05/09/14, with diagnoses of Dementia, Hypertension, Diabetes and Schizophrenia. Review of Unsampled Resident W's Quarterly MDS assessment, completed on 03/14/15, revealed a BIMS exam was conducted and the resident scored a fourteen (14) indicating the resident was cognitively intact and interviewable. Continued review of the MDS revealed the resident required extensive physical assistance of two (2) staff for bed mobility, transfers, and toileting. The MDS assessment also assessed the resident as needing the assistance of one (1) with dressing and bathing. The resident required set up assistance for meals and staff to provide oversight, encouragement and cueing while eating. The MDS assessed the resident as occasionally incontinent of bladder and always	F 246		

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F 246	Continued From page 130 continent of bowel. Observation, on 04/28/15 at 1:35 PM, revealed Unsampled Resident W's call light button was stuck behind a dresser. Interview with the Unit Manager, on 04/20/15 at 12:10 PM, revealed she was not able to conduct routine rounds to ensure residents were receiving the needed care and services. She stated the facility had a staffing shortage and due to the shortage she had to fill in and provide direct resident care as a floor nurse. Interview with the Assistant Director of Clinical Services (ADCS), on 04/20/15 at 2:35 PM, revealed the facility had a staffing shortage and due to the insufficient numbers of staff this prevented the facility from providing all the necessary care and services. She stated answering call lights was not always timely when they were short staffed but call lights should be within reach of all residents. She stated she was unable to complete her ADCS Supervisory duties because she had been working as a floor nurse and aide due to staffing shortages. Interview with the Interim Director of Clinical Services (DCS), on 04/29/15 at 7:55 AM, revealed she was only employed by the facility for two (2) weeks and was not aware resident needs were not being met. Interview with the Director of Clinical Services	F 246		

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F 246	Continued From page 131 (DCS), employed as of 04/20/15, on 05/04/15 at 2:20 PM, revealed she expected staff to answer call lights timely and check on residents frequently to meet their needs and assure call lights were within reach. She stated she expected nursing to make rounds to ensure residents' activities of daily living were completed. She stated she expected staff to report issues or if they were not able to complete their tasks. The DCS expected the Nurse Managers to supervise the staff and the ADCS to supervise the Nurse Managers to ensure resident care needs were met. Interview with Interim Executive Director/Regional Vice President of Operations, on 04/28/15 at 9:40 AM, revealed she was not aware of any complaints from residents not receiving care and services. She stated prior to becoming the Interim Executive Director she visited the building and made rounds with the previous Executive Director to discuss and identify opportunities for improvement. She stated she did not make notes of their findings or discussions for follow up and was unable to provide evidence of any corrections made from the rounds. Interview, on 05/05/15 at 2:30 PM, with the Interim Executive Director/Vice President of Operations, revealed call light should at all times be within reach of the residents. She stated CNAs and licensed nurses should check the placement of all resident call light buttons.	F 246		
F 253 SS=F	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES	F 253		

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The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, review of the facility's policy, and review of the Housekeeping and Laundry Services Agreement, and the Facility Monthly Tour Quality Assurance Round Sheet, it was determined the facility failed to have an adequate system in place to ensure housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable environment for twelve (12) of forty-three (43) sampled residents (Residents #3, #4, #5, #6, #7, #8, #9, #10, #18, #22, #31, #36 and six (6) of thirty-nine (39) unsampled residents (Unsampled Residents O, P, Q, R, DD, and EE.)

Observations of the environment revealed residents' rooms with food debris on the floor, stained privacy curtain, bathroom floors with standing and dried urine, feces on the bathroom floor and hallway, heating and air conditioning (AC) units contained debris, Nourishment Room's floor, cabinets, and refrigerator were in disrepair/dirty; and, unknown brown substances were noted in the resident shower room.

The findings include:

Review of the facility's policy and procedure regarding Maintenance, effective date 11/30/14, revealed the facility's physical plant and equipment would be maintained through a program of preventive maintenance and prompt action to identify areas/items in need of repair.

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The Director of Environmental Services would follow all policies regarding routine periodic maintenance and perform daily rounds of the building to ensure the plant was free of hazards and in proper physical condition. The Maintenance Repair Request form was utilized to report items needing maintenance assistance.

Review of the Housekeeping and Laundry Services Agreement between the facility and the contract company that provided the facility with daily housekeeping, laundry, and dietary services, dated 05/06/13, revealed the contract housekeeping services established housekeeping policies and objectives to provide the facility with housekeeping services that met all of the facility's legal, regulatory, and professional obligations.

Review of the Facility Monthly Tour Quality Assurance Round Sheet, dated 02/10/15, 03/10/15, and 04/10/15, revealed the Maintenance Director conducted monthly checks of furniture, walls for paint and holes, windows, screens, call lights, lights, and bathrooms. Further review of the Facility Monthly Tour Quality Assurance Round Sheet revealed the facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior, and that the form was to be completed before the 10th of every month and turned in to the Executive Director. Additionally, the room audits included inspection of furniture to identify any missing handles, drawers or damage such as scratches, bedside tables and bed rails were included in the furniture assessment.

1. Review of the Facility Monthly Tour Quality Assurance Round Sheets, dated 02/10/15,

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F 253	Continued From page 134 03/10/15, and 04/10/15, revealed the Maintenance Director documented the furniture, walls for paint and holes, windows, screens, call lights, lights, and bathrooms for rooms 100 thru 119, rooms 10 thru 27, rooms 28 thru 40, and rooms 200 thru 225 had been checked. The form, dated 02/10/15, 03/10/15, 04/10/15, had each category for each room checked indicating all items were "ok" with a comment on the 02/10/15 form that Therapy received two (2) window screens. The form dated 04/10/15 revealed with the exception of room 117 and a comment that painting was in process. Each Facility Monthly Tour Quality Assurance Round Sheet was dated and signed as being completed by the Maintenance Director. Review of the facility's audit of resident rooms, on 05/12/15, conducted by the Medical Records Coordinator, Social Services Director, Social Services Assistant, and Central Supply revealed fourteen (14) rooms on the 100 Unit had busted closet doors, broken lights in the bathrooms, opened access panels, holes in the bathroom walls, broken toilet seats, loose towel racks, loose electrical outlets, no telephone outlet covers, and loose faucets; rooms #105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 116, 117, 101, and 100. Twenty-one (21) rooms on the 200 Unit had loose or no air conditioner vents, broken floor tiles, loose bathroom sinks, broken blinds, loose electrical outlets, loose closet doors, tape used over electrical outlets, and loose bathroom grab bars; rooms #200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 215, 216, 217, 219, 220, 222, 223, and 225. Further review of the audits revealed ten (10) rooms on Journey 1 Unit that had no cable wall	F 253		

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F 253	Continued From page 135 plates, loose electrical outlets, loose air conditioner covers, closet doors not secured, loose sinks, broken towel racks, chipped floor tiles, and the wall cabinet and heater in the shower room were loose and there were holes in wall behind the doors; rooms #28, 30, 32, 33, 35, 36, 37, 38, 39, and 40. Additional rooms noted with concerns were located on the Rehabilitation Unit and included #13, 14, 21, 22, and 23. 2. Observation of the Nourishment Room on the 200 Unit, on 04/16/15 at 10:30 AM, revealed the floor tile covered with a brown grimy substance, the floor had missing tiles, a cup of applesauce and straws were on the floor behind a rolling cart, a tray on top of the refrigerator had both sides covered with a crusted sticky brown substance and there were several dead brown bugs on top of the refrigerator; cabinet drawers. The bottom of the cabinets were covered with a sticky brown substance; the cabinet doors were in disrepair and two (2) doors would not close. Inside the refrigerator was a brown paper bag marked with a resident's name and dated 04/06/15 that contained a restaurant take-out food container. Inside the cabinet on a top shelf was a partially eaten red velvet cake in a plastic container with no name and no date. A live brown spider was observed on the floor next to a hole in the base of the wall next to the refrigerator. 3. Observation, on 04/16/15 at 10:30 AM, revealed the Northwest exit door outside of the 200 Unit had approximately a one-inch gap at the bottom making the pavement outside of the door clearly visible. An exit hallway on the Journey 1 Unit had a fluorescent light cover that had a	F 253		

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F 253	Continued From page 136 broken piece, approximately 8 inches x 5 inches in size, triangular shaped with sharp edges at the corner, and was partially hanging down. 4. Observation of the 200 Unit, on 04/17/15 at 11:24 AM, revealed upon entering the locked unit there was an odor of urine. 5. On 05/01/15 at 9:57 AM, observation of Resident #31's room revealed the outside window there were no blinds or window coverings to provide privacy to the resident during a skin assessment and dressing change on his/her coccyx. The view through the window was open to the residents' smoking patio. 6. Review of Resident #7's clinical record revealed the facility admitted the resident on 03/17/15, with diagnoses of Vascular Dementia, Cerebral Vascular Accident, and Osteoarthritis of the Hip and Knee. The Admission Minimum Data Set (MDS) assessment, completed on 03/25/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of ninety-nine (99) meaning the resident was rarely/never understood. Observation, on 04/16/15 at 11:07 AM, of Resident #7's room revealed a strong smell of urine, a sticky yellow substance on the floor in a corner by the bed (the State Survey Agency Surveyor's shoes stuck to the floor), seven (7) pairs of briefs stored on top of the heating/AC unit, and one (1) pair of briefs was stuck in the heating/AC's control panel.	F 253		

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F 253	Continued From page 137 Observation, on 04/21/15 at 4:14 PM of Resident #7's room, revealed a brown substance on the floor between the wall and the resident's bed. Observation, on 04/22/15 at 9:33 AM, of Resident #7's room, revealed a box on the floor of the closet with briefs stored on top of the box. 7. Observation of the Laundry Room, on 04/16/15 at 11:07 AM, revealed a large plastic bag on the bottom shelf of a clothes cart. The bottom of the plastic bag was busted and two (2) pairs of pants and one (1) blanket were hanging from the bag touching the floor. Clean clothes that were hanging on racks were in direct contact with chemicals used in the washing process. The clothes were touching the washer with no space in between. A substance ran down the side of the washer where the chemical hoses attached to the washer. There was a large residue build-up surrounding the connectors on each washer that ran down the side of each machine onto the floor, which made contact with clean clothing. 8. Observation of the hallway adjacent to the 200 Unit, on 04/17/15 at 12:30 PM, revealed what appeared to be a hair net that was wadded up and stuck in a crack between two windows, and a discarded applesauce lid was on the window seal. The windows located in the common areas on the 200 Unit and Journey 2 Unit did not have window coverings. A window screen in the common area on Journey 2 Unit was pushed out at the bottom and the window seal was covered with a grayish fluffy substance and small dead brown bugs.	F 253		

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F 253	Continued From page 138 9. Observation of the common/dining area on the Journey 2 Unit, had one (1) of five (5) ceiling fluorescent lights and one (1) of twelve (12) recessed lights that did not work, a ceiling ventilation cover approximately 5 feet by 5 feet in size was coated with a black fluffy substance, a recessed ceiling ventilation cover in the second common area, approximately eight feet long was coated with a black grimy substance, and there were two (2) eleven 11 x 12 inch cracks in the ceiling. 10. Review of Resident #22's clinical record revealed the facility admitted the resident on 06/27/12, with diagnoses of Hypertension, Gastro-esophageal Reflux Disease, Osteoporosis, and Non-Alzheimer's Dementia. The Admission MDS assessment, completed on 03/20/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of ninety-nine (99) meaning the resident was rarely/never understood. 11. Observation, on 04/17/15 at 3:20 PM revealed feces on the floor and toilet in Resident #22's room. Feces was smeared across the bathroom floor and running down the toilet seat. There was a feces filled brief in the bathroom garbage can, feces on the sheet in the middle of Resident 22's bed, and track marks of feces from the bathroom through the bedroom and out into the hallway. Two (2) pieces of tile at the room's entrance were broken off; one (1) piece had an approximate 2 inches x1 inch piece of broken and one (1) piece had an approximate ½ inch half-moon shape piece broken off. An electrical outlet in the room	F 253		

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F 253	Continued From page 139 was detached from the wall and two (2) nail heads were exposed and sticking out of the wall. In Unsampled Resident P's room, the window blinds were broken on the bottom left side, the light bulb in the bathroom was dim, the tile around and behind the toilet had a brown dry substance, three (3) tiles in front of the toilet were cracked and three (3) were sloped. Observation at this time, revealed the entrance to Unsampled Resident Q's room had a tile with a piece broken out, approximately 2 inches x 5 inches in size. 12. Observations, on 04/20/15 at 8:59 AM, on a tour of the facility's grounds with the Maintenance Director revealed a cigarette extinguisher container located to the right of the main entrance door overflowing with paper garbage and extinguished cigarette butts; a wasp nest attached to the gutter in the corner of the building next to an entrance/exit door to the Activity Room; the gutter located between the Activity Room and Kitchen had fallen off the building; three (3) discarded rubber gloves were on the ground; the two (2) doors on the back-up generator were unlocked (the back-up generator was located in an open area accessible to the public and residents); the exhaust fan from the Laundry Room did not have a screen/cover and the inside of the Laundry Room was visible through the exhaust fan; approximately ten (10) roof shingles on the 200 Unit had became loose and had slide down the roof; the electrical circuit breaker box for the Heating Ventilating and Air Conditioning (HVAC) system did not have a lock on the door; the insulation surrounding wires to the HVAC system had rotted, exposing the wires; the lock and the key attached to the emergency oxygen supply connection box was covered with a	F 253		

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F 253	Continued From page 140 reddish/brownish color that resembled oxidization; the outside of the Rehabilitation Unit had a section of gutter that was partially hanging off and a section that had completely fallen off and was lying on the ground. 13. Observation, on 04/22/15 at 9:19 AM, of Resident #31's room revealed food from the meal tray on the floor and a yellow liquid on the floor running down underneath the foot of bed. The privacy curtain was stained with an unknown brown substance in multiple places. 14. Observation, on 04/22/15 at 10:53 AM, revealed two (2) packages of briefs, one (1) unopened, and one (1) opened, stored on the floor behind the Nurses' Station on the 200 Unit (locked unit). 15. Observation, on 04/27/15 at 1:29 PM, revealed Unsampled Resident R's room on the 100 Unit had four (4) paper straw covers, one pair of disposable medical gloves, two needle caps, one auxiliary clamp, and an identification bracelet behind the bed; one plastic cup and a pair of disposable medical gloves behind the nightstand; gray fluffy and black sticky substances on the floor underneath the bed and around the edges of the room; food particles and crumbs on the floor underneath the bed and nightstand; the mattress cover had ten (10) circular stains and an approximately twelve (12) inch long piece of tape holding together a tear in the mattress. 16. Observation, on 04/27/15 at 1:45 PM,	F 253		

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F 253	Continued From page 141 revealed a white trash can lid behind a six (6) drawer dresser in Unsampled Resident DD's room and numerous pieces of paper on Unsampled Resident EE's closet floor and a spider and spider web in the corner by his/her bed, and his/her briefs were stored in a medical washbasin. 17. Observation, on 04/17/15 at 11:46 AM, of Resident #43 and Unsampled Resident DD revealed no privacy curtain between the two (2) resident beds. 18. Review of Resident #36's clinical record revealed the facility admitted the resident on 09/19/15 with diagnoses of Dementia, Arthritis, Cerebral Vascular Accident, and Atrial Fibrillation. Review of Resident #36's Quarterly MDS assessment, completed on 03/21/15, revealed a BIMS examination was conducted and the facility assessed the resident with a score of fourteen (14) which meant the resident was cognitively intact and interviewable. Observation, on 04/29/15 at 3:00 PM, of Resident #36's room revealed a sticky liquid substance on the floor behind the head of the bed, a stained and torn bed sheet that had a circular stain in the center, a plastic "Tupperware" like container sitting on the nightstand was filled to the top with a dark brown liquid that when opened had a strong urine odor, ants were crawling up the wall behind the bed, and insects flying around food left over from lunch sitting on the bedside table, and	F 253		

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F 253	Continued From page 142 the left side bedrail was broken and would not raise in the upright position. 19. Observations of Unsampled Resident O, on 04/16/15 at 11:23 AM, revealed the resident's call light laying on the floor. 20. Interview with Family Member #2, on 04/21/15 at 4:52 PM, revealed the facility smelled of urine and feces all of the time. When she visited Unsampled Resident FF twice weekly, she brought disinfectant spray to spray the resident's room because the place stunk. 21. Interview with Family Member #1 on 04/22/15 at 4:18 PM, revealed during visitation with Resident #33, she found food in the resident's bed. Interview with CNA #21 on 04/21/15 at 4:52 PM, revealed the facility had offensive smells all the time. She stated the smells were of urine and feces. Further interview with CNA #21 on 04/29/15 at 3:25 PM revealed she had reported the broken bedrail (Resident #36) to Maintenance over sixty (60) days ago by documenting it in the Maintenance Log Book, which was maintained at the Nurse's Station. Interview, on 04/22/15 at 11:11 AM, with Housekeeper/Laundry Aide #1 assigned to the 200 Unit revealed when working as a housekeeper, her duties included checking trash	F 253		

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F 253	Continued From page 143 cans in the residents' rooms, checking the bathroom in each room, wiping down televisions, tables and beds, making sure there was enough paper towels and tissue in the restrooms. Interview, on 04/27/15 at 1:29 PM with Housekeeper/Laundry Aide #1 revealed she was assigned to the 100 Unit on 04/27/15. She stated that when a room needed to be deep cleaned her Manager would inform her of which one to clean. She stated the Deep Clean Schedule was kept in the Laundry Room and she did not usually look at it. She related that she did not know Unsampled Resident R's room was on the schedule for a deep clean and that the room had not been deep cleaned. Housekeeper/Laundry Aide #1 stated she received deep cleaning training during orientation. Interview with the Unit Manager for the 200 Unit, on 04/17/15 at 10:05 AM, revealed that if urine was detected on the floor in a resident's room, a CNA would clean up what they could and call housekeeping if the floor needed to be moped. Resident's briefs were usually stored at the bottom of the closet, and stored on a shelf in the "regular closet". She related briefs should not be stored on the floor and on top of the AC/Heating Unit, because it could become an infection control problem or start a fire. Observation of the double window by the Nurse's Station at the left side of the 200 Unit, on 04/17/15 at 11:48 AM, on 05/01/15 at 9:03 AM, revealed the left window was open about one (1) to two (2) inches and would not close. The	F 253		

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F 253	Continued From page 144 window on the right side had a broken track hanging down from the window and the outer screen was propped against the window, leaving a gap between the screen and the window. 22. Observation of the 100 Unit shower room, on 04/22/15 at 9:15 AM, revealed a hole in the wall behind the door. A shower bed with three (3) plastic spoons holding the side rails in place, had long brown hairs on the railings and blue mat. The toilet had a brown substance on the seat and that same brown substance was in numerous areas on the floor and the shower chair seat. The linen and garbage cans were over flowing. One garbage can was towards the back of the room and did not contain a plastic liner, but was full of an unknown orange/brown substance. The sink contained dirt and debris and had chips and gouges in the counter top. The shower room contained numerous carts with briefs, gloves, gowns and other resident care supplies in and on top of them. Observation also revealed a stack of baby clothes were on top of one of the carts. 23. Review of Resident #3's clinical record revealed the facility admitted the resident on 07/27/12, with diagnoses of Chronic Pain, Cerebral Vascular Accident, Anxiety, and Depression. The Quarterly MDS assessment, completed on 03/27/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of ninety-nine (99), meaning the resident was rarely/never understood. Interview with Resident #3, on 04/14/15 at 1:15 PM, revealed the resident had made complaints regarding care, services and environmental issues. Resident #3 stated the facility had not	F 253		

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F 253	Continued From page 145 resolved the issues discussed at the meetings. Resident #3 stated he/she had complained to the facility staff about the laundry staff throwing her roommate's (Resident #18) clean clothes on the floor in their closet; however, nothing had been done to rectify her complaint and the clothes were still on the floor. Resident #3 stated Resident #18 was blind and required total care by staff and he/she was advocating for Resident #18. The resident also stated there was a hole in the closet door. Observation of Resident #3's shared closet space with Resident #18, on 04/14/15 at 1:15 PM, revealed the right side of the closet contained numerous folded and unfolded items of clothing on the closet floor and the bottom of the right door had a hole in it. Observation of heating and air conditioning unit revealed the vent was filled with dirt and debris. Interview with Maintenance, on 04/14/15 at 3:00 PM, revealed he was aware of Resident #3's request to fix the closet door. He stated he had forgotten about the request. He stated he was the only maintenance person in the building and did not have any assistance with completing all his tasks. He stated he had to prioritize his tasks and resident requests and not everything was completed timely. Surveyor requested to review the work order for the repair of Resident #3's closet door. The Maintenance technician stated he was unable to locate one for review. Interview with the Housekeeping Director, on 05/15/15 at 1:45 PM, revealed the laundry staff was responsible for putting the resident's clean laundry in the resident's dressers and closets. He stated his laundry staff was trained not to put	F 253		

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F 253	Continued From page 146 clean clothes on the floor and if resident's closets or dressers were full their families would be called to discuss storage/placement of all clean clothes. He stated he was unaware of Resident #3's grievance regarding Resident #18's clothes being thrown on the floor in the closet. Interview with the Executive Director, on 04/23/15 at 8:34 AM, revealed she did not remember specifics regarding resident grievances or complaints. She stated the resident council and other individual residents made complaints regarding lost clothing and clothing not being returned timely, linen shortages, along with call lights not being answered timely. She stated the facility staffing shortage was the underlying issue to the problems in the facility. She stated she tried to address the resident's concerns with the contracted Housekeeping and Laundry Company the facility used and said improvements occurred, but did not last and the issues would return again. 24. Review of Resident #4's clinical record revealed the facility admitted the resident on 05/16/13 with diagnoses of Atrial Fibrillation, Chronic Obstructive Airway, Rheumatoid Arthritis, Osteoporosis and Open Wound Site. The Quarterly MDS assessment, completed on 03/09/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of ninety-nine (99), indicating the resident was rarely/never understood. Observation of Resident #4, on 04/15/15 at 1:30 PM, revealed Resident #4's room had a strong odor of urine, along with food debris on the floor	F 253		

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and the bedside table. Observation of heating and air conditioning unit revealed the vent was filled with dirt and debris.

Observation of Resident #4, on 04/16/15 at 8:45 AM, revealed the resident's room had a strong odor of urine. Observation of heating and air conditioning unit revealed the vent was filled with dirt and debris.

Observation of Resident #4, on 04/17/15 at 10:44 AM, revealed the bed pillow had holes, duct tape was around the window between the top and bottom window panes, and a food like substance was on the floor.

Interview with the Housekeeping Director, on 04/16/15 at 1:45 PM, revealed housekeeping staff on their first round of the unit should focus on removing trash then start cleaning resident's rooms. He stated there was a lack of communication between the aides and the housekeepers to ensure resident's rooms were clean and neat. He stated the housekeeper would not touch personal items belonging to the resident, like a soda can. He stated that was the responsibility of the nursing staff to dispose of in the trash. He stated housekeeping did not clean the air conditioning vents that was the responsibility of maintenance.

Interview with Maintenance, on 04/14/15 at 3:00 PM, revealed the heating/air conditioners were being replaced a few at a time. He stated the plan was to replace all the heating/air conditioners eventually. He stated he did not have a written

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plan or a deadline as to when the project would be finished. He stated he kept three (3) heating/air conditioning units in the shed so he would have a replacement if one broke down and when he had time he would install a new one in a resident's room. He stated he did not have a routine schedule to clean the vents of debris and he depended on the nursing staff to tell him if one needed to be cleaned out.

25. Review of Resident #5's clinical record revealed the facility admitted the resident on 03/13/15 with diagnoses of Altered Mental Status, Parkinson's, Gastro Esophageal Reflux Disease, and Chest Pain. The Significant Change MDS assessment, completed on 04/25/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of ninety-nine (99), indicating the resident was rarely/never understood.

Observation of Resident #5, on 04/15/15 at 1:05 PM, revealed the resident was in a recliner wearing a white t-shirt and gray pants with no shoes or socks on his/her feet.

Observation of Resident #5, on 04/16/15 at 3:30 PM, revealed the resident had food debris on his/her clothes and on the mattress in a semi-private room with no privacy curtain. The heating and air conditioning unit vent was filled with dirt and debris.

Observation of Resident #5, on 05/13/15 at 9:41 AM, revealed the resident was in the common

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F 253	Continued From page 149 area in a recliner with pants down to ankles.	F 253		
	26. On 04/1715 at 11:31 AM, observation of Unsample Resident M revealed the bottom dresser drawer was missing and there was no privacy curtain in the room to provide privacy to Unsampled Resident M or Resident #5.			
	27. Review of Resident #6's clinical record revealed the facility admitted the resident on 11/14/13 with diagnoses of Toxic Encephalopathy, Bradycardia, Renal Insufficiency, Gastro-esophageal Reflux Disease, Neurogenic Bladder, and Seizures. The Quarterly MDS assessment, completed on 01/08/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score a fourteen (14), meaning the resident was cognitively intact and interviewable.			
	Observation of Resident #6, on 04/16/15 at 10:45 AM, revealed the resident was laying in a bariatric bed. The sheet underneath the resident was thin, frayed and contained holes. The resident's hair appeared uncombed and greasy. The heating and air conditioning unit vent was filled with dirt and debris.			
	Observation of Resident #6, on 04/17/15 at 11:10 AM, revealed the heating and air conditioning unit vent remained filled with dirt and debris.			
	Observation, on 04/17/15 at 11:05 AM, of Resident #6 revealed the window blinds had			

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F 253	Continued From page 150 broken vanes, and the privacy curtain between the two (2) resident beds was torn partially off the track. A brown substance was observed between the top of the walls and the ceiling around the room. The bathroom door had a hole and a portable O2 concentrator was stored on the floor next to the dresser and television (TV). Continued observation of Resident #6, on 04/17/15 at 1:58 PM, on 04/27/15 at 10:51 AM, on 05/01/15 at 8:45 AM, on 05/05/15 at 1:28 PM, and on 05/13/15 at 9:19 AM, revealed window blinds remained broken and a portable O2 concentrator continued to be stored on the floor next to the dresser with the TV. Interview with Resident #6, on 04/16/15 at 10:45 AM, revealed maintenance was aware of the broken blinds; however, nothing had been done to replace them. Interview with Interim Executive Director, on 04/28/15 at 9:40 AM, revealed she was aware there were resident rooms and common areas without blinds and/or with broken blinds. She stated as of now they were just looking into finding blinds that were more durable to replace them. 27. Review of Resident #8's clinical record revealed the facility admitted the resident on 04/18/14, with diagnoses of Hypoxia, Respiratory Failure, Stage Three Renal Disease, Cerebral Vascular Accident, Congestive Heart Failure, Decubitus, and Toxic Metabolic Encephalopathy. The Quarterly MDS assessment, completed on 03/25/15, revealed a BIMS exam was conducted	F 253		

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F 253	Continued From page 151 and the facility assessed the resident with a score of fifteen (15) meaning the resident was cognitively intact and interviewable. Observation of Resident #8, on 04/22/15 at 9:15 AM, revealed the resident was sitting in a wheelchair beside the bed in the middle of the room. Observation of the wall beside the bed revealed ants were crawling on the wall and inside the baskets and bin that was on the floor next to the bed. Continued observation and interview with Certified Nursing Assistant (CNA) #9 revealed she removed the baskets and bins that were on the other side of the bed by the wall and window and said there were ants crawling inside the baskets, bin and on the wall. Observation revealed the baskets and bins had numerous dead ants and live ants crawling amongst the items. CNA #9 removed the baskets and bins from Resident #8's room and took them to the shower room and emptied the contents of the baskets and bin. The items found inside were; ten (10) soft drink cans, dirty clothing, a tin foil food container with debris inside, boxes of briefs, and a lift pad. Observation of Resident #8, on 04/17/15 at 10:35 AM, revealed behind the bed there was a hole and gouges in the wall. The closet shelf was broken and leaned against the closet rod with clothes hanging from it. A bag of clothes was observed on the floor. A small portable oxygen (O2) concentrator was stored on top of the heating and cooling unit. The oxygen tank had a yellow sticker dated 04/06/12 and was due for service on April 2013. Interview with Resident #8, on 04/22/15 at 9:20 AM, revealed he/she had ants crawling in the bed	F 253		

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with him/her and the staff cleaned them off of his/her body and removed the sheets from the bed. Resident #8 stated he/she felt like the management staff did not care and that it did not do any good to complain. The resident stated he/she put on their call light again last night because he/she was wet and wanted to be pulled up in the bed and the staff answered the light and said they would be back because they needed help. The resident said he/she fell back to sleep, woke up again and pushed the call light again and they turned if off again and did not come back for a while.

Interview with Certified Nursing Assistant (CNA) #9, 04/22/15 at 9:15 AM, revealed she had seen ants in the bed with Resident #8 this morning during incontinent care. She stated she got the resident up out of the bed and removed the sheets. She said she had not informed her supervisor yet, but the process was for her to write her findings in the maintenance book for management to address.

28. Review of Resident #9's clinical record revealed the facility admitted the resident on 08/14/14, with diagnoses of Peripheral Vascular Disease, Traumatic Brain Injury, Anxiety, Depression, and Chronic Obstructive Pulmonary Disease and Dementia. The Sixty-day (60) scheduled MDS assessment, completed on 03/03/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of fifteen (15) meaning the resident was cognitively intact and interviewable.

Interview with Resident #9, on 04/16/15 at 8:41 AM, revealed the staff do not help keep the room

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F 253	Continued From page 153 clean. Observation of Resident #9, on 04/17/15 at 10:40 AM, revealed the resident was on the bed with no covering over their body. The resident's left leg was amputated above the knee, the resident's face was unshaven and the room had a strong odor of urine. Observation revealed the resident's garbage cans did not have liners and there was food debris on the floor, wall and privacy curtain. The resident's clothing/shoes/personal items were in the floor beside the head of the bed. The resident's fan was on the floor, face down and running with no staff present. Interview with Certified Nursing Assistant (CNA) #1, on 04/17/15 at 10:55 AM, revealed she was assigned to take care of Residents #4, #8 and #9. When her shift started today there were just two (2) aides and the third aide did not come until 10:00 AM. She stated she changed the incontinent residents and dressed those that were gotten up, but due to time constraints and staffing she was not able to ensure resident's room were neat and clutter free. Interview with Licensed Practical Nurse (LPN) #5, on 04/22/15 at 3:25 PM, revealed that staffing was an issue and there were only two(2) or three (3) aides were on the unit maintaining a clean environment in the resident's rooms was difficult. 29. Review of Resident #10's clinical record revealed the facility admitted the resident on 05/01/14, with diagnoses of Chronic Atrial Fibrillation, Quadriplegic, Neuropathy, Muscle	F 253		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 154 Spasms, Gastro-esophageal Disease, Proteus Urinary Tract Infection, and Chronic Ileus resolved. The Annual MDS assessment, completed on 02/03/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of fifteen (15) meaning the resident was cognitively intact and interviewable. Observation of Resident #10, on 04/15/15 at 9:25 AM, revealed the resident was laying in a bariatric bed with torn, tattered and frayed sheets. The resident's floor had a brown stain by the bed and the room had a strong odor of urine. Interview with Resident #10, on 04/15/15 at 9:25 AM, revealed the resident had many concerns with nursing care and linens provided by the facility. Resident #10 stated he/she was unable to move and was totally dependent upon staff for care. The resident stated the housekeeping staff did not always keep the floor clean and the garbage picked up. Interview with Resident #10, on 04/27/15 at 2:24 PM, revealed the toilet in his/her bathroom ran constantly. He/she reported his/her concern to the previous and current Maintenance Director and nothing was done to correct the problem. Resident #10 stated that the current Maintenance Director's response was that he would look into it. Interview with the Head of Housekeeping and Laundry, on 04/22/15 at 9:41 AM, revealed there was one (1) of three (3) washers and one (1) of three (3) dryers out of service, and that his	F 253		

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predecessor had reported both to the Maintenance Director approximately two (2) months ago. He was unsure if written documentation existed.

Continued interview with the Head of Housekeeping and Laundry, on 04/28/15 at 3:05 PM, revealed it was not good for the residents when rooms were not cleaned, as this could lead to contamination issues and illness to the residents. He monitored housekeeping through a daily Quality Control Inspection (QCI). He stated the protocol and procedure required him to physically check areas that had been cleaned; however, there were times when he did not get around to it, and only got around to conducting QCI three (3) days out of five (5), Monday through Friday.

Interview, on 04/22/15 at 10:22 AM, with the Maintenance Director revealed he only found out on 04/22/15 that one (1) washer and one (1) dryer was not working. He stated if equipment in the Laundry was in need of repair, it was the responsibility of the Head of Housekeeping and Laundry to make verbal or written (work order) notification to him. He maintained that he was never notified verbally or in writing. He stated all repairs should be documented in the Maintenance Log kept at each Nurse's Station. Further interview revealed he checked the Maintenance Log daily to see what needed repaired.

Interview via telephone, on 04/22/15 at 2:22 PM, with the former Maintenance Director revealed he

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was an employee of the facility from approximately May 2014 to 03/23/15 or 03/24/15. He stated that during his employment, the Maintenance Department consisted of himself and an assistant. He stated that to keep track of what repairs needed to be completed, a Maintenance Request Log was kept at each Nurse's Station, and he kept "mental" notes of what needed to be done. In regards to the Laundry Room, he recalled there was an issue with one (1) washer, and at some point an issue with all three (3) dryers. He stated the washer and dryers would break down, and sometimes a repair company would be called to come in and repair the machines. He stated that when he left his employment with the facility in March 2015, washer #1 was not working and was still probably not working. He stated the repair company refused to come out and make repairs because the facility had not paid the repair bills since September 2014. Further interview revealed he stated the pest control company had refused to service the facility around February and March 2015, because the facility had not paid the pest control company.

Interview, on 04/17/15 at 1:30 PM, with the Interim Executive Director/Vice President of Operation revealed Department Heads conducted mock surveys on Monday thru Friday daily rounds, that identified resident care needs, environmental safety concerns, and if environmental issues were identified, a work order was filled out and forwarded to the Maintenance Director for repairs. The Maintenance Director followed a preventative maintenance schedule. Further interview revealed she had no knowledge of how long the Maintenance Department had been operating

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	with one staff member. She stated that one maintenance staff member was manageable because in the event of an emergency the facility would pull staff from another corporate facility to assist with any maintenance needs. Continued interview, on 04/21/15 at 5:49 PM, with the Interim Executive Director/Vice President of Operations revealed the facility had a process for work order requests. When repair of equipment in the laundry room was needed, the Head of Laundry would complete a work order form detailing what was in need of repair. The work order was then forwarded to the Maintenance Director, who in turn reported to the Executive Director. She related that she did not know what the break down was in the facility's process that caused the information to not reach the ED. She explained, that given the capacity of the machines, having one (1) washer and one (1) dryer not operational would not affect the productivity for getting laundry done.			
F 254 SS=F	483.15(h)(3) CLEAN BED/BATH LINENS IN GOOD CONDITION The facility must provide clean bed and bath linens that are in good condition. 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 ensure an adequate number of pillows, sheets, blankets, towels, wash clothes, bath blankets, clothing protectors, and pillow cases, that were in good condition, were available to provide resident care	F 254		

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F 254	Continued From page 158 for nine (9) of forty-three (43) sampled residents, (Residents #3, #6, #7, #8, #10, #20, #25, #33 and #36), and two (2) of thirty-nine (39) unsampled residents, (Unsampled Resident D and Z). The average daily census of the facility during the survey was 122 residents. The findings include: Review of the contract company's (housekeeping, laundry, and dietary services) policy, Linen Par System, not dated, revealed flat sheets, fitted sheets, blankets, pillowcases, wash cloths, and bath towels needed to have a three (3) Par Level, meaning three (3) of each item was needed in inventory per resident. Review of the Monthly Linen Inventory, dated 03/25/15, revealed the facility had in inventory, 182 flat sheets, 180 fitted sheets, 274 pillow cases, 178 towels, 1202 washcloths, 72 gowns, 24 pads, 28 bath blankets, 152 blankets, 49 spreads, 30 bibs, and 260 pillows. The inventory counted items in the soiled area, wash area, dryer area, folding area, closets on units, soiled in barrels, linens on beds, storage. Observation of the Laundry Room, on 04/16/15 at 11:07 AM, revealed a large plastic bag on the bottom shelf of a clothes cart. The bottom of the plastic bag was busted and two (2) pairs of pants and one (1) blanket were hanging from the bag touching the floor.	F 254		

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F 254	Continued From page 159 Observation of the Laundry Room, on 04/21/15 at 3:50 PM, revealed an "Out of Order" sign taped to the door on one (1) of three (3) washers and one (1) of three (3) dryers. Interview, on 04/22/15 at 11:11 AM, with Housekeeper/Laundry Aide #1 assigned to the 200 Unit, revealed her duties as a Laundry Aide included washing, drying, folding linen and clothing, and delivering clothing to the resident rooms. Further interview revealed she had not noticed a shortage of linen; however, there had been times when there was no linen in the 200 Unit linen closet and staff would have to go to another unit to locate sheets. Interview, on 04/17/15 at 10:05 AM, with the 200 Unit Manager, revealed the 200 Unit had a shortage of linen for the past two (2) months. At least twice weekly the unit would be short of sheets, washcloths, towels, and incontinence underpads, especially first thing in the mornings. When there was no linen in the linen closet, the aides would have to check the laundry room to determine if any laundry had been done or check another unit for linen. There were times when the unit was out of incontinence underpads, and staff would have to use folded sheets to place in the beds underneath the residents. She stated four (4) of five (5) days of the week, she reported to the Executive Director, the issue with the shortage of linen. Sometimes after she expressed to the Executive Director her concerns, the unit received linen for the residents. Interview, on 04/21/15 at 3:50 PM, with the Head	F 254		

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F 254	Continued From page 160 of Housekeeping and Laundry, related a washer and dryer had been out of order for the two (2) months he had been assigned to the facility. He had been employed with the contract company since 01/01/15. His company's procedure to ensure the repair of equipment required that he reported via e-mail to his immediate supervisor, the District Manager. He could not recall if he reported the out of order machines to the Maintenance Director, and did not know whether maintenance performed routine checks to determine the operational status of the washers and dryers. He stated the out of order machines affected the residents in that the Laundry Department's productively was decreased by 30%. Continued interview, on 04/28/15 at 3:05 PM, with the Head of Housekeeping and Laundry, revealed the budget determined the number of linen he was allowed to purchase. He informed the District Manager that the linen inventory had gotten drastically low. The protocol and process was to reorder linen on the 25th of each month; however, if in the event of an emergency an order could be placed. His supervisor wanted him to ensure that he managed inventory to maintain enough linen until the 25th of each month. He stated he was to blame for the linen shortage. Being new to the facility, he did not know how much to order and he did not conduct a thorough inventory to ensure enough sheets were ordered. He stated he had been properly trained by his supervisors, and that he took sole responsibility for the facility's linen shortage. Interview, on 04/21/15 at 3:50 PM, with the	F 254		

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F 254	Continued From page 161 Regional Manager for the contract company that provided housekeeping and laundry services for the facility, revealed a washer and a dryer had been out of order since November 2014. He stated he had no knowledge of a linen shortage until 04/18/15, when the Head of Housekeeping and Laundry informed him. Interview, on 04/17/15 at 1:30 PM, with the Interim Executive Director/Vice President of Operations (ED/RVPO), revealed the contract company that provided laundry services determined the Par Level for the facility. If extra linen was needed the contract laundry company would order more linen. She stated that the facility had been having problems with aides throwing linen away; however, she did not know the reason the aides threw away linen. She related that she had talked with some aides on the night of 04/16/15 to find out the reason linen was being thrown away. She stated that if the linen had feces on it, the aides might throw the linen away rather than send it to the laundry for washing. She stated that if there was a problem with the linen, the contract laundry service would bring it to her attention and she then would talk with the Executive Director, corporate office, and on up the ladder to Regional in order to ensure the facility had linen. She stated that she became aware of the linen issue when she personally checked a supply closet and found the inventory was low, and then ensured the contract laundry service ordered more linen. She stated the facility usually had enough linen in inventory; however, if the inventory became low or if the supply in the linen closet was low, it did not have a negative effect on the residents because facility would order more linen or ensure staff checked	F 254		

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F 254	Continued From page 162 the laundry room for clean linen. Continued interview, on 04/21/15 at 5:49 PM, with the ED/RVPO, revealed the facility had a process for work order requests. When repair of equipment in the laundry room was needed, the Head of Housekeeping and Laundry would complete a work order form detailing what was in need of repair. The work order was then forwarded to the Maintenance Director, who in turn reported to the Executive Director. She related that she did not know what the break down was in the facility's process that caused the information not to reach the Executive Director. She explained given the capacity of the machines, one inoperable (1) washer and one (1) dryer would not affect the productivity for getting laundry done. Interview, on 04/27/15 at 2:13 PM, with the Activity Assistant, revealed one of her responsibilities included recording the minutes at each Resident Council Meeting. She recalled recording in January, February, and March 2015 residents' concerns about personal laundry not being picked up and returned timely. She did not know whether the Laundry Department was short staffed. The facility provided a contact telephone number for the previous Housekeeping and Laundry. A telephone call was placed on 04/23/15 at 1:52 PM, and a message was received that stated the voicemail had not been set up	F 254		

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F 254	Continued From page 163 1. Review of the clinical record for Resident #7 revealed the facility admitted the resident on 03/17/15, with diagnoses of Vascular Dementia, and Cerebral Vascular Accident. The Admission MDS, dated 03/25/15, revealed a Brief Interview for Mental Status (BIMS) score of ninety-nine (99) meaning the resident was rarely/never understood. Observation, on 04/21/15 at 4:14 PM, revealed a hole in the fitted sheet on Resident #7's bed. The fitted sheet was threadbare. 2. Review of the clinical record for Unsampled Resident D revealed the facility admitted the resident on 07/09/14 with diagnoses of Multiple Sclerosis, Anemia, and Arthritis. Review of the Quarterly MDS assessment, dated 04/17/15, revealed a BIMS score of fifteen (15) meaning the resident ws cognitively intact and interviewable. Interviews with Unsampled Resident D, on 04/17/15 at 4:00 PM, revealed there was a terrible problem with the linen. The residents often could not get blankets and had trouble getting sheets and urine pads for their bariatric beds. Instead of using urine pads (underpads), the CNAs used rolled up sheets to place underneath them. Unsampled Resident D stated the sheets on his/her bed on 04/17/15 were ripped and he/she did not even get a folded sheet to use as a urine pad. Unsampled Resident D related they did not feel good about not having urine pads, as the folded sheets do not work as well.	F 254		

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F 254	Continued From page 164 3. Review of Resident #3's clinical record revealed the facility admitted the resident on 07/27/12, with diagnoses of Chronic Pain, Cerebral Vascular Accident, Anemia, Heart Failure, Hypertension, Anxiety, Depression, and Chronic Lung Disease. Review of Resident #3's Quarterly Minimum Data Set (MDS) assessment, completed on 02/17/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the resident was assessed with a score of thirteen (13), which meant the resident was cognitively intact and interviewable. Interview with Resident #3, on 04/14/15 at 1:15 PM, revealed the resident routinely attended the monthly Resident Council meeting and had made complaints regarding care, services and environmental issues. Resident #3 stated the facility had not resolved the issues discussed at the meetings. The resident stated he/she had an overactive bladder and recently had put on the call light for assistance in order to go to the toilet. The resident stated he/she had to wait over an hour for staff to answer the call light. Resident #3 stated while waiting he/she was incontinent of urine and this had upset the resident. Resident #3 continued to state he/she had complained to the facility staff about the laundry staff throwing the roommate's (Resident #18) clean clothes on the floor in their closet; however, nothing had been done to rectify his/her complaint and the clothes were still on the floor.	F 254		

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F 254	Continued From page 165 Resident #3 stated Resident #18 was blind and required total care by staff and he/she was advocating for Resident #18. Resident #3 stated he/she had made complaints to staff related to the preference of wanting to stay up to 9:00 PM. Resident #3 stated due to staffing shortages and the need for transfer assistance by staff, he/she had to go to bed between 6:00 PM and 8:30 PM and this was also upsetting. But he/she felt they did not have a choice and had to comply. Observation of Resident #3's shared closet space with Resident #18, on 04/14/15 at 1:15 PM, revealed the right side of the closet contained numerous folded and unfolded items of clothing on the closet floor. Interview with Maintenance, on 04/14/15 at 3:00 PM, revealed he was aware of Resident #3's request to fix the closet door. He stated he had forgotten about the request. He stated he was the only maintenance person in the building and did not have any assistance with completing all his tasks. He stated he had to prioritize his tasks and resident requests and not everything was completed timely. The Maintenance technician stated he was unable to locate a repair request for Resident #3's closet door. Interview with the Housekeeping Director, on 05/15/15 at 1:45 PM, revealed the laundry staff was responsible for putting the resident's clean laundry in the resident's dressers and closets. He stated his laundry staff was trained not to put clean clothes on the floor and if resident's closets or dressers were full their families would be called	F 254		

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F 254	Continued From page 166 to discuss storage or placement of all clean clothes. He stated he was unaware of Resident #3's grievance regarding Resident #18's clothes being thrown on the floor in the closet. 4. Review of Resident #6's clinical record revealed the facility admitted the resident on 11/14/13 with diagnoses of Toxic Encephalopathy, Sepsis, Bradycardia, Hypertension, Renal Insufficiency, Gastro-esophageal Reflux Disease, Neurogenic Bladder, and Seizures. Review of Resident #6's Quarterly Minimum Data Set (MDS) assessment, completed on 01/08/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of fourteen (14), which meant the resident was cognitively intact and interviewable. Observation of Resident #6, on 04/16/15 at 10:45 AM, revealed the resident was lying in a bariatric bed. The sheet underneath the resident was thin, frayed and contained holes. The resident's hair appeared uncombed and greasy. Interview with Resident #6, on 04/16/15 at 10:45 AM, revealed he/she was left wet for seventeen hours (17) due to the facility not having enough staff and linens to meet his/her needs. The resident stated he/she did not want to be a "pain in the ass because it would just get worse and I do not want to throw anyone under the bus". Continued interview with Resident #6 revealed there were times the facility did not have full size bariatric fitted bed sheets to change his/her bed linens. The resident stated that if the staff	F 254		

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F 254	Continued From page 167 removed the full size sheet it would take two (2) or three (3) days to get one back. The resident also stated he/she would get cold and there were never any blankets available when he/she needed one for warmth. Interviews with Resident #6 on 04/17/15 at 4:00 PM, revealed there was a terrible problem with the linen and urine pads for their bariatric beds. Instead of using urine pads, the CNAs used rolled up sheets to place underneath them. Resident #6 related that on 04/17/15 a folded sheet was placed in the center of his/her bed to be used as a urine pad. Resident #6 stated he/she did not feel good about not having urine pads, as the folded sheets did not work as well. Interview with Certified Nursing Assistant (CNA) #6, on 04/16/15 at 11:00 AM, revealed he was not able to complete all his assigned duties for twenty three (23) residents that needed assistance with activities of daily living. He stated at times the facility did not have enough linens, wash clothes or towels. He stated there were times when he had to cut up sheets to dry residents after giving them a bath. CNA #6 stated he informed management staff regarding the linen shortage, but nothing was ever done about it. 5. Review of Resident #8's clinical record revealed the facility admitted the resident on 04/18/14, with diagnoses of Hypoxia, Respiratory Failure, Stage Three Renal Disease, Cerebral Vascular Accident, Congestive Heart Failure, Hypertension, Decubitus, and Toxic Metabolic Encephalopathy.	F 254		

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F 254	Continued From page 168	F 254		
	Review of Resident #8's Quarterly Minimum Data Set (MDS) assessment, completed on 03/25/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of fifteen (15) which meant the resident was cognitively intact and interviewable.			
	Observation, on 04/16/15 at 8:48 AM, revealed Resident #8's fitted sheet for their bariatric bed was thin and torn in various areas.			
	6. Review of Resident #10's clinical record revealed the facility admitted the resident on 05/01/14, with diagnoses of Hypertension, Chronic Atrial Fibrillation, Quadriplegic, Neuropathy, Muscle Spasms, Gastro-esophageal Disease, Proteus Urinary Tract Infection, and Chronic Ileus resolved.			
	Review of Resident #10's Annual Minimum Data Set (MDS) assessment, completed on 02/03/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of fifteen (15) meaning the resident was cognitively intact and interviewable.			
	Observation of Resident #10, on 04/15/15 at 9:25 AM, revealed the resident was lying on a bariatric bed with sheets that were thin, torn and tattered with pillows under both arms that had the stuffing protruding out.			

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F 254	Continued From page 169	F 254		
	7. Review of Resident #20's clinical record revealed the facility admitted the resident on 02/10/15, with diagnoses of Anemia, Hypertension, Encephalopathy, Pneumonia, Dementia, Hypothyroidism, Chronic Venous Stasis of both lower extremities, and Lymphedema. Review of Resident #20's Annual Minimum Data Set (MDS) assessment, completed on 02/24/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of fifteen (15) meaning the resident was cognitively intact and interviewable Interview with Resident #20, on 04/16/15 at 9:11AM, revealed the resident was wet from urinary incontinence and had requested to be changed, but was told by staff that he/she would have to wait until staff picked up the morning breakfast trays. Interview with Resident #20, on 04/16/15 at 10:00 AM, revealed the resident was still wet and staff had not been into change his/her brief or linens that were wet with urine. Interview with Resident #20, on 04/16/15 at 3:20 PM, revealed staff came into change his/her brief and sheets at noon. The resident stated it felt like forever to get cleaned up and changed. The resident said staff told him/her that it took them a while to find a sheet to fit his/her bariatric bed.			

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F 254	Continued From page 170 Interview with Certified Nursing Assistant #35, on 04/16/15 at 12:30 PM, revealed the facility did not have any clean bariatric bed sheets available for her to change Resident #20's bed. She stated the resident was incontinent of urine and requested to be changed; however, it took her over an hour to find a sheet for the bed and then she had to find someone to assist with turning and repositioning. She stated it was hard to meet the resident's request timely when linens were short. 8. Review of Resident #36's clinical record revealed the facility admitted the resident on 09/19/15 with diagnoses of Dementia, Arthritis, Hypertension, Anemia, Cerebral Vascular Accident, Congestive Heart Failure and Atrial Fibrillation. Review of Resident #36's Quarterly Minimum Data Set (MDS) assessment, completed on 03/21/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of fourteen (14) which meant the resident was cognitively intact and interviewable. Observation of Resident #36, on 04/29/15 at 9:55 AM, revealed the resident's bed sheets contained a yellow/brown circular stain and the bottom of the sheet was torn. 9. Review of Resident #25's clinical record revealed the facility admitted the resident on 12/30/14 with a diagnosis of Vascular Dementia. The MDS, dated 01/06/15, revealed the resident had impaired cognitive status and was not interviewable.	F 254		

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Observation, on 04/22/15 at 10:50 AM, of Resident #25 revealed the resident was in his/her room lying in the bed on his/her back. The bed had no linens and two (2) pillows did not have pillowcases.

Observation of Resident #25, on 04/22/15 at 10:59 AM, revealed the resident ambulated in his/her room independently. The resident's bed had no linens, and the two (2) pillows did not have cases.

Interview with Resident #25, on 04/22/15 at 10:59 AM, revealed he/she could not answer questions appropriately and stated he/she did not know the sheets were gone or for how long.

Continued observation of Resident #25, on 04/22/15 at 3:07 PM, 04/23/15 at 7:57 AM, 04/23/15 at 8:18 AM, and 04/23/15 at 8:40 AM, revealed sheets on the bed; however, the two (2) pillows did not have pillowcases.

10. Review of Resident #33's clinical record revealed the facility admitted the resident on 03/19/09, with diagnoses of Dementia, Hemiplegia, Diabetes and Breast Cancer. Review of Resident #33's Quarterly Minimum Data Set Assessment, dated 03/30/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident iwth a ninety-nine (99) meaning the resident was rarely/never understood.

Interview with Family Member #1, on 04/22/15 at 4:18 PM, revealed when she visited on Saturdays and Sundays, the nursing aides would have to go

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F 254	Continued From page 172 in search of linen for her parent, Resident #33, as there would be no linen on the 100 Unit where the resident resided.	F 254		
	11. Review of Unsampled Resident Z's clinical record revealed the facility admitted the resident on 06/13/14, with diagnoses of Dementia, Dementia, Diabetes and Schizophrenia. Review of Unsampled Resident Z's Quarterly Minimum Data Set Assessment, dated 03/12/15, revealed a BIMS exam was conducted and the facility assessed the resident with a ninety-nine (99) meaning the resident was rarely/never understood.			
	Observation, on 04/16/15 at 11:07 AM, revealed Unsampled Resident Z had no sheets on his/her bed. Observation of the Laundry Room on 04/16/15 at 11:07 AM, revealed a large plastic bag on the bottom shelf of a clothes cart. The bottom of the plastic bag was busted and two (2) pairs of pants and one (1) blanket were hanging from the bag touching the floor.			
F 279 SS=J	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		
	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.			
	The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive			

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F 279	Continued From page 173 assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system in place to ensure residents' care plans were developed to address the assessed needs for three (3) of forty-three (43) sampled residents (Residents #14, #15 and #31). Interview and record review revealed the facility failed to ensure a plan of care was developed to promote resident safety for Residents #14 and #15, whom the facility assessed to require supervision while smoking. Observation, on 04/20/15 at 10:00 AM, revealed Resident #14 and #15 were outside in the court yard smoking cigarettes without staff supervision. The resident's did not have smoking aprons applied. (Refer to F323) In addition, the facility failed to develop a care plan for Resident #31 with an indwelling urinary catheter. The facility's failure to have an effective system in	F 279		

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F 279	Continued From page 174	F 279		

place to ensure care plans were developed based on the assessed needs of the resident has caused or is likely to cause serious injury, harm, impairment or death to resident. Immediate Jeopardy was identified on 04/22/15 and determined to exist on 04/20/15.

An acceptable Allegation of Compliance (AOC) was received on 05/19/15 alleging the Immediate Jeopardy was removed on 05/16/15. The State Survey Agency validated the Immediate Jeopardy was removed on 05/16/15 as alleged, prior to exit on 05/22/15. The scope and severity was lowered to an E while the facility monitors the implementation of the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes.

The findings include:

Review of the facility's policy regarding Care Plans, dated 11/30/14, revealed an interdisciplinary plan of care would be established for every resident and updated in accordance with the state and federal regulatory requirements and on an as needed basis. Goals must be measurable and objective. The facility must develop a comprehensive Care Plan for each resident that included measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. An Interim Care Plan must be developed within twenty-four (24) hours of admission to ensure that the resident's needs are met appropriately until the Comprehensive Care Plan was completed. A Comprehensive Care Plan must be developed by the Interdisciplinary Care Planning Team within seven (7) days after completion of the

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F 279	Continued From page 175 comprehensive assessment. Review of the facility's policy regarding Smoking, dated 11/30/14, revealed each resident would be assessed on admission and quarterly to determine if the resident was a safe smoker. Residents would be evaluated for safety regarding smoking upon admission and quarterly. 1. Review of Resident #14's clinical record revealed the facility admitted the resident on 01/23/15, with diagnoses of Chronic Kidney Disease (CKD), Bipolar Disorder, Difficulty Walking, Peripheral Vascular Disease (PVD), Hypertension (HTN), Depression, and Urinary Tract Infection (UTI). Review of Resident #14's Admission Minimum Data Set (MDS) assessment, completed on 02/22/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of fifteen (15), meaning the resident was cognitively intact and interviewable. Review of Resident #14's Admission/Readmission Data Collection form, dated 03/03/15, revealed the facility performed a Safe Smoking Evaluation and determined the resident was not able to light or smoke a cigarette safely, use an ash tray properly, or extinguish a cigarette safely. Review of the Comprehensive Care Plan for Resident #14 revealed the facility did not develop	F 279		

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F 279	Continued From page 176 a care plan with updated goals and a target date for unsafe smoking. 2. Review of Resident #15's clinical record revealed the facility admitted the resident on 09/11/14, with diagnoses of Anemia, Hypertension (HTN), Hyperlipidemia, Cerebral Vascular Accident (CVA), and Hemiplegia. Review of Resident #15's Admission MDS assessment, completed on 03/23/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of fifteen (15), meaning the resident was cognitively intact and interviewable. Review of Resident #15's undated, Admission/Readmission Data Collection form, revealed the facility assessed the resident as unaware of safety limitations and required constant supervision while smoking. Review of the Comprehensive Care Plan for Resident #15 revealed the facility did not develop a plan of care with updated goals and a target date for unsafe smoking. Observation, on 04/20/15 at 10:00 AM, revealed Residents #14 and #15 were outside in the court yard smoking cigarettes without staff supervision. Interview with the Unit Manager (UM), on 04/21/15 at 3:25 PM, revealed a smoking care	F 279		

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F 279	Continued From page 177 plan should have been developed after the smoking assessment had been completed for Residents #14 and #15. She stated she was unaware that Residents' #14 and #15 care plans related to unsafe smoking had not been developed. The UM stated both residents were assessed as unsafe smokers and needed supervision at all times while smoking and should not have been outside smoking without staff. Interview with the Assistant Director of Clinical Services (ADCS), on 04/20/15 at 1:50 PM, revealed each resident was assessed as an unsafe smoker should have a care plan developed. She stated the residents were assessed as unsafe smokers and should have been supervised by staff while smoking and the care plan directed staff on what to do for each resident. She stated the residents could have burned themselves. 3. Review of Resident #31's clinical record revealed the facility admitted the resident on 08/11/14, with diagnoses of Peripheral Vascular Disease (PVD), Above Knee Amputation (AKA), Diabetes Mellitus (DM), and Pressure Ulcer. Review of Resident #31's Admission MDS assessment, completed on 08/19/14, revealed a BIMS exam was conducted and the facility assessed the resident with a score of fifteen (15), meaning the resident was cognitively intact and interviewable. A Quarterly MDS assessment was completed on 02/17/15 and assessed the resident to have a BIMS of six (6), meaning the resident was cognitively impaired and not interviewable.	F 279		

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Review of Resident #31's Kardex, undated, revealed the resident wore a brief for elimination, and use of a indwelling urinary catheter was not marked. Continued review of the facility care plan, dated 08/22/14, revealed a care plan for risk of incontinence of bowel and bladder included interventions to assist with toileting needs, check frequently for incontinence, and assess the resident's skin with each incontinent episode. The resident's care plan did not indicate the resident had an indwelling urinary catheter. Continued review of the care plan, dated 04/14/15 and printed on 05/01/15, for an indwelling urinary catheter revealed interventions to change the catheter tubing and bag every thirty (30) days; evaluate for removal of the catheter; and, provide catheter care every shift.

Continued review of Resident #31's clinical record revealed physician orders from a local hospital, dated 03/27/15, that the resident was going to be discharged to the facility and to leave the indwelling urinary catheter in place at the facility, and change the indwelling urinary catheter every two (2) weeks.

Review of Resident #31's facility Admission/Readmission Data Collection form, dated 03/27/15, revealed the resident was incontinent and used an indwelling urinary catheter for wound healing, with no plan to discontinue the catheter. The physician orders for March and April 2015 revealed the use of an indwelling urinary catheter; however, catheter care was not listed in the physician orders. Notes by the Nurse Practitioner (NP), dated 04/06/15, 04/10/15, and 04/13/15, revealed the resident used an indwelling urinary catheter. A physician order, dated 05/01/15, revealed the resident

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should use an indwelling urinary catheter with catheter care provided each shift.

The facility was unable to locate the Medication Administration Records (MAR) or Treatment Administration Records (TAR) for Resident #31 for March or April 2015.

Observations of Resident #31, on 04/29/15 at 9:00 AM, 9:12 AM, 12:33 PM, 12:52 PM, 1:05 PM, and 1:57 PM, revealed the resident used a wheelchair and kept a blanket over his/her lap. Observation, on 04/30/15 at 1:40 PM and on 05/01/15 at 9:57 AM, revealed both of the resident's legs had been amputated and the resident had an indwelling urinary catheter.

Interview with Registered Nurse (RN) #7, on 04/30/15 at 4:41 PM, revealed the Certified Nurse Assistants (CNAs) were responsible to provide catheter care and perineal (peri) care to residents; however, there would need to be an order to flush or change the indwelling urinary catheter. She stated Resident #31 had an indwelling urinary catheter in place. She further stated she could not find in the care plan for Resident #31 or any information related to the resident using an indwelling urinary catheter. The RN reported the resident's care plan did not reflect the use of an indwelling urinary catheter. She further stated if there was no physician order, then care of the indwelling urinary catheter would not be on the TAR for the nurses to document. The nurse revealed there was no other place in the chart to find any information about the indwelling urinary catheter for Resident #31.

Interview with CNA # 2, on 04/30/15 at 4:43 PM, revealed the CNAs were responsible to provide

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catheter care and perineal (peri) care to residents. She stated Resident #31 used an indwelling urinary catheter and she had provided care; however, she did not document it.

Continued interview with RN #7, on 04/30/15 at 5:00 PM, revealed the use of an indwelling urinary catheter required a physician order. She stated the nurse who received the order should also ensure the indwelling urinary catheter was initiated for the resident's care plan. She further stated if there was not a physician order for the indwelling urinary catheter, then the staff would not know how to care for the indwelling urinary catheter. The nurse reported an order was required for the resident to have the indwelling urinary catheter; when to change the indwelling urinary catheter; if and when to flush the indwelling urinary catheter; and, then would need to be transcribed onto the resident's care plan.

Interview, on 05/01/15 at 1:36 PM, with the UM revealed she was unsure how long Resident #31 had an indwelling urinary catheter; however, the resident had the indwelling urinary catheter since she transferred to the 200 Unit. She stated the nurse who re-admitted the resident into the facility was responsible to obtain the physician's orders, assess the resident, and initiate the resident's care plan and Kardex. The UM further stated she would then be responsible to review the admission information. She stated the admission orders would also be reviewed in the morning meeting. She also stated the purpose of the care plan was to guide the provision of care to a resident to meet the resident's needs. The UM stated if the indwelling urinary catheter and care of the catheter were not on the care plan, then the staff would not meet the resident's needs, or if

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HURSTBOURNE CARE CENTRE AT STONY BROOK	2200 STONY BROOK DR LOUISVILLE, KY 40220

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F 279	Continued From page 181 catheter care was not provided the resident could get a UTI. On 05/04/15 at 2:18 PM, with the DCS revealed a resident with an indwelling urinary catheter should receive care every shift; which should be documented. She stated if the indwelling urinary catheter was not cleaned, the resident could get an infection, such as a UTI. The DCS further stated she was unsure how long Resident #31 had used the indwelling urinary catheter. Interview with the Interim Executive Director/Regional Vice President of Operations (ED/RVPO), on 05/05/15 at 3:05 PM, revealed the records for Resident #31 were not accurate and the facility failed to document the resident's indwelling urinary catheter. She stated without the documentation she could not validate any care was provided. Interview with the MDS Coordinator, on 05/20/15 at 1:00 PM, revealed the facility would initiate the care plan for an indwelling urinary catheter when the physician order was received. She stated Resident #31 had an indwelling urinary catheter for a while and there should have been an order prior to 05/01/15. She further stated the date of the catheter care plan, 04/13/15, was based on the Nurse Practictioner's note, dated 04/13/15. The MDS Coordinator also stated the physician order was 05/01/15, and there were no other orders for the indwelling urinary catheter prior to that date in the clinical record. The MDS Coordinator then stated the care plan, date of 04/13/15, must have come from a nurse or the physician order for the indwelling urinary catheter; however, she was unable to locate any other orders for the indwelling urinary catheter. She	F 279		

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further stated the MDS staff would initiate a resident's care plan, and the floor nurses would be responsible to ensure the care plan was accurate if there was a change in the resident.

Continued interview with the DCS, on 05/20/15 at 2:04 PM, revealed the resident care plan should have been initiated for Resident #31 when the indwelling urinary catheter was placed. The DCS stated Resident #31's indwelling urinary catheter care plan was initiated on 05/01/15, when the physician order was received, and not on 04/14/15. She stated the care plan should be reviewed and updated to reflect new orders or new issues. The DCS further stated the initial care plan should be completed by the admission nurse and then the MDS Coordinator reviews the care plan quarterly. She stated when new orders were received, the orders and care plan were reviewed in the morning meeting. The DCS stated if the resident had a new problem, such as a new indwelling urinary catheter, then there should be a new care plan. She stated if there was not an order then there would not have been a care plan initiated for the indwelling urinary catheter. She voiced the purpose of the care plan was to identify how to properly care for an individual resident.

Continued interview with the Interim ED/RVPO, on 05/21/15 at 8:23 AM, revealed the resident's care plan should be individualized to address the resident's needs. She stated she relied on nursing to ensure the resident's medical information was current and for accurate resident assessments. The Interim ED/RVPO reported she did not usually participate in the care plan meetings.

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F 279	Continued From page 183 The facility took the following actions to remove the Immediate Jeopardy on 05/16/15 as follows: 1. The SSD completed safe smoking evaluations on fifteen (15) residents who smoke, on 05/13/15, with three (3) identified to require a smoking apron and two (2) referred to therapy for adaptive smoking equipment. Residents who smoke were given a copy of the facility's safe smoking rules on 05/13/15 and 05/14/15. 2. One hundred and one (101) of 149 staff and 10 agency staff were educated regarding resident behaviors and documentation, care planning and following the care plan, reporting maintenance issues, safe smoking policy, on 05/13/15 and 05/14/15 by the Corporate Administrative RNs. IDT will meet to ensure behaviors were documented and care planned, notification to the physician, and document on the 24 hour report. Residents with behaviors would be reviewed during the weekly IDT meeting beginning 05/12/15. The 24 hour report would be reviewed in the morning meeting. Forty-eight (48) staff not educated will not be allowed to work until they have been trained. No staff will be allowed to work after 05/14/15 until they have been educated prior to the start of their shift. The ED or DCS would monitor the schedule and appoint a department manager to stand at the time clock to direct employees still needing education to the in-service. 3. QAPI meeting was held on 05/13/15 to review the P&P for care plans and behavior management, resident weights, skin assessments, ADLs, smoking, assistive devices related to lifts and shower bed, facility maintenance, pest control, housekeeping/	F 279		

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laundry, and staffing, falls, incidents/accidents, grievances, with no changes made. The facility's action plan for removal of the IJ was reviewed and tasks assigned, with department managers assigned to provide daily oversight along with the RDCS/ RVPO/ RDHC/ RCMC/Corporate Administrative RNs.

4. On 05/13/15, Corporate Administrative RNs educated facility Administrative Staff on the regulations and P&P for staffing, pest control, housekeeping, and maintenance, with competencies completed. The ED would monitor the facility's process for notification, abuse, hiring, dignity, care plan revision, professional standards, assessments, behavior and falls management, incidents and accidents, smoking, call lights, pest control, and staffing.

5. Beginning 05/13/15 training and return demonstration of five (5) nursing staff will be completed five (5) times weekly. Observations of five (5) residents during supervised smoking by a member of the IDT five (5) times weekly. Rounds of five (5) resident rooms for incendiary items by a member of the IDT would be completed five (5) times weekly. Any issues would be brought to the daily meeting.

6. Room rounds were conducted by the ED, on 05/13/15, for incendiary smoking items, with any items found removed and maintained in a locked box at the nurse's station for supervised smoking times by facility staff. A list of residents who smoke and who require supervision or aprons would be kept in the locked box with the Kardexes.

7. Beginning 05/15/15, residents with new falls

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and behaviors were reviewed by the Daily IDT team for completion of SBAR, assessment, notification, immediate interventions, and investigation with root cause analysis. Care plans and Kardexes were reviewed/updated with appropriate interventions. No issues were identified, and would be validated five (5) times weekly.

8. QAPI monitoring, beginning 05/15/15 of the facility process for falls, smoking, assistive devices, lifts, shower beds, and facility maintenance.

9. Review of the 24 hour report, incident/ accident reports, in the daily meeting with the IDT; documentation in the clinical record included notification to the physician and new orders, and to the RP; the IDT made rounds in five (5) resident care areas to observe for maintenance and safety concerns; observations of five (5) residents during supervised smoking by the IDT; room rounds for five (5) residents to search for incendiary items by a member of the IDT, maintenance concerns were written in the maintenance books and taken to the daily meeting and prioritized for repair; observations of five (5) residents to ensure falls interventions were in place per the care plan by the IDT; call lights checked in resident rooms and bathrooms to ensure lights and sound; five (5) staff educated what to do if call light inoperable; resident care areas checked for no live pests; were validated five (5) times weekly.

10. Daily oversight since 04/22/15 on all shifts to ensure residents were safe and the plan of care was followed to meet resident needs, by the ED/ DCS/ RVPO/RDCS/Corporate Administrative

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F 279	Continued From page 186 Nurses. 11. The IDT would meet at least monthly to discuss facility action plan and ensure tasks were completed for the removal of the IJ, and QA monitoring completed according to the AOC during the IJ period, validated by the ED/RVPO/RDCS/Corporate Administrative RNs. 12. Per the Ad-Hoc QAPI meeting, on 05/15/15, QI monitoring would be done utilizing approved audit tool with oversight by the ED, beginning 05/16/15, five (5) resident interview; new resident/ family concerns; daily department head meeting to ensure new resident injuries or concerns were discussed; five (5) new employee files reviewed two (2) times weekly; residents with new falls or behaviors were reviewed in the daily meeting with IDT and care plans/ Kardexes reviewed and updated; review of the 24 hour report and the incident and accident reports in the daily meeting with IDT; review of the clinical record for timely notifications to the physician and RP; the IDT rounds in five (5) resident care areas to observe the environment for safety and maintenance concerns; observations of five (5) residents during supervised smoking; room rounds of five (5) residents for incendiary items; maintenance concerns listed in the maintenance book and taken to the daily meeting to discuss and prioritize repairs; observations of five (5) residents to ensure falls interventions were in place per the care plan by the IDT; five (5) resident rooms call lights checked to ensure they light at the door, nurse's station, and sound; five (5) staff education what to do if a call light was inoperable; five (5) times weekly; weekly falls and behavior management meetings occur with IDT one (1) time weekly.	F 279		

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F 279	Continued From page 187 13. The RVPO/RDCS/Corporate Administrative RNs would provide daily oversight of the ED and DCS in areas of falls, incidents, accidents, change in condition, sufficient staffing to meet resident needs, housekeeping and laundry, and pest control during the IJ period until removal. The State Survey Agency validated the removal of Immediate Jeopardy on 05/22/15 as follows: 1. Review of resident Safe Smoking Evaluations for fifteen (15) residents and completed by the SSD, on 05/13/15, revealed three (3) residents were identified to need a smoking apron. Review of the therapy screening tool revealed, and two (2) residents were referred to therapy. Observation, on 05/22/15 at 4:53 PM, revealed one (1) resident was smoking, used an apron, and staff assisted the resident to smoke. Interview with the DSS, on 05/22/15 at 2:52 PM, revealed she completed the resident smoking assessments and if the resident needed an apron. 2. Record review of in-services conducted 05/13/15 and 05/14/15 revealed one hundred one (101) staff were educated by Corporate Administrative Registered Nurses on bathing, AM care, shaving, hair care, change in condition, notifications to physician and RP, assessments, linens and laundry, falls, behaviors, abuse, resident smoking and use of aprons. Observation on the IDT in daily morning meeting, on 05/22/15 at 9:05 AM, revealed specific residents and behaviors, the 24 hour report, with department heads noted an new orders or changes to the care plans.	F 279		

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F 279	Continued From page 188 3. Review of a QAPI sign in sheet, dated 05/13/15, and agenda revealed the P&P for care plans and behavior management were discussed with no changes made. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Staff Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS attended the QA meetings. 4. Review of in-service records, dated 05/13/15, revealed Administrative staff were trained on staffing, pest control, housekeeping and maintenance, and would be monitored by the ED. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS revealed they had been trained on staffing, pest control, housekeeping and maintenance, and any concerns of audits would be taken to the morning meeting. Interview with Resident #3 on 05/22/15 at 1:00 PM, revealed staffing had improved and were answering lights timely and the facility looked cleaner. 5. Review of staff training records, beginning 05/13/15, revealed five (5) staff were trained with return demonstration for transfers. Review of the smoking list revealed residents who smoked were listed, with resident who required an apron and/or supervised smoking were identified. Review of rounding sheets, beginning 05/13/15, revealed resident rooms were searched for incendiary smoking items by the Executive Director. Observation of the facility's smoking box on the 200 unit, on 05/22/15 at 4:57 PM, revealed cigarettes were stored for the entire facility, and contained a list of residents who smoked, with those who required an apron identified. Interview	F 279		

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with CNA #2, on 05/22/15 at 4:57 PM, revealed the box should be locked in the med room and the box had the cigarettes and lighters for all residents who smoked in the facility.

6. Observation of the resident smoking area, on 05/22/15 at 4:53 PM, revealed eight (8) aprons hanging near the door, one (1) resident smoking with staff assistance, and wearing an apron. Observation of the smoking box on the 200 Unit, on 05/22/15 at 4:57 PM, revealed boxes of cigarettes for all residents of the facility; a list of residents who smoked and who required an apron. Interview with CNA #2, on 05/22/15 at 4:57 PM, revealed Central Supply and a staff from the 200 Unit cover the smoking times during the day; resident cigarettes and lighters should be kept in the smoking box which was kept locked in the medication room.

7. Review of audit tools revealed residents with new falls and behaviors were reviewed by the Interdisciplinary Team in the daily meeting for completion of the documentation, notifications, care plans and Kardexes. Observation, on 05/22/15 at 9:05 AM, of the IDT morning meeting revealed specific resident concerns were reviewed, 24 hour report and behaviors were discussed, and care plans reviewed. Interview, on 05/22/15 at 2:52 PM, with the DCS revealed facility audits were reviewed in the daily meeting and any concerns discussed.

8. Review of a QAPI sign in sheet, dated 05/15/15, audit tools, and agenda revealed monitoring of falls, smoking, assistive devices, lifts, shower beds, and maintenance occurred. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM,

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F 279	Continued From page 190 Schedule Coordinator, Medical Records, MDS Coordinator, Housekeeping Supervisor, and DSS revealed they attended the QA meetings. 9. Observation of the daily morning meeting, on 05/22/15 at 9:05 AM, revealed review of the 24 hour report, notifications made and documented, new physician orders, maintenance concerns and books, pests, rounds and audits, call lights, care plans. Interview with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, MDS Coordinator, and DSS, on 05/22/15 at 2:52 PM, revealed they participate in the morning meeting and review the 24 hour report, notifications were made, maintenance books reviewed, physician orders, call lights, care plans, and audits/ round were reviewed in the morning meeting. 10. Interview, on 05/22/15 at 2:52 PM, with the DCS revealed facility concerns were reviewed in the morning meeting, including audits and rounding results, for department heads to address. She stated she (the DCS) or the ED would initial when concerns were resolved. Observation, on 05/22/15 at 9:05 AM, of the morning meeting revealed the DCS provided direction and asked clarifying questions related to information discussed with follow up items determined. 11. Review of sign in sheets, dated 04/22/15, 05/13/15, and 05/15/15, revealed QAPI meetings were held on those dates. Interview, with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS revealed they attended the QAPI meetings. Interview with the RDCS, on 05/22/15 at 5:05 PM, revealed the next QAPI meeting was	F 279		

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F 279	Continued From page 191 scheduled for 06/17/15. Interview with the Medical Director, on 05/22/15 at 8:00 AM, revealed he was informed by the Executive Director of the resident care issues, attended the QA meetings held by the facility and provided direction regarding corrective action plans that were developed to meet the needs of the residents. 12. Review of the QAPI sign in sheet, dated 05/15/15, and agenda revealed audit tools were approved for QA monitoring and discussed: resident interviews; resident/family concerns; morning meeting; new employee files; falls or behaviors reviewed; care plans and Kardexes update; review of the 24 hour report; notifications; maintenance rounds and book; supervised smoking; falls interventions in place; call lights; weekly falls; and, behavior management meetings. 13. Review of the sign in sheet for QAPI, dated 05/13/15, revealed the ED and DCS presented and reviewed falls, changes in condition, staffing, housekeeping, and laundry, and pest control, and would provide daily oversight.	F 279		
F 280 SS=K	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an	F 280		

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F 280	Continued From page 192 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.	F 280		
	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 have an effective system in place to ensure resident care plans were revised after an accident or incident; such as a fall or resident to resident altercation for four (4) of the forty-three (43) sampled residents (Residents #4, #25, #30, and #31). (Refer to F323) On 01/30/15, Resident #4 sustained a fall from the wheelchair which resulted in a hematoma (a collection of blood under the skin caused by a break in a blood vessel) to the forehead and bilateral upper extremity hematomas and was diagnosed with an acute transverse fracture of the distal clavicle with approximately four (4) millimeters of inferior displacement of the distal fragment. On 02/25/15 at approximately 12:30 AM, Resident #4 sustained another fall and was diagnosed with a right tibia fracture. Review of the Fall Root Cause Investigation Report, dated			

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F 280	Continued From page 193 01/30/15 and 02/25/15, revealed the facility did not identify root cause for the resident's falls. Review of the resident's plan of care revealed the facility failed to revise the care plan with immediate fall interventions that would promote resident safety after each fall. On 02/26/15, with no time of incident, Resident #31 sustained a fall when attempting to self-transfer from the wheelchair (w/c) to the bed. The resident's fall resulted in small skin tears to his/her arms and swelling to the left eye with a hematoma to the left side of the face. The resident was transferred to a local hospital on 02/26/15 and diagnosed with a Contusion, Bilateral Frontal Lobe Hemorrhage, and Mild Subarachnoid Hemorrhage and returned to the facility on 03/03/15. Interview and record review revealed the care plan was not revised to address any additional interventions to prevent future falls. Review of the clinical record for Resident #25 revealed the resident wandered and had socially and sexually inappropriate behaviors. On 03/25/15 during the 7:00 AM-3:00 PM shift, Registered Nurse (RN) #6 noted the Resident #25's right eye was swollen and bruised on the side with a small cut. Interview with Resident #29, on 04/27/15 at 11:40 AM, revealed Resident #25 had wandered into his/her room and tried to get into Unsampled Resident A's bed. Resident #29 stated he/she "busted" the resident in the jaw a couple of times to get the resident out of the room. Resident #29 stated he/she told Resident #25 if he/she ever came around bothering them again the resident "would get more of the same". Interview revealed staff was aware of the altercation; however, no revision to the care plan was completed to ensure the resident's safety.	F 280		

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F 280	Continued From page 194 Resident #30 reported a fall at approximately 5:00 AM to 5:15 AM, in which the resident fell to his/her knees while using the commode. Interview with the Director of Clinical Services (DCS), on 05/04/15 at 2:18 PM, revealed she could not locate any documentation related to the revision of the fall care plan. The facility's failure to have an effective system in place to revise the care plans after an accident or incident has caused or is likely to cause serious injury, harm, impairment or death to resident. Immediate Jeopardy was identified on 04/22/15 and determined to exist on 02/25/15. An acceptable Allegation of Compliance (AOC) was received on 05/19/15 alleging the Immediate Jeopardy was removed on 05/16/15. The State Survey Agency validated the Immediate Jeopardy was removed on 05/16/15 as alleged, prior to exit on 05/22/15. The scope and severity was lowered to an E while the facility monitors the implementation of the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes. The findings include: Review of the facility's policy regarding Care Plans, dated 11/30/14, revealed an interdisciplinary plan of care would be established for every resident and updated in accordance with the state and federal regulatory requirements and on an as needed basis.	F 280		

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F 280	Continued From page 195 1. Review of Resident #4's clinical record revealed the facility admitted the resident on 05/16/13 with diagnoses of Hypertension, Atrial Fibrillation, Chronic Obstructive Airway, Congestive Heart Failure, Macular Degeneration, Rheumatoid Arthritis, Osteoporosis and Open Wound Site. Review of Resident #4's Quarterly Minimum Data Set (MDS) assessment, completed on 03/09/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of ninety-nine (99), meaning the resident was rarely/never understood. Continued review of the MDS revealed the resident needed the extensive assistance of two (2) staff for bed mobility, bathing, transferring and needed the physical assistance of one (1) with meals. Review of the Comprehensive Care Plan for Resident #4 revealed the facility developed a care plan on 06/04/13, with updated goals and target date for 04/29/15. The problem on the care plan stated Resident #4 was at risk for falls due to overall physical condition and psychotropic medications. The goal stated the resident would not experience any injuries related to falls. The approaches included direction for staff to monitor for changes in condition that may warrant increased supervision/assistance and notify the physician. Remind the resident to ask for assistance with all transfers and staff should assist with toileting and provide frequent reminders to the resident for assistance with	F 280		

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F 280	Continued From page 196 toileting.	F 280		

Interview with the Licensed Practical Nurse #5, on 04/24/15 at 1:30 PM, revealed she witnessed Resident #4's fall from the wheelchair on 01/30/15. She stated the resident was reaching for a hairbrush that was on the floor. The resident fell forward and hit their head on the floor causing a hematoma to the forehead. LPN #5 stated the resident complained of left shoulder pain and also had a hematoma on the shoulder and was diagnosed with a clavicle fracture. LPN #5 stated she did not update the care plan and she believed the interventions on the care plan were completed by the interdisciplinary team the morning after the fall.

Interview with the LPN #8, on 04/24/15 at 2:40 PM, revealed Resident #4's physician informed him the resident had a shoulder were positive for a clavicle fracture. He stated the physician ordered a sling and he wrote the order and placed a copy with the morning report papers. He stated he did not revise the care plan because that was the responsibility of management and the Minimum Data Set Nurses.

Review of the Fall Root Cause Investigation Reports, dated 01/30/15 revealed the facility did not document interventions to be put in place immediately after the fall to promote resident safety or to reduce the likelihood of a future fall.

Further review of the care plan revealed on the back page was handwritten approaches dated

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F 280	Continued From page 197 01/30/15 that stated: send resident to the emergency room for treatment and then have therapy evaluate for anti-tippers for the wheelchair. Continued interview with LPN #5 on 04/24/15 at 1:30 PM, revealed the antitippers for the wheelchair would not have benefited Resident #4, because the resident fell forward out of the wheelchair not backwards. Review of Accident/Incident Report Form, dated 02/25/15, revealed Resident #4 sustained another fall from the bed and was found on the floor at 12:30 AM. Review of the Nursing Progress Note, dated 02/25/15 and timed at 6:00 AM, revealed Resident #4 was found on the floor by a Certified Nursing Assistant while performing rounds at 12:30 AM. Review of the Nursing Progress Note, dated 02/25/15 and timed at 4:30 PM, revealed nursing documented the right lower leg was swollen, warm, bruised and tender; xrays were ordered; and, the resident was diagnosed with a right tibial fracture. Review of the Fall Root Cause Investigation Reports, dated 02/25/15, revealed the facility did not document interventions to be put in place immediately after the fall to promote resident safety or to reduce the likelihood of a future fall. Further review of the resident's care plan	F 280		

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F 280	Continued From page 198 revealed handwritten notations made for 02/25/15 that stated the resident was to see the physician, have an x-ray of the right leg, have labs drawn immediately, and for pharmacy to review the resident's medication list. Continued review of the care plan revealed no documented evidence the facility revised the care plan to implement immediate interventions to prevent another fall or injury. Interview with LPN #1, on 04/21/15 at 3:05 PM, revealed he did not revise the resident's care plan related to the fall on 02/25/15 and believed the staff on day shift probably did that in the morning meeting. Interview with Registered Nurse (RN) #1, on 04/21/15 at 11:20 PM, who was working when the resident fell, revealed the nurse assigned to the unit where a resident experienced a fall had the responsibility of revising the care plan. He stated he did not make any revisions to Resident #4's care plan the night of the fall. Further interview revealed the assigned nurse to the unit had not reported to work. Interview with the Minimum Data Set (MDS) Nurse Coordinator, on 04/22/15 at 9:30 AM, revealed the only interventions added after Resident #4's two falls were the ones listed on the care plan. She stated she believed sending the resident to the emergency room, having therapy evaluate and reminding the resident to call for assistance were appropriate for immediate fall prevention interventions.	F 280		

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Interview with the Unit Manager and the Assistant Director of Clinical Services on, 04/21/15 at 3:25 PM, revealed the facility's interdisciplinary team revised resident care plans when there was a change in a resident's condition, new orders were obtained or an incident occurred.

Interview with Director of Clinical Services (DCS), employed as of 04/20/15, on 04/24/15 at 1:05 PM, revealed as far as she could determine no information or direction was provided by nursing regarding the care of the fractured clavicle and the care plan was not revised. She stated the CNAs were also not provided any direction regarding how to promote healing, decrease discomfort or how to safely transfer the resident. She stated nursing staff were responsible for updating care plans immediately after a fall and the IDT reviewed the revisions to determine if additional measure were needed. She stated the team met every morning and if the team determined there were additional interventions that could be implemented they would add them during the meeting.

Interview with the previous facility Administrator in charge at the time of Resident #4's fall, on 04/23/15 at 8:34 AM, revealed she did not remember reviewing the forms or providing any direction to staff to ensure or promote resident safety.

2. Review of the clinical record for Resident #31 revealed the facility admitted the resident on 08/11/14 with diagnoses of Peripheral Vascular Disease, Above Knee Amputation, Diabetes

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F 280	Continued From page 200 Mellitus, and Pressure Ulcer. Review of the Admission MDS on 08/19/14 and assessed the resident with a BIMS of a fifteen (15). A Readmission Data Collection, dated 02/14/15 at 1:30 PM, revealed the facility readmitted the resident after he/she had a left above knee amputation, and assessed the resident to need assistance to transfer by two (2) staff. The facility assessed the resident at risk for falls with a score of twenty (20). A Quarterly MDS was completed on 02/17/15 and assessed the resident to have a BIMS of a six (6) and the resident meaning the resident was cognitively impaired and not interviewable. The resident had not had any falls. Review of Resident #31's comprehensive care plan for a risk of falls, dated 08/22/14, included interventions to encourage rest as necessary, and an undated note to be aware the resident had a history of attention seeking behaviors and throwing him/herself on the floor. The risk for falls care plan indicated the resident had a fall on 11/14/14 without injury and an additional intervention for staff to re-educate the resident to call for assistance with toileting was added. The falls risk care plan next intervention, on 04/22/15, indicated the resident used a w/c and was not able to walk. Continued review of Resident #31's clinical record revealed an Situation, Background, Assessment, Review (SBAR), dated 02/26/15, that indicated the resident wanted to get up, yelled that he/she wanted to get up, and sat him/herself on the floor. The SBAR indicated the family was notified on 02/26/15. The Fall Root Cause Investigation Report, dated 02/26/15 at 6:48 AM, revealed the form was not complete, with no information provided under "Intervention for minimizing future	F 280		

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F 280	Continued From page 201 occurrences". Review of an additional SBAR, dated 02/26/15, for Resident #31 revealed the resident had tried to transfer him/herself from the wheelchair (w/c) to the bed and slid to the floor, which resulted in small skin tears to his/her arms and swelling to the left eye and a hematoma to the left side of the face. The physician was notified, the skin tears were treated, and the resident was transferred to a local hospital and diagnosed with a contusion, bilateral frontal lobe hemorrhage, and mild subarachnoid hemorrhage. Further review of the resident's care plan revealed there were no other interventions added to address the resident's attempts at placing self on the floor or unsafe self transfers. On 05/20/15 at 1:00 PM, interview with the MDS Director revealed she had worked with Resident #31. She stated she was unaware of every update made to the resident care plans by the nurses. Interview with the DCS, on 05/20/15 at 2:04 PM, revealed Resident #31's care plan should be updated when there was a new problem or a change in the resident's existing care plan. She stated the updated care plan should be dated with new interventions put into place. The DCS revealed the purpose of the resident care plan was to provide individualized care to residents, and direct the staff how to properly care for the resident. She stated Resident #31's care plan was not complete or accurate, and was not reflective of when the changes occurred. Interview with the Interim Executive	F 280		

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F 280	Continued From page 202 Director/Regional Vice President of Operations (ED/RVPO), on 04/28/15 at 9:43 AM, revealed resident care plans were not discussed in the morning meeting; however, the DCS stated in interview the care plans were reviewed during the morning meeting. She stated care plan meetings already scheduled were discussed to send out letters to invite the residents or RP to the care plan meetings. 3. Review of the clinical record for Resident #25, revealed the facility admitted the resident on 12/30/14 with diagnoses of Vascular Dementia and Cerebral Vascular Accident. The facility completed an Admission Data Collection, on 12/30/14, that indicated the resident ambulated independently and wandered, and cognition was severely impaired. The facility completed an Admission Minimum Data Set (MDS) on 01/06/15 and assessed the resident as a ninety-nine (99), with a cognitive level of a three (3) by staff interview. Review of Resident #25's care plan, dated 01/08/15, for Resident #25 revealed the care plan for risk of falls, included an intervention to monitor the resident for change in condition that may warrant an increase in supervision or assistance, and notify the physician. Additional care plans dated 01/06/15 revealed a care plan for resident behaviors that identified the resident had a history of combative and agitated behaviors, wandering, would refuse medications at times, would place him/herself on the floor, and exhibited socially inappropriate behavior. Interventions included to praise appropriate behavior, the resident wore a WanderGuard, monitor and document the resident's behaviors, and place the resident in an area where he/she could be frequently observed.	F 280		

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Continued review of Resident #25's clinical record revealed a nurse's note, dated 01/20/15 at 12:00 PM, that stated Resident #25 wandered the unit. On 01/21/15 at 2:00 PM, the resident had wandered into the nurse's station, had an increase in agitation, and restlessness. On 02/19/15 at 6:00 PM, the resident had wandered into other resident rooms and had tried to get into another resident's bed. On 03/24/15 at 3:30 PM, the resident had wandered into another resident's room. On 03/25/15 from 7:00 AM through the 3:00 PM shift, Registered Nurse (RN) #6 documented the resident had wandered in the dayroom. The resident's right eye was swollen and bruised on the side with a small cut. The resident had often wandered into other resident rooms, both male and female.

Review of a Psychiatric note, dated 03/30/15, stated the resident had right eye bruising. The note further stated per nursing staff notes the resident wandered the unit day and night, often into other resident rooms. The resident was recently punched by another resident whose room Resident #25 had wandered into.

Review of the resident's care plan revealed this information and no interventions were not added to the care plan to attempt prevention of further injury.

Interview, on 04/23/15 at 9:35 AM, with the Unit Manager (UM) revealed a resident's Kardex and care plan should be updated when there was a change in the resident's orders or when an incident occurred. She further stated the care plan should be updated by the nurse and would be reviewed in the morning meeting for update by

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F 280	Continued From page 204 MDS. The UM stated if the resident care plan was not updated, such as Resident #25's care plan when he/she had a black eye, then the facility would not be able to meet the resident's care needs. Interview, on 05/20/15 at 1:00 PM, with the Director of MDS revealed the resident's care plan was the standard for care the facility would provide to the resident and the nurses on the units were responsible to update the care plan when needed. On 04/28/15 at 8:35 AM, interview with the Director of Clinical Services (DCS) revealed Resident #25's care plan should be updated depending on the injury. The DCS revealed the nurse on duty who found the resident with a black eye was responsible to update the resident's care plan. Continued interview, on 05/21/15 at 8:23 AM, with the Interim ED/Regional Vice President of Operations (ED/RVPO) revealed the facility should have put interventions in place to try to prevent Resident #25 from wandering into other resident rooms. She stated the resident care plan should be individualized and updated to address the resident's needs. 4. Review of the clinical record for Resident #30 revealed the facility admitted the resident on 03/20/15 with diagnoses of Dementia and history of Traumatic Brain Injury. The Admission Data Collection, dated 03/20/15, revealed the resident ambulated independently, was continent of bowel and bladder, and assessed the resident as not at risk for falls with a fall risk score of six (6). The facility completed an initial MDS on 03/30/15 and	F 280		

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assessed the resident with a BIMS score of 12, which meant the resident was interviewable and had not had any falls while at the facility.

Continued review of Resident #30's clinical record revealed a nurse's note, on 03/26/15 from the 7:00 am to 3:00 PM shift, that staff (not identified) and the resident reported a fall at approximately 5:00 AM to 5:15 AM, in which the resident fell to his/her knees while using the commode. A Psychiatric note, dated 04/13/15, revealed the resident had a fall on 03/26/15. The resident's comprehensive care plan for a risk of falls, reprinted on 04/01/15, contained the same interventions of non-skid socks as appropriate, encourage rest as necessary, and to notify family and physician of falls; however no new interventions were added. The Kardex, not dated, identified the resident as independent with ambulation, transfers, bed mobility, and using the bathroom. The Kardex included the old intervention of non-skid socks or shoes.

The facility did not provide an investigation, root cause analysis, SBAR, notifications, or neuro checks for Resident #30 for the fall on 03/26/15 or identified any new interventions to prevent future falls.

Interview with the DCS, on 05/04/15 at 2:18 PM, revealed she did not locate any documentation related to the fall or revision of the resident's care plan.

Post survey interview, on 06/04/15 at 10:58 AM, with RN #6 revealed the resident told her he/she slipped in the bathroom and fell that morning, when she (RN #6) arrived to the unit for the start of her shift. RN #6 stated she could not recall

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who the nurse on duty was at the time but she asked the nurse if all the documentation and care plan had been completed, and she was told by the nurse that it was done; however, RN #6 stated she did not see the documentation.

On 04/24/15 at 9:35 AM, interview with the Unit Manager (UM) revealed the nurse should update the resident care plan and management would ensure the care plan had been updated. She stated the care plans were reviewed in the morning meeting and updated by MDS.

On 05/20/15 at 1:00 PM, interview with the MDS Director revealed the nurse on the floor was responsible to immediately update the resident care plan when there was a change on the unit. She stated the following day the resident's chart would be taken to the morning meeting and the IDT team would review the care plan and make any additional updates. The MDS Director reported the MDS nurse would initiate a resident's care plan, with updates by the nurse on the unit when needed, and MDS would update quarterly with the MDS assessments. She further reported she reviewed physician orders in the morning meeting and was aware when the resident care plan should be updated.

Interview, on 04/28/15 at 8:35 AM, with the Director of Clinical Services (DCS) revealed any changes to a resident's care plan would depend on the injury. She stated the resident's injury would be treated and monitored, with a root cause analysis to try and determine what caused the injury. The DCS revealed the nurse on duty at the time of the incident was responsible to update the resident's care plan. She further stated incidents, including falls, were discussed in the

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NAME OF PROVIDER OR SUPPLIER
HURSTBOURNE CARE CENTRE AT STONY BROOK

STREET ADDRESS, CITY, STATE, ZIP CODE
2200 STONY BROOK DR
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F 280	Continued From page 207 morning clinical meeting on Monday through Friday. She stated the 24 hour report was taken to the morning clinical meeting and should have any change in condition documented, and if there were any new orders. The DCS further stated the clinical meeting would review the resident care plan and Kardex to ensure all documentation was updated. She stated the facility also conducted a weekly falls meeting and reviewed the resident's care plans during that meeting with updates completed by the Interdisciplinary Team (IDT). The DCS stated if the resident's care plan was not updated the resident would not receive the care needed. Continued interview, on 05/21/15 at 8:23 AM, with the Interim ED/Regional Vice President of Operations (ED/RVPO) revealed the nurses complete the MDS assessments and the facility relied on the nurses to provide adequate information. She reported the UM was responsible to ensure the care plan was updated to meet the resident's needs. She further reported if the UM was needed to work as a floor nurse, then MDS should take the work of the UM for the resident care plans. The facility took the following actions to remove the Immediate Jeopardy on 05/16/15 as follows: 1. The facility notified Resident #4's physician, of a fall that occurred on 02/25/15 with new orders given to the nurse. The resident transferred to a local hospital on 02/25/15 for a tibia fracture and returned to the facility on 02/28/15 with new orders. The DCS assessed Resident #4 on 04/22/15 and was found in stable condition. 2. On 04/22/15, one hundred twenty-six (126)	F 280		

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F 280	Continued From page 208 residents were assessed by the ADCS, Nurse Manager, and Licensed Nurse to determine if any residents had an incident or accident or change in condition that would warrant physician notification and further intervention. One (1) resident was identified as having an incident, accident, or change of condition and the physician was notified by the nurse on 04/22/15. Additionally, the Nurse notified the RP and documented this in the clinical record. Nurses would additionally report incidents, accidents, or changes in condition to the clinical administrative team. 3. On 04/22/15 the Corporate Administrative Nurses educated twenty-three (23) of thirty-eight (38) Nurses regarding timely notification to the physician related to resident incidents, accidents, or change in condition; care plan policies, evidence of assessments and care planning with immediate falls preventions interventions to meet the resident's needs; and falls procedures, immediate assessment by the Nurse after a resident's fall, notifications to the physician and RP, implementation of an immediate intervention by the Nurse, documentation of the fall in the clinical record by the Nurse, fall root cause investigation report initiated by the Nurse and reviewed by the DCS, and follow up by the IDT in the weekly falls meeting. Nurses were also trained related to reporting an incident, accident, or change in condition, to the resident ' s RP and documentation in the medical record to include the incident, accident, or change in condition, notifications to the physician, RP, and clinical administrative team, nurse's assessment, and interventions; evidence of assessment would include Situation, Background, Appearance, and Review (SBAR) sheet, Interdisciplinary Progress Note, and Neurological (neuro) checks sheet, and	F 280		

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F 280	Continued From page 209 documentation of falls. Staff competencies were completed. Nursing staff not educated by midnight on 04/22/15 would not be allowed to work until they received training. Agency Nurses would be trained by the Corporate Administrative Nurses, DCS, Assistant DCS, or Nurse Manager prior to working their next shift. The DCS and ED would ensure staff that had not been educated were educated prior to working their next shift. The ED and DCS would monitor the daily schedule and highlight staff already trained. A department manager would stand by the time clock at shift change to direct staff that needed education to the training. The IDT would monitor daily incidents and accidents. Notifications of accidents, incidents, or changes of condition would be reviewed for completion by the DCS, ADCS, or Nurse Manager, who would make notifications if not done. 4. An Ad-Hoc Quality Assurance/ Performance Improvement (QAPI) meeting was conducted on 04/22/15 to discuss facility policy and procedure (P&P) for falls, and notifications of incidents, accidents, or changes of condition; care plans as related to immediate falls interventions and revision status post fall, nursing assessment and documentation for falls; with no changes made. Also discussed the facility protocol related to shift relief and report; and additional avenues to attract new staff and maintaining current staff with a plan for performance improvement. 5. On 04/22/15, 126 residents were reviewed for fall risk with a fall risk assessment completed by the DCS and MDS Nurses who had previously been educated on 04/22/15, and care plans and Kardexes were also reviewed, with seventy-four (74) residents whose fall care plans were updated	F 280		

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F 280	Continued From page 210 on 04/22/15. 6. On 04/22/15 the Corporate Administrative Nurses educated the DCS, ADCS, and Nurse Manager regarding evidence of assessment and care planning, with immediate falls prevention interventions to meet the resident's needs. On 04/22/15, thirty (30) of fifty-eight (58) CNAs and two (2) Agency CNAs were educated to review the Kardex for specific fall risk information. 7. Certified Medication Technician's (CMT) would be supervised by the Nurse they work with on the unit. The current resident census was reviewed by the ED and DCS to determine which residents required total care, assistance, or were independent with care. 8. On 04/22/15, 126 residents were assessed by Nurses using a visual and/or verbal nursing assessment that included vital signs to ensure there were no current physical or emotional distress or needs that were not met as related to inadequate staffing. One (1) resident was identified in physical distress and the Nurse timely notified the physician. 9. On 04/22/15, The Corporate Administrative Nurses educated twenty-three (23) of thirty-eight (38) Nurses, thirty (30) of fifty-eight (58) CNAs, and two (2) Agency CNAs related to staffing, to notify the ED, DCS, or ADCS for any staff call outs. The ED, DCS, ADCS, or Scheduler would attempt to replace the staff member who called out by calling on facility staff to stay over or come into work. If staffing needs could not be met the ED, DCS, ADCS could mandate staff currently working. Staff were educated on waiting for their relief to arrive prior to leaving the facility, and to	F 280		

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F 280	Continued From page 211 give shift report to oncoming staff, that would include resident status, falls that occurred, and any new interventions. Staff competencies were completed. 10. On 04/28/15, the facility reported to the SSA that Resident #25 was found to have a black eye on 03/25/15. The incident was investigated and with the assistance of the SSD and DCS the source of the black eye was determined as a result of a resident to resident altercation and abuse was unsubstantiated. 11. Current residents were reviewed for behaviors, on 05/12/15 and 05/13/15, by Corporate Administrative RNS and two (2) members of the IDT. Care plans were reviewed for sixty-six (66) residents with behaviors, with twenty (20) care plans updated, with one (1) resident placed on 1:1 supervision. 12. 101 of 149 staff and 10 agency staff were educated regarding resident behaviors and documentation, care planning and following the care plan, reporting maintenance issues, safe smoking policy, on 05/13/15 and 05/14/15 by the Corporate Administrative RNs. IDT will meet to ensure behaviors were documented and care planned, notification to the physician, and document on the 24 hour report. Residents with behaviors would be reviewed during the weekly IDT meeting beginning 05/12/15. The 24 hour report would be reviewed in the morning meeting. Forty-eight (48) staff not educated will not be allowed to work until they have been trained. No staff will be allowed to work after 05/14/15 until they have been educated prior to the start of their shift. The ED or DCS would monitor the schedule and appoint a department manager to stand at	F 280		

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the time clock to direct employees still needing education to the in-service.

13. QAPI meeting was held on 05/13/15 to review the P&P for care plans and behavior management, resident weights, skin assessments, ADLs, smoking, assistive devices related to lifts and shower bed, facility maintenance, pest control, housekeeping/ laundry, and staffing, falls, incidents/accidents, grievances, with no changes made. The facility's action plan for removal of the IJ was reviewed and tasks assigned, with department managers assigned to provide daily oversight along with the RDCS/ RVPO/ RDHC/ RCMC/Corporate Administrative RNs.

14. Beginning 05/15/15, residents with new falls and behaviors were reviewed by the Daily IDT team for completion of SBAR, assessment, notification, immediate interventions, and investigation with root cause analysis. Care plans and Kardexes were reviewed/updated with appropriate interventions. No issues were identified, and would be validated five (5) times weekly.

15. Beginning 05/12/15 weekly falls management meeting and weekly behavior management meeting occurred with IDT, with no issues identified. The IDT in the daily meeting reviewed the 24 hour report with no issues identified, and validated one (1) time weekly.

16. A weekly behavior meeting was held on 05/12/15 and 05/13/15 and discussed six (6) residents with resident to resident behaviors or sexual/ physical behaviors to ensure behaviors were documented, care planned, and

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F 280	Continued From page 213 interventions in place. 17. On 05/13/15 and 05/14/15 twenty-two (22) nurses were educated by the Corporate Administrative RNS to complete skin sweeps weekly and PRN, and complete residents' weights per physician order. 18. The IDT would review in the daily meeting incidents and accidents reports and the 24 hour report for investigation reports, nursing documentation in the clinical record, an SBAR, notifications to the physician and RP, and care plans with appropriate interventions. 19. On 04/30/15, one hundred twenty-four (124) residents were reviewed for appropriate transfer/lift method and updated the care plans and Kardexes, including Residents #4 and #34. The shower bed was removed from the facility and discarded. A new shower bed was ordered on 05/07/15. A shower bed located in the shed was inspected and discarded by Maintenance on 05/13/15. 20. Five (5) residents would be observed, beginning 05/12/15, to ensure fall interventions were in place per the care plan would be completed by IDT five (5) times weekly. 21. On 05/13/15, Corporate Administrative RNs educated facility Administrative Staff on the regulations and P&P for staffing, pest control, housekeeping, and maintenance, with competencies completed. The ED would monitor the facility's process for notification, abuse, hiring, dignity, care plan revision, professional standards, assessments, behavior and falls management, incidents and accidents, smoking,	F 280		

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call lights, pest control, and staffing.

22. Review of the 24 hour report, incident/ accident reports, in the daily meeting with the IDT; documentation in the clinical record included notification to the physician and new orders, and to the RP; the IDT made rounds in five (5) resident care areas to observe for maintenance and safety concerns; observations of five (5) residents during supervised smoking by the IDT; room rounds for five (5) residents to search for incendiary items by a member of the IDT, maintenance concerns were written in the maintenance books and taken to the daily meeting and prioritized for repair; observations of five (5) residents to ensure falls interventions were in place per the care plan by the IDT; call lights checked in resident rooms and bathrooms to ensure lights and sound; five (5) staff educated what to do if call light inoperable; resident care areas checked for no live pests; were validated five (5) times weekly.

23. Daily oversight since 04/22/15 on all shifts to ensure residents were safe and the plan of care was followed to meet resident needs, by the ED/ DCS/ RVPO/RDCS/Corporate Administrative Nurses.

24. The IDT would meet at least monthly to discuss facility action plan and ensure tasks were completed for the removal of the IJ, and QA monitoring completed according to the AOC during the IJ period, validated by the ED/RVPO/RDCS/Corporate Administrative RNs.

25. Per the Ad-Hoc QAPI meeting, on 05/15/15, QI monitoring would be done utilizing approved audit tool with oversight by the ED, beginning

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F 280	Continued From page 215 05/16/15, five (5) resident interview; new resident/ family concerns; daily department head meeting to ensure new resident injuries or concerns were discussed; five (5) new employee files reviewed two (2) times weekly; residents with new falls or behaviors were reviewed in the daily meeting with IDT and care plans/ Kardexes reviewed and updated; review of the 24 hour report and the incident and accident reports in the daily meeting with IDT; review of the clinical record for timely notifications to the physician and RP; the IDT rounds in five (5) resident care areas to observe the environment for safety and maintenance concerns; observations of five (5) residents during supervised smoking; room rounds of five (5) residents for incendiary items; maintenance concerns listed in the maintenance book and taken to the daily meeting to discuss and prioritize repairs; observations of five (5) residents to ensure falls interventions were in place per the care plan by the IDT; five (5) resident rooms call lights checked to ensure they light at the door, nurse's station, and sound; five (5) staff education what to do if a call light was inoperable; five (5) times weekly; weekly falls and behavior management meetings occur with IDT one (1) time weekly. 26. The RVPO/RDCS/Corporate Administrative RNs would provide daily oversight of the ED and DCS in areas of falls, incidents, accidents, change in condition, sufficient staffing to meet resident needs, housekeeping and laundry, and pest control during the IJ period until removal. 27. Grievances were reviewed, on 05/13/15, by the ED/SSD/DCS back to 05/1/15 for any areas requiring additional follow up, which was handled by 05/15/15.	F 280		

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F 280	Continued From page 216 28. On 05/12/15 rounds were completed by the DCS/ADCS/ Nurse Managers, and Corporate Administrative Nurses to identify residents who needed additional grooming or incontinent care; bed linens checked to ensure they were clean and pest free; call lights checked to ensure they were within resident reach and answered timely; resident's skin observed to ensure free from pests; and privacy curtains in place. Additional grooming was provided to residents requiring it, and one (1) resident room was identified to need a privacy curtain on 05/13/15. 29. On 05/13/15 and 05/14/15, nursing staff and ten (10) agency staff were educated on incontinent care, bathing, shaving, washing resident's hair, with those not trained would not allowed to work until trained prior to the start of their shift. 30. On 05/13/15 and 05/14/15, 101 of 149 staff and ten (10) agency staff were educated to notify housekeeping when privacy curtains were needed; report pest sightings in the pest sightings book; any pests noticed on residents should be reported immediately to the nurse supervisor/DCS/ADCS for completion of a skin assessment; resident privacy. Forty-eight (48) staff not educated will be trained prior to working their next scheduled shift. 31. A QAPI meeting was held, on 05/13/15, to discuss the facility's P&P for incontinent care, resident privacy, shaving, AM care, with no changes made. 32. Daily rounds were conducted by department managers and corporate administration Monday	F 280		

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through Friday to identify any issues with resident incontinent care, privacy, shaving and AM care, with any issues identified discussed in the daily IDT meeting and resolved with further Ad-Hoc education.

33. An Ad-Hoc QAPI meeting, on 05/15/15, discussed QI monitoring would be completed beginning 05/16/15 for: beginning 05/12/15 observations of five (5) residents to ensure they were shaven, hair combed, provided incontinent care, privacy curtains were clean, bed linens were clean, rooms/bed/residents were free from pests, privacy provided for care, call lights in reach and answered timely, would be conducted five (5) times weekly.

The State Survey Agency validated the removal of Immediate Jeopardy on 05/22/14 as follows:

1. Review of the facility's SBAR's, incident report, neuro checks, progress notes and physician orders, all dated 02/25/15, revealed Resident #4 had a fall on 02/25/15, the physician was notified on 02/25/15 with new orders received. The resident was transferred to a local hospital on 02/25/15 for a tibia fracture on 02/25/15, and returned to the facility on 02/28/15 with new orders. The DCS assessed Resident #4 on 04/22/15 and found the resident was stable.

2. Review of one hundred twenty-six (126) resident assessments, completed by ADCS/Nurse Manager/Licensed Nurse, on 04/22/15, revealed residents were assessed for any incident or accident, or change in condition that warranted notification to the physician. One (1) resident was identified as experienced a change in condition, accident, or incident and the

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F 280	Continued From page 218 physician was notified on 04/22/15. 3. Review of in-service records, revealed twenty-three (23) nurses were educated by Corporate Administrative Registered Nurses regarding: timely notification to the physician related to incidents, accidents, and changes in condition; care plan policies; resident assessments, including SBAR, neuro checks; falls and immediate interventions; notification to the physician and RP; documentation of the fall in the clinical record; fall root cause investigation report. Staff competencies were completed. No staff had worked prior to them receiving the training. Review of staffing schedules revealed staff who had not yet been trained were not highlighted, which noted they required education. Review of facility records revealed notifications of incidents, accidents, and changes in condition were reviewed for completion by the DCS/ADCS/ Nurse Manager. Interview with the DCS and RDCS, on 05/04/15 at 4:18 PM, revealed twenty-three (23) nurses had been trained. Interview with RN #8, on 05/04/15 at 4:33 PM, with CNA #11, on 05/05/15 at 9:51 AM, with the UM, on 05/05/15 at 9:55 AM, CNA #14, on 05/05/15 at 10:03 AM, CNA #13, on 05/05/15 at 10:10 AM, revealed they had been educated on falls, notifications, Kardex and care plans. Interview, on 05/05/15 at 2:00 PM, with the DCS, ADCS, Nurse Manager, ED, Admissions Coordinator, DSS, MDS Director revealed they had all been trained on care plans, changes in condition, staff look at interventions for residents, the 24 hour report, falls, SBAR, incident reports, Kardex and care plans, notifications to the physician and family. 4. Review of a QAPI sign in sheet, dated	F 280		

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NAME OF PROVIDER OR SUPPLIER
HURSTBOURNE CARE CENTRE AT STONY BROOK

STREET ADDRESS, CITY, STATE, ZIP CODE
2200 STONY BROOK DR
LOUISVILLE, KY 40220

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F 280	Continued From page 219 04/22/15, and agenda revealed the committee discussed the P&P for falls management, notifications of incidents, care plans, falls interventions, nursing assessments, shift to shift relief and report, with no changes made. Interview with the DCS, ADCS, Nurse Manager, ED, Admission Coordinator, DSS, MDS Director, on 05/05/15 at 2:00 PM, revealed QA would track and trend falls information to validate interventions and notifications were being completed. 5. Review of resident assessments for risk for falls, dated 04/22/15, for one hundred twenty-six (126) residents revealed seventy-four (74) residents were assessed by the ADCS as at risk for falls. Review of the Kardexes and Care Plans for the seventy-four (74) residents assessed at risk for falls revealed the Kardexes and care plans had been updated, on 04/22/15. Observation of room 107-A, on 05/05/15 at 1:26 PM, revealed the resident had falls interventions in place. Observation, on 05/05/15 at 1:30 PM, of room 112-A, revealed the resident's falls interventions were in place. Observation, on 05/05/15 at 1:30 PM, of Unsampled Resident Y revealed the resident had falls interventions in place. Observation of Unsampled Resident O, on 05/05/15 at 2:52 PM, revealed the resident's falls interventions were in place. 6. Review of training records, dated 04/22/15, revealed thirty (30) CNAs and two (2) agency staff were educated on the Kardex and falls risk. The Corporate Administrative RNs educated the DCS/ADCS/Nurse Manager, on 04/22/15, regarding assessments, care plans, documentation of falls, and immediate falls interventions. Interview with CNA #6, on 05/05/15	F 280		

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at 10:12 AM, revealed he received training on the Kardex, falls, and notify the nurse if a resident had a change in condition.

7. Review of staff schedules revealed CMTs were scheduled to work with another nurse present on the unit. Review of a resident census revealed, on 04/22/15, the ED and DCS reviewed which residents required total care, assistance, or were independent with care. Observation, on 05/05/15 at 10:15 AM, revealed CMT/ CNA #11 on the 200 unit was supervised by LPN #1.

8. Review of assessments for one hundred twenty-six (126) residents, dated 04/22/15, revealed residents were assessed by the DCS, with vital signs taken. One (1) resident was identified in distress and the physician was notified at that time.

9. Review of in-service records, dated 04/22/15, revealed twenty-three (23) nurses, thirty (30) CNAs, and two (2) agency staff were educated who to call when they call out and how the shift may be covered to ensure adequate staffing, shift report. Staff competencies were completed. Interview, on 05/04/15 at 4:00 PM, with the RDCS and Interim ED, revealed twenty-three (23) nurses were educated on staffing. Interview with LPN #1, on 05/05/15 at 9:45 AM, revealed he had been trained on what to do and who to call if calling in, and call in to the ED, DCS, or ADCS; stated he had to go through training before he was allowed to work. Interview, on 05/05/15 at 9:51 AM, with CNA #11 revealed she had been educated on staffing, to call the ED, DCS, or ADCS, and had to be trained prior to working. Interview with the UM, on 05/05/15 at 9:55 AM, revealed she was educated on staffing and the

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ED, DCS, or ADCS should be called if staff were to call in. Interview with CNA #6, on 05/05/15 at 10:12 AM, revealed he could only call the ED, DCS, or ADCS if he could not come in to work and he was to wait for the next shift before leaving.

10. Review of the facility investigation, dated 04/28/15, for Resident #25's black eye noted on 03/25/15, revealed the SSA was notified on 04/28/15, investigated, and followed up on 05/04/15. The investigation resulted in the cause of the injury from a resident to resident altercation. Interview with the DCS, on 05/20/15 at 2:04 PM, revealed she investigated Resident #25's black eye and the cause was determined to be a resident to resident altercation. Observation, on 05/22/15 at 2:11 PM of Resident #25 revealed the resident was in his/her recliner with the TV on and staff sitting with him/her on a 1:1.

11. Review of current residents were assessed for behaviors by the Corporate Administrative Registered Nurses/Interdisciplinary Team, on 05/12/15 and 05/13/15, revealed sixty-four (64) residents with behaviors had their care plans reviewed, with nineteen (19) care plans updated. One (1) resident was placed on 1:1 supervision, on 05/13/15. Interview with the RDCS, on 05/22/15, revealed sixty-four (64) residents were reviewed, and nineteen (19) actually had care plan interventions updated.

12. Record review of in-services conducted 05/13/15 and 05/14/15 revealed one hundred one (101) staff were educated by Corporate Administrative Registered Nurses on bathing, AM care, shaving, hair care, change in condition, notifications to physician and RP, assessments,

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F 280	Continued From page 222 linens and laundry, falls, behaviors, abuse, resident smoking and use of aprons. Observation on the IDT in daily morning meeting, on 05/22/15 at 9:05 AM, revealed specific residents and behaviors, the 24 hour report, with department heads noted an new orders or changes to the care plans. 13. Review of a QAPI sign in sheet, dated 05/13/15, and agenda revealed the P&P for care plans and behavior management were discussed with no changes made. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Staff Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS attended the QA meetings. 14. Review of audit tools revealed residents with new falls and behaviors were reviewed by the Interdisciplinary Team in the daily meeting for completion of the documentation, notifications, care plans and Kardexes. Observation, on 05/22/15 at 9:05 AM, of the IDT morning meeting revealed specific resident concerns were reviewed, 24 hour report and behaviors were discussed, and care plans reviewed. Interview, on 05/22/15 at 2:52 PM, with the DCS revealed facility audits were reviewed in the daily meeting and any concerns discussed. 15. Review of the weekly falls meeting and behavior management meeting with the IDT, beginning 05/12/15, revealed meetings were conducted. Observation of the daily IDT meeting, on 05/22/15 at 9:05 AM, revealed the 24 hour report was discussed. Interview with the DCS, on 05/22/15 at 2:52 PM, revealed resident behaviors were reviewed in the behavior management meeting.	F 280		

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F 280	Continued From page 223 16. Review of weekly behavior meeting notes, dated 05/12/15 and 05/13/15, revealed six (6) residents with resident to resident behaviors or sexual/physical behaviors were reviewed for documentation, care plan interventions. Interview with the DCS, on 05/22/15 at 2:52 PM, revealed the behavior meeting reviewed and monitored residents with behaviors, notifications, interventions were in place, and possibility for more frequent monitoring. 17. Record review of in-services conducted on 05/13/15 and 05/14/15 revealed education provided for skin assessments, resident weights. Interview with CNA #7, on 05/22/15 at 8:05 AM, with RN #1, on 05/22/15 at 8:13 AM, with LPN #1, on 05/22/15 at 8:25 AM, with CNA #8, on 05/22/15 at 8:37 AM, revealed they had been trained on resident weights and skin assessments. Observation, on 05/22/15 at 3:30 PM, revealed Resident #34 skin assessment was performed by Registered Nurse #11 and no new skin issues were identified and the documentation was completed as required. 18. Observation of the morning meeting, on 05/22/15 at 9:05 AM, revealed the IDT reviewed the 24 hour report, care plans, and specific resident concerns. 19. Review of facility assessments, dated 04/30/15, revealed one hundred twenty-four (124) residents were assessed for transfer/lift with Kardexes and care plans updated. Observation, on 05/22/15 at 2:20 PM, revealed no concerns with a broken shower bed in the 100 Unit shower room and lifts were functional.	F 280		

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F 280	Continued From page 224 20. Review of the facility's audit tool revealed, beginning 05/12/15, residents were observed to ensure fall interventions were in place per the care plan. Interview with the DCS, ADCS, UM, Medical Records, BOM, and DSS, on 05/22/15 at 2:52 PM, revealed audits were conducted every morning and looked for falls interventions compared to the care plan and discussed in morning meeting. 21. Review of in-service records, dated 05/13/15, revealed Administrative staff were trained on staffing, pest control, housekeeping and maintenance, and would be monitored by the ED. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS revealed they had been trained on staffing, pest control, housekeeping and maintenance, and any concerns of audits would be taken to the morning meeting. Interview with Resident #3 on 05/22/15 at 1:00 PM, revealed staffing had improved and were answering lights timely and the facility looked cleaner. 22. Observation of the daily morning meeting, on 05/22/15 at 9:05 AM, revealed review of the 24 hour report, notifications made and documented, new physician orders, maintenance concerns and books, pests, rounds and audits, call lights, care plans. Interview with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, MDS Coordinator, and DSS, on 05/22/15 at 2:52 PM, revealed they participate in the morning meeting and review the 24 hour report, notifications were made, maintenance books reviewed, physician orders, call lights, care plans, and audits/ round were reviewed in the morning meeting.	F 280		

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23. Interview, on 05/22/15 at 2:52 PM, with the DCS revealed facility concerns were reviewed in the morning meeting, including audits and rounding results, for department heads to address. She stated she (the DCS) or the ED would initial when concerns were resolved. Observation, on 05/22/15 at 9:05 AM, of the morning meeting revealed the DCS provided direction and asked clarifying questions related to information discussed with follow up items determined.

24. Review of sign in sheets, dated 04/22/15, 05/13/15, and 05/15/15, revealed QAPI meetings were held on those dates. Interview, with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS revealed they attended the QAPI meetings. Interview with the RDCS, on 05/22/15 at 5:05 PM, revealed the next QAPI meeting was scheduled for 06/17/15. Interview with the Medical Director, on 05/22/15 at 8:00 AM, revealed he was informed by the Executive Director of the resident care issues, attended the QA meetings held by the facility and provided direction regarding corrective action plans that were developed to meet the needs of the residents.

25. Review of the QAPI sign in sheet, dated 05/15/15, and agenda revealed audit tools were approved for QA monitoring and discussed: resident interviews; resident/family concerns; morning meeting; new employee files; falls or behaviors reviewed; care plans and Kardexes update; review of the 24 hour report; notifications; maintenance rounds and book; supervised

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F 280	Continued From page 226 smoking; falls interventions in place; call lights; weekly falls; and, behavior management meetings. 26. Review of the sign in sheet for QAPI, dated 05/13/15, revealed the ED and DCS presented and reviewed falls, changes in condition, staffing, housekeeping, and laundry, and pest control, and would provide daily oversight. 27. Review of grievance audit, dated 05/13/15, revealed grievances were reviewed since 05/01/15 and resolved by 05/15/15. Interviews on 05/22/15 with Resident #3 at 2:10 PM, Resident #8 at 2:00 PM, and Resident #10 at 12:30 PM, revealed the issues and concerns they had regarding linens, pests, environment repairs and answering call lights were resolved. 28. Review of the facility rounds, dated 05/12/15, revealed residents were observed to identify residents grooming, incontinent care, bed linens, pests, call lights in reach, and privacy curtains in place. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Staffing Coordinator, BOM, Central Supply, Housekeeping Supervisor, and DSS revealed daily rounds were completed to identify resident grooming needs and care, linens, pests, call lights in reach, and privacy curtains in place. Interviews with Resident #3, #8 and #10 on 05/22/15, revealed the issues and concerns they had regarding linens, pests, environment repairs and answering call lights had improved. 29. Review of in-service records, dated 05/13/15 and 05/14/15, revealed nursing staff and ten (10) agency staff were educated on incontinent care, bathing, shaving, and hair care. Interview, on	F 280		

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F 280	Continued From page 227 05/22/15 at 2:52 PM, with the DCS, ADCS, UM, and Staffing Coordinator revealed staff were trained on grooming, incontinent care, shaving, and bathing. Interview with CNA #31, on 05/22/15 at 8:10 AM, revealed she received training on incontinent care, bathing, shaving, hair care, reporting pest, broken equipment, fall prevention, lifts, reporting change in condition, and answering call lights, abuse, resident laundry and linens. 30. Review of in-service records, dated 05/13/15 and 05/14/15, revealed one hundred one (101) staff and ten (10) agency staff were educated on privacy curtains; using the pest sightings book; resident privacy. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, Staffing Coordinator, Central Supply and Housekeeping Supervisor revealed they were trained on privacy curtains, resident privacy, and pests. Interview with Housekeeper #1, on 05/22/15 at 8:20 AM, revealed she received training on cleaning resident rooms, privacy curtains, reporting pests and broken equipment. Interview with Registered Nurse #11, on 05/22/15 at 8:10 AM, revealed she was educated on abuse, falls, physician orders, dignity, grievances, infection control, call lights, and reporting pests and maintenance issues. 31. Review of QAPI sign in sheet, dated 05/13/15, revealed incontinent care, resident privacy, shaving and AM care P&P were reviewed. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Staffing Coordinator, MDS Director, Housekeeping Supervisor, and DSS attended the QA meetings. 32. Review of rounding sheets revealed residents were observed by staff to identify any issues with	F 280		

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F 280	Continued From page 228 grooming, incontinent care, privacy, shaving and AM care. Interview, on 05/22/15 at 2:52 PM with the DCS, ADCS, UM, Staffing Coordinator, Medical Records, BOM, MDS Director, Central Supply, Housekeeping Supervisor, and DSS revealed they conducted rounds to assess residents grooming, privacy, shaved, and care. 33. Review of a QAPI sign in sheet, dated 05/15/15, revealed residents would be observed to ensure they were shaved, hair combed, incontinent care, privacy curtains and bed linens in place and clean, residents and environment free from pests, resident privacy, and call lights. On 05/22/15 at 2:52 PM, interview with the Maintenance Director, DCS, ADCS, UM, Staffing Coordinator, MDS Director, Housekeeping Supervisor, and DSS attended the QA meetings. Interview with Resident #8, on 05/22/15 at 4:20 PM, Resident #6, on 05/05/15 at 2:26 PM, Resident #24, on 05/22/15 at 8:07 AM, revealed the issues they had with not getting shaved, hair washed and combed, incontinent care provided, bed linens without tears, an environment free from pests, and call lights answered timely had improved. Observation of Resident #43, on 05/22/15 at 8:00 AM, revealed two staff were using a lift to transfer the resident into a wheelchair and then proceeded to shave the resident.	F 280		
F 282 SS=K	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		

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F 282	Continued From page 229 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 have an effective system in place to ensure the staff followed the resident's care plans of sixteen (16) of forty-three (43) sampled residents (Resident #4, #5, #6, #7, #8, #9, #10, #12, #19, #20, #22, #25, #31, #34, #36, and #39). The facility failed to follow Resident #25's care plan regarding notification to the physician and responsible party when there was any change and/or the need for treatment. On 03/25/15 Registered Nurse (RN) #6, noted Resident #25 had wandered in the dayroom. The resident's right eye was swollen and bruised on the side with a small cut. A skin assessment was completed on 03/24/15 by RN #6; however, the right eye bruising and cut were not documented until 04/24/15 and the staff failed to notifiy the physician and the responsible party creating a delay in treatment. (Refer to F157, F225, F309, F323) The facility failed to follow Resident #4's care plans for pressure wounds, nutrition, and activities of daily living. The resident sustained a fall on 02/25/15 that resulted in a fracture to the right tibia. The Physician ordered the resident to wear a right leg brace and the nursing care plan directed staff to assess the skin under the brace; however this was not performed and the resident developed unstageable pressure wounds from the brace. Review of Resident #4's documented weight's and meal intake records revealed the facility failed to obtain weights as ordered and did	F 282		

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F 282	Continued From page 230 not routinely record meal consumption. The resident experienced a thirteen pound weight loss from 01/19/15 through 04/17/15. The resident had numerous long hairs on their chin and the resident's room had a strong odor of urine, along with food debris on the floor and the bedside table. (Refer to F312, F314, and F325) The facility further failed to ensure incontinent care and checking and changing were provided timely so residents did not remain in wet briefs for extended periods or in urine stained sheets. The facility also failed to offer toileting assistance timely to prevent a resident from being embarrassed from a urinating on themselves. The facility failed to consistently document weights to monitor for weight loss and failed to provide basic care to ensure residents were kept clean, neat for thirteen (13) of forty-three (43) sampled residents (Residents #5, #6, #7, #8, #9, #10, #12, #19, #20, #22, #31, #34, #36, and #39). In addition, the facility further assessed Resident #34 as a risk for aspiration and the staff knew this and allowed the resident to feed themself in the their room without any monitoring and observations revealed the resident was eating a paper napkin although the care plan directed staff to observe the resident for choking or coughing before, during and after swallowing, and observe for wet gurgling sound after swallowing. The facility's failure to have an effective system in place to ensure care plan interventions were implemented related to skin assessments, activities of daily living and safety has caused or is likely to cause serious injury, harm, impairment	F 282		

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or death to resident. The Immediate Jeopardy was identified on 05/12/15 and determined to exist on 03/25/15.

An acceptable Allegation of Compliance (AOC) was received on 05/19/15 alleging the Immediate Jeopardy was removed on 05/16/15. The State Survey Agency validated the Immediate Jeopardy was removed on 05/16/15 as alleged, prior to exit on 05/22/15. The scope and severity was lowered to an E while the facility monitors the implementation of the Plan of Correction and the facility's Quality Assurance monitors the effectiveness of the systemic changes.

The findings include:

Review of the facility's policy regardng Care Plans, dated 11/30/14, revealed an interdisciplinary plan of care would be established for every resident and updated in accordance with the state and federal regulatory requirements and on an as needed basis. Goals must be measurable and objective. The facility must develop a comprehensive Care Plan for each resident that included measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. An Interim Care plan must be developed within 24 hours of admission to insure that the resident's needs are met appropriately until the Comprehensive Care Plan was completed. A Comprehensive Care Plan must be developed by the Interdisciplinary Care Planning Team within seven days after completion of the

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F 282	Continued From page 232 comprehensive assessment. The Comprehensive Care Plan would be reviewed and updated at least every ninety (90) days by the interdisciplinary team. In cases of a significant change in the resident's condition, the Care Plan must be updated within seven (7) days of the new full Minimum Data Set Assessment. 1. Review of Resident #4's clinical record revealed the facility admitted the resident on 05/16/13 with diagnoses of Hypertension, Atrial Fibrillation, Chronic Obstructive Airway, Congestive Heart Failure, Macular Degeneration, Rheumatoid Arthritis, Osteoporosis and an Open Wound Site. Review of Resident #4's Quarterly Minimum Data Set (MDS) assessment, completed on 03/09/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of ninety-nine (99), meaning the resident was rarely/never understood. Review of the Comprehensive Care Plan for Resident #4 revealed the facility developed a care plan on 06/04/13, with updated goals and a target date for 06/09/15. The problem on the care plan stated Resident #4 required assistance with all activities of daily living due to generalized weakness and multiple medical problems. The goal stated the resident would be up daily in his/her wheelchair, dressed appropriately, clean and odor free. The approaches included direction for staff to provide incontinent care, assist with oral care daily and to encourage the resident to	F 282		

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participate in their own care and praise all attempts.

Observation of Resident #4, on 04/15/15 at 1:30 PM, revealed the resident had numerous long hairs on their chin and a brace on the lower right leg. Resident #4's room had a strong odor of urine, along with food debris on the floor and the bedside table.

Observation of Resident #4, on 04/16/15 at 8:45 AM, revealed the resident had numerous long hairs on their chin and a brace on the lower right leg. Resident #4's room had a strong odor of urine.

Interview with Licensed Practical Nurse (LPN) #5, on 04/22/15 at 3:25 PM, revealed staffing was an issue and not all activities of daily living could be completed when only two (2) or three (3) aides were on the unit. She stated care plan interventions were to be implemented; however when there was a staffing shortage it was difficult to accomplish.

Further review of the resident's clinical record revealed the resident sustained a fall on 02/25/15 which resulted in a fractured right tibia and a leg brace was applied.

Further review revealed the facility developed a plan of care a new fracture, on 03/10/15 with updated goals and a target date for 06/09/15. The problem on the care plan stated the resident

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had a tibial/fibula fracture to the right leg. The goal was the resident would not have unrecognized complications related to the right lower leg fracture. The approaches listed directed staff to maintain an immobilizer per physician orders and observe skin under the immobilizer for signs and symptoms of redness or breakdown. However, review of nursing documentation revealed no evidence the skin under the immobilizer was assessed daily or during showers or bath time.

Review of the Wound Physician's documentation, dated 04/03/15, revealed Resident #4 had new wounds to the bilateral lower extremities after having a brace for a fracture. The Physician documented wounds to the left lateral ankle, the left mid-foot wound, the right medial ankle, the right medial lower leg, and the left medial lower leg.

Interview with the Wound Care Physician on, 04/24/15 at 1:56 PM, revealed the wounds to both Resident #4's lower legs were caused by the brace on the right leg.

Review of the Physician orders, dated 04/01/15, revealed Resident #4's brace to the right leg was to remain on at all times. Interview with Resident #4's Physician, on 04/24/15 at 10:55 AM, revealed even though he ordered the brace to remain on at all times, he did not mean he did not expect nursing to perform skin assessments. He stated monitoring for skin breakdown was a nursing responsibility.

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F 282	Continued From page 235 Interview with the Licensed Practical Nurse (LPN) #5, on 04/23/15 at 2:55 PM, revealed she was unable to find nursing assessments/documentation that identified when nursing first determined Resident #4 obtained the wounds to the lower extremities and stated nursing should have assessed the skin, underneath the immobilizer, per the care plan, and documented their findings; however that was not done. Interview with the Assistant Director of Clinical Services, on 04/24/15 at 10:05 AM, revealed she was unaware Resident #4 had wounds to the back of the right lower leg or that the brace he/she had in place for the fractured tibia caused the pressure wounds. She stated the facility conducted a wound meeting every week where the care plan would have been discussed to determine if it was being followed. She stated she did not remember the team discussing the resident's wound from the brace. She stated the standard of care for a resident with a brace would be for nursing to routinely assess the skin under the brace even if there was an order saying not to remove the brace. Interview with the previous facility ED, in charge at the time Resident #4's developed the pressure areas, on 04/23/15 at 8:34 AM, revealed nursing was responsible for developing, implementing and documenting the care plan interventions. She stated management would have discussed the wound issues at the wound meetings that were held weekly and reviewed any forms completed by nursing. She stated she did not remember discussing Resident #4's wounds in the morning meeting or providing direction to staff regarding	F 282		

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F 282	Continued From page 236 the resident's care. Further review of Resident #4's comprehensive care plan revealed a care plan, dated 03/02/15, with a review date of 07/06/15, which stated the resident was at risk for altered nutrition and hydration due to possible medical causes and or increase nutrition requirements. The goal stated the resident would maintain adequate nutrition status and would maintain weight and have no unexplained significant weight changes and intake would be at least seventy-five percent (75%). The approaches stated the resident would receive a mechanical soft diet, supplements, and staff would monitor weight, laboratory values and intakes. The care plan did not specify the amount of assistance needed for meals and did not specify weighing the resident. Interview with the Dietitian, on 04/17/15 at 11:05 AM, revealed Resident #4 had a decline in health and weight was at about 81 pounds. She stated she also had downgraded the resident's meal to a pureed and ordered the resident to be fed; however, review of the care plan revealed this was documented. She further stated she recommended the staff provide snacks and speech therapy was to evaluate the resident. Review of the Dietitian notes, dated 03/20/15, revealed per nursing resident would probably benefit from moving to the dining room to eat with cues and assistance. Recommend to move the resident to the dining room seating in order to increase intake. Further review of Dietitian notes made, on 04/17/15, revealed the residents' current body weight was 84.4 pounds. The resident had a 17% weight loss in the last 180	F 282		

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F 282	Continued From page 237 days and 13% weight loss in the last 90 days. Review of the Physician orders, dated 04/01/15, revealed the resident was to have meals in the dining room. Observation of Resident #4, on 04/20/15 at 9:20 AM, revealed the resident was in bed laying on the left side. The resident's breakfast tray was on the over bed table and the food and beverages appeared untouched. Observation of Certified Nursing Assistants (CNAs) #1 and #34, on 04/20/15 at 9:20 AM, revealed they were in the common area sitting at tables feeding residents. Interview with CNAs #1 and #34, revealed the unit had approximately eight (8) to ten (10) residents that were dependent on staff or needed assistance with eating meals. They both stated they had not been able feed Resident #4 as of yet. 2. Review of the clinical record for Resident #25, revealed the facility admitted the resident on 12/30/14 with a diagnosis of Vascular Dementia. The facility completed an initial Minimum Data Set (MDS) on 01/06/15 and assessed the resident as ninety-nine (99), with a cognitive level of a three (3) by staff interview. The facility care plan, dated 01/06/15, revealed the resident had impaired cognitive status with interventions that included inform the responsible party of any changes. Review of Resident #25's care plan revealed the Kardex, not dated, identified the resident urinated in common areas and was combative with care, and was on 15 minute safety checks. The facility	F 282		

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care plan for behaviors, dated 01/06/15, revealed the resident would refuse medications at times, had combative and agitated behaviors, had aggressive behaviors with ADLs, exhibited socially inappropriate behaviors, and wandered. Interventions included praise for appropriate behavior, the resident wore a Wanderguard and place the resident in an area where frequent observation was possible, monitor and document his/her behavior, and remove the resident from public areas when his/her behavior was disruptive or unacceptable. The care plan for risk for falls, dated 01/08/15, included an intervention to monitor changes in Resident #25's condition that may warrant increased supervision or assistance, and to notify the physician. The care plan for the resident's impaired cognitive status, dated 01/06/15, revealed the RP should be notified of any changes.

Review of the facility Behavior Symptom Monitoring Flow Record for Resident #25, for January, February, March, and April 2015, revealed the resident wandered, had socially and sexually inappropriate behaviors with interventions to redirect the resident, allow the resident to express him/herself, snacks, and one (1) to one (1) observation. The March/ April 2015 Behavior Monitoring Flow Record also included an intervention to toilet the resident.

Continued review of Resident #25's clinical record revealed a nurse's note, dated 02/19/15 at 6:00 PM, that indicated the resident had wandered into another resident's room and had tried to get into the other resident's bed. On 03/24/15 at 3:30 PM, revealed the resident had wandered into another resident's room. On 03/24/15 at 7:00 PM, the resident was assisted to his/her room. On

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F 282	Continued From page 239 03/25/15 from 7:00 AM through 3:00 PM, a nurse's note by Registered Nurse (RN) #6, revealed the resident had wandered in the dayroom. The resident's right eye was swollen and bruised on the side with a small cut. The resident had often wandered into other resident rooms, both male and female. A skin assessment was completed on 03/24/15 by RN #6; however, the right eye bruising and cut were not documented until 04/24/15. Continued review of the clinical record for Resident #25 revealed a Psychiatric progress note, dated 01/17/15, that stated the resident had an increase in agitated and aggressive behaviors and had struck the spouse of the roommate. A psychiatric note, dated 03/30/15, that stated the resident had right eye bruising. The note further stated per nursing staff notes the resident wandered the unit day and night, often into other resident rooms. The resident was recently punched by another resident whose room Resident #25 had wandered into. The facility did not provide an investigation, root cause analysis, SBAR, notifications or neurological (neuro) checks for Resident #25 that would have occurred at the time of the black eye, around 03/24/15 or 03/25/15. Observation of Resident #25, on 04/22/15 at 10:50 AM, revealed the resident had a yellowed discoloration of the skin around the outside of the right eye, from the forehead to cheekbone. Observations, on 04/22/15 at 10:59 AM, 04/23/15 at 2:10 PM, 04/24/15 at 11:21 AM, 04/27/15 at 11:04 AM, 04/27/15 at 11:08 AM, revealed the resident ambulated independently throughout the unit.	F 282		

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Interview with Resident #25, on 04/22/15 at 10:59 PM, revealed he/she did not know what had happened to his/her eye.

Interview with RN #6, on 04/23/15 at 1:15 PM, revealed Resident #25 would have behaviors such as the resident would sit on the floor, sexual acting out, and urinating in the public areas. The nurse reported she had seen Resident #25 exhibit behaviors. She stated the nurses and CNA could implement the resident's care plan interventions.

Interview, on 04/23/15 at 2:35 PM, with CNA #2 revealed Resident #25 could be combative with care, had disrobed in public areas, urinated and defecated in public areas, and would wander in and out of resident rooms. She stated the resident had wandered into another resident's room and the other resident hit Resident #25, and caused the black eye. The CNA stated she saw a cut above Resident #25's right eye. She stated the CNAs had access to the resident care plan and Kardex for interventions that were in place for resident care.

On 04/24/15 at 9:35 AM, interview with the Unit Manager (UM) revealed Resident #25 had Dementia, was able to walk, and had behaviors. She stated the resident would be combative with staff, liked to sit on the floor, was socially inappropriate, urinated anywhere, and would refuse his/her medications at times. The UM stated when Resident #25 received the black eye, the physician and RP should have been notified. She further stated the resident's care plan was not followed in relation to his/her black eye. The UM stated if the care plan was not followed, the

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F 282	Continued From page 241 resident's needs would not be met. Continued interview, on 04/24/15 at 1:24 PM, with RN #6 revealed when she came on duty she noticed Resident #25's black eye. She stated the shift in which the injury occurred was responsible to document and make notifications about the incident. The nurse revealed she did not complete documentation or notifications about the injury. Interview, on 04/27/15 at 1:05 PM, with the Medical Director revealed he or the Nurse Practitioner were always on call; however, he could not remember being notified by the facility that Resident #25 had a black eye. Interview with RN #9, on 04/27/15 at 1:21 PM, revealed Resident #25 was combative, wandered into other resident rooms, would get into other residents beds, would sit on the floor, and would urinate on the floor. She stated the resident's behaviors were documented in the behavior book; however, she was unsure what happened with the information in the book. On 04/28/15 at 8:35 AM, interview with the Director of Clinical Services (DCS) revealed in light of Resident #25's injury, an SBAR should have been completed. She stated the SBAR included notifications to the physician and RP. She stated a resident on 15 minute safety checks could need the checks for risk of wandering or behaviors. The DCS further stated if a resident was aggressive or combative the resident may need 15 minute safety checks to keep the resident and other residents safe. She stated if the safety checks were not completed the resident could have an altercation with another	F 282		

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F 282	Continued From page 242 resident. Interview with the Interim Executive Director/Regional Vice President of Operations (ED/RVPO), on 04/28/15 at 9:43 AM, revealed the facility did not investigate Resident #25's black eye. She stated there was no other documentation about the incident, including notifications. The Interim ED/RVPO reported the resident's behaviors would need to be considered for the eye injury. She further stated without the injury documented by the nurse when the incident occurred, then the facility policy and procedure would not have been followed. 3. Review of Resident #34's clinical record revealed the facility admitted the resident on 03/19/09, with diagnoses of Hypertension, Dementia and Cerebral Vascular Accident. Review of Resident #34's Quarterly Minimum Data Set (MDS) assessment, completed on 02/21/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of ninety-nine (99), meaning the resident was rarely/never understood. Continued review of the MDS revealed the resident was totally dependent on staff for bed mobility, transferring, bathing, eating and personal hygiene. The MDS stated the resident was always incontinent of bowel and bladder. In addition, the MDS stated the resident had impairment in the range of motion to one side of the body. Review of the Comprehensive Care Plan for Resident #34 revealed the facility developed a	F 282		

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care plan on 06/20/13, with updated goals and a target date for 08/26/15. The problem on the care plan stated the resident was always incontinent of bowel and bladder. The goal stated the resident would not experience any skin conditions or infections from incontinence. The approaches listed directed staff to provide incontinent care with each incontinent episode and assess skin daily for irritation and redness.

Further review revealed the facility developed a care plan related to Aspiration, on 06/20/13, with updated goals and a target date of 08/26/15. The problem stated the resident was at risk for aspiration related to dysphagia secondary to a stroke and a history of Aspiration Pneumonia. The goal stated the resident would remain free of signs and symptoms of aspiration through the next review. The approaches stated the staff was to observe the resident for choking or coughing before, during and after swallowing, observe for wet gurgling sound after swallowing.

Observation of Resident #34, on 05/13/15 at 2:15 PM, revealed the resident was in bed with a lunch tray in front of them on the over bed table and no staff present in the room. Continued observation revealed the resident had a paper napkin in the right hand. The resident took a bite of the napkin, chewed it and then swallowed and this was done three times. The resident then picked up a butter knife and used it to eat pudding out of a dish that had fallen over on to the resident's stomach.

Interview with Certified Nursing Assistant (CNA) #1, on 05/13/15 at 2:18 PM, and said the resident

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was able to feed themself if the tray was set up for them. The CNA stated she knew the resident needed assistance with eating as part of the plan of care, but allowed the resident to feed themself anyway.

Interview with Licensed Practical Nurse (LPN) #5, on 04/30/15 at 2:40 PM, revealed residents were to be assisted with feeding.

4. Review of the clinical record for Resident #31 revealed the facility admitted the resident on 08/11/14 with diagnoses of Peripheral Vascular Disease, Above Knee Amputation, Diabetes Mellitus, and Pressure Ulcer. The facility completed an initial MDS on 08/19/14 and assessed the resident with a BIMS of fifteen (15) meaning the resident was interviewable. Continued review of Resident #31's clinical record revealed a physician ordered, dated 12/18/14, for the resident to be weighed weekly. A Readmission Data Collection, dated 02/14/15 at 1:30 PM, revealed the facility readmitted the resident after he/she had a Left Above Knee Amputation.A Quarterly MDS was completed on 02/17/15 and assessed the resident to have a BIMS of six (6) meaning the resident was no longer interviewable.

Review of the facility care plan for Resident #31 revealed the care plan for alteration in nutrition, dated 08/15/14, identified the resident had a significant weight loss and increased needs due to a pressure ulcer, with interventions that included to monitor the residents weight and intake, and encourage the resident to eat over 75% of most meals. The care plan for risk of dehydration, dated 08/22/14, included an

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F 282	Continued From page 245 intervention to observe weights as ordered. The care plan for potential complications secondary to a pressure ulcer, dated 12/07/14, included intervention of weekly weights while on Nutritionally At Risk (NAR). Continued review of Resident #31's clinical record revealed the resident's weight on 12/07/14 was 133 pounds (lbs). However record review revealed the next recorded weight was on 01/05/15 at 127.6 lbs, approximately four (4) weeks later. Further review revealed weights were recorded on 01/16/15 at 119 lbs and on 01/19/15 at 118 lbs. Review of the next recorded weight was on 02/25/15 was 111lbs., approximately two (2) weeks after re-admission. The resident was out of the facility 03/16/15 through 03/27/15. The resident's recorded weight on 04/06/15 was 102 lbs. There was no documented evidence of another weight obtained for Resident #31 in the month of April even though the resident was still on weekly weights. The resident was out of the facility again 05/03/15 through 05/07/15. Readmission orders, dated 05/07/15, revealed the resident would be weighed monthly. The resident's recorded weight on 05/12/15 was 109.2 lbs. Review of the facility's Intake Detail Report for Resident #31, dated 01/01/15 through 05/20/15, revealed missing entries for the resident's breakfast, lunch, dinner, and evening snack for January, February, March, April, and May. The Intake Report identified by meal, the date and time, and the percentage (%) of food eaten by the resident. For January 2015, twelve (12) entries were documented for breakfast, ten (10) entries	F 282		

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F 282	Continued From page 246 for lunch, fourteen (14) for dinner, and fourteen (14) for the evening snack. The February 2015 intake entries had zero (0) for breakfast, zero (0) for lunch, one (1) entry for dinner, and one (1) for the evening snack. The Intake Report for March 2015 revealed four (4) entries for breakfast, four (4) for lunch, three (3) for dinner, and three (3) for the evening snack. The April 2015 Intake Report revealed fifteen (15) entries for breakfast, fifteen (15) for lunch, twelve (12) for dinner, and twelve (12) for evening snack. The May 2015 entries through 05/20/15 revealed one (1) for breakfast, zero (0) for lunch, three (3) for dinner, and three (3) for the evening snack. Interview with CNA #2, on 04/30/15 at 3:37 PM, revealed the aides should document how much the resident ate in the computer Kiosk Caretracker System and Resident #31 should be weighed every week. She stated no particular shift was assigned to weigh residents; however, the nurses would tell the aides who needed to be weighed that day. Interview with the Director of Clinical Services (DCS), on 05/04/15 at 2:18 PM, revealed the day the residents weights were due, the nurse would tell the CNA to get the resident's weight and the Unit Manager (UM) was responsible to monitor that the weights were completed. She stated the dietician monitored the resident's weights and if the resident had weight loss, the dietician would make recommendations. On 05/05/15 at 3:05 PM, with the Interim ED/RVPO revealed the facility failed to document Resident #31's weights. The facility could not validate that needed care was provided to the resident.	F 282		

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F 282	Continued From page 247 Interview with Resident #31, on 05/13/15 at 10:12 AM, revealed the resident was afraid he/she would lose weight. On 05/13/15 at 10:43 AM, continued interview with CNA #2 revealed the unit received the list of weekly weights from the Dietary Department and the CNAs were responsible to get the resident weights. She stated she turned the weights in to the UM, who turned in the weights to dietary. She further stated all meals for all residents should be documented in the Caretracker what the resident's percentage of intake was for that meal. Interview, on 05/13/15 at 10:50 AM, with Licensed Practical Nurse (LPN) #2 revealed the CNAs were responsible to obtain resident weights and give those weights to any nurse to be put on the MAR and 24 hour book. She stated a resident was to have weekly weights if his/her nutrition was not very good. The nurse stated Resident #31 was to have weekly weights due to weight loss, even though the standing order is for monthly weights. She stated the CNAs were responsible to document the percentage a resident ate, for all residents, for all meals, to know what the resident's intake was. The LPN stated the care plan stated what the resident needed. She stated the weights and intakes, were on the care plan, to know what the facility was doing for the resident to determine if any changes were needed. Interview with Registered Nurse (RN) #10, on 05/14/15 at 2:46 PM, revealed the CNAs should document the percentage eaten during meals, including Resident #31. She stated the CNAs document the percentage eaten for every	F 282		

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F 282	Continued From page 248 resident for every meal. The nurse stated the purpose was to track how much the resident ate. The RN stated the care plan interventions were to track the resident's intake and nutritional value and to ensure the resident was getting enough food to progress in his/her care. She stated if the resident's intakes were not documented the facility would not be able to identify if there was a change in the resident's condition or if the interventions needed to be changed to increase the resident's appetite. The RN stated she monitored that the CNAs provided the necessary care. She further reported she could look at the Caretracker for what the CNAs documented the residents ate. Interview, on 05/20/15 at 2:04 PM, with the DCS revealed the care plan provided the process of care for the resident. She stated if the care plan interventions were not followed for documenting intakes and weights for Resident #31, the it would be difficult to evaluate if the resident's condition was improving. The DCS stated if the resident did not eat well, or had pressure ulcers, the facility could have difficulty assessing the care plan was effective. The DCS stated the facility was missing documented weekly weights and percentage of meal eaten for Resident #31. She further stated if the weights and intakes were not completed, or documented, the facility would not know if the resident received proper nutrition to heal his/her pressure ulcer. The DCS reported without the weights and intakes by the CNAs, the Dietician would not be able to assess how much the resident consumed or how to continue to provide care to the resident, or evaluate if the interventions were effective. Continued interview, on 05/20/15 at 2:15 PM, with	F 282		

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F 282	Continued From page 249 the DCS, revealed the nursing care plan directed the care of the resident and was individualized in order to evaluate the resident for a decline or improvement. She stated if the facility did not monitor and document how much a resident consumed during a meal or their weight as ordered it would be difficult to make an evaluation to determine if the weight loss was avoidable or not. Interview with the Interim ED/RVPO, on 05/21/15 at 8:23 AM, revealed Resident #31 was to have weekly weights and the resident's weights were not obtained and the resident's intakes were not documented on a daily basis. She stated the dietician needed the information as the resident's nutrition was an overall part of the healing of his/her pressure ulcer. Continued interview with the Interim ED/RVPO, on 05/21/15 at 8:25 AM, revealed she was aware the facility had an issue with not obtaining weekly weights timely. She also stated the computer system the CNAs documented meal intake into had not been working correctly and she was not aware of this until she tried to obtain/print information from the system. 5. Review of Resident #5's clinical record revealed the facility admitted the resident on 03/13/15 with diagnoses of Altered Mental Status, Parkinson's, Hypertension, Gastro Esophageal Reflux Disease, and Chest Pain. Review of Resident #5's Significant Change Minimum Data Set (MDS) assessment,	F 282		

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F 282	Continued From page 250 completed on 04/25/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of ninety-nine (99), indicating the resident was rarely/never understood. Review of the Comprehensive Care Plan for Resident #5 revealed the facility developed a care plan on 02/17/15, with updated goals and a target date of 05/17/15. The problem on the care plan stated Resident #5 had a decline in strength and endurance related to a recent hospital stay; now receiving assistance with activities of daily living. The goal stated the resident would continue to participate with activities of daily living (ADL) as able and would be neat, clean and dressed daily. The approaches included direction for staff to assist with activities of daily living as needed and to observe for changes with ADL's and report to the physician and therapy as needed. Observation of Resident #5, on 04/15/15 at 1:05 PM, revealed the resident was in a recliner wearing a white t-shirt and gray pants with no shoes or socks on his/her feet. Interview with CNA #3, on 04/15/15 at 2:50 PM, revealed Resident #5 frequently disrobed and staff had to assist the resident to remain clothed. The CNA stated he was very busy today and was not aware the resident did not have socks or shoes in place. Observation of Resident #5, on 04/16/15 at 3:30 PM, revealed the resident had food debris on	F 282		

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F 282	Continued From page 251 his/her clothes and on the mattress in a semi-private room with no privacy curtain. Observation of Resident #5, on 05/13/15 at 9:41 AM, revealed the resident was in the common area in a recliner with pants down to ankles. Interview with LPN #1, on 04/15/15 at 3:10 PM revealed Resident #5 disrobes. The LPN said the resident needed frequent reminding to leave clothes on. However, if they were busy sometime they would not be aware the resident was disrobing. Interview with the Unit Manager, on 04/21/15 at 3:25 PM, revealed if the resident's care plan was not followed in relation to activities of daily living then the resident's needs would not be met. She stated due to the staffing shortage not all residents had their needs met timely. 6. Review of Resident #6's clinical record revealed the facility admitted the resident on 11/14/13 with diagnoses of Toxic Encephalopathy, Sepsis, Bradycardia, Hypertension, Renal Insufficiency, Gastro-esophageal Reflux Disease, Neurogenic Bladder, and Seizures. Review of Resident #6's Quarterly Minimum Data Set (MDS) assessment, completed on 01/08/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of fourteen (14), indicating the resident was cognitively intact and interviewable.	F 282		

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F 282	Continued From page 252 Review of the Comprehensive Care Plan for Resident #6 revealed the facility developed a care plan on 11/03/13, with updated goals and a target date of 07/09/15. The problem on the care plan stated Resident #6 was incontinent of bowel and bladder related to Urinary Tract Infection and Obesity. The goal stated the resident would show no evidence of skin breakdown related to incontinence through next review. The approaches included direction for staff to assist with toileting needs as needed and on a consistent schedule to promote continence, check frequently for incontinence. Interview with Resident #6, on 04/16/15 at 10:45 AM, revealed he/she was left wet for seventeen hours (17) due to the facility not having enough staff. The resident stated it took at least two (2) staff members to get him/her cleaned up after an incontinent episode. Resident #6 said he/she would be wet during the night shift and would have to wait till the day shift staff came on to get cleaned up. Resident #6 stated if he/she had an incontinent episode while up in the wheelchair, and requested to be changed, he/she had to wait until there was adequate staff available to change his/her brief, which at times took over an hour for there to be enough staff. Interview with CNA #6, on 04/16/15 at 11:00 AM, revealed he was not able to complete all his assigned duties for twenty-three residents that needed assistance and had several residents that required total care. He stated the facility was short staffed and due to that, those residents that	F 282		

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F 282	Continued From page 253 required the assistance of two (2) to get up, turn and reposition or check and change, did not always have their needs met or if they were, it was not timely. 7. Review of Resident #7's clinical record revealed the facility admitted the resident on 03/17/15, with diagnoses of Vascular Dementia, Cerebral Vascular Accident, Osteoarthritis of the Hip and Knee, Cocaine Abuse, and Hypertension. Review of Resident #7's Admission Minimum Data Set (MDS) assessment, completed on 03/25/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of ninety-nine (99) meaning the resident was rarely/never understood. Review of the Comprehensive Care Plan for Resident #7 revealed the facility developed a care plan on 03/26/15, with updated goals and a target date for 06/26/15. The problem on the care plan stated Resident #7 required assistance from staff with grooming and personal hygiene. The goal stated the resident would not experience any skin conditions from incontinence. The approaches listed, directed staff to monitor the resident for signs of emotional distress with incontinence and to provide ongoing assessment of the resident's voiding patterns. Observation of Resident #7, on 04/16/15 at 3:37 PM, revealed the resident was seated on the floor in his/her bathroom, with pants down and stool on	F 282		

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F 282	Continued From page 254 the resident's bottom and floor. No staff was present in the room at the time of this observation.	F 282		
	Interview with CNA #36, on 04/16/15 at 3:43 PM, revealed there was not enough staff to tend to Resident #7's incontinent care needs on the locked unit. She stated there were only three (3) aides on the unit for the second shift for the forty-five (45) to forty-eight (48) residents and several were total care requiring the assistance of two.			
	8. Review of Resident #8's clinical record revealed the facility admitted the resident on 04/18/14, with diagnoses of Hypoxia, Respiratory Failure, Stage Three Renal Disease, Cerebral Vascular Accident, Congestive Heart Failure, Hypertension, Decubitus, and Toxic Metabolic Encephalopathy.			
	Review of Resident #8's Quarterly Minimum Data Set (MDS) assessment, completed on 03/25/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of fifteen (15) meaning the resident was cognitively intact and interviewable.			
	Review of the Comprehensive Care Plan for Resident #8 revealed the facility developed a care plan on 08/11/14, with updated goals and a target date for 05/24/15. The problem on the care plan stated Resident #8 had impaired ability to perform own activities of daily living and self-mobility			

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related to weakness, immobilization and Chronic Obstructive Pulmonary Disease. The goal stated the resident would improve self-care skills in at least one area of activities of daily living and mobility by next review on 05/24/15. The approaches listed stated staff was to provide assistance with activities of daily living, while promoting independence, promote dignity by assuring privacy and organize supplies by how or when they should be used and placed within reach. The resident also had a care plan developed on 08/11/14 for urinary incontinence with updated goals and a target date for 05/24/15. The problem stated the resident was incontinent of urine and the goal stated the resident would have decreased episodes of urinary incontinence. The approaches stated staff would assist with toileting and provide incontinence device of resident's choice for dignity.

Interview with Resident #8, on 04/16/15 at 8:48 AM, revealed the resident had urinated on him/herself during the night. The resident said he/she was unable to reach the call light to ring for assistance and instead hollered for staff to come help him/her. The resident stated staff walked by and did not come into his/her room.

Interview with CNA #1, on 04/16/15 at 8:48 AM, revealed she could not answer Resident #8's call light because she was only one person and could not address all the residents she needed to take care of even though the care plan stated to meet the resident's needs promptly.

Interview with Resident #8, on 04/22/15 at 9:20

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F 282	Continued From page 256 AM, revealed he/she had felt like the management staff did not care and it did not do any good to complain. The resident stated he/she put on their call light again last night because he/she was wet and wanted to be pulled up in the bed and the staff answered the light and said they would be back because they needed help. The resident said he/she fell back to sleep, woke up again and pushed the call light again and they turned if off again and did not come back for a while. 9. Review of Resident #9's clinical record revealed the facility admitted the resident on 08/14/14, with diagnoses of Anemia, Coronary Artery Disease, Hypertension, Peripheral Vascular Disease, Traumatic Brain Injury, Anxiety, Depression, and Chronic Obstructive Pulmonary Disease and Dementia. Review of Resident #9's Sixty-day (60) scheduled Minimum Data Set (MDS) assessment, completed on 03/03/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of fifteen (15) meaning the resident was cognitively intact and interviewable. Review of the Comprehensive Care Plan for Resident #9 revealed the facility developed a care plan on 04/17/14, with updated goals and a target date for 06/03/15. The problem on the care plan stated Resident #9 had urinary incontinence related to impaired physical mobility, Right Above the Knee Amputation, Neurogenic Bladder and	F 282		

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F 282	Continued From page 257 evidence of being incontinent of urine. The goal stated the resident would have no unrecognized Urinary Tract Infections or skin breakdown related to incontinence. The approaches listed for staff to implement were to place the call light within reach at all times and to provide incontinence device of resident's choice for dignity. Interview with Resident #9, on 04/16/15 at 8:41 AM, revealed the resident had put on the call light thirty (30) minutes ago and wanted help with getting some cranberry juice and a brief changed. Interview with Certified Nursing Assistant (CNA) #1, on 04/17/15 at 10:55 AM, revealed she was assigned to take care of Residents #8 and #9 and when her shift started today there were just two (2) aides and the third aide did not come until 10:00 AM and due to time constraints and staffing she was not able to shave, provide oral, or comb the hair for Resident #8 and #9. 10. Review of Resident #10's clinical record revealed the facility admitted the resident on 05/01/14, with diagnoses of Hypertension, Chronic Atrial Fibrillation, Quadriplegic, Neuropathy, Muscle Spasms, Gastro-esophageal Disease, Proteus Urinary Tract Infection, and Chronic Ileus resolved. Review of Resident #10's Annual Minimum Data Set (MDS) assessment, completed on 02/03/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of fifteen (15)	F 282		

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F 282	Continued From page 258 meaning the resident was cognitively intact and interviewable. Review of the Comprehensive Care Plan for Resident #10 revealed the facility developed a care plan on 03/31/14, with updated goals and a target date for 05/03/15. The problem on the care plan stated Resident #10 was incontinent of bowel and bladder related to quadriplegia. The goal stated the resident would show no evidence of skin breakdown related to incontinence through next review. The approaches listed for staff to implement stated staff would assist with toileting needs as needed and on a consistent schedule to promote continence and to check frequently for incontinence. Interview with Resident #10, on 04/15/15 at 9:25 AM, revealed the resident was unable to move and was totally dependent upon staff for care. The resident stated he/she was left wet all night long due to the facility not having enough staff. Interview with CNA #7, on 04/15/15 at 9:10 AM, revealed she was normally assigned to Resident #10. She stated she worked by herself most of the time. CNA #7 stated she was now responsible for sixteen residents and Resident #10 was totally dependent on staff due to being quadriplegic. She stated there were several other residents that also required the assistance of two staff to check and change, toilet and transfer and she could not do that by herself. 11. Review of Resident #12's clinical record	F 282		

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F 282	Continued From page 259 revealed the facility admitted the resident on 05/17/14, with diagnoses of Gastro-esophageal Disease, Coronary Artery Disease, Hypertension, Dementia, Status Post Hip Fracture Repair, Mild Anemia, History of Gastro-intestinal Bleeding, and Peripheral Vascular Disease. Review of Resident #12's Quarterly Minimum Data Set (MDS) assessment, completed on 02/21/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of ninety-nine (99) meaning the resident was rarely/never understood. Review of the Comprehensive Care Plan for Resident #12 revealed the facility developed a care plan on 05/28/14, with updated goals and a target date of 05/22/15. The problem on the care plan stated the resident required assistance from staff for activities of daily living. The goal stated the resident would be up and dressed neat/clean with the assist of staff daily. The approaches stated the staff would provide assistance with activities of daily living, oral care, and anticipate and meet all the resident's needs daily. Observation of Resident #12, on 04/17/15 at 11:30 AM, revealed the resident's hair was in uncombed. The resident also had long hairs on their chin. Observation of Resident #12, on 4/20/15 at 11:30 AM, revealed the resident had long hairs on their chin and their hair was uncombed.	F 282		

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F 282	Continued From page 260 12. Review of Resident #19's clinical record revealed the facility admitted the resident on 01/31/07, with diagnoses of Mental Retardation, Osteoarthritis, Idiopathic Scoliosis, Kyphosis, Hypertension, Esophageal Reflux Disease, and Cerebral Palsy. Review of Resident #19's Quarterly Minimum Data Set (MDS) assessment, completed on 03/12/15, revealed a Brief Interview for Mental Status (BIMS) exam was not conducted because the resident was rarely/never understood. Review of the Comprehensive Care Plan for Resident #19 revealed the facility developed a care plan on 07/03/13, with updated goals and a target date for 06/24/15. The problem on the care plan stated the resident had a self-care deficit related to Mental Retardation and Cerebral Palsy and the inability to complete self-care tasks independently. The goal stated the resident would be clean, neat and dressed in appropriate clothing daily through staff assistance. The approaches stated staff would promote dignity, provide incontinent care, anticipate resident's wants and needs and provide necessary care. Observation of Resident #19, on 04/17/15 at 11:30 AM, revealed the resident had long hairs on their chin, a yellowish/white drainage coming out of the right eye, teeth were full of unknown debris, and hair was greasy an uncombed.	F 282		

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F 282	Continued From page 261 Observation of Resident #19, on 4/20/15 at 11:30 AM, revealed the resident had long hairs on their chin and their hair was not combed. 13. Review of Resident #22's clinical record revealed the facility admitted the resident on 06/27/12, with diagnoses of Anemia, Coronary Artery Disease, Hypertension, Gastro-esophageal Reflux Disease, Diabetes Mellitus, Hyperlipidemia, Osteoporosis, Non-Alzheimer's Dementia, Manic Depression, and Cataracts. Review of Resident 22's Admission Minimum Data Set (MDS) assessment, completed on 03/20/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of ninety-nine (99) meaning the resident was rarely/never understood. Review of the Comprehensive Care Plan for Resident #22 revealed the facility developed a care plan on 06/27/13, with updated goals and a target date for 06/23/15. The problem on the care plan stated the resident required limited to extensive assistance with activities of daily living and at other times only required supervision. The goal stated the resident would continue to participate in activities of daily living within safety limits and would be clean, neat and dressed daily. The approaches listed stated staff should provide cues and redirection, assist the resident with activities of daily living as needed and encourage the resident to be highly involved.	F 282		

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F 282	Continued From page 262 Observation of Resident #22, on 04/15/15 at 9:07 AM and on 04/16/15 at 8:56 AM, revealed the resident was in the common area seated at a table with hair uncombed and long hairs on chin. Interview with CNAs #2 and #3, on 04/17/15 at 2:50 PM, revealed they started their 7:00 AM to 3:00 PM shift with only two (2) aides and were responsible for Resident's #12, #19, and #22. They stated the best they could do was to get the resident's checked and changed and up for breakfast. Both stated they did not have time to do mouth and hair care for forty eight (48) residents between them and have the residents ready for breakfast. The CNAs stated they were also responsible for passing trays and assisting residents with feeding. 14. Review of Resident #20's clinical record revealed the facility admitted the resident on 02/10/15, with diagnoses of Anemia, Hypertension, Encephalopathy, Pneumonia, Dementia, Hypothyroidism, Chronic Venous Stasis of both lower extremities, and Lymphedema. Review of Resident #20's Annual Minimum Data Set (MDS) assessment, completed on 02/24/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of fifteen (15) meaning the resident was cognitively intact and interviewable Review of the Comprehensive Care Plan for	F 282		

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F 282	Continued From page 263 Resident #20 revealed the facility developed a care plan on 02/27/15, with updated goals and a target date of 05/27/15. The problem on the care plan stated the resident required total/extensive assistance with activities of daily living secondary to medical problems. The goal stated the resident would continue to be highly involved with daily care and make his/her wishes known through the next review. The approach for staff to implement stated staff would provide assistance with activities of daily living as indicated. The facility also developed a care plan on 02/27/15 with a problem that stated Resident #20 was incontinent of bowel related to functional abilities. The goal stated the resident would not experience any skin conditions or infections from incontinence. The approaches listed stated staff would offer and provide the bedpan upon request and assess for environmental factors that may contribute to the resident's incontinence. Interview with Resident #20, on 04/16/15 at 9:11 AM, revealed the resident was wet from urinary incontinence and had requested to be changed, but was told by staff that he/she would have to wait until staff picked up the morning breakfast trays. Interview with Resident #20, on 04/16/15 at 10:00 AM, revealed the resident was still wet and staff had not been into change his/her brief or linens that were wet with urine. Interview with Resident #20, on 04/16/15 at 3:20 PM, revealed staff came into change his/her brief and sheets at noon. The resident stated it felt like	F 282		

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F 282	Continued From page 264 forever to get cleaned up and changed. The resident said staff told him/her that it took them a while to find a sheet to fit his/her bariatric bed. Interview with CNA #35, on 04/16/15 at 12:30 PM, revealed the facility did not have any clean bariatric bed sheets available for her to change Resident #20's bed. She stated the resident was incontinent of urine and requested to be changed; however, it took her over an hour to find a sheet for the bed and then she had to find someone to assist with turning and repositioning. Although the care plan stated to assist with ADLs and keep the resident highly involved in their care. She stated it was hard to meet the resident's request timely when linens were short. 15. Review of Resident #36's clinical record revealed the facility admitted the resident on 09/19/15 with diagnoses of Dementia, Arthritis, Hypertension, Anemia, Cerebral Vascular Accident, Congestive Heart Failure and Atrial Fibrillation. Review of Resident #36's Quarterly Minimum Data Set (MDS) assessment, completed on 03/21/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of fourteen (14) which meant the resident was cognitively intact and interviewable. Continued review of the MDS revealed the resident required extensive physical assistance of two (2) staff for bed mobility, transfers, and toileting. The MDS assessment also indicated the resident needed the assistance of one (1) with dressing and	F 282		

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F 282	Continued From page 265 bathing. The resident required set up assistance for meals and staff to provide oversight, encouragement and cueing while eating. The MDS also stated the resident was frequently incontinent of bowel and bladder. Review of the Comprehensive Care Plan for Resident #36 revealed the facility developed a care plan on 11/18/14, with updated goals and a target date for 06/30/15. The problem stated the resident required the assistance from staff for all activities of daily living related to multiple medical problems. The goal stated the resident would be up daily, neat clean and dressed appropriately. The approaches stated the staff would encourage the resident to participate in daily care needs with verbal prompts and break up the resident's tasks into smaller steps. Observation of Resident #36, on 04/29/15 at 9:55 AM, revealed the resident was sitting in a wheelchair beside the bed with food debris on his/her face and clothing. Observation of Resident #36, on 04/29/15 at 12:53 PM, revealed the resident had entered the bathroom and was trying to self-toilet without assistance; surveyor obtained staff assistance. Interview with Resident #36, on 04/29/15 at 9:55 AM and 12:55 PM, revealed the resident wanted assistance with clothing and getting cleaned up. The resident was upset that staff had not been into assist with getting clothing from closet and helping him/her get cleaned up.	F 282		

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Interview with CNA #33, on 04/29/15 at 3:00 PM, revealed she had not provided care to Resident #36 prior to coming into the room upon the surveyors' request. She stated the CNA assigned to the resident had left and she was not familiar with this resident's care plan.

Interview with the Director of Clinical Services (DCS), on 05/04/15 at 2:18 PM, revealed Resident #36's care plans were developed to direct the staff in relation to the resident's individualized care needs; and if it was not followed the resident's needs were not met. She stated if the care plan interventions were not followed for wounds, falls, intakes, weights, incontinent care and activities of daily living it would be difficult to evaluate if the resident's condition was improving or if the care plan was effective. She further stated the purpose of the care plan was to provide individual care to the resident.

16. Review of Resident #39's clinical record revealed the facility admitted the resident on 03/24/15, with diagnoses of General Weakness, Edema, Urinary Tract Infection, Bladder Spasms, Coronary Artery Disease, Seizures, Hypertension, Diabetes, Gastro-esophageal Reflux Disease, and Atrial Fibrillation.

Review of Resident #39's Annual Minimum Data Set (MDS) assessment, completed on 03/31/15, revealed a Brief Interview for Mental Status

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F 282	Continued From page 267 (BIMS) exam was conducted and the facility assessed the resident with a score of fifteen (15) meaning the resident was cognitively intact and interviewable. Review of the Comprehensive Care Plan for Resident #39 revealed the facility developed a plan of care on 04/01/15, with updated goals and a target date for 06/30/15. The problem on the care plan stated the resident was occasionally incontinent of urine due to stress incontinence. The goal stated the resident would not experience any infections or skin conditions from incontinence. The approach stated staff would assist the resident to the bathroom or commode as needed. Observation on, 04/29/15 at 2:12 PM, revealed Resident #39's call light was illuminated and at 2:15 PM the Activity Assistant entered and immediately exited the room and the light was no longer illuminated. Interview with Resident #39, on 04/29/15 at 2:15 PM, revealed the Activity Assistant said she was going to find someone to help the resident. Resident #39 said routinely it took a long time for staff to answer his/her call light and because they had waited so long for assistance they had urinated on themselves. The resident said he/she had held their urine as long as they could and it was very embarrassing to talk about wetting on themselves with this surveyor. The resident stated he/she was heavy and it took two (2) people to assist with toileting and because staff was not fast enough he/she had wet on	F 282		

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F 282	Continued From page 268 himself/herself on many nights. The resident also said they were admitted in March and because of her impaired mobility and staffing issues he/she had only had their hair washed one time. Interview with CNA #7, on 04/29/15 at 2:25 PM, revealed she was in another resident's room providing incontinent care when the Activity Assistant told her that Resident #39 needed her assistance. She stated she was the only aide working on the Journey two (2) Unit and would be back to take care of Resident #39 when she finished with the other resident. Interview with Certified Nursing Assistant (CNA) #1, on 04/17/15 at 10:55 AM, revealed it was difficult to get all the residents up and ready for breakfast with only two aides on the unit. She stated she was also responsible for passing the breakfast trays and feeding the ten (10) residents that needed total assistance. She stated several residents needed the assistance of two (2) to get out of bed. She stated she changed the incontinent residents and dressed those that were gotten up, but due to time constraints and staffing she was not able to shave, provide oral, or comb the hair of all her residents. Interview with LPN #5, on 04/22/15 at 3:25 PM, revealed not all activities of daily living could be completed, as the care plan directed staff to do, when they were short staffed. She stated when she came into work most mornings the night shift aides were already gone. She stated the unit had about thirty-six (36) to thirty-seven (37) residents and most of the time they would only have 2 to 3 aides and she would be the only nurse working with a CMT that passed medications on one hall while she passed medications on the other hall.	F 282		

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She stated the night shift would only have two (2) aides and one nurse and one CMT most of the time. Further interview with LPN #5, on 04/30/15 at 2:40 PM, revealed she was unable to monitor the CNA's to determine if the residents care needs were provided, as directed by the plan of care, because she had numerous responsibilities and tasks to do.

Interview with the Director of Clinical Services (DCS), on 05/04/15 at 2:18 PM, revealed the resident's care plans were developed to direct the staff in relation to the resident's individualized care needs; and if it was not followed the resident's needs were not met.

Interview with the Interim ED/RVPO, on 05/21/15 at 8:23 AM, revealed the resident care plan should be individualized to the resident based on the resident's needs. She stated staff should follow care plan interventions in order to meet the resident's needs. She stated she had identified there were some issues with the facility meeting the needs of its residents.

The facility took the following actions to remove the Immediate Jeopardy on 05/16/15 as follows:

1. The facility notified Resident #4's physician, of a fall that occurred on 02/25/15 with new orders given to the nurse. The resident transferred to a local hospital on 02/25/15 for a tibia fracture and returned to the facility on 02/28/15 with new orders. The DCS assessed Resident #4 on 04/22/15 and was found in stable condition.

2. On 04/22/15, one hundred twenty-six (126) residents were assessed by the ADCS, Nurse

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F 282	Continued From page 270 Manager, and Licensed Nurse to determine if any residents had an incident or accident or change in condition that would warrant physician notification and further intervention. One (1) resident was identified as having an incident, accident, or change of condition and the physician was notified by the nurse on 04/22/15. Additionally, the Nurse notified the RP and documented this in the clinical record. Nurses would additionally report incidents, accidents, or changes in condition to the clinical administrative team. 3. On 04/22/15 the Corporate Administrative Nurses educated twenty-three (23) of thirty-eight (38) Nurses regarding timely notification to the physician related to resident incidents, accidents, or change in condition; care plan policies, evidence of assessments and care planning with immediate falls preventions interventions to meet the resident's needs; and falls procedures, immediate assessment by the Nurse after a resident's fall, notifications to the physician and RP, implementation of an immediate intervention by the Nurse, documentation of the fall in the clinical record by the Nurse, fall root cause investigation report initiated by the Nurse and reviewed by the DCS, and follow up by the IDT in the weekly falls meeting. Nurses were also trained related to reporting an incident, accident, or change in condition, to the resident ' s RP and documentation in the medical record to include the incident, accident, or change in condition, notifications to the physician, RP, and clinical administrative team, nurse's assessment, and interventions; evidence of assessment would include Situation, Background, Appearance, and Review (SBAR) sheet, Interdisciplinary Progress Note, and Neurological (neuro) checks sheet, and documentation of falls. Staff competencies were	F 282		

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F 282	Continued From page 271 completed. Nursing staff not educated by midnight on 04/22/15 would not be allowed to work until they received training. Agency Nurses would be trained by the Corporate Administrative Nurses, DCS, Assistant DCS, or Nurse Manager prior to working their next shift. The DCS and ED would ensure staff that had not been educated were educated prior to working their next shift. The ED and DCS would monitor the daily schedule and highlight staff already trained. A department manager would stand by the time clock at shift change to direct staff that needed education to the training. The IDT would monitor daily incidents and accidents. Notifications of accidents, incidents, or changes of condition would be reviewed for completion by the DCS, ADCS, or Nurse Manager, who would make notifications if not done. 4. An Ad-Hoc Quality Assurance/ Performance Improvement (QAPI) meeting was conducted on 04/22/15 to discuss facility policy and procedure (P&P) for falls, and notifications of incidents, accidents, or changes of condition; care plans as related to immediate falls interventions and revision status post fall, nursing assessment and documentation for falls; with no changes made. Also discussed the facility protocol related to shift relief and report; and additional avenues to attract new staff and maintaining current staff with a plan for performance improvement. 5. On 04/22/15, 126 residents were reviewed for fall risk with a fall risk assessment completed by the DCS and MDS Nurses who had previously been educated on 04/22/15, and care plans and Kardexes were also reviewed, with seventy-four (74) residents whose fall care plans were updated on 04/22/15.	F 282		

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6. On 04/22/15 the Corporate Administrative Nurses educated the DCS, ADCS, and Nurse Manager regarding evidence of assessment and care planning, with immediate falls prevention interventions to meet the resident's needs. On 04/22/15, thirty (30) of fifty-eight (58) CNAs and two (2) Agency CNAs were educated to review the Kardex for specific fall risk information.

7. Certified Medication Technician's (CMT) would be supervised by the Nurse they work with on the unit. The current resident census was reviewed by the ED and DCS to determine which residents required total care, assistance, or were independent with care.

8. On 04/22/15, 126 residents were assessed by Nurses using a visual and/or verbal nursing assessment that included vital signs to ensure there were no current physical or emotional distress or needs that were not met as related to inadequate staffing. One (1) resident was identified in physical distress and the Nurse timely notified the physician.

9. On 04/22/15, The Corporate Administrative Nurses educated twenty-three (23) of thirty-eight (38) Nurses, thirty (30) of fifty-eight (58) CNAs, and two (2) Agency CNAs related to staffing, to notify the ED, DCS, or ADCS for any staff call outs. The ED, DCS, ADCS, or Scheduler would attempt to replace the staff member who called out by calling on facility staff to stay over or come into work. If staffing needs could not be met the ED, DCS, ADCS could mandate staff currently working. Staff were educated on waiting for their relief to arrive prior to leaving the facility, and to give shift report to oncoming staff, that would

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F 282	Continued From page 273 include resident status, falls that occurred, and any new interventions. Staff competencies were completed. 10. On 04/28/15, the facility reported to the SSA that Resident #25 was found to have a black eye on 03/25/15. The incident was investigated and with the assistance of the SSD and DCS the source of the black eye was determined as a result of a resident to resident altercation and abuse was unsubstantiated. 11. Current residents were reviewed for behaviors, on 05/12/15 and 05/13/15, by Corporate Administrative RNS and two (2) members of the IDT. Care plans were reviewed for sixty-six (66) residents with behaviors, with twenty (20) care plans updated, with one (1) resident placed on 1:1 supervision. 12. 101 of 149 staff and 10 agency staff were educated regarding resident behaviors and documentation, care planning and following the care plan, reporting maintenance issues, safe smoking policy, on 05/13/15 and 05/14/15 by the Corporate Administrative RNs. IDT will meet to ensure behaviors were documented and care planned, notification to the physician, and document on the 24 hour report. Residents with behaviors would be reviewed during the weekly IDT meeting beginning 05/12/15. The 24 hour report would be reviewed in the morning meeting. Forty-eight (48) staff not educated will not be allowed to work until they have been trained. No staff will be allowed to work after 05/14/15 until they have been educated prior to the start of their shift. The ED or DCS would monitor the schedule and appoint a department manager to stand at the time clock to direct employees still needing	F 282		

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F 282	Continued From page 274 education to the in-service. 13. QAPI meeting was held on 05/13/15 to review the P&P for care plans and behavior management, resident weights, skin assessments, ADLs, smoking, assistive devices related to lifts and shower bed, facility maintenance, pest control, housekeeping/ laundry, and staffing, falls, incidents/accidents, grievances, with no changes made. The facility's action plan for removal of the IJ was reviewed and tasks assigned, with department managers assigned to provide daily oversight along with the RDCS/ RVPO/ RDHC/ RCMC/Corporate Administrative RNs. 14. Beginning 05/15/15, residents with new falls and behaviors were reviewed by the Daily IDT team for completion of SBAR, assessment, notification, immediate interventions, and investigation with root cause analysis. Care plans and Kardexes were reviewed/updated with appropriate interventions. No issues were identified, and would be validated five (5) times weekly. 15. Beginning 05/12/15 weekly falls management meeting and weekly behavior management meeting occurred with IDT, with no issues identified. The IDT in the daily meeting reviewed the 24 hour report with no issues identified, and validated one (1) time weekly. 16. A weekly behavior meeting was held on 05/12/15 and 05/13/15 and discussed six (6) residents with resident to resident behaviors or sexual/ physical behaviors to ensure behaviors were documented, care planned, and interventions in place.	F 282		

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F 282	Continued From page 275 17. On 05/13/15 and 05/14/15 twenty-two (22) nurses were educated by the Corporate Administrative RNS to complete skin sweeps weekly and PRN, and complete residents' weights per physician order. 18. The IDT would review in the daily meeting incidents and accidents reports and the 24 hour report for investigation reports, nursing documentation in the clinical record, an SBAR, notifications to the physician and RP, and care plans with appropriate interventions. 19. On 04/30/15, one hundred twenty-four (124) residents were reviewed for appropriate transfer/lift method and updated the care plans and Kardexes, including Residents #4 and #34. The shower bed was removed from the facility and discarded. A new shower bed was ordered on 05/07/15. A shower bed located in the shed was inspected and discarded by Maintenance on 05/13/15. 20. Five (5) residents would be observed, beginning 05/12/15, to ensure fall interventions were in place per the care plan would be completed by IDT five (5) times weekly. 21. On 05/13/15, Corporate Administrative RNs educated facility Administrative Staff on the regulations and P&P for staffing, pest control, housekeeping, and maintenance, with competencies completed. The ED would monitor the facility's process for notification, abuse, hiring, dignity, care plan revision, professional standards, assessments, behavior and falls management, incidents and accidents, smoking, call lights, pest control, and staffing.	F 282		

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22. Review of the 24 hour report, incident/ accident reports, in the daily meeting with the IDT; documentation in the clinical record included notification to the physician and new orders, and to the RP; the IDT made rounds in five (5) resident care areas to observe for maintenance and safety concerns; observations of five (5) residents during supervised smoking by the IDT; room rounds for five (5) residents to search for incendiary items by a member of the IDT, maintenance concerns were written in the maintenance books and taken to the daily meeting and prioritized for repair; observations of five (5) residents to ensure falls interventions were in place per the care plan by the IDT; call lights checked in resident rooms and bathrooms to ensure lights and sound; five (5) staff educated what to do if call light inoperable; resident care areas checked for no live pests; were validated five (5) times weekly.

23. Daily oversight since 04/22/15 on all shifts to ensure residents were safe and the plan of care was followed to meet resident needs, by the ED/ DCS/ RVPO/RDCS/Corporate Administrative Nurses.

24. The IDT would meet at least monthly to discuss facility action plan and ensure tasks were completed for the removal of the IJ, and QA monitoring completed according to the AOC during the IJ period, validated by the ED/RVPO/RDCS/Corporate Administrative RNs.

25. Per the Ad-Hoc QAPI meeting, on 05/15/15, QI monitoring would be done utilizing approved audit tool with oversight by the ED, beginning 05/16/15, five (5) resident interview; new resident/

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F 282	Continued From page 277 family concerns; daily department head meeting to ensure new resident injuries or concerns were discussed; five (5) new employee files reviewed two (2) times weekly; residents with new falls or behaviors were reviewed in the daily meeting with IDT and care plans/ Kardexes reviewed and updated; review of the 24 hour report and the incident and accident reports in the daily meeting with IDT; review of the clinical record for timely notifications to the physician and RP; the IDT rounds in five (5) resident care areas to observe the environment for safety and maintenance concerns; observations of five (5) residents during supervised smoking; room rounds of five (5) residents for incendiary items; maintenance concerns listed in the maintenance book and taken to the daily meeting to discuss and prioritize repairs; observations of five (5) residents to ensure falls interventions were in place per the care plan by the IDT; five (5) resident rooms call lights checked to ensure they light at the door, nurse's station, and sound; five (5) staff education what to do if a call light was inoperable; five (5) times weekly; weekly falls and behavior management meetings occur with IDT one (1) time weekly. 26. The RVPO/RDCS/Corporate Administrative RNs would provide daily oversight of the ED and DCS in areas of falls, incidents, accidents, change in condition, sufficient staffing to meet resident needs, housekeeping and laundry, and pest control during the IJ period until removal. 27. Grievances were reviewed, on 05/13/15, by the ED/SSD/DCS back to 05/1/15 for any areas requiring additional follow up, which was handled by 05/15/15.	F 282		

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F 282	Continued From page 278 28. On 05/12/15 rounds were completed by the DCS/ADCS/ Nurse Managers, and Corporate Administrative Nurses to identify residents who needed additional grooming or incontinent care; bed linens checked to ensure they were clean and pest free; call lights checked to ensure they were within resident reach and answered timely; resident's skin observed to ensure free from pests; and privacy curtains in place. Additional grooming was provided to residents requiring it, and one (1) resident room was identified to need a privacy curtain on 05/13/15. 29. On 05/13/15 and 05/14/15, nursing staff and ten (10) agency staff were educated on incontinent care, bathing, shaving, washing resident's hair, with those not trained would not allowed to work until trained prior to the start of their shift. 30. On 05/13/15 and 05/14/15, 101 of 149 staff and ten (10) agency staff were educated to notify housekeeping when privacy curtains were needed; report pest sightings in the pest sightings book; any pests noticed on residents should be reported immediately to the nurse supervisor/DCS/ADCS for completion of a skin assessment; resident privacy. Forty-eight (48) staff not educated will be trained prior to working their next scheduled shift. 31. A QAPI meeting was held, on 05/13/15, to discuss the facility's P&P for incontinent care, resident privacy, shaving, AM care, with no changes made. 32. Daily rounds were conducted by department managers and corporate administration Monday through Friday to identify any issues with resident	F 282		

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F 282	Continued From page 279 incontinent care, privacy, shaving and AM care, with any issues identified discussed in the daily IDT meeting and resolved with further Ad-Hoc education. 33. An Ad-Hoc QAPI meeting, on 05/15/15, discussed QI monitoring would be completed beginning 05/16/15 for: beginning 05/12/15 observations of five (5) residents to ensure they were shaven, hair combed, provided incontinent care, privacy curtains were clean, bed linens were clean, rooms/bed/residents were free from pests, privacy provided for care, call lights in reach and answered timely, would be conducted five (5) times weekly. The State Survey Agency validated the removal of Immediate Jeopardy on 05/22/15 as follows: 1. Review of the facility's SBAR's, incident report, neuro checks, progress notes and physician orders, all dated 02/25/15, revealed Resident #4 had a fall on 02/25/15, the physician was notified on 02/25/15 with new orders received. The resident was transferred to a local hospital on 02/25/15 for a tibia fracture on 02/25/15, and returned to the facility on 02/28/15 with new orders. The DCS assessed Resident #4 on 04/22/15 and found the resident was stable. 2. Review of one hundred twenty-six (126) resident assessments, completed by ADCS/Nurse Manager/Licensed Nurse, on 04/22/15, revealed residents were assessed for any incident or accident, or change in condition that warranted notification to the physician. One (1) resident was identified as experienced a change in condition, accident, or incident and the physician was notified on 04/22/15.	F 282		

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F 282	Continued From page 280 3. Review of in-service records, revealed twenty-three (23) nurses were educated by Corporate Administrative Registered Nurses regarding: timely notification to the physician related to incidents, accidents, and changes in condition; care plan policies; resident assessments, including SBAR, neuro checks; falls and immediate interventions; notification to the physician and RP; documentation of the fall in the clinical record; fall root cause investigation report. Staff competencies were completed. No staff had worked prior to them receiving the training. Review of staffing schedules revealed staff who had not yet been trained were not highlighted, which noted they required education. Review of facility records revealed notifications of incidents, accidents, and changes in condition were reviewed for completion by the DCS/ADCS/ Nurse Manager. Interview with the DCS and RDCS, on 05/04/15 at 4:18 PM, revealed twenty-three (23) nurses had been trained. Interview with RN #8, on 05/04/15 at 4:33 PM, with CNA #11, on 05/05/15 at 9:51 AM, with the UM, on 05/05/15 at 9:55 AM, CNA #14, on 05/05/15 at 10:03 AM, CNA #13, on 05/05/15 at 10:10 AM, revealed they had been educated on falls, notifications, Kardex and care plans. Interview, on 05/05/15 at 2:00 PM, with the DCS, ADCS, Nurse Manager, ED, Admissions Coordinator, DSS, MDS Director revealed they had all been trained on care plans, changes in condition, staff look at interventions for residents, the 24 hour report, falls, SBAR, incident reports, Kardex and care plans, notifications to the physician and family. 4. Review of a QAPI sign in sheet, dated 04/22/15, and agenda revealed the committee	F 282		

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F 282	Continued From page 281 discussed the P&P for falls management, notifications of incidents, care plans, falls interventions, nursing assessments, shift to shift relief and report, with no changes made. Interview with the DCS, ADCS, Nurse Manager, ED, Admission Coordinator, DSS, MDS Director, on 05/05/15 at 2:00 PM, revealed QA would track and trend falls information to validate interventions and notifications were being completed. 5. Review of resident assessments for risk for falls, dated 04/22/15, for one hundred twenty-six (126) residents revealed seventy-four (74) residents were assessed by the ADCS as at risk for falls. Review of the Kardexes and Care Plans for the seventy-four (74) residents assessed at risk for falls revealed the Kardexes and care plans had been updated, on 04/22/15. Observation of room 107-A, on 05/05/15 at 1:26 PM, revealed the resident had falls interventions in place. Observation, on 05/05/15 at 1:30 PM, of room 112-A, revealed the resident's falls interventions were in place. Observation, on 05/05/15 at 1:30 PM, of Unsampled Resident Y revealed the resident had falls interventions in place. Observation of Unsampled Resident O, on 05/05/15 at 2:52 PM, revealed the resident's falls interventions were in place. 6. Review of training records, dated 04/22/15, revealed thirty (30) CNAs and two (2) agency staff were educated on the Kardex and falls risk. The Corporate Administrative RNs educated the DCS/ADCS/Nurse Manager, on 04/22/15, regarding assessments, care plans, documentation of falls, and immediate falls interventions. Interview with CNA #6, on 05/05/15 at 10:12 AM, revealed he received training on the	F 282		

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F 282	Continued From page 282 Kardex, falls, and notify the nurse if a resident had a change in condition. 7. Review of staff schedules revealed CMTs were scheduled to work with another nurse present on the unit. Review of a resident census revealed, on 04/22/15, the ED and DCS reviewed which residents required total care, assistance, or were independent with care. Observation, on 05/05/15 at 10:15 AM, revealed CMT/ CNA #11 on the 200 unit was supervised by LPN #1. 8. Review of assessments for one hundred twenty-six (126) residents, dated 04/22/15, revealed residents were assessed by the DCS, with vital signs taken. One (1) resident was identified in distress and the physician was notified at that time. 9. Review of in-service records, dated 04/22/15, revealed twenty-three (23) nurses, thirty (30) CNAs, and two (2) agency staff were educated who to call when they call out and how the shift may be covered to ensure adequate staffing, shift report. Staff competencies were completed. Interview, on 05/04/15 at 4:00 PM, with the RDCS and Interim ED, revealed twenty-three (23) nurses were educated on staffing. Interview with LPN #1, on 05/05/15 at 9:45 AM, revealed he had been trained on what to do and who to call if calling in, and call in to the ED, DCS, or ADCS; stated he had to go through training before he was allowed to work. Interview, on 05/05/15 at 9:51 AM, with CNA #11 revealed she had been educated on staffing, to call the ED, DCS, or ADCS, and had to be trained prior to working. Interview with the UM, on 05/05/15 at 9:55 AM, revealed she was educated on staffing and the ED, DCS, or ADCS should be called if staff were	F 282		

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to call in. Interview with CNA #6, on 05/05/15 at 10:12 AM, revealed he could only call the ED, DCS, or ADCS if he could not come in to work and he was to wait for the next shift before leaving.

10. Review of the facility investigation, dated 04/28/15, for Resident #25's black eye noted on 03/25/15, revealed the SSA was notified on 04/28/15, investigated, and followed up on 05/04/15. The investigation resulted in the cause of the injury from a resident to resident altercation. Interview with the DCS, on 05/20/15 at 2:04 PM, revealed she investigated Resident #25's black eye and the cause was determined to be a resident to resident altercation. Observation, on 05/22/15 at 2:11 PM of Resident #25 revealed the resident was in his/her recliner with the TV on and staff sitting with him/her on a 1:1.

11. Review of current residents were assessed for behaviors by the Corporate Administrative Registered Nurses/Interdisciplinary Team, on 05/12/15 and 05/13/15, revealed sixty-four (64) residents with behaviors had their care plans reviewed, with nineteen (19) care plans updated. One (1) resident was placed on 1:1 supervision, on 05/13/15. Interview with the RDCS, on 05/22/15, revealed sixty-four (64) residents were reviewed, and nineteen (19) actually had care plan interventions updated.

12. Record review of in-services conducted 05/13/15 and 05/14/15 revealed one hundred one (101) staff were educated by Corporate Administrative Registered Nurses on bathing, AM care, shaving, hair care, change in condition, notifications to physician and RP, assessments, linens and laundry, falls, behaviors, abuse,

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F 282	Continued From page 284 resident smoking and use of aprons. Observation on the IDT in daily morning meeting, on 05/22/15 at 9:05 AM, revealed specific residents and behaviors, the 24 hour report, with department heads noted an new orders or changes to the care plans. 13. Review of a QAPI sign in sheet, dated 05/13/15, and agenda revealed the P&P for care plans and behavior management were discussed with no changes made. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Staff Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS attended the QA meetings. 14. Review of audit tools revealed residents with new falls and behaviors were reviewed by the Interdisciplinary Team in the daily meeting for completion of the documentation, notifications, care plans and Kardexes. Observation, on 05/22/15 at 9:05 AM, of the IDT morning meeting revealed specific resident concerns were reviewed, 24 hour report and behaviors were discussed, and care plans reviewed. Interview, on 05/22/15 at 2:52 PM, with the DCS revealed facility audits were reviewed in the daily meeting and any concerns discussed. 15. Review of the weekly falls meeting and behavior management meeting with the IDT, beginning 05/12/15, revealed meetings were conducted. Observation of the daily IDT meeting, on 05/22/15 at 9:05 AM, revealed the 24 hour report was discussed. Interview with the DCS, on 05/22/15 at 2:52 PM, revealed resident behaviors were reviewed in the behavior management meeting.	F 282		

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16. Review of weekly behavior meeting notes, dated 05/12/15 and 05/13/15, revealed six (6) residents with resident to resident behaviors or sexual/physical behaviors were reviewed for documentation, care plan interventions. Interview with the DCS, on 05/22/15 at 2:52 PM, revealed the behavior meeting reviewed and monitored residents with behaviors, notifications, interventions were in place, and possibility for more frequent monitoring.

17. Record review of in-services conducted on 05/13/15 and 05/14/15 revealed education provided for skin assessments, resident weights. Interview with CNA #7, on 05/22/15 at 8:05 AM, with RN #1, on 05/22/15 at 8:13 AM, with LPN #1, on 05/22/15 at 8:25 AM, with CNA #8, on 05/22/15 at 8:37 AM, revealed they had been trained on resident weights and skin assessments. Observation, on 05/22/15 at 3:30 PM, revealed Resident #34 skin assessment was performed by Registered Nurse #11 and no new skin issues were identified and the documentation was completed as required.

18. Observation of the morning meeting, on 05/22/15 at 9:05 AM, revealed the IDT reviewed the 24 hour report, care plans, and specific resident concerns.

19. Review of facility assessments, dated 04/30/15, revealed one hundred twenty-four (124) residents were assessed for transfer/lift with Kardexes and care plans updated. Observation, on 05/22/15 at 2:20 PM, revealed no concerns with a broken shower bed in the 100 Unit shower room and lifts were functional.

20. Review of the facility's audit tool revealed,

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F 282	Continued From page 286 beginning 05/12/15, residents were observed to ensure fall interventions were in place per the care plan. Interview with the DCS, ADCS, UM, Medical Records, BOM, and DSS, on 05/22/15 at 2:52 PM, revealed audits were conducted every morning and looked for falls interventions compared to the care plan and discussed in morning meeting. 21. Review of in-service records, dated 05/13/15, revealed Administrative staff were trained on staffing, pest control, housekeeping and maintenance, and would be monitored by the ED. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS revealed they had been trained on staffing, pest control, housekeeping and maintenance, and any concerns of audits would be taken to the morning meeting. Interview with Resident #3 on 05/22/15 at 1:00 PM, revealed staffing had improved and were answering lights timely and the facility looked cleaner. 22. Observation of the daily morning meeting, on 05/22/15 at 9:05 AM, revealed review of the 24 hour report, notifications made and documented, new physician orders, maintenance concerns and books, pests, rounds and audits, call lights, care plans. Interview with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, MDS Coordinator, and DSS, on 05/22/15 at 2:52 PM, revealed they participate in the morning meeting and review the 24 hour report, notifications were made, maintenance books reviewed, physician orders, call lights, care plans, and audits/ round were reviewed in the morning meeting.	F 282		

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F 282	Continued From page 287 23. Interview, on 05/22/15 at 2:52 PM, with the DCS revealed facility concerns were reviewed in the morning meeting, including audits and rounding results, for department heads to address. She stated she (the DCS) or the ED would initial when concerns were resolved. Observation, on 05/22/15 at 9:05 AM, of the morning meeting revealed the DCS provided direction and asked clarifying questions related to information discussed with follow up items determined. 24. Review of sign in sheets, dated 04/22/15, 05/13/15, and 05/15/15, revealed QAPI meetings were held on those dates. Interview, with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS revealed they attended the QAPI meetings. Interview with the RDCS, on 05/22/15 at 5:05 PM, revealed the next QAPI meeting was scheduled for 06/17/15. Interview with the Medical Director, on 05/22/15 at 8:00 AM, revealed he was informed by the Executive Director of the resident care issues, attended the QA meetings held by the facility and provided direction regarding corrective action plans that were developed to meet the needs of the residents. 25. Review of the QAPI sign in sheet, dated 05/15/15, and agenda revealed audit tools were approved for QA monitoring and discussed: resident interviews; resident/family concerns; morning meeting; new employee files; falls or behaviors reviewed; care plans and Kardexes update; review of the 24 hour report; notifications; maintenance rounds and book; supervised smoking; falls interventions in place; call lights;	F 282		

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F 282	Continued From page 288 weekly falls; and, behavior management meetings. 26. Review of the sign in sheet for QAPI, dated 05/13/15, revealed the ED and DCS presented and reviewed falls, changes in condition, staffing, housekeeping, and laundry, and pest control, and would provide daily oversight. 27. Review of grievance audit, dated 05/13/15, revealed grievances were reviewed since 05/01/15 and resolved by 05/15/15. Interviews on 05/22/15 with Resident #3 at 2:10 PM, Resident #8 at 2:00 PM, and Resident #10 at 12:30 PM, revealed the issues and concerns they had regarding linens, pests, environment repairs and answering call lights were resolved. 28. Review of the facility rounds, dated 05/12/15, revealed residents were observed to identify residents grooming, incontinent care, bed linens, pests, call lights in reach, and privacy curtains in place. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Staffing Coordinator, BOM, Central Supply, Housekeeping Supervisor, and DSS revealed daily rounds were completed to identify resident grooming needs and care, linens, pests, call lights in reach, and privacy curtains in place. Interviews with Resident #3, #8 and #10 on 05/22/15, revealed the issues and concerns they had regarding linens, pests, environment repairs and answering call lights had improved. 29. Review of in-service records, dated 05/13/15 and 05/14/15, revealed nursing staff and ten (10) agency staff were educated on incontinent care, bathing, shaving, and hair care. Interview, on 05/22/15 at 2:52 PM, with the DCS, ADCS, UM,	F 282		

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and Staffing Coordinator revealed staff were trained on grooming, incontinent care, shaving, and bathing. Interview with CNA #31, on 05/22/15 at 8:10 AM, revealed she received training on incontinent care, bathing, shaving, hair care, reporting pest, broken equipment, fall prevention, lifts, reporting change in condition, and answering call lights, abuse, resident laundry and linens.

30. Review of in-service records, dated 05/13/15 and 05/14/15, revealed one hundred one (101) staff and ten (10) agency staff were educated on privacy curtains; using the pest sightings book; resident privacy. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, Staffing Coordinator, Central Supply and Housekeeping Supervisor revealed they were trained on privacy curtains, resident privacy, and pests. Interview with Housekeeper #1, on 05/22/15 at 8:20 AM, revealed she received training on cleaning resident rooms, privacy curtains, reporting pests and broken equipment. Interview with Registered Nurse #11, on 05/22/15 at 8:10 AM, revealed she was educated on abuse, falls, physician orders, dignity, grievances, infection control, call lights, and reporting pests and maintenance issues.

31. Review of QAPI sign in sheet, dated 05/13/15, revealed incontinent care, resident privacy, shaving and AM care P&P were reviewed. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Staffing Coordinator, MDS Director, Housekeeping Supervisor, and DSS attended the QA meetings.

32. Review of rounding sheets revealed residents were observed by staff to identify any issues with grooming, incontinent care, privacy, shaving and

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F 282	Continued From page 290 AM care. Interview, on 05/22/15 at 2:52 PM with the DCS, ADCS, UM, Staffing Coordinator, Medical Records, BOM, MDS Director, Central Supply, Housekeeping Supervisor, and DSS revealed they conducted rounds to assess residents grooming, privacy, shaved, and care. 33. Review of a QAPI sign in sheet, dated 05/15/15, revealed residents would be observed to ensure they were shaved, hair combed, incontinent care, privacy curtains and bed linens in place and clean, residents and environment free from pests, resident privacy, and call lights. On 05/22/15 at 2:52 PM, interview with the Maintenance Director, DCS, ADCS, UM, Staffing Coordinator, MDS Director, Housekeeping Supervisor, and DSS attended the QA meetings. Interview with Resident #8, on 05/22/15 at 4:20 PM, Resident #6, on 05/05/15 at 2:26 PM, Resident #24, on 05/22/15 at 8:07 AM, revealed the issues they had with not getting shaved, hair washed and combed, incontinent care provided, bed linens without tears, an environment free from pests, and call lights answered timely had improved. Observation of Resident #43, on 05/22/15 at 8:00 AM, revealed two staff were using a lift to transfer the resident into a wheelchair and then proceeded to shave the resident.	F 282		
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the facility's policy and procedures it was determined the facility failed to have an effective system to ensure residents were assessed and monitored after sustaining an injury for two (2) of forty-three (43) sampled residents (Resident #4 and Resident #25). (Refer to F323)

On 02/25/15 at approximately 12:30 AM, Resident #4 sustained a fall. Interview and record review revealed the fall was documented at 6:00 AM on 02/25/15; however, there was no documented evidence the resident's physician was notified at the time of the fall and there was no evidence the resident received a complete nursing assessment, which included the lower extremities, after the fall until 4:30 PM on 02/25/15 when nursing documented the right lower leg was swollen, warm, bruised and tender. An x-ray was ordered and the resident was diagnosed with a right tibia fracture.

On 03/25/15 during the 7:00 AM-3:00 PM shift, Registered Nurse (RN) #6 noted the Resident #25's right eye was swollen and bruised on the side with a small cut. Interview and record review revealed the resident's eye injury was not assessed or monitored. There was no documented assessment of the injury until 04/24/15, thirty (30) days after the bruising was identified.

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The facility's failure to have an effective system in place to assess and monitor residents after an injury has caused or is likely to cause serious injury, harm, impairment or death to a resident. The Immediate Jeopardy was identified on 04/22/15 and determined to exist on 02/25/15.

An acceptable Allegation of Compliance (AOC) was received on 05/19/15 alleging the Immediate Jeopardy was removed on 05/16/15. The State Survey Agency validated the Immediate Jeopardy was removed on 05/16/15 as alleged, prior to exit on 05/22/15. The scope and severity was lowered to a D while the facility monitors the implementation of the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes.

The findings include:

Review of the facility's policy regarding Resident Incident/Accident Reports, dated 11/30/14, revealed any happening not consistent with routine operations of the facility or care of a resident may warrant the completion of an incident report. Following a nursing assessment, the physician would be notified of any noted or suspected injury, and would implement appropriate interventions.

Review of the facility's blank Situation, Background, Appearance, Review (SBAR) Communication Form, dated 2014, revealed the Situation of the incident, Background of the resident's care, Resident's Evaluation, the Appearance of the resident, and Review and Notification to the physician, and also to the responsible party (RP) was to be documented.

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F 309	Continued From page 293 1. Review of Resident #4's clinical record revealed the facility admitted the resident on 05/16/13 with diagnoses of Hypertension, Atrial Fibrillation, Chronic Obstructive Airway, Congestive Heart Failure, Macular Degeneration, Rheumatoid Arthritis, Osteoporosis and Open Wound Site. Review of Resident #4's Quarterly Minimum Data Set (MDS) assessment, completed on 03/09/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of ninety-nine (99), meaning the resident was rarely/never understood. Review of the Comprehensive Care Plan for Resident #4 revealed a plan was developed on 06/04/13 with updated goals and a target date for 06/09/15. The problem stated the resident was at risk for falls due to overall physical condition and psychotropic medications. The goal stated the resident would be free from any falls and would not experience injuries related to falls. The approaches directed the staff to anticipate resident needs, follow a daily routine, and remind the resident to ask for assistance for all transfers. Review of an Accident/Incident Report Form, dated 02/25/15, revealed Resident #4 sustained a fall from the bed and was found on the floor at 12:30 AM. Review of the Nursing Progress Note written, on 02/25/15 and timed at 6:00 AM, revealed Resident #4 was found on the floor by a Certified Nursing Assistant while performing rounds. The Nursing Progress Note written on 02/25/15 at	F 309		

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F 309	Continued From page 294 4:30 PM, revealed nursing documented the right lower leg was swollen, warm, bruised and tender. The Nursing Note written at 4:30 PM, continued to state the first shift reported Resident #4 experienced a fall on the night shift and x-ray results were pending. The X-ray results were positive for a right tibia fracture and the facility notified the nurse practitioner of the results and orders were received to transfer the resident to the hospital. Further review of the resident's clinical record revealed nursing no documented evidence Resident #4's lower extremities were assessed or monitored after the fall occurred. Interview with Certified Nursing Assistant (CNA) #15, on 04/22/15 at 12:05 AM, revealed she arrived for her 11:00 PM to 7:00 AM shift on 02/24/15, to find no other CNAs were present to work the unit with her that night and the only other staff working on the unit was Certified Medication Technician (CMT) #16. She stated she began checking on residents and heard Resident #4 hollering. She stated she went to the resident's room and found the resident on the floor, under the bed, with dried feces on the resident's bottom. The CNA stated the resident's right foot was black and the resident complained the foot hurt. She stated at the time, 100 Unit did not have a nurse present on the unit, so she informed CMT #16 of Resident #4's fall and together they cleaned the resident up and put the resident back to bed. She stated each time she checked on the resident during the shift the right foot did not look good to her and the resident complained the foot hurt. She stated Licensed Practical Nurse (LPN) #1 had been in the room and she believed he knew about the resident's condition.	F 309		

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NAME OF PROVIDER OR SUPPLIER
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STREET ADDRESS, CITY, STATE, ZIP CODE
2200 STONY BROOK DR
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Interview with the CMT #16, on 04/21/15 at 11:25 PM, revealed the scheduled nurse did not report to work that night. CMT #16 stated CNA #15 told her she found Resident #4 on the floor and this occurred around 12:00 AM or a little after. She stated they both put the resident back to bed and cleaned feces off the resident's bottom.

Interview with LPN #1, on 04/21/15 at 3:05 PM, revealed he was working on the 200 Unit when RN #1 notified him the 100 Unit did not have a nurse and Resident #4 had fallen. He stated RN #1 directed him to leave his assigned 200 Unit, which then would be without a licensed nurse, to go staff the 100 Unit. He stated CMT #16 and CNA #15 had already put Resident #4 back to bed when he got to the unit. He stated he conducted a head to toe assessment, sometime after 12:30 AM, which only consisted of him laying eyes on the resident. He stated he did not pull back the resident's covers to assess the resident's right lower leg. He stated he observed the resident moving all extremities, with the covers on, while in the bed, and to him this meant the resident had not experienced an injury to the right lower leg. LPN #1 stated he documented he performed a head to toe assessment at 6:00 AM on 02/25/15 and believed this covered him for the whole shift, even though he conducted this assessment sometime after 12:30 AM. LPN #1 stated that nursing staff was required to conduct neuro-checks on residents that experienced an un-witnessed fall and those were started. However, record review revealed LPN #1 only completed three (3) neuro-checks on Resident #4 and documented five (5) times the resident refused assessment. LPN #1 also stated he did not immediately notify the resident's physician

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after the fall, due to the fall occurring during the night time hours and he did not want to bother the physician with what he believed to be a non-injury fall.

Interview with Registered Nurse (RN) #1, on 04/21/15 at 11:20 PM, revealed he did not remember if he assessed Resident #4 the night of the fall. He stated if the 100 Unit did not have a nurse the night Resident #4 fell he probably did direct LPN #1 to leave his unit to go staff the 100 unit. He stated the nurse assigned to the unit where a resident experienced a fall had the responsibility of completing the resident assessment, root cause form, nursing progress note documentation, revising the care plan, and making the appropriate notifications. He stated since he was not the nurse on the unit he did not make any nursing documentation in the medical record or contact the physician and family regarding the fall. He also stated since the incident happened on 02/25/15 he could not remember that far back to provide any additional information regarding what supervisory responsibilities he conducted.

Interview with Director of Clinical Services (employed as of 04/20/15), on 04/24/15 at 1:05 PM, revealed nursing did not document nursing assessments regarding Resident #4's fall. She stated nursing should complete a full assessment of a resident after an incident or accident and document the findings. She stated if nursing assessments were not completed, injuries would not be detected and treatment would not be provided timely.

Interview with the previous Executive Director (ED) in charge at the time of Resident #4's fall, on

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F 309	Continued From page 297 04/23/15 at 8:34 AM, revealed she had not been told that CMT #16 and CNA #15 had moved Resident #4 before a nurse assessed the resident for injuries. She stated it was the responsibility of the nurse assigned to the resident that experienced the fall, to assess and monitor the resident. 2. Review of the clinical record for Resident #25, revealed the facility admitted the resident on 12/30/14 with a diagnosis of Vascular Dementia. The facility completed an initial MDS on 01/06/15 and assessed the resident as ninety-nine (99), with a cognitive level of a three (3) by staff interview. Resident #25's care plan, dated 01/06/15, revealed the resident had impaired cognitive status with interventions that included to inform the responsible party of any changes. The care plan for risk of falls, dated 01/08/15, included an intervention to monitor the resident for change in condition that may warrant an increase in supervision or assistance, and notify the physician. Continued review of Resident #25's clinical record revealed on 03/25/15 from 7:00 AM through 3:00 PM, a nurse's note by RN # 6 stating the resident's right eye was swollen and bruised on the side with a small cut. A skin assessment was completed by RN #6; however, she did not document the resident's eye injury. Record review revealed the right eye bruising and cut were not assessed until 04/24/15, thirty (30) days after the bruising was identified. Observation of Resident #25, on 04/22/15 at 10:50 AM, revealed the resident had a yellowed discoloration of the skin around the outside of the right eye, from the forehead to cheekbone.	F 309		

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F 309	Continued From page 298 Interview with Resident #25, on 04/22/15 at 10:59 PM, revealed he/she did not know what had happened to the eye. On 04/23/15 at 2:35 PM, interview with CNA #2 revealed she had worked third shift and noticed a small cut over Resident #25's eye, and about an hour later the eye began to bruise. The CNA further stated she reported to the charge nurse on third shift when the eye started to bruise; however, she could not remember who the nurse was at the time. She stated she did not receive any additional instructions for the care of Resident #25's black eye. Interview, on 04/27/15 at 11:42 PM, with RN #1 revealed he worked with Resident #25 on third shift. He stated he could not remember when the resident's eye injury had been brought to his attention; however, he stated he had been given the information in report. The RN stated the nurse on duty at the time of the incident should have assessed the resident, completed an SBAR, notified the physician and RP, and completed neuro checks for 24 hours. He stated he did not conduct neuro checks for Resident #25. Interview with RN #6, on 04/23/15 at 1:15 PM and on 04/24/15 at 1:24 PM, revealed she could not recall specifically what occurred to cause Resident #25's eye injury. She stated no one completed an SBAR or any other documentation, or neuro checks for the incident, all of which should have been completed by the shift which the incident occurred, and the incident should be documented on the twenty-four (24) hour report. The nurse stated she did not complete any of the required forms and did not complete neuro checks.	F 309		

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Interview with the UM, on 04/24/15 at 9:35 AM, revealed she was on vacation at the time of Resident #25's injury that resulted in a black eye. She stated the nurse's note by RN #6 for first shift on 03/25/15 stated the resident had bruising to his/her right eye. The UM stated the resident's injury would require neuro checks; however, there were none found in the resident's chart. She further stated if neuro checks were not completed, then the facility would not be aware if there were any problems from the injury, such as hematoma, or bleeding. She further stated she assessed Resident #25 and saw bruising; however, she did not document her assessment because it had been so long since the incident occurred. The UM stated the nurse should have also completed an SBAR, which would also include notification the physician and RP. Continued interview with the UM, on 04/24/15 at 11:29 AM, revealed the 24 hour report was only kept for two (2) weeks and the facility no longer had it for the time of Resident #25's eye injury.

On 04/27/15 at 1:05 PM, interview with Resident #25's physician revealed he could not recall if the resident had a black eye, or if he had been notified of the resident's eye injury. He stated he or the Nurse Practitioner were always on call, and either of them should be notified by the facility.

On 04/28/15 at 8:35 AM, interview with the DCS revealed Resident #25's injury would expect to find an SBAR, incident report, and neuro checks since the injury occurred on the head, and physician and family notifications. She stated if those items were not completed, the resident could have an injury the facility was not aware of, which could cause harm to the resident. The DCS

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stated the nurse who found the injury should have began neuro checks, which would be completed for 24 hours. She stated if neuro checks were not conducted, the facility would not recognize if the resident had a change in condition.

The facility could not provide evidence of the completion of a SBAR, notifications or neurological (neuro) checks for Resident #25 that would have occurred at the time of the black eye was identified on 03/25/15.

The facility took the following actions to remove the Immediate Jeopardy on 05/16/15 as follows:

1. The facility notified Resident #4's physician, of a fall that occurred on 02/25/15 with new orders given to the nurse. The resident transferred to a local hospital on 02/25/15 for a tibia fracture and returned to the facility on 02/28/15 with new orders. The DCS assessed Resident #4 on 04/22/15 and was found in stable condition.

2. On 04/28/15, the facility reported to the SSA that Resident #25 was found to have a black eye on 03/25/15. The incident was investigated and with the assistance of the SSD and DCS the source of the black eye was determined as a result of a resident to resident altercation and abuse was unsubstantiated.

3. On 04/22/15, one hundred twenty-six (126) residents were assessed by the ADCS, Nurse Manager, and Licensed Nurse to determine if any residents had an incident or accident or change in condition that would warrant physician notification and further intervention. One (1) resident was identified as having an incident, accident, or change of condition and the physician was

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F 309	Continued From page 301 notified by the nurse on 04/22/15. Additionally, the Nurse notified the RP and documented this in the clinical record. Nurses would additionally report incidents, accidents, or changes in condition to the clinical administrative team. 4. On 04/22/15 the Corporate Administrative Nurses educated twenty-three (23) of thirty-eight (38) Nurses regarding timely notification to the physician related to resident incidents, accidents, or change in condition; care plan policies, evidence of assessments and care planning with immediate falls preventions interventions to meet the resident's needs; and falls procedures, immediate assessment by the Nurse after a resident's fall, notifications to the physician and RP, implementation of an immediate intervention by the Nurse, documentation of the fall in the clinical record by the Nurse, fall root cause investigation report initiated by the Nurse and reviewed by the DCS, and follow up by the IDT in the weekly falls meeting. Nurses were also trained related to reporting an incident, accident, or change in condition, to the resident ' s RP and documentation in the medical record to include the incident, accident, or change in condition, notifications to the physician, RP, and clinical administrative team, nurse's assessment, and interventions; evidence of assessment would include Situation, Background, Appearance, and Review (SBAR) sheet, Interdisciplinary Progress Note, and Neurological (neuro) checks sheet, and documentation of falls. Staff competencies were completed. Nursing staff not educated by midnight on 04/22/15 would not be allowed to work until they received training. Agency Nurses would be trained by the Corporate Administrative Nurses, DCS, Assistant DCS, or Nurse Manager prior to working their next shift. The DCS and ED	F 309		

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F 309	Continued From page 302 would ensure staff that had not been educated were educated prior to working their next shift. The ED and DCS would monitor the daily schedule and highlight staff already trained. A department manager would stand by the time clock at shift change to direct staff that needed education to the training. The IDT would monitor daily incidents and accidents. Notifications of accidents, incidents, or changes of condition would be reviewed for completion by the DCS, ADCS, or Nurse Manager, who would make notifications if not done. 5. An Ad-Hoc Quality Assurance/ Performance Improvement (QAPI) meeting was conducted on 04/22/15 to discuss facility policy and procedure (P&P) for falls, and notifications of incidents, accidents, or changes of condition; care plans as related to immediate falls interventions and revision status post fall, nursing assessment and documentation for falls; with no changes made. Also discussed the facility protocol related to shift relief and report; and additional avenues to attract new staff and maintaining current staff with a plan for performance improvement. 6. The IDT would review in the daily meeting incidents and accidents reports and the 24 hour report for investigation reports, nursing documentation in the clinical record, an SBAR, notifications to the physician and RP, and care plans with appropriate interventions. 7. On 05/13/15, Corporate Administrative RNs educated facility Administrative Staff on the regulations and P&P for staffing, pest control, housekeeping, and maintenance, with competencies completed. The ED would monitor the facility's process for notification, abuse, hiring,	F 309		

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F 309	Continued From page 303 dignity, care plan revision, professional standards, assessments, behavior and falls management, incidents and accidents, smoking, call lights, pest control, and staffing. 8. Review of the 24 hour report, incident/ accident reports, in the daily meeting with the IDT; documentation in the clinical record included notification to the physician and new orders, and to the RP. 9. The IDT would meet at least monthly to discuss facility action plan and ensure tasks were completed for the removal of the IJ, and QA monitoring completed according to the AOC during the IJ period, validated by the ED/RVPO/RDCS/Corporate Administrative RNs. 10. Per the Ad-Hoc QAPI meeting, on 05/15/15, QI monitoring would be done utilizing approved audit tool with oversight by the ED, beginning 05/16/15, review of the clinical record for timely notifications to the physician and RP. The State Survey Agency validated the removal of Immediate Jeopardy on 05/22/15 as follows: 1. Review of the facility's SBAR's, incident report, neuro checks, progress notes and physician orders, all dated 02/25/15, revealed Resident #4 had a fall on 02/25/15, the physician was notified on 02/25/15 with new orders received. The resident was transferred to a local hospital on 02/25/15 for a tibia fracture on 02/25/15, and returned to the facility on 02/28/15 with new orders. The DCS assessed Resident #4 on 04/22/15 and found the resident was stable. 2. Review of the facility investigation, dated	F 309		

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F 309	Continued From page 304 04/28/15, for Resident #25's black eye noted on 03/25/15, revealed the SSA was notified on 04/28/15, investigated, and followed up on 05/04/15. The investigation resulted in the cause of the injury from a resident to resident altercation. Interview with the DCS, on 05/20/15 at 2:04 PM, revealed she investigated Resident #25's black eye and the cause was determined to be a resident to resident altercation. Observation, on 05/22/15 at 2:11 PM of Resident #25 revealed the resident was in his/her recliner with the TV on and staff sitting with him/her on a 1:1. 3. Review of one hundred twenty-six (126) resident assessments, completed by Assistant DCS/Nurse Manager/Licensed Nurse, on 04/22/15, revealed residents were assessed for any incident or accident, or change in condition that warranted notification to the physician. One (1) resident was identified as experienced a change in condition, accident, or incident and the physician was notified on 04/22/15. 4. Review of in-service records, revealed twenty-three (23) nurses were educated by Corporate Administrative Registered Nurses regarding: timely notification to the physician related to incidents, accidents, and changes in condition; care plan policies; resident assessments, including SBAR, neuro checks; falls and immediate interventions; notification to the physician and RP; documentation of the fall in the clinical record; fall root cause investigation report. Staff competencies were completed. No staff had worked prior to them receiving the training. Review of staffing schedules revealed staff who had not yet been trained were not highlighted, which noted they required education. Review of facility records revealed notifications of	F 309		

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incidents, accidents, and changes in condition were reviewed for completion by the DCS/ADCS/ Nurse Manager. Interview with the DCS and RDCS, on 05/04/15 at 4:18 PM, revealed twenty-three (23) nurses had been trained. Interview with RN #8, on 05/04/15 at 4:33 PM, with CNA #11, on 05/05/15 at 9:51 AM, with the UM, on 05/05/15 at 9:55 AM, CNA #14, on 05/05/15 at 10:03 AM, CNA #13, on 05/05/15 at 10:10 AM, revealed they had been educated on falls, notifications, Kardex and care plans. Interview, on 05/05/15 at 2:00 PM, with the DCS, ADCS, Nurse Manager, ED, Admissions Coordinator, DSS, MDS Director revealed they had all been trained on care plans, changes in condition, staff look at interventions for residents, the 24 hour report, falls, SBAR, incident reports, Kardex and care plans, notifications to the physician and family.

5. Review of a QAPI sign in sheet, dated 04/22/15, and agenda revealed the committee discussed the P&P for falls management, notifications of incidents, care plans, falls interventions, nursing assessments, shift to shift relief and report, with no changes made. Interview with the DCS, ADCS, Nurse Manager, ED, Admission Coordinator, DSS, MDS Director, on 05/05/15 at 2:00 PM, revealed QA would track and trend falls information to validate interventions and notifications were being completed.

6. Observation of the morning meeting, on 05/22/15 at 9:05 AM, revealed the IDT reviewed the 24 hour report, care plans, and specific resident concerns.

7. Review of in-service records, dated 05/13/15,

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F 309	Continued From page 306 revealed Administrative staff were trained on staffing, pest control, housekeeping and maintenance, and would be monitored by the ED. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, Assistant DCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS revealed they had been trained on staffing, pest control, housekeeping and maintenance, and any concerns of audits would be taken to the morning meeting. Interview with Resident #3 on 05/22/15 at 1:00 PM, revealed staffing had improved and were answering lights timely and the facility looked cleaner. 8. Observation of the daily morning meeting, on 05/22/15 at 9:05 AM, revealed review of the 24 hour report, notifications made and documented, new physician orders, maintenance concerns and books, pests, rounds and audits, call lights, care plans. Interview with the Maintenance Director, DCS, Assistant DCS, UM, Schedule Coordinator, MDS Coordinator, and DSS, on 05/22/15 at 2:52 PM, revealed they participate in the morning meeting and review the 24 hour report, notifications were made, maintenance books reviewed, physician orders, call lights, care plans, and audits/ round were reviewed in the morning meeting. 9. Review of sign in sheets, dated 04/22/15, 05/13/15, and 05/15/15, revealed QAPI meetings were held on those dates. Interview, with the Maintenance Director, DCS, Assistant DCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, Business Office Manager, Housekeeping Supervisor, and DSS revealed they attended the QAPI meetings. Interview with the RDCS, on 05/22/15 at 5:05 PM, revealed the	F 309		

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NAME OF PROVIDER OR SUPPLIER
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STREET ADDRESS, CITY, STATE, ZIP CODE
2200 STONY BROOK DR
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F 309	Continued From page 307 next QAPI meeting was scheduled for 06/17/15. Interview with the Medical Director, on 05/22/15 at 8:00 AM, revealed he was informed by the Executive Director of the resident care issues, attended the QA meetings held by the facility and provided direction regarding corrective action plans that were developed to meet the needs of the residents. 10. Review of the QAPI sign in sheet, dated 05/15/15, and agenda revealed audit tools were approved for QA monitoring and discussed: resident interviews; resident/family concerns; morning meeting; new employee files; falls or behaviors reviewed; care plans and Kardexes update; review of the 24 hour report; notifications; maintenance rounds and book; supervised smoking; falls interventions in place; call lights; weekly falls; and, behavior management meetings.	F 309		
F 312 SS=E	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, interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system in place to ensure residents assessed as needing assistance with activities of daily living were provided assistance. The facility failed to	F 312		

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F 312	Continued From page 308 provide oral care, nail care, removal of facial hair and to ensure hair was washed and combed. The facility failed to ensure residents clothing and bed linens remained clean, neat and free of food debris for thirteen (13) of forty-three (43) sampled residents(Residents #4, #5, #6, #7, #8, #9, #10, #12, #19, #20, #22, #34, and #36). The findings include: Review of the facility's policy regarding Incontinent Resident Care, dated 11/30/14, revealed incontinent residents would be cared for by nursing personnel to ensure adequate skin care, odor control, and provide personnel hygiene. Review of the facility's policy regarding Activities of Daily Living, dated 11/30/14, revealed all residents would remain at their highest level of self-help or independence. The role of the Clinical Services staff was to teach, support and supervise the resident in regaining and maintaining these functions. Review of the facility's policy regarding AM Care, dated 11/30/14, revealed Clinical Services personnel would offer AM care each day to ensure resident's overall comfort, cleanliness good grooming, and general well-being. Residents who were capable of performing their own personal care would be encouraged to do so. Showers, baths, and shampoos were scheduled at least weekly and more often if needed.	F 312		

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F 312	Continued From page 309 Tour of the 100 Unit, on 04/14/15 at 1:00 PM, revealed a strong odor of urine permeated throughout the unit. Tour of the 200 Unit, on 04/16/15 at 1:45 PM, revealed a strong odor of urine permeated throughout the unit and was stronger by rooms 211 and 212. Observation of the 200 Unit, on 04/16/15 at 3:16 PM, revealed the odor of urine remained strong and was stronger by room 206 and going down that hallway. 1. Review of Resident #20's clinical record revealed the facility admitted the resident on 02/10/15, with diagnoses of Anemia, Hypertension, Encephalopathy, Pneumonia, Dementia, Hypothyroidism, Chronic Venous Stasis of both lower extremities, and Lymphedema. Review of Resident #20's Annual MDS assessment, completed on 02/24/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of fifteen (15) meaning the resident was cognitively intact and interviewable. Review of the Comprehensive Care Plan for Resident #20 revealed the facility developed a care plan on 02/27/15, with updated goals and a target date for 05/27/15. The problem on the care	F 312		

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F 312	Continued From page 310 plan stated the resident required total/extensive assistance with activities of daily living secondary to medical problems. The goal stated the resident would continue to be highly involved with daily care and make his/her wishes known through the next review. The approach for staff to implement stated staff would provide assistance with activities of daily living as indicated. The facility also developed a care plan on 02/27/15 with a problem that stated Resident #20 was incontinent of bowel related to functional abilities. The goal stated the resident would not experience any skin conditions or infections from incontinence. The approaches listed stated staff would offer and provide the bedpan upon request and assess for environmental factors that may contribute to the resident's incontinence. Observation of Resident #20, on 04/16/15 at 9:11 AM, revealed the resident was sitting up in a bariatric bed. Interview with Resident #20, on 04/16/15 at 9:11 AM, revealed the resident was wet from urinary incontinence and had requested to be changed but was told by staff that he/she would have to wait until staff picked up the morning breakfast trays. Interview with Resident #20, on 04/16/15 at 10:00 AM, revealed the resident was still wet and staff had not been into change his/her brief or linens that were wet with urine. Interview with Resident #20, on 04/16/15 at 3:20	F 312		

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F 312	Continued From page 311 PM, revealed staff came into change his/her brief and sheets at noon. The resident stated it felt like forever to get cleaned up and changed. The resident said staff told him/her that it took them a while to find a sheet to fit his/her bariatric bed. Interview with Certified Nursing Assistant #1, 04/17/15 at 10:55, revealed she had helped CNA #34 change Resident #20 on 04/16/15 and said the unit was out of sheets and they had to wait until laundry came to the unit to change the resident. She stated the unit was always short of linen and it prevented them from completing incontinent care timely. The CNA stated if they have time they would go to another unit and get sheets, but they are usually out or low on linens too. Interview with the Housekeeping Director, on 04/15/15 at 1:45 PM, revealed the facility only had five (5) bariatric sheets for the five (5) bariatric beds in the facility. The Director stated he was unaware that the quantity was not sufficient to meet the needs of the residents. He stated he would put in an order, but it would not go out until the 25th of the month. He stated if it was an emergency situation he could expedite the order, but he would first have to obtain approval. Interview on 04/16/15 at 8:50 AM with the Director revealed he still had not placed the order for the bariatric sheets due to the approval process. 2. Review of Resident #34's clinical record revealed the facility admitted the resident on 03/19/09, with diagnoses of Hypertension,	F 312		

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F 312	Continued From page 312 Dementia and Cerebral Vascular Accident. Review of Resident #34's Quarterly MDS assessment, completed on 02/21/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of ninety-nine (99), meaning the resident was rarely/never understood. The facility developed a care plan related to Aspiration, on 06/20/13, with updated goals and a target date of 08/26/15. The problem stated the resident was at risk for aspiration related to dysphagia secondary to a stroke and a history of Aspiration Pneumonia. The goal stated the resident would remain free of signs and symptoms of aspiration through the next review. The approaches stated the staff was to observe the resident for choking or coughing before, during and after swallowing, observe for wet gurgling sound after swallowing. Observation of Resident #34, on 05/13/15 at 2:15 PM, revealed the resident was up in his/her and the lunch tray win in front of the resident. The tray was placed on an the overbed table. No staff were observed in the room, at this time. Continued observation revealed the resident had a paper napkin in the right hand. The resident took a bite of the napkin, three times. The resident chewed and then swallowed the napkin. The resident was also observed to picked up a butter knife and used it to eat pudding out of a dish that had fallen over on to the resident's stomach.	F 312		

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F 312	Continued From page 313	F 312		

Interview with Certified Nursing Assistant (CNA) #1, on 05/13/15 at 2:18 PM, stated the resident was able to feed his/her self if the tray was set up for them. The CNA stated she knew the resident needed assistance with eating as part of the plan of care, but allowed the resident to feed themselves.

Interview with Licensed Practical Nurse (LPN) #5, on 04/30/15 at 2:40 PM, revealed residents were to be assisted with feeding. She stated she was unable to monitor the CNAs to determine if the residents care needs were provided, as directed by the plan of care, because she had numerous responsibilities and tasks to do.

3. Review of Resident #36's clinical record revealed the facility admitted the resident on 09/19/15 with diagnoses of Dementia, Arthritis, Hypertension, Anemia, Cerebral Vascular Accident, Congestive Heart Failure and Atrial Fibrillation.

Review of Resident #36's Quarterly MDS assessment, completed on 03/21/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of fourteen (14) which meant the resident was cognitively intact and interviewable.

Review of the Comprehensive Care Plan for Resident #36 revealed the facility developed a care plan on 11/18/14, with updated goals and a target date for 06/30/15. The problem stated the

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F 312	Continued From page 314 resident required the assistance from staff for all activities of daily living related to multiple medical problems. The goal stated the resident would be up daily, neat clean and dressed appropriately. The approaches stated the staff would encourage the resident to participate in daily care needs with verbal prompts and break up the resident's tasks into smaller steps. Observation of Resident #36, on 04/29/15 at 9:55 AM, revealed the resident was sitting in a wheelchair beside the bed with food debris on his/her face and clothing. Observation of the resident's bed sheet revealed a yellow/brown circular stain. The resident's room had a strong odor of urine. Observation of Resident #36, on 04/29/15 at 10:35 AM, revealed the resident's bed was made; however, there was a light brown circular stain on the pillow case. The resident's room had a strong odor of urine. Observation of Resident #36, on 04/29/15 at 12:53 PM, revealed The resident's room still had a strong odor of urine. Further observation revealed small insects were flying around the resident's lunch tray and urinal. Food debris was observed on the floor. 4. Review of Resident #4's clinical record revealed the facility admitted the resident on 05/16/13 with diagnoses of Hypertension, Atrial Fibrillation, Chronic Obstructive Airway, Congestive Heart Failure, Macular Degeneration,	F 312		

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F 312	Continued From page 315 Rheumatoid Arthritis, Osteoporosis and Open Wound Site. Review of Resident #4's Quarterly Minimum Data Set (MDS) assessment, completed on 03/09/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of ninety-nine (99), meaning the resident was rarely/never understood. Review of the Comprehensive Care Plan for Resident #4 revealed the facility developed a care plan on 06/04/13, with updated goals and a target date for 06/09/15. The problem on the care plan stated Resident #4 required assistance with all activities of daily living due to generalized weakness and multiple medical problems. The goal stated the resident would be up daily in his/her wheelchair, dressed appropriately, clean and odor free. The approaches included direction for staff to provide incontinent care, assist with oral care daily and to encourage resident to participate in own care and praise all attempts. Observation of Resident #4, on 04/15/15 at 1:30 PM, revealed the resident was laying in the bed and observed to have numerous long hairs on the resident's chin. Resident #4's room had a strong odor of urine, along with food debris on the residents bed, floor and the bedside table. An observation of Resident #4, on 04/16/15 at 8:45 AM, revealed the resident's continued to have numerous long hairs on his/hers chin. Also,	F 312		

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F 312	Continued From page 316 Resident #4's room had a strong odor of urine. Interview with Licensed Practical Nurse (LPN) #5, on 04/22/15 at 3:25 PM, revealed staffing was an issue and not all activities of daily living could be completed when only two (2) or three (3) aides were providing care on the unit. She stated there was a shortage of linens, which made it difficult to complete morning care and daily baths. On 05/05/15 at 3:55 PM, interview with the Interim Executive Director/Vice President of Operations, revealed the nursing staff was responsible for meeting the needs of the residents. She stated she was not aware Resident #4's needs were not met. 5. Review of Resident #5's clinical record revealed the facility admitted the resident on 03/13/15 with diagnoses of Altered Mental Status, Parkinson's, Hypertension, Gastro Esophageal Reflux Disease, and Chest Pain. Review of Resident #5's Significant Change MDS assessment, completed on 04/25/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of ninety-nine (99), indicating the resident was rarely/never understood. Observation of Resident #5, on 04/15/15 at 1:05 PM, revealed the resident was in a recliner wearing a white T-shirt and gray pants with no shoes or socks on his/her feet.	F 312		

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F 312	Continued From page 317	F 312		

Observation of Resident #5, on 04/16/15 at 3:30 PM, revealed the resident's mattress was laying directly on the floor and the resident was laying on top of the mattress. Next to the mattress was a blue vinyl mat with two (2) torn areas. The resident had food debris on his/her clothes and on the mattress.

Observation of Resident #5, on 04/15/15 at 1:05 PM, revealed the resident was in the common area in a recliner with their pants down to the ankles exposing the brief. Continued observation revealed other residents were also sitting in common area and near Resident #5.

Interview with Certified Nursing Assistant (CNA) #3, on 04/15/15 at 2:50 PM, revealed Resident #5 frequently disrobed and staff had to assist the resident to remain clothed. The CNA stated he was very busy today and was not aware the resident did not have socks or shoes in place.

Interview with Licensed Practical Nurse (LPN) #1, on 04/15/15 at 3:10 PM, revealed Resident #5 disrobes. The LPN said the resident needed frequent reminding to leave clothes on. However, if they were busy, they would not be aware the resident was disrobing.

Interview with the Unit Manager, on 04/21/15 at 3:25 PM, revealed if the resident's care plan was not followed in relation to activities of daily living then the resident's needs would not be met. She

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F 312	Continued From page 318 stated due to the staffing shortage not all residents had their needs met timely. 6. Review of Resident #6's clinical record revealed the facility admitted the resident on 11/14/13 with diagnoses of Toxic Encephalopathy, Sepsis, Bradycardia, Hypertension, Renal Insufficiency, Gastro-esophageal Reflux Disease, Neurogenic Bladder, and Seizures. Review of Resident #6's Quarterly MDS assessment, completed on 01/08/15, revealed a BIMS exam was conducted and the resident scored a fourteen (14), meaning the resident was cognitively intact and inevitable. Review of the Comprehensive Care Plan for Resident #6 revealed the facility developed a care plan on 11/03/13, with updated goals and a target date for 07/09/15. The problem on the care plan stated Resident #6 was incontinent of bowel and bladder related to Urinary Tract Infection, and Obesity. The goal stated the resident would show no evidence of skin breakdown related to incontinence through next review. The approaches included direction for staff to assist with toileting needs as needed and on a consistent schedule to promote continence, and check frequently for incontinence. Observation of Resident #6, on 04/16/15 at 10:45 AM, revealed the resident was laying on a bariatric bed. Observation revealed the sheet underneath the resident was thin, frayed and contained holes. The resident's hair was uncombed and greasy.	F 312		

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Interview with Resident #6, on 04/16/15 at 10:45 AM, revealed he/she was left wet for seventeen hours (17) due to the facility not having enough staff to meet his/her needs. The resident stated he/she did not want to be a "pain in the ass because it would just get worse and he/she did not want to throw anyone under the bus". The resident stated he/she weighed 332 pounds and due to this it took at least two (2) staff members to get him/her cleaned up after an incontinent episode. Resident #6 stated due to his/her weight the staff had to use a lift to get him/her out of bed and using the lift required the assistance of two (2) staff also. The resident stated she had to routinely take a bed bath because the shower bed was unsafe to use. Resident #6 stated due to this, he/she did not get his/her hair washed as often as desired.

Observation of Resident #6, on 04/17/15 at 11:10 AM, revealed the resident's hair appeared uncombed and greasy.

Interview with Resident #6, on 04/17/15 at 11:10 AM, revealed staff did not help the resident wash up prior to breakfast. The resident stated that type of assistance only happened on shower day.

Interview with Certified Nursing Assistant (CNA) #6, on 04/16/15 at 11:00 AM, revealed he was not able to complete all his assigned duties for twenty three residents that needed assistance with activities of daily living. He stated he had several residents that required total care and stated at times the facility did not have enough linens, wash clothes or towels. He stated there were times when he had to cut up sheets to dry residents after giving them a bath. He stated the facility was short staffed and due to this, those

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HURSTBOURNE CARE CENTRE AT STONY BROOK	2200 STONY BROOK DR LOUISVILLE, KY 40220

(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 320 residents that required the assistance of two (2) to get up, turn and reposition, did not always have their needs met or if they were it was not timely. He stated if he was the only one working and he was giving a bath or assisting a resident he could not tend to his other assigned residents' needs. He stated some nurses answer the call lights and some do not, which meant residents needs were not met timely. He stated he had complained about the staffing shortage and not being able to meet the needs of his residents, but nothing has been done. 7. Review of Resident #7's clinical record revealed the facility admitted the resident on 03/17/15, with diagnoses of Vascular Dementia, Cerebral Vascular Accident, Osteoarthritis of the Hip and Knee, Cocaine Abuse, and Hypertension. Review of Resident #7's Admission MDS assessment, completed on 03/25/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of ninety-nine (99) meaning the resident was rarely/never understood. Review of the Comprehensive Care Plan for Resident #7 revealed the facility developed a care plan on 03/26/15, with updated goals and a target date for 06/26/15. The problem on the care plan stated Resident #7 required assistance from staff with grooming and personal hygiene. The goal stated the resident would not experience any skin conditions from incontinence. The approaches listed, directed staff to monitor the resident for signs of emotional distress with incontinence and to provide ongoing assessment of the resident's	F 312		

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F 312	Continued From page 321 voiding patterns. In addition, Resident #7 had a plan of for the potential for falls related to impaired mobility, unsafe decision making, poor safety awareness, and psychotropic drug use. The goal stated the resident would remain free from injuries related to fall through the next review. The approach for staff to follow stated staff was to anticipate and meet all needs. Observation of Resident #7's room, on 04/16/15 at 1:50 PM, revealed the resident was observed to be sitting in a straight backed chair bedside the bed. Observation of Resident #7, on 04/16/15 at 3:37 PM, revealed the resident was seated on the floor in his/her bathroom, with pants down and stool on the resident's bottom and floor. No staff was present in the room at the time of this observation. Interview with Certified Nursing Assistant #36, on 04/16/15 at 3:43 PM, revealed there was not enough staff to tend to the residents' incontinent care needs on the locked unit. She stated the resident could get combative with care and would need more staff to tend to the resident at those times. She stated there were only three (3) aides on the unit for the second shift for the forty-five (45) to forty-eight (48) residents and several were total care requiring the assistance of two. 8. Review of Resident #8's clinical record revealed the facility admitted the resident on 04/18/14, with diagnoses of Hypoxia, Respiratory	F 312		

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F 312	Continued From page 322 Failure, Stage Three Renal Disease, Cerebral Vascular Accident, Congestive Heart Failure, Hypertension, Decubitus, and Toxic Metabolic Encephalopathy.	F 312		
	Review of Resident #8's Quarterly MDS assessment, completed on 03/25/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of fifteen (15) meaning the resident was cognitively intact and interviewable.			
	Review of the Comprehensive Care Plan for Resident #8 revealed the facility developed a care plan on 08/11/14, with updated goals and a target date for 05/24/15. The problem on the care plan stated Resident #8 had impaired ability to perform own activities of daily living and self-mobility related to weakness, immobilization and chronic obstructive pulmonary disease. The goal stated the resident would improve self-care skills in at one area of activities of daily living and mobility by next review on 05/24/15. The approaches listed stated staff was to provide assistance with activities of daily living, while promoting independence, promote dignity by assuring privacy and organize supplies by how or when they should be used and place within reach.			
	Observation of Resident #8, on 04/16/15 at 8:48 AM, revealed the resident's finger nails were long and had an unknown black substance underneath them. The resident's mouth was full of unknown debris.			
	Observation of Resident #8's skin assessment and incontinent care, on 04/20/15 at 10:35 AM,			

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F 312	Continued From page 323 revealed the skin on both feet was dry and scaly and the resident's toe nails were long and curling upward. Interview with Resident #8, on 04/20/15 at 8:48, revealed he/she had not been seen by the Podiatrist since admission 04/18/14 and the black substance under the finger nails was from him/her scratching his/her scalp. Review of Resident #8's medical record, on 04/20/15, revealed no evidence the resident was seen by Podiatry. Interview with Licensed Practical Nurse (LPN) #2, on 04/20/15 at 8:48 AM, revealed she had not seen or been told that podiatry had been in the building to address the resident's needs related to the long curling toe nails. Interview with Certified Nursing Assistant (CNA) #9, 04/22/15 at 9:15 AM, revealed she had seen ants in the bed with Resident #8 this morning during incontinent care. She stated she got the resident up out of the bed and removed the sheets. She said she would be writing her findings in the maintenance book for management to address. Interview with Licensed Practical Nurse (LPN) #5, on 04/22/15 at 3:25 PM, revealed that staffing was an issue and not all activities of daily living could be completed when only two (2) or three (3) aides were on the unit. She stated the unit had about thirty-six (36) to thirty-seven (37) residents and most needed the assistance of two (2) staff for activities of daily living. She said most of the time they would only have two (2) to (3) aides and she would be the only nurse working with a CMT,	F 312		

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who both passed medications. She indicated she could not always complete all the required tasks and this included supervising the certified nursing assistants.

9. Review of Resident #9's clinical record revealed the facility admitted the resident on 08/14/14, with diagnoses of Anemia, Coronary Artery Disease, Hypertension, Peripheral Vascular Disease, Traumatic Brain Injury, Anxiety, Depression, and Chronic Obstructive Pulmonary Disease and Dementia.

Review of Resident #9's Sixty-day (60) scheduled MDS assessment, completed on 03/03/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of fifteen (15) indicating the resident was cognitively intact and inevitable.

Review of the Comprehensive Care Plan for Resident #9 revealed the facility developed a care plan on 04/17/14, with updated goals and a target date for 06/03/15. The problem on the care plan stated Resident #9 had urinary incontinence related to impaired physical mobility, right above the knee amputation, neurogenic bladder and evidence of being incontinent of urine. The goal stated the resident would have no unrecognized urinary tract infections or skin breakdown related to incontinence. The approaches listed for staff to implement were to place call light within reach at all times and to provide incontinence device of resident's choice for dignity.

Observation of Resident #9, on 04/16/15 at 8:41

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F 312	Continued From page 325 AM, revealed the resident was laying in the bed with an unshaven face and the room had a strong odor of urine. The resident's bed, floor, privacy curtain and wall beside the bed contained food debris. Interview with Resident #9, on 04/16/15 at 8:41 AM, revealed the resident had put on the call light thirty (30) minutes ago and wanted help with getting some cranberry juice and a brief changed. The resident stated it had been two weeks since he/she had taken a shower in the shower room. Observation of Resident #9, on 04/17/15 at 10:40 AM, revealed the resident was in the bed with no covering over their body, wearing a brief and a T-shirt. The resident's left leg was amputated above the knee, the resident's face was unshaven and the room had a strong odor of urine. Interview with Certified Nursing Assistant (CNA) #1, on 04/17/15 at 10:55 AM, revealed she was assigned to take care of Resident #4, #8 and #9 and when her shift started today there were just two (2) aides and the third aide did not come into 10:00 AM. She stated it was difficult to get residents up and ready for breakfast with only two aides on the unit. She stated she was also responsible for passing the breakfast trays and feeding the ten (10) residents that needed total assistance. She stated several residents needed the assistance of two (2) to get out of bed. She stated she changed the incontinent residents and dressed those that were gotten up, but due to time constraints and staffing she was not able to	F 312		

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F 312	Continued From page 326 shave, provide oral, or comb the hair of all her residents. 10. Review of Resident #10's clinical record revealed the facility admitted the resident on 05/01/14, with diagnoses of Hypertension, Chronic Atrial Fibrillation, Quadriplegic, Neuropathy, Muscle Spasms, Gastro-esophageal Disease, Proteus Urinary Tract Infection, and Chronic Ileus resolved. Review of Resident #10's Annual MDS assessment, completed on 02/03/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of fifteen (15) meaning the resident was cognitively intact and interviewable. Review of the Comprehensive Care Plan for Resident #10 revealed the facility developed a care plan on 03/31/14, with updated goals and a target date for 05/03/15. The problem on the care plan stated Resident #10 was incontinent of bowel and bladder related to quadriplegia. The goal stated the resident would show no evidence of skin breakdown related to incontinence through next review. The approaches listed for staff to implement stated staff would assist with toileting needs as needed and on a consistent schedule to promote continence and to check frequently for incontinence. Interview with Resident #10, on 04/15/15 at 9:25 AM, revealed the resident had many concerns with nursing care, food service and linens	F 312		

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F 312	Continued From page 327 provided by the facility. Resident #10 stated he/she was unable to move and was totally dependent upon staff for care. The resident stated he/she was left wet all night long due to the facility not having enough staff. Resident #10 stated his/her food was cold most of the time due to not enough staff to deliver it timely and to assist with feeding him/her. The resident stated there were not enough sheets to change their bariatric bed and the few sheets available had holes in them and they were thin. The resident stated there were not enough pillow cases to cover the pillows so the staff would put them under the sheets when they positioned him. The resident stated he/she had spoken with the staff regarding the issues; however they had yet to be resolved. Observation of Resident #10, on 04/15/15 at 9:25 AM, revealed the resident was laying on a bariatric bed with sheets that were thin, torn and tattered with pillows under both arms that had the stuffing protruding out. Interview with Certified Nursing Assistant (CNA) #7, on 04/15/15 at 9:10 AM, revealed she was normally assigned to Resident #10. She stated the facility had a shortage of linens and a staffing shortages as well. CNA #7 stated she was now responsible for sixteen residents and Resident #10 was totally dependent on staff due to being a quadriplegic. She stated there were several other residents that also required the assistance of two staff to check and change, toilet and transfer and she could not do that by herself. She stated the nurses were not always available to assist her when needed. She stated Resident #10 had	F 312		

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made complaints about not getting needs met and the linen issues. CNA #7 stated she had also made complaints about the issues, but nothing had been done to correct them.

11. Review of Resident #12's clinical record revealed the facility admitted the resident on 05/17/14, with diagnoses of Gastro-esophageal Disease, Coronary Artery Disease, Hypertension, Dementia, Status Post Hip Fracture Repair, Mild Anemia, History of Gastro-intestinal Bleeding, and Peripheral Vascular Disease.

Review of Resident #12's Quarterly MDS assessment, completed on 02/21/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of ninety-nine (99) meaning the resident was rarely/never understood.

Review of the Comprehensive Care Plan for Resident #12 revealed the facility developed a care plan on 05/28/14, with updated goals and a target date for 05/22/15. The problem on the care plan stated the resident required assistance from staff for activities of daily living. The goal stated the resident would be up and dressed neat/clean with the assist of staff daily. The approaches stated the staff would provide assistance with activities of daily living, oral care, and anticipate and meet all the resident's needs daily.

Observation of Resident #12, on 04/17/15 at 11:30 AM, revealed the resident's hair was in disarray/uncombed and also had long hairs on

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his/her chin.

Observation of Resident #12, on 4/20/15 at 11:30 AM, revealed the resident had long hairs on His/Her's chin and their hair was uncombed.

12. Review of Resident #19's clinical record revealed the facility admitted the resident on 01/31/07, with diagnoses of Mental Retardation, Osteoarthritis, Idiopathic Scoliosis, Kyphosis, Hypertension, Esophageal Reflux Disease, and Cerebral Palsy.

Review of Resident #19's Quarterly MDS assessment, completed on 03/12/15, revealed a BIMS exam was not conducted because the resident was rarely/never understood.

Review of the Comprehensive Care Plan for Resident #19 revealed the facility developed a care plan on 07/03/13, with updated goals and a target date for 06/24/15. The problem on the care plan stated the resident had a self-care deficit related to Mental Retardation and Cerebral Palsy and the inability to complete self-care tasks independently. The goal stated the resident would be clean, neat and dressed in appropriate clothing daily through staff assistance. The approaches stated staff would promote dignity, provide incontinent care, anticipate resident's wants and needs and provide necessary care.

Observation of Resident #19, on 04/17/15 at 11:30 AM, revealed the resident had long hairs on

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F 312	Continued From page 330 their chin, a yellowish/white drainage coming out of the right eye, teeth were full of unknown debris, and hair was greasy an uncombed. Observation of Resident #19, on 4/20/15 at 11:30 AM, revealed the resident had long hairs on His/Her's chin and their hair appeared to have not been combed. 13. Review of Resident #22's clinical record revealed the facility admitted the resident on 06/27/12, with diagnoses of Anemia, Coronary Artery Disease, Hypertension, Gastro-esophageal Reflux Disease, Diabetes Mellitus, Hyperlipidemia, Osteoporosis, Non-Alzheimer's Dementia, Manic Depression, and Cataracts. Review of Resident #22's Admission MDS assessment, completed on 03/20/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of ninety-nine (99) meaning the resident was rarely/never understood. Review of the Comprehensive Care Plan for Resident #22 revealed the facility developed a care plan on 06/27/13, with updated goals and a target date for 06/23/15. The problem on the care plan stated the resident required limited to extensive assistance with activities of daily living at and other times only requires supervision. The goal stated the resident would continue to participate in activities of daily living within safety limits and would be clean, neat and dressed daily. The approaches listed stated staff should to	F 312		

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F 312	Continued From page 331 provide cues and redirection, assist resident with activities of daily living as needed and encourage the resident to be highly involved. Observation of Resident #22, on 04/15/15 at 2:55 PM, revealed the resident's hair was uncombed and long hairs were on the chin and face. Observation of Resident #22, on 04/16/15 at 8:56 AM, revealed the resident's hair was uncombed and long hairs were on the chin and face of the resident. Interview with CNAs #2 and #3, on 04/17/15 at 2:50 PM, regarding Residents #12, #19 and #22 revealed they started their 7:00 AM to 3:00 PM shift with only two (2) aides. They stated the best they could do was to get the resident's checked and changed and up for breakfast. Both stated they did not have time to do oral care and/or mouth and hair care for forty eight (48) residents. The CNAs stated they were also responsible for passing trays and assisting residents with feeding. CNA #2 stated she did not have time to shave Unsampled Resident J during her shift because of the staffing shortage. Both CNAs stated the unit normally was staffed with four (4) certified nursing assistant and another staff member who conducted the fifteen (15) minute safety checks for the unit. However, the CNAs indicated the unit had not been staffed with that number of employees for some time. Interview with the Director of Clinical Services (DCS), employed as of 04/20/15, on 05/04/15 at	F 312		

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F 312	Continued From page 332 2:20 PM and 05/20/15 at 2:15 PM, revealed she expected staff to check on residents frequently to meet their needs. She stated she expected nursing to make rounds to ensure residents' activities of daily living were completed. She stated she expected staff to report issues with the environment or if they were not able to complete their tasks. The DCS expected the Nurse Managers to supervise the staff and the ADCS to supervise the Nurse Managers to ensure resident care needs were met. The DCS stated obviously someone was not doing their job. She stated she had determined the facility was short sixteen (16) certified nurse aide and five (5) to six (6) licensed nursing positions and this hindered their ability to meet the residents needs. Interview with the Medical Director, on 04/24/15 at 10:55 AM, revealed he had concerns regarding the care and services the facility was providing.	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review	F 314		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HURSTBOURNE CARE CENTRE AT STONY BROOK	2200 STONY BROOK DR LOUISVILLE, KY 40220

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F 314	Continued From page 333 and review of the facility's policy, it was determined the facility failed to have an effective system in place to ensure residents who were at risk for pressure sores were assessed and care planned to prevent the developement of pressure sores for two (2) of forty-three (43) sampled residents (Residents #4 and #31). Resident #4 was assessed at risk for skin breakdown due to a leg brace and developed a pressure wound from the brace. In addition, the facility failed to assess resident #31's pressure areas routinely to identify progressive skin breakdown and prevent unstageable wounds from developing. The findings include: Review of the facility's policy regarding Skin Evaluations, dated 11/30/14, revealed a Licensed Nurse would complete a total body evaluation on each resident weekly, paying particular attention to any skin tears, bruises, stasis ulcers, rashes, pressure ulcers, lesion, abrasions, reddened areas and skin problems. A Licensed Nurse would document the observation on the Weekly Skin Integrity Review form. The evaluating nurse must date and sign each review. Review of the facility's policy regarding Wound Care Prevention and Treatment Objectives, dated 11/30/14, revealed the objectives were to identify at-risk residents, prevention of the development of pressure sores ulcers by performing routine skin and risk assessments, maintain and improve	F 314		

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F 314	Continued From page 334 tissue tolerance, protect against adverse effects of external forces and provide proactive intervention and education. 1. Review of Resident #4's clinical record revealed the facility admitted the resident on 05/16/13 with diagnoses which included Hypertension, Atrial Fibrillation, Chronic Obstructive Airway, Congestive Heart Failure, Macular Degeneration, Rheumatoid Arthritis, Osteoporosis and Open Wound Site. Review of Resident #4's Quarterly Minimum Data Set (MDS) assessment, completed on 03/09/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of ninety-nine (99), meaning the resident was rarely/never understood. Review of the Comprehensive Care Plan for Resident #4 revealed the facility developed a plan of care on 03/10/15 with updated goals and a target date for 06/09/15. The problem on the care plan stated the resident sustained a tibial/fibula fracture to the right leg on 02/25/15 and an immobilizer for stablization was also placed on the same date. The goal was the resident would not have unrecognized complications related to the right lower leg fracture. The approaches listed directed staff to maintain the immobilizer per physician orders and observe skin under the immobilizer for signs and symptoms of redness or breakdown. However, review of the nursing documentation revealed no evidence the skin under the immobilizer was assessed daily or	F 314		

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F 314	Continued From page 335	F 314		

during showers or at bath time. There was no documented evidence on the MAR or TAR to observe the skin under the immobilizer.

Review of the Wound Physician's documentation, dated 04/03/15, revealed Resident #4 had new wounds to the right lower extremity after having a brace for a fracture. The Physician documentation described the right medial ankle as an eschar covered trauma wound measuring 1.7 cm in length by 0.7 cm in width, with an area of 1.19 squared cm. The Right medial lower leg wound measured 3.7 cm in length by 1 cm in width, with an area of 3.7 squared cm. The wound had a moderate amount of serous drainage noted with yellow slough. The second Right medial lower leg wound with eschar measured 1.5 cm in length by 1 cm in width, with an area of 1.5 squared cm had a moderate amount of serous drainage noted, the resident reported a pain level of a 3.

Interview with the Wound Care Physician, on 04/24/15 at 1:56 PM, revealed the wounds to both Resident #4's lower legs were caused by the brace on the right leg. She stated she first identified the wound on the back of the resident's right lower leg (the one described as the Right medial lower leg wound measured as 3.7 cm in length by 1 cm in width, with an area of 3.7 squared cm) on 04/03/15 and noted in her 04/03/15 documentation. The Physician was observed, on 04/24/15 at 1:56 PM, while conducting the wound treatments to Resident #4's right and left legs and feet, buttocks and right and left hips. She stated the wounds to the left lower leg were red and both feet and legs had

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F 314	Continued From page 336 areas that looked worse since her last assessment of 04/03/15 and the resident would require antibiotic treatment for these issues. She stated she had evaluated the resident's wounds on 02/13/15, 03/20/15 and 04/3/15 and the resident was out to the hospital for treatment when she was in the facility a couple of other dates, so the resident was not seen on those dates. Interview with Certified Nursing Assistant (CNA) #1, on 04/24/15 at 3:50 PM, revealed she routinely was assigned to care for Resident #4 and was not aware of the unstageable wound to the back of the right leg. She stated she did not remove the immobilizer during bed baths. She stated she opened the immobilizer and wiped down the top of the leg but did not raise the leg to clean underneath. She stated the CNA's filled out a pink piece of paper and put it in a binder at the front desk if they noticed any skin issues during the residents' bath/shower. She stated she did not remember filling one out for Resident #4 recently and was not sure what nursing did with the pink sheets once they were put in the binder. Interview with the Licensed Practical Nurse #5, on 04/23/15 at 2:55 PM, revealed residents were bathed two times a week and more freguenlty if needed. She stated she was unable to find the CNA's pink sheets containing any noted skin issues or any other nursing documentation of the unstageable wound to the back of Resident #4's right leg that was determined to exist on 04/03/15 by the Wound Care Physician. She stated the resident's skin should have been assessed underneath the immobilizer daily to monitor for skin breakdown by nursing; however, that was not	F 314		

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F 314	Continued From page 337	F 314		

done.

Interview with the Assistant Director of Clinical Services, on 04/24/15 at 10:05 AM, revealed she was unaware Resident #4 had unstageable wounds to the right lower leg or that the brace he/she had in place for the fractured tibia caused the pressure wounds. She stated the facility conducted a wound meeting every week and she did not remember the team discussing the resident developing a wound from the brace. She stated she knew Resident #4 had chronic wounds to both hips, but that was it. She stated every resident was required to have a skin assessment every week and if a resident had a brace nursing should be assessing the skin under the brace even if there was an order saying not to remove the brace.

Interview with the previous facility Executive Director, in charge at the time Resident #4's developed pressure areas, on 04/23/15 at 8:34 AM, revealed nursing was responsible for developing, implementing and documenting the care plan interventions. She stated management would have discussed the wound issues at the "weight and wound" meetings that were held weekly and reviewed any forms completed by nursing. She stated she did not remember discussing Resident #4's wounds in the morning meeting or providing direction to staff regarding the resident's care.

2. Review of Resident #31's clinical record revealed the facility admitted the resident on 08/11/14, and readmitted the resident on 03/27/15 with diagnoses which included Above Knee Amputation (AKA), Below Knee Amputation (BKA), Diabetes Mellitus (DM), Peripheral Vascular Disease (PVD), and Pressure Ulcer.

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F 314	Continued From page 338 The facility completed a quarterly MDS, on 02/17/15, and assessed the resident to have a BIMS of six (6) meaning the resident was not interviewable. Observations of Resident #31, on 04/29/15 at 9:00 AM, 9:12 AM, 12:33 PM, 12:52 PM, 1:05 PM, and 1:57 PM, revealed the resident was able to self-propel in a wheel chair and kept a blanket over his/her lap. Observation, on 04/30/15 at 1:40 PM, revealed both of the resident's legs had been amputated. On 05/01/15 at 9:57 AM, observation of a skin assessment revealed the resident had an open pressure ulcer to his/her coccyx. Review of the Comprehensive Care Plan for risk of skin breakdown, dated 08/22/14, revealed interventions included perform skin assessments per facility policy, wound consult weekly, and assist to turn and reposition. The Care Plan for potential complications secondary to a coccyx ulcer, revised 12/07/14, revealed interventions included medications per order, followed by wound care, and supplements as ordered. Review of the Wound Physician's documentation, dated 01/09/15, revealed Resident #31, complained of pain in the buttock area and staff reported the resident was noted to be pulling at the dressings in that area. The Physician documentation described the wound to the Coccyx as unstageable necrotic tissue that measured 4.5 centimeters (cm) in length by 2.5 centimeters in width, by 0.5cm in depth, with an area of 11.25 squared centimeters, with a moderate amount of serious drainage noted, which had no odor, and 76-100% adherent, with yellow slough.	F 314		

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F 314	Continued From page 339 Measurements taken by the Wound Physician on 01/23/15 revealed the Coccyx wound had necrotic tissue that measured 3.5cm in length by 2 cm in width, by 1 cm in depth, with an area of 7 squared cm with yellow slough. On 01/30/15, the Wound Care Physician noted the Coccyx wound was now a Stage Three (3) Pressure Ulcer that measured 2.7 cm in length by 2 cm in width, by 1.5 cm in depth with an area of 5.4 squared cm and a volume of 8.1cubic cm, with a moderate amount of serous drainage noted with 51-75% adherent yellow slough. On 02/20/15, the Wound Physician noted the Coccyx wound as a Stage three (3) pressure wound that measured 5.4 cm in length by 5 cm in width by 2.4 cm in depth, with an area of 27 squared cm with a volume of 64.8 cubic cm. The wound had a moderate amount of serous drainage noted with 26-50% adherent, yellow slough. On 04/03/16, the Wound Physician noted the Coccyx wound as a Stage four (4) that measured 9 cm in length by 10 cm in width, by 1.5 cm in depth with an area of 90 squared cm and a volume of 135 cubic cm. The Wound Physician continued to note there was now bone, joint and muscle exposure with 51-75% adherent yellow slough and the temperature of the wound was warm. On 04/10/15, the Wound Physician noted the Coccyx wound was a Stage four (4) and measured 9 cm in length by 11 cm in width by 1 cm in depth, with an area of 99 squared cm and volume of 99 cubic cm. The wound bed contained 51-75% adherent yellow slough with bone, joint and muscle exposure. On 04/17/15, the Wound Physician noted the Coccyx wound was a Stage four (4) and measured 8.5 cm in length by 11cm	F 314		

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F 314	Continued From page 340 in width by 1.5 cm in depth, with an area of 93.5 squared cm and a volume of 140.25 cubic cm. The wound bed contained 26-50% yellow adherent slough with bone, joint and muscle exposure. Review of Resident #31's clinical record revealed a Physician Order Sheet for December 2014 and March 2015, for weekly skin assessments to be performed. Review of the weekly skin assessments for Resident #31, for January 2015 revealed the resident had an open area to his/her coccyx on 01/05/15 and 01/12/15. However, the skin assessments did not reveal any measurements, or description of the open area on the coccyx. Continued review of the medical record revealed the facility did not consistently perform skin/wound assessments as required by the policy. The facility was unable to provide weekly skin assessments for Resident #31 for the weeks of 01/19/15, 01/26/15, 02/16/15, 02/23/15, 03/30/15 or 04/06/15. Interview with the Interim Executive Director/Regional Vice President of Operations (ED/RVPO), on 05/05/15 at 3:05 PM, revealed the staff failed to document skin assessments for Resident #31. She stated without the documentation of the skin assessments, it would be difficult to validate the care was given to the resident. On 05/01/15 at 1:36 PM, interview with the Unit Manager (UM) revealed resident skin assessments should be completed weekly. The UM stated the skin assessments were not documented for Resident #31. She reported the	F 314		

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F 314	Continued From page 341	F 314		
	purpose of conducting the weekly skin assessments was to assist in preventing new skin breakdown and to find any new areas of concern. She further reported if the skin assessments were not completed weekly there was the potential wounds could worsen. Interview, on 05/04/15 at 2:18 PM, with the Director of Clinical services (DCS) revealed weekly skin assessments should be completed for Resident #31 to identify any changes in his/her skin and any skin breakdown. She stated a treatment would need to be ordered for changes in the resident's skin in order to keep the wound from getting worse. The DCS reported the nurses were responsible to complete the skin assessments. Interview with Licensed Practical Nurse (LPN) #2, on 05/13/15 at 10:50 AM, revealed the nurses were responsible to conduct the weekly skin assessments for residents. She stated the nurse should document what they see during the skin assessment. The nurse reported the purpose of the weekly skin assessment was to ensure the resident did not have any new areas of concern with his/her skin. She further reported if the skin assessment was not completed Resident #31's pressure ulcer could become larger. Continued interview with the DCS, on 05/20/15 at 2:04 PM, revealed if a resident had wounds then a weekly skin assessment would be needed to determine if the wounds were improved. She stated if the facility did not have documentation of the skin assessments, then it would be difficult to evaluate if the care being provided was effective.			
F 315	483.25(d) NO CATHETER, PREVENT UTI,	F 315		

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F 315 SS=E	Continued From page 342 RESTORE BLADDER	F 315		

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

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 ensure the resident's incontinent and toileting care needs were met for seven (7) of forty-three (43) sampled residents (#6, #7, #8, #10, #20, #31 and #39). In addition, Resident #31's indwelling urinary catheter was not evaluated for continued use to prevent Urinary Tract Infections (UTI).

The findings include:

Review of the facility's policy regarding Incontinent Resident Care, dated 11/30/14, revealed incontinent residents would be cared for by nursing personnel to ensure adequate skin care, odor control, and provide personnel hygiene.

Review of the facility's policy regarding Activities

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F 315	Continued From page 343 of Daily Living (ADLs), dated 11/30/14, revealed all residents would remain at their highest level of self-help or independence. The role of the Clinical Services staff was to teach, support and supervise the resident in regaining and maintaining these functions. 1. Review of Resident #6's clinical record revealed the facility admitted the resident on 11/14/13 with diagnoses of Sepsis, Renal Insufficiency, and Neurogenic Bladder. Review of Resident #6's Quarterly Minimum Data Set (MDS) assessment, completed on 01/08/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of fourteen (14), meaning the resident was cognitively intact and interviewable. Review of the Comprehensive Care Plan for Resident #6, dated 11/03/13, revealed Resident #6 was incontinent of bowel and bladder related to a Urinary Tract Infection (UTI), and Obesity. The approaches included direction for staff to assist with toileting needs as needed and on a consistent schedule to promote continence, and to check frequently for incontinence. Interview with Resident #6, on 04/16/15 at 10:45 AM, revealed he/she was left wet for seventeen (17) hours due to the facility not having enough staff to meet his/her needs. The resident stated he/she did not want to be a "pain in the ass because it would just get worse and did not want to throw anyone under the bus". The resident	F 315		

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F 315	Continued From page 344 stated he/she weighed 332 pounds and due to this it took at least two (2) staff members to get him/her cleaned up after an incontinent episode. Resident #6 stated due to his/her weight the staff had to use a lift to get him/her out of bed and using the lift required the assistance of two (2) staff also. Resident #6 said he/she would be wet during the night shift and would have to wait until the day shift staff came on to get cleaned up. Resident #6 stated if he/she had an incontinent episode while up in the wheelchair, and requested to be changed, he/she had to wait until there was adequate staff available to change his/her brief, which at times took over an hour for there to be enough staff. The resident stated the staff would have to put him/her back to bed to change the brief and then due to time constraints and staffing shortages; would then encourage the resident not to get back into the wheelchair so the resident felt like he/she had to comply. Interview with Certified Nursing Assistant (CNA) #6, on 04/16/15 at 11:00 AM, revealed he was not able to complete all his assigned duties for twenty-three (23) residents that needed assistance with ADLs. He stated he had several residents that required total care. He stated the facility was short staffed and due to this, those residents that required the assistance of two (2) to check and change, did not always have their needs met or if they were it was not timely. He stated if he was the only one working and he was giving a bath or assisting a resident he could not tend to his other assigned residents' needs. He stated some nurses answered the call lights and some did not, which meant residents needs were not met timely. CNA #6 stated he arrived at 7:00 AM and breakfast trays arrived on the unit at 7:40 AM and it took him forty-five (45) minutes this	F 315		

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F 315	Continued From page 345 morning to get three (3) residents out of bed for breakfast and he had three (3) residents to feed for breakfast. He stated he had complained about the staffing shortage and not being able to meet the needs of his residents, but nothing had been done. 2. Review of Resident #7's clinical record revealed the facility admitted the resident on 03/17/15, with diagnoses of Vascular Dementia, Cerebral Vascular Accident (CVA), and Osteoarthritis of the Hip and Knee. Review of Resident #7's Admission MDS assessment, completed on 03/25/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of ninety-nine (99), meaning the resident was rarely/never understood. Review of the Comprehensive Care Plan for Resident #7, dated 03/26/15, revealed Resident #7 would not experience any skin conditions from incontinence. The approaches directed staff to monitor the resident for signs of emotional distress with incontinence and to provide ongoing assessment of the resident's voiding patterns. Assessments of voiding patterns could not be located in the clinical record nor could the facility produce documents to validate that assessments of the resident's voiding pattern had been completed. Observation of Resident #7's room, on 04/16/15 at 1:50 PM, revealed a strong odor of urine and feces permeated the room. Observation of the	F 315		

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NAME OF PROVIDER OR SUPPLIER
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STREET ADDRESS, CITY, STATE, ZIP CODE
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F 315	Continued From page 346 toilet bowl revealed a large amount of stool in the bowl. The resident was observed to be sitting in a straight back chair beside the bed. Observation of Resident #7, on 04/16/15 at 3:37 PM, revealed the resident was seated on the floor in his/her bathroom, with pants down and stool on the resident's bottom and floor. No staff was present in the room at the time of this observation. Interview with CNA #36, on 04/16/15 at 3:43 PM, revealed there was not enough staff to tend to the residents' incontinent care needs on the locked unit. She stated the resident could get combative with care and would need more staff to tend to the resident at those times. She stated there were only three (3) aides on the unit for the second shift for the forty-five (45) to forty-eight (48) residents and several were total care requiring the assistance of two. 3. Review of Resident #8's clinical record revealed the facility admitted the resident on 04/18/14, with diagnoses of Hypoxia, Stage Three Renal Disease, Cerebral Vascular Accident (CVA), and Decubitus. Review of Resident #8's Quarterly MDS assessment, completed on 03/25/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of fifteen (15), meaning the resident was cognitively intact and interviewable. The facility assessed the resident as occasionally incontinent of urine.	F 315		

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Review of the Comprehensive Care Plan for Resident #8, dated 08/11/14, revealed Resident #8 had impaired ability to perform ADLs and self-mobility related to weakness, immobilization and Chronic Obstructive Pulmonary Disease (COPD). Goals included improvement in self-care skills in at least one (1) area of ADLs and mobility. The care plan stated staff would provide assistance with ADLs while promoting independence, promote dignity by assuring privacy and organize supplies by how or when they should be used and place within reach. The resident also had a care plan developed on 08/11/14 for urinary incontinence with updated goals and a target date for 05/24/15. The problem stated the resident was incontinent of urine and the goal stated the resident would have decreased episodes of urinary incontinence. The approaches stated staff would assist with toileting and provide incontinence device of resident's choice for dignity.

Interview with Resident #8, on 04/16/15 at 8:48 AM, revealed the resident had urinated on him/herself during the night. The resident said he/she was unable to reach the call light to ring for assistance and instead hollered for staff to come help him/her. The resident stated staff walked by and did not come into his/her room.

Interview with Resident #8, on 04/22/15 at 9:20 AM, revealed Resident #8 felt like the management staff did not care and that it did not do any good to complain. The resident stated he/she put on their call light again last night because he/she was wet and wanted to be pulled

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F 315	Continued From page 348 up in the bed and the staff answered the light and said they would be back because they needed help. He said he fell back to sleep, woke up again and pushed the call light again and they turned if off again and did not come back for a while. 4. Review of Resident #10's clinical record revealed the facility admitted the resident on 05/01/14, with diagnoses of Quadriplegic, Neuropathy, Muscle Spasms, and Proteus Urinary Tract Infection. Review of Resident #10's Annual MDS assessment, completed on 02/03/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of fifteen (15), meaning the resident was cognitively intact and interviewable. The facility assessed the resident as incontinent of bowel and bladder. Review of the Comprehensive Care Plan for Resident #10, dated 03/31/14, revealed Resident #10 was incontinent of bowel and bladder related to quadriplegia and the resident would show no evidence of skin breakdown related to incontinence through the next review. Further, the care plan stated staff would assist with toileting needs as needed and on a consistent schedule to promote continence and to check frequently for incontinence. Interview with Resident #10, on 04/15/15 at 9:25 AM, revealed he/she was left wet all night long due to the facility not having enough staff. The resident stated there were not enough sheets to change their bariatric bed after an incontinent	F 315		

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episode and the few sheets available had holes in them and they were thin. The resident stated he/she had spoken with the staff regarding the issues; however, they have yet to be resolved.

Interview with CNA #7, on 04/15/15 at 9:10 AM, revealed she was normally assigned to Resident #10. She stated she worked by herself most of the time. She stated even though the schedule listed another aide as working the unit with her the aide actually left and said they were not coming back and no replacement was provided. CNA #7 stated she was now responsible for sixteen (16) residents and Resident #10 was totally dependent on staff due to being quadriplegic. She stated there were several other residents that also required the assistance of two staff to check and change, toilet and transfer and she could not do that by herself. She stated the nurses were not always available to assist her when needed. She stated Resident #10 had made complaints about not getting needs met and the linen issues. CNA #7 stated she had also made complaints about the issues, but nothing had been done to correct them.

5. Review of Resident #20's clinical record revealed the facility admitted the resident on 02/10/15, with a diagnoses of Dementia. Review of Annual MDS assessment, completed on 02/24/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of fifteen (15), meaning the resident was cognitively intact and interviewable. The facility assessed the resident as incontinent of bowel and bladder.

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F 315	Continued From page 350 Review of the Comprehensive Care Plan for Resident #20, dated 02/27/15, revealed Resident #20 was incontinent related to functional abilities. The care plan stated the resident would not experience any skin conditions or infections from incontinence and staff would offer and provide the bedpan upon request and assess for environmental factors that may contribute to the resident's incontinence. Interview with Resident #20, on 04/16/15 at 9:11 AM, revealed the resident was wet from urinary incontinence and had requested to be changed, but was told by staff that he/she would have to wait until staff picked up the morning breakfast trays. Interview with Resident #20, on 04/16/15 at 10:00 AM, revealed the resident was still wet and staff had not been in to change his/her brief or linens that were now wet with urine. Interview with Resident #20, on 04/16/15 at 3:20 PM, revealed staff came into change his/her brief and sheets at noon. The resident stated it felt like forever to get cleaned up and changed. The resident said staff told him/her that it took them a while to find a sheet to fit his/her bariatric bed. Interview with CNA #1, 04/17/15 at 10:55 AM, revealed she had helped CNA #34 change Resident #20 on 04/16/15 and said the unit was out of sheets and they had to wait until laundry came to the unit to change the resident. She	F 315		

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F 315	Continued From page 351 stated the unit was always short of linen and it prevented them from completing incontinent care timely. She stated if they have time, they will go to another unit and get sheets, but they were usually out or low on linens too. Interview with the Director of Clinical Services (DCS), on 04/29/15 at 7:55 AM, revealed she was not aware the resident's care needs were not met while she was employed by the facility. She stated she was only employed by the facility for two (2) weeks and her last day was 04/17/15. Interview with the previous Executive Director (ED), on 04/23/15 at 8:34 AM, revealed she was not aware that Resident's #6, #8, #10 and #20 care needs were not met. She stated it was the responsibility of nursing to ensure residents incontinent care needs were met. She stated the facility had a staffing shortage and believed this was the underlying issue to not meeting the needs of the residents and the reason for her resignation. 6. Review of Resident #39's clinical record revealed the facility admitted the resident on 03/24/15, with diagnoses of General Weakness, Edema, Urinary Tract Infection (UTI), Bladder Spasms, and Diabetes Mellitus (DM). Review of the Annual MDS assessment, completed on 03/31/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of fifteen (15), meaning the resident was cognitively intact and interviewable. The facility assessed the resident as occasionally	F 315		

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F 315	Continued From page 352 incotinent of bladder. Review of the Comprehensive Care Plan for Resident #39, dated 04/01/15, revealed the resident was occasionally incontinent of urine due to stress incontinence. The care plan stated the resident would not experience any infections or skin conditions from incontinence and staff would assist the resident to the bathroom or commode as needed. Observation, on 04/29/15 at 2:12 PM, revealed Resident #39's call light was illuminated and at 2:15 PM the Activity Assistant entered and immediately exited the room and the light was no longer illuminated. Interview with Resident #39, on 04/29/15 at 2:15 PM, revealed the Activity Assistant said she was going to find someone to help the resident. Resident #39 said routinely it took a long time for staff to answer his/her call light and because they had waited so long for assistance they had urinated on themselves. The resident said he/she had held their urine as long as they could and it was very embarrassing to talk about wetting on themselves with this surveyor. The resident stated he/she was heavy and it took two (2) people to assist with toileting and because staff was not fast enough he/she had wet on himself/herself on many nights. Interview with CNA #7, on 04/29/15 at 2:25 PM, revealed she was in Resident #10's room providing incontinent care when the activity	F 315		

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assistant told her that Resident #39 needed her assistance. She stated she was the only aide working on the Journey two (2) Unit and would be back to take care of Resident #39 when she finished with Resident #10.

Interview with the DCS, on 05/04/15 at 2:18 PM, revealed she had determined after she was hired on 04/20/15, that the facility was short sixteen (16) certified nursing assistant positions and this shortage directly correlated to Resident #39's needs not being met. She stated the facility should be addressing toileting needs in a timely manner for the residents.

7. Review of the facility's policy regarding Catheter Care, Urinary, dated 11/30/14, revealed perineal (peri) care would be provided to residents with a catheter by nursing personnel.

Review of Resident #31's clinical record revealed the facility admitted the resident on 08/11/14 with diagnoses of Pressure Ulcer, Above Knee Amputation (AKA), Diabetes Mellitus (DM), and Peripheral Vascular Disease.

Review of the Quarterly MDS, on 02/17/15, and assessed the resident with a BIMS of six (6), meaning the resident was not interviewable.

Continued review of Resident #31's clinical record revealed a local hospital note, dated 03/27/15, that stated the resident was going to be discharged to the facility and leave the indwelling catheter in place and to change the catheter every two (2) weeks. A facility Admission and Readmission Data Collection form, dated 03/27/15, revealed the resident used an indwelling urinary catheter for wound healing, with

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F 315	Continued From page 354 no plan to discontinue the catheter. Notes by the Nurse Practitioner (NP), dated 04/06/15, 04/10/15, and 04/13/15, revealed the resident used an indwelling urinary catheter. Review of the Physician Order Sheets (POS) for March and April 2015 revealed neither the indwelling urinary catheter, nor catheter care, were listed in the physician's orders. Review of the April 2015 MAR for Resident #31 revealed an indwelling urinary catheter and catheter care were not listed. Review, on 05/01/15, of the Kardex for Resident #31, not dated, revealed the use of an indwelling urinary catheter was not marked; however, the resident was identified as wearing a brief for elimination. Review of the facility's care plan, dated 08/22/14, revealed the care plan included a risk of incontinence of bowel and bladder; however, the comprehensive care plan did not address the resident had an indwelling urinary catheter in place. Observations, on 04/30/15 at 1:40 PM, on 05/01/15 at 9:57 AM, of Resident #31 revealed both of the resident's legs had been amputated and the resident had an indwelling catheter in place. Interview with CNA #2, on 04/30/15 at 3:37 PM and 04/30/15 at 4:43 PM, revealed Resident #31 had a catheter; however, the resident was incontinent of bowel and wore a brief. She stated the aides should clean the catheter, empty the catheter drainage bag, and provide perineal (peri) care for the resident.	F 315		

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F 315	Continued From page 355 On 04/30/15 at 4:41 PM and 04/30/15 at 5:00 PM, interview with Registered Nurse (RN) #7 revealed the CNAs were responsible to provide perineal (peri) care and the nurses were responsible to flush or change the indwelling urinary catheter which would depend on the physician's order. She stated Resident #31 had an indwelling urinary catheter; however, she was unable to find a physician's order for the use of the catheter or catheter care. The nurse stated the physician's order was needed to transcribe the indwelling urinary catheter on the MAR, TAR and care plan. She further stated the indwelling urinary catheter was not on Resident #31's care plan as the physician's order was needed to transcribe the indwelling urinary catheter to the care plan. She stated the nurse was responsible to chart on the MAR or TAR when the catheter was changed or flushed. RN #7 reported without the order the nurse would not know what care should be provided to the resident with the indwelling urinary catheter. Interview with the Unit Manager (UM), on 05/01/15 at 1:36 PM, revealed Resident #31 should have a physician's order to use an indwelling urinary catheter; if it should have a bedside draining bag; if it was related to a pressure ulcer; and, it should specify catheter care on each shift. She stated a physician's order was needed to identify when the indwelling urinary catheter should be changed. The UM reported if there was not a physician's order for the indwelling catheter and its care, it was possible the catheter care would not be provided. The UM further reported the nurse who admitted the resident with the indwelling catheter was responsible to get the physician's order. She stated new admissions and readmissions to the	F 315		

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facility were reviewed in the morning meeting for orders, assessment, care plan in place, and that the Kardex was current.

Interview, on 05/04/15 at 2:18 PM, with the DCS revealed a resident with an indwelling catheter should have catheter care every shift, empty the bedside drainage bag every shift, and document the care provided. She stated urinary output should also be documented, so the output could be compared to intake to ensure the resident's kidneys were functioning. The DCS reported catheter care, completed by the CNAs, included perineal (peri) care provided to the resident and cleaning the catheter tube. The DCS further stated catheter care should be provided any time a resident had a bowel movement, every shift, and as needed. She stated a physician order was required for a resident to have an indwelling catheter, as well as the reason for the catheter. She stated a resident should not have an indwelling catheter unless absolutely necessary as it allowed for entry of bacteria and set up for infection for the resident, such as a UTI. She stated if a resident was admitted with an indwelling catheter the physician would need to be called for an order for the catheter and the catheter care.

Interview with the Interim Executive Director/Regional Vice President of Operations (ED/RVPO), on 05/05/15 at 3:05 PM, revealed the clinical record for Resident #31 was not accurate and the facility failed to document the resident's indwelling catheter. She stated without documentation of the indwelling catheter or catheter care, it was not possible to validate the facility provided any care to the resident's indwelling catheter.

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F 315	Continued From page 357 On 05/13/15 at 10:34 AM, interview with CNA #2 revealed when catheter care was provided to a resident by the aides, the Caretracker System (electronic documentation) did not have any place to document that catheter or perineal (peri) care were provided. She stated the aides were to check on a resident's catheter every two (2) hours. The CNA further stated the Caretracker System allowed documentation if a resident was continent or incontinent, and the time documented in the Caretracker would be the time of the documentation not the time the care was actually provided.	F 315		
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. 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 have an effective system to ensure each resident received supervision to prevent accidents. The facility failed to investigate accidents/incidents, to include falls and resident to resident altercation, to determine the root cause and to implement interventions to prevent recurrence. In addition, the facility failed to maintain the environment to	F 323		

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ensure resident safety related to a shower bed that did not have all four metal pins that secured the side rails in the up position. The facility also failed to ensure supervision was provided for residents assessed as requiring supervision while smoking. The facility's failure to have an effective system related to supervision affected seven (7) residents of forty-three (43) sampled residents (Resident #4, #6, #14, #15, #25, #30 and #31).

On 01/30/15, Resident #4 sustained a fall from the wheelchair which resulted in a hematoma (a collection of blood under the skin caused by a break in a blood vessel) to the forehead and bilateral upper extremity hematomas and was diagnosed with an acute transverse fracture of the distal clavicle with approximately four (4) millimeters of inferior displacement of the distal fragment. On 02/25/15 at approximately 12:30 AM, Resident #4 sustained another fall. Interview and record review revealed no documented evidence the resident's physician was notified at the time of the fall and there was no evidence interventions were implemented to prevent recurrence. An x-ray was ordered and the resident was diagnosed with a right tibia fracture. Review of the Fall Root Cause Investigation Report, dated 01/30/15 and 02/25/15, revealed the facility did not identify root cause for the resident's falls. (Refer to F157, F280 and F309)

On 02/26/15, with no time of incident, Resident #31 sustained a fall when attempting to self-transfer from the wheelchair (w/c) to the bed. The resident's fall resulted in small skin tears to his/her arms and swelling to the left eye with a hematoma to the left side of the face. The resident was transferred to a local hospital on 02/26/15 and diagnosed with a Contusion,

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F 323	Continued From page 359 Bilateral Frontal Lobe Hemorrhage, and Mild Subarachnoid Hemorrhage and returned to the facility on 03/03/15. Interview and record review revealed the facility failed to conduct an investigation of the fall on 02/26/15 which resulted in a hematoma. (Refer to F280) Review of the clinical record for Resident #25 revealed the resident wandered and had socially and sexually inappropriate behaviors. On 03/25/15 during the 7:00 AM-3:00 PM shift, Registered Nurse (RN) #6 noted the Resident #25's right eye was swollen and bruised on the side with a small cut. Interview with Resident #29, on 04/27/15 at 11:40 AM, revealed Resident #25 had wandered into his/her room and tried to get into Unsampled Resident A's bed. Resident #29 stated he/she "busted" the resident in the jaw a couple of times to get the resident out of the room. Resident #29 stated he/she told Resident #25 if he/she ever came around bothering them again the resident "would get more of the same". Interview revealed staff was aware of the altercation; however, there was no documented evidence the facility investigated Resident #25's injury/incident until 04/28/15 after surveyor intervention. Due to the lack of a timely investigation, there was no evidence of increased monitoring/supervision related to this resident to resident altercation to prevent recurrence. (Refer to F157, F280 and F309) The facility also failed to assess and investigate a fall sustained by Resident #30 and failed to supervise Residents #14 and #15 who had been assessed as requiring supervision while smoking. In addition, the facility failed to ensure resident safety related to a shower bed that did not have all four metal pins that secured the side rails in	F 323		

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F 323	Continued From page 360 the up position. Observation and interview with Resident #6 revealed the shower bed had three (3) plastic spoons and only one metal pin securing the side rails in the up position. The facility's failure to have an effective system in place to provide adequate supervision, to determine the root cause of falls and to assess and implement prevention processes to prevent recurrent accidents has caused or is likely to cause serious injury, harm, impairment or death to resident. The Immediate Jeopardy was identified on 04/22/15 and determined to exist on 02/25/15. An acceptable Allegation of Compliance (AOC) was received on 05/19 /15 alleging the Immediate Jeopardy was removed on 05/16/15. The State Survey Agency validated the Immediate Jeopardy was removed on 05/16/15 as alleged, prior to exit on 05/22/15. The scope and severity was lowered to an E while the facility monitors the implementation of the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes. The findings include: Review of the facility's policy regarding Resident Incident/Accident Reports, dated 11/30/14, revealed any happening not consistent with routine operations of the facility or care of a resident may warrant the completion of an incident report. Following a nursing assessment, the physician would be notified of any noted or suspected injury, and would implement appropriate interventions. The event, along with assessment, physician and other required notification would be documented in the clinical	F 323		

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record. The resident's family or legal representative would be notified of the incident. Incident reports would be reviewed by the Director of Clinical Services for completion and follow up. Following review by the Director of Clinical Services, the event would be reviewed by the Interdisciplinary Team and the Executive Director.

Review of the facility's policy regarding Resident Safety Checks, dated 11/30/14, revealed safety checks could be initiated when a resident was deemed at risk to self or others. The resident should be checked at the required intervals and the form initialed to indicate the check was completed. The form would be filed in the resident's clinical record.

1. Review of Resident #4's clinical record revealed the facility admitted the resident on 05/16/13 with diagnoses of Hypertension, Atrial Fibrillation, Chronic Obstructive Airway, Congestive Heart Failure, Macular Degeneration, Rheumatoid Arthritis, Osteoporosis and Open Wound Site.

Review of Resident #4's Quarterly Minimum Data Set (MDS) assessment, completed on 03/09/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of ninety-nine (99), meaning the resident was rarely/never understood.

Review of the Comprehensive Care Plan for Resident #4 revealed a plan was developed on 06/04/13 with updated goals and a target date for 06/09/15. The problem stated the resident was at risk for falls due to overall physical condition and

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F 323	Continued From page 362 psychotropic medications. The goal stated the resident would be free from any falls and would not experience injuries related to falls. The approaches directed the staff to anticipate resident needs, follow a daily routine, and remind the resident to ask for assistance for all transfers. Review of the clinical record revealed the resident had sustained falls on 11/25/14, 12/29/14, and 01/20/15; however, each were documented as non-injury falls. Further review of the medical record revealed a physician's order, dated 01/20/15, for a fall mat to the right side of the bed and to check placement every shift. Review of the Nurse Tech Information Kardex, not dated, revealed a bed/chair alarm and a fall mat to the right side of the bed was to be in place for safety precautions as a nursing measure. However, this information was not documented on the Comprehensive Care Plan. Review of the Fall Root Cause Investigation Report and Nursing Progress note, dated 01/30/15, revealed the resident fell from the wheelchair and sustained a hematoma (collection of blood under the skin caused by a break in the wall of a blood vessel) to the forehead approximately two (2) inches by three (3) inches. The facility did not identify a root cause for the fall or immediately put fall prevention interventions in place to prevent or reduce the likelihood of a future fall or injury. Review of Nursing documentation, dated 02/05/15 and timed 2:20 PM, revealed the resident's left shoulder appeared abnormal and the physician ordered an x-ray of the shoulder to rule out a dislocation or fracture.	F 323		

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Review of Physician orders, dated 02/09/15, revealed the physician ordered a Computerized Tomography (CAT) scan of the left shoulder and humerus due to the resident having a hematoma, pain and swelling to the left shoulder with decrease range in motion after a fall. Continued review of nursing notes revealed the CAT insurance authorization was received on 02/13/15 and the CAT scan was scheduled for 02/20/15 (11 days after the order was received). Interview with Licensed Practical Nurse #5, on 04/30/15 at 9:30 AM revealed the scan was scheduled as routine instead of immediately. The facility had to obtain insurance clearance before scheduling the CAT scan and once the clearance was obtained the scan was scheduled and performed. Review of the CAT Scan report, dated 02/20/15, revealed an acute transverse fracture of the left distal clavicle with approximately four (4) millimeters of inferior displacement of the distal fragment. The report continued to state there was remodeling and a somewhat deformity of the scapula compatible with a healed remote fracture and mild irregularity and remodeling of the left posterior second and sixth rib likely caused by the remote trauma.

Review of an Accident/Incident Report Form, dated 02/25/15, revealed Resident #4 sustained a fall from the bed and was found on the floor at 12:30 AM. Review of the documented information on the Report Form revealed the physician had not been contacted, the resident did not receive any treatment and no immediate fall prevention interventions were put in place to protect the resident from further injuries.

Review of the Nursing Progress Note written, on

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F 323	Continued From page 364 02/25/15 and timed at 6:00 AM, revealed Resident #4 was found on the floor by a Certified Nursing Assistant (CNA) while performing rounds. The Nursing Progress Note written at 4:30 PM, revealed nursing documented the right lower leg was swollen, warm, bruised and tender. The Nursing Note written at 4:30 PM, continued to state the first shift reported Resident #4 experienced a fall on the night shift and x-ray results were pending. The X-ray results were positive for a right tibia fracture and the facility notified the nurse practitioner of the results and orders were received to transfer the resident to the hospital. Interview with CNA #15, on 04/22/15 at 12:05 AM, revealed she arrived for her 11:00 PM to 7:00 AM shift on 02/24/15, to find the previous shift CNAs, assigned to the 100 Unit, had already left the building. CNA #15 stated after she arrived she determined no other CNAs were present to work the unit with her that night and the only other staff working on the unit was Certified Medication Technician (CMT) #16. She stated she began checking on residents and heard Resident #4 hollering. She stated she went to the resident's room and found the resident on the floor, under the bed, with dried feces on the resident's bottom. She stated no bed alarm was sounding and believed the resident did not have a bed alarm device on the bed at the time of the fall. The CNA stated the resident's right foot was black and the resident complained the foot hurt. She stated at the time, 100 Unit did not have a nurse present on the unit, so she informed CMT #16 of Resident #4's fall and together they cleaned the resident up and put the resident back to bed. She stated each time she checked on the resident during the shift the right foot did not look	F 323		

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good to her and the resident complained the foot hurt. She stated Licensed Practical Nurse (LPN) #1 had been in the room and believed he knew about the resident's condition.

Interview with the CMT #16, on 04/21/15 at 11:25 PM, revealed the two nurses that worked the 3:00 PM to 11:00 PM shift gave her report on the 100 Unit residents and left the building. She stated the scheduled nurse did not report to work that night. CMT #16 stated CNA #15 told her she found Resident #4 on the floor and this occurred around 12:00 AM or a little after. She stated they both put the resident back to bed and cleaned feces off the resident's bottom. She stated she did not hear a bed alarm going off in Resident #4's room and believed the resident did not have one on the bed at the time of the fall. She stated after this she did not return to Resident #4's room during her shift.

Interview with LPN #1, on 04/21/15 at 3:05 PM, revealed he was working on the 200 Unit when RN #1 notified him the 100 Unit did not have a nurse and Resident #4 had fallen. He stated RN #1 directed him to leave his assigned 200 Unit, which then would be without a licensed nurse, to go staff the 100 Unit. He stated CMT #16 and CNA #15 had already put Resident #4 back to bed when he got to the unit. He stated his head to toe assessment, which he conducted sometime after 12:30 AM, consisted of him laying eyes on the resident. He stated he did not pull back the resident's covers to assess the resident's right lower leg. He stated he observed the resident moving all extremities, with the covers on, while in the bed, and to him this stated the resident had not experienced an injury to the right lower leg. LPN #1 stated he did not revise the resident's care plan with additional interventions to promote

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safety or reduce the chance of another fall because he assumed RN #1 had completed that documentation. LPN #1 also stated he did not immediately notify the resident's physician after the fall, due to the fall occurring during the night time hours and he did not want to bother the physician with what he believed to be a non-injury fall. He gave report to the first shift nurse and believed the first shift staff notified the nurse practitioner after he left.

Interview with RN #1, on 04/21/15 at 11:20 PM, revealed he did not remember if he assessed Resident #4 the night of the fall. He stated if the 100 Unit did not have a nurse the night Resident #4 fell he probably did direct LPN #1 to leave his unit to go staff the 100 unit. He stated the nurse assigned to the unit where a resident experienced a fall had the responsibility of completing the resident assessment, root cause form, nursing progress note documentation, revising the care plan, and making the appropriate notifications. He stated since he was not the nurse on the unit he did not make any nursing documentation in the medical record or contact the physician and family regarding the fall.

Interview with the previous Executive Director (ED) in charge at the time of Resident #4's fall, on 04/23/15 at 8:34 AM, revealed she had not been told that CMT #16 and CNA #15 had moved Resident #4 before a nurse assessed the resident for injuries. She stated it was the responsibility of the nurse assigned to the resident that experienced the fall, to complete all the forms which included revising the care plan and completing the root cause form. She stated management would have discussed the fall and reviewed the forms the day after the fall. She

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F 323	Continued From page 367 stated she remembered discussing the fall in the morning meeting; however, she did not remember reviewing the forms or providing any direction to staff to ensure or promote resident safety. She stated neither RN #1 nor her management staff called her to inform her of the staffing shortage, on the 100 Unit the night of 02/24/15, or that a CMT had taken report from nursing staff and that the same nursing staff left prior to the next shift nurse assuming care of the residents in the building. 2. Review of the clinical record for Resident #31 revealed the facility admitted the resident on 08/11/14 with diagnoses of Peripheral Vascular Disease and Above Knee Amputation (AKA). The facility completed an initial MDS on 08/19/14 and assessed the resident with a BIMS of fifteen (15). The facility completed a Quarterly MDS on 02/17/15 and assessed the resident to have a BIMS of six (6) and not interviewable and the resident had not had any falls. Review of the facility's care plan for Resident #31 for a risk of falls, dated 08/22/14, revealed an undated note to be aware the resident had a history of attention seeking behaviors and throwing him/herself on the floor. Interventions included to encourage rest as necessary, anticipate and meet all needs, and to notify family and physician of falls. A Readmission Data Collection, dated 02/14/15 at 1:30 PM, revealed the facility readmitted the resident after he/she had a left above the knee amputation (AKA), and assessed the resident to need assistance to transfer with two (2) staff. The facility assessed the resident at risk for falls with a score of twenty (20).	F 323		

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Continued review of Resident #31's clinical record revealed an SBAR, dated 02/26/15, stated the resident wanted to get up, yelled that he/she wanted to get up, and sat him/herself on the floor. The SBAR stated the RP was notified on 02/26/15.

Review of the Fall Root Cause Investigation Report, dated 02/26/15 at 6:48 AM, when Resident #31 sat him/herself on the floor revealed the form was incomplete, with no information provided in multiple areas and the DCS review was not signed.

Review of an additional SBAR, also dated 02/26/15 with no time of incident, for Resident #31 revealed the resident slid to the floor when he/she attempted to self-transfer from the wheelchair (w/c) to the bed. The resident's fall resulted in small skin tears to his/her arms and swelling to the left eye with a hematoma to the left side of the face. The physician was notified at 3:45 PM, the skin tears were treated, and the resident was transferred to a local hospital on 02/26/15. A Skin Evaluation Prior to Discharge/ Transfer/ LOA, dated 02/26/15, revealed the resident had a left AKA, a right BKA, a hematoma at the eye on the left side of the face, and skin tears to both forearms. Review of the hospital Discharge Summary, dated 03/03/15, revealed the resident was admitted after a fall on 02/26/15 with final diagnoses of Contusion, Bilateral Frontal Lobe Hemorrhage, and Mild Subarachnoid Hemorrhage.

The facility did not provide evidence of Resident #31's investigation for the fall on 02/26/15 which resulted in a hematoma.

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Interview, on 04/23/15 at 1:15 PM, with RN #6 revealed when the resident had a fall the nurse on duty was responsible to complete the SBAR, neuro checks, a nurse's note, the 24 hour report, update the care plan and notify the physician and RP. She stated if the required records for the fall were not completed, the resident could have another fall. The nurse further stated the nurse's notes were not completed each day on each shift.

On 04/24/15 at 9:35 AM, interview with the UM revealed a resident's fall should be documented on an SBAR and incident report, notifications should be made to the physician and RP, neuro checks completed for a head injury, and the fall should be investigated. The UM stated the care plan should be updated by the nurse who received any orders from the physician. She stated the fall information was then taken to the morning meeting to review the care plan and make any additional changes.

Interview with the Director of Clinical Services (DCS) on, 04/28/15 at 11:15 AM, revealed after an incident or accident such as a fall; nursing should revise the resident's care plan and implement interventions to maintain resident safety. She said resident's recently admitted had an Admission Care Plan developed and followed until the Comprehensive Care Plan was developed. She stated staff should implement all care plan interventions in order to meet the needs of the resident. However, due to staffing the facility was not meeting the needs of all their residents.

Continued interview with the DCS On 05/04/15 at 2:18 PM, revealed she was unable to locate the root cause fall investigation, or any other

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F 323	Continued From page 370 additional information, related to Resident #31's fall on 02/26/15 when the resident received a hematoma during a self-transfer, or any other information for the fall on 02/26/15 when the resident sat him/herself on the floor. 3. Review of the clinical record for Resident #25, revealed the facility admitted the resident on 12/30/14 with a diagnosis of Vascular Dementia. The facility completed an initial Minimum Data Set (MDS) on 01/06/15 and assessed the resident as ninety-nine (99), with a cognitive level of a three (3) by staff interview. Resident #25's care plan, dated 01/06/15, revealed the resident had impaired cognitive status with interventions that included to inform the responsible party of any changes. The care plan for aggressive behaviors, dated 01/08/15, directed staff to monitor and document resident's behavior and follow up with psychiatric services as needed. The care plan for risk of falls, dated 01/08/15, included an intervention to monitor the resident for change in condition that may warrant an increase in supervision or assistance, and notify the physician. Review of the facility's Behavior Symptom Monitoring Flow Record for Resident #25, for January, February, March, and April 2015, revealed the resident wandered, had socially and sexually inappropriate behaviors. The behavior sheets did not have an entry for 03/24/15 or 03/25/15. Continued review of Resident #25's clinical record revealed a nurse's note, dated 02/19/15 at 6:00 PM, that stated the resident had wandered into other resident rooms and had tried to get into the other resident's bed. A nurse's note, on 03/24/15 at 3:30 PM, revealed the resident had wandered into another resident's room. On 03/24/15 at 7:00	F 323		

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F 323	Continued From page 371 PM, the resident was assisted to his/her room. On 03/25/15 from 7:00 AM through 3:00 PM, a nurse's note by Registered Nurse (RN) # 6 revealed the resident had wandered in the dayroom. The resident's right eye was swollen and bruised on the side with a small cut. The resident had often wandered into other resident rooms, both male and female. Continued review of the clinical record for Resident #25 revealed a Psychiatric progress note, dated 03/30/15, that stated the resident had right eye bruising. The note further state per nursing staff notes the resident wandered the unit day and night, often into other resident rooms. The resident was recently punched by another resident whose room Resident #25 had wandered into. Review of the Resident #25's fifteen (15) minute resident Safety Checks revealed the facility was to check on the resident every fifteen (15) minutes for elopement safety concerns. Safety checks on 03/24/15 were not completed from 7:00 AM through 2:45 PM. Interview with CNA #19, on 04/28/15 at 3:40 PM, revealed she usually worked second and third shifts and was usually assigned to complete the fifteen (15) minute safety checks. The aide reported when she came in to work, the day after the incident occurred, she was informed by CNA #2 that Resident #25 had a black eye. She revealed she was not assigned to care for a group of residents and no one completed the fifteen (15) minute safety checks. She stated she was not given any information about any additional requirements or supervision for Resident #25 related to the incident.	F 323		

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F 323	Continued From page 372 Observation of Resident #25, on 04/22/15 at 10:50 AM, revealed the resident had a yellowed discoloration of the skin around the outside of the right eye, from the forehead to cheekbone. Observations, on 04/22/15 at 10:59 AM, 04/23/15 at 2:10 PM, 04/24/15 at 11:21 AM, 04/27/15 at 11:04 AM, 04/27/15 at 11:08 AM, revealed the resident ambulated independently throughout the unit. Interview with Resident #25, on 04/22/15 at 10:59 PM, revealed he/she did not know what had happened to the eye. Interview with RN #6, on 04/23/15 at 1:15 PM, revealed she could not recall specifically what occurred to cause Resident #25's eye injury. The nurse stated if those records were not completed, the incident could re-occur. On 04/23/15 at 2:35 PM, interview with CNA #2 revealed Resident #25 had at times wandered in and out of resident rooms. She stated the resident had a black eye because he/she wandered into another resident's room about a month ago. The aide stated she did not witness the incident; however, was told about it from the roommate, Unsampled Resident A. She stated the incident occurred on second shift. She stated she had worked third shift and noticed a small cut over Resident #25's eye, and about an hour later the eye began to bruise. The CNA further stated she reported to the charge nurse on third shift when the eye started to bruise; however, she could not remember who the nurse was at the time. She stated she did not receive any additional instructions for the care or supervision of Resident #25.	F 323		

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Interview with the UM, on 04/24/15 at 9:35 AM, revealed she was on vacation at the time of Resident #25's injury that resulted in a black eye. She stated the nurse's note by RN #6 for first shift on 03/25/15 stated the resident had bruising to his/her right eye. The UM stated the DCS at the time of the incident would be responsible to investigate the injury. She stated an incident report should have been completed, and the physician and RP notified immediately. The UM stated she became aware of the eye injury when she returned from vacation on 03/31/15. She stated the injury was documented on the twenty-four (24) hour report; however, those reports were only kept by the facility for a few weeks.

On 04/24/15 at 1:24 PM, continued interview with the RN #6 revealed she noticed Resident #25's eye when she came in to work that day, on 03/25/15. The nurse stated she was informed by staff they heard a loud yell and found the resident in his/her bed with blood all over the pillow, and staff thought Resident #25 had been hit. She further stated she was not sure which nurse had reported the incident to her and was uncertain if the incident occurred on second or third shift. She stated Resident #25 had a noticeably big black eye and she completed a nurse's note. The RN stated one of the Social Workers talked to Resident #29 and Unsampled Resident A. She further stated Unsampled Resident A had reported that Resident #29 hit Resident #25. She could not recall if she notified anyone in management about the incident.

On 04/27/15 at 11:04 AM and 11:40 AM, interview with Resident #29 revealed he/she did hit

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Resident #25 because Resident #25 tried to get into the bed with Resident #29's roommate, Unsampled Resident A. Resident #29 stated no staff had come to check on them or interview them; however, Resident #29, did not report the incident to staff.

Interview with the DSS, on 04/27/15 at 2:05 PM, revealed RN #6 had reported she had come on duty on first shift and had discovered Resident #25 with an injury to the eye and that Unsampled Resident A had been irritable with Resident #25. The DSS stated she spoke to Resident #29 and Unsampled Resident A who both said they did not know anything about the incident. She stated she talked to Resident #25 who was not able to answer reliably or sensibly and saw his/her black eye. The DSS further stated she did not document the instance as both Resident #29 and Unsampled Resident A said they did not know anything. She stated she could not recall if the black eye was discussed in the morning meeting or if it was on the 24 hour report.

Interview, on 04/27/15 at 11:42 PM, with RN #1 revealed he worked with Resident #25 on third shift. He stated he could not remember when the resident's eye injury had been brought to his attention; however, had been given the information in report. The RN stated the nurse who gave him report was unsure what had occurred and he was unsure which nurse had given him the report.

On 04/28/15 at 8:35 AM, interview with the DCS revealed she had just begun as the DCS on 04/20/15. She stated Resident #25 had a bruise and fall before she began working at the facility. She stated the UM had informed her Resident

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F 323	Continued From page 375 #25 had a fall that resulted in the eye bruising, and the UM had been on vacation. Per interview, the DCS was not aware of the resident to resident altercation until informed by the SSA. Further interview revealed the purpose of the investigation was to try and determine what happened. She further stated she could not find any information about Resident #25's black eye. She stated the incident report was the root cause analysis form that should be completed by the nurse that discovered the injury. The DCS further stated if the incident report was not completed, there would not be any follow up with the resident, the facility would not know if the resident was injured, and the facility would not know how the incident occurred. She stated the purpose of the root cause analysis was to try and determine how the incident occurred in order to try to prevent the incident from occurring again. The DCS stated certain residents were placed on fifteen (15) minute safety checks to monitor behaviors to keep the resident and other residents safe. She stated if the safety checks were not completed then the resident could elope, or have an altercation with another resident. She further stated the safety checks were not reviewed by anyone for completeness or accuracy and were sent to medical records to be filed. The DCS stated the 24 hour reports were reviewed in the morning clinical meeting and any change of a resident's condition should be documented on the 24 hour report. She further stated the 24 hour reports were kept for thirty (30) days and then shredded. She stated the facility had already discarded the 24 hour reports from the time of Resident #25's black eye. The DCS further stated if the incident information was not in the clinical record, then the facility would not know how to sufficiently care and supervise the resident.	F 323		

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Interview with the Interim ED/RVPO, on 04/28/15 at 9:43 AM, revealed she had been the Interim ED since 04/17/15, and had been the facility RVPO since May 2014. She stated she first became aware of Resident #25's eye injury when the State Survey Agency (SSA) survey process began. She stated the facility did not conduct an investigation into the black eye. The Interim ED further stated the purpose of the root cause analysis was to prevent other injuries. She stated the incident report should have been completed by the nurse and given to the UM, who would take the information to the morning meeting. She stated the facility no longer had the morning meeting notes for March as they were only kept for thirty (30) days. The Interim ED stated if the investigation was not completed the facility would not know what the cause of the incident was and could place the resident at risk of re-injury. She stated resident fifteen (15) minute safety checks were conducted to ensure the resident was where he/she was supposed to be and safe in the environment. She further stated the UM should have monitored that the safety checks were completed. She stated if the safety checks were not completed, a resident could be at risk of wandering or elopement from the facility.

The facility could not provide an investigation or root cause analysis for Resident #25 that would have occurred at the time of the black eye was identified on 03/25/15.

4. Review of the clinical record for Resident #30 revealed the facility admitted the resident on 03/20/15 with diagnoses of Dementia and a history of Traumatic Brain Injury. The Admission Data Collection, dated 03/20/15, revealed the

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F 323	Continued From page 377 resident ambulated independently, was continent of bowel and bladder, and assessed the resident was not at risk for falls with a fall risk score of six (6) and had not had any falls while at the facility. The facility completed an initial MDS on 03/30/15 and assessed the resident with a BIMS score of 12 meaning the resident was interviewable. Continued review of Resident #30's clinical record revealed a nurse's note, on 03/26/15 from the 7:00 am to 3:00 PM shift, that staff (not identified) and the resident reported a fall at approximately 5:00 AM to 5:15 AM, in which the resident fell to his/her knees while using the commode. A Psychiatric note, dated 04/13/15, revealed the resident had a fall on 03/26/15. The resident's comprehensive care plan did not include a risk for falls until 04/01/15. The facility did not provide an investigation, root cause analysis, SBAR, notifications, or neuro checks for Resident #30 for the fall on 03/26/15. Interview with Resident #30, on 04/29/15 at 8:52 AM, revealed the resident answered some questions appropriately and made some unintelligible statements. The resident stated he/she took him/herself to the bathroom and completed the grooming. The resident did not provide any information about a fall since admission to the facility. Interview with the DCS, on 05/04/15 at 2:18 PM, revealed she did not locate an incident report, investigation, SBAR, or neuro checks, or any other documentation related to the fall. Post survey interview with RN #6, on 06/04/15 at 10:58 AM, revealed she worked the morning shift	F 323		

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F 323	Continued From page 378 with Resident #30 on 03/26/15. She stated when she came on duty the resident told her he/she had fallen and had slipped in the bathroom. The nurse stated she received report from the nurse going off duty that Resident #30 had fallen and the nurse had completed all the documentation, notifications, SBAR, and care plan. She stated she had not seen the completed records and she and the physician had not spoken about the resident's fall. RN #6 stated if the documents could not be located, then the records were not completed and the resident would not receive the care needed, and the facility would not be able to address the resident's needs. Post survey interview, on 06/04/15 at 11:08 AM, with CNA #2 revealed she could not recall being informed of the resident fall since the facility admitted the resident. Post survey interview with the UM, on 06/04/15 at 11:12 AM, revealed she could not recall Resident #30 had a fall on 03/26/15; however, she was on vacation at the time, and did not return until 03/31/15. The UM stated she did not remember seeing any documentation related to the fall, such as SBAR, notifications, incident report, or fall root cause report. She stated when the resident had a fall the SBAR, investigation report, root cause analysis, clinical record, care plan, and Kardex were taken to the morning meeting and reviewed. She further stated the team reviewed what the nurse had put into place, and could make any additional changes. 5. Review of the facility's policy regarding Smoking, dated 11/30/14, revealed each resident would be assessed on admission and quarterly to determine if the resident was a safe smoker.	F 323		

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F 323	Continued From page 379 Residents would be evaluated for safety regarding smoking upon admission and quarterly. Interview and record review revealed the facility failed to ensure ensure supervision was provided to Residents #14 and #15, whom the facility assessed to require supervision while smoking. Observation, on 04/20/15 at 10:00 AM, revealed Resident #14 and #15 were outside in the court yard smoking cigarettes without staff supervision. The resident's did not have smoking aprons on as identified by staff. There were smoking aprons available hanging on hooks on the wall inside the door. Review of Resident #14's clinical record revealed the facility admitted the resident on 01/23/15, with diagnoses of Chronic Kidney Disease, Bipolar Disorder, Difficulty Walking, Peripheral Vascular Disease, Hypertension, Depression, and Urinary Tract Infections. Review of Resident #14's Admission Minimum Data Set (MDS) assessment, completed on 02/22/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of fifteen (15) meaning the resident was cognitively intact and interviewable. Review of Resident #14's Admission and Readmission Data Collection form, dated 03/03/15, revealed the facility performed a Safe Smoking Evaluation and determined the resident was not able to light or smoke a cigarette safely, use an ash tray properly, or extinguish a cigarette safely.	F 323		

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Review of the Comprehensive Care Plan for Resident #14 revealed the facility failed to develop a care plan with updated goals and a target date for unsafe smoking.

Review of Resident #15's clinical record revealed the facility admitted the resident on 09/11/14, with diagnoses of Anemia, Hypertension, Hyperlipidemia, Cerebral Vascular Accident, and Hemiplegia.

Review of Resident #15's Admission Minimum Data Set (MDS) assessment, completed on 03/23/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of fifteen (15) meaning the resident was cognitively intact and interviewable.

Review of Resident #15's undated, Admission/Readmission Data Collection form, revealed the facility assessed the resident as unaware of safety limitations and required constant supervision while smoking.

Review of the Comprehensive Care Plan for Resident #15 revealed the facility failed to develop a plan of care with updated goals and a target date for unsafe smoking.

Interview with Unit Manager (UM), on 04/21/15 at 3:25 PM, revealed both residents were assessed as unsafe smokers and needed supervision at all times while smoking and should not have been

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F 323	Continued From page 381 outside smoking without staff. Interview with Assistant Director of Clinical Services (ADCS), on 04/20/15 at 1:50 PM, revealed the residents were assessed as unsafe smokers and should have been supervised by staff while smoking and the care plan directed staff on what to do for each resident. She stated the residents could have burned themselves. 6. Interview on 04/16/15 at 10:45 AM with Resident #6, whom the facility assessed with a BIMS score of fourteen (14), meaning the resident was cognitively intact and interviewable, revealed the resident had to take a bed bath routinely because he/she believed the shower bed was unsafe and was afraid he/she would fall on the floor because the rails would not stay up. Observation of the shower bed, on 04/22/15 at 10:10 AM revealed the shower bed had three (3) plastic spoons and only one metal pin securing the side rails in the up position. Interview with CNA #6, on 04/16/15 at 11:00 AM, revealed the shower bed pins had been missing for a while; however, he was not sure who put the plastic spoons in the holes. Interview with the Assistant Director of Clinical Services, on 04/22/15 at 10:10 AM, revealed the shower bed was used by the facility's bariatric and quadriplegic residents. She stated the side rails should be secured with metal pins and not plastic spoons. She stated the plastic spoons created a safety hazard and a resident could fall off the shower bed if used in this manner.	F 323		

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Interview with the Director of Clinical Services, on 05/22/15 at 2:15 PM, revealed the pins to the shower bed were found in a resident's room when the facility staff were making rounds. She stated the bed was unsafe without the required metal pins and could result in a resident fall with injury.

The facility took the following actions to remove the Immediate Jeopardy on 05/16/15 as follows:

1. The facility notified Resident #4's physician, of a fall that occurred on 02/25/15 with new orders given to the nurse. The resident transferred to a local hospital on 02/25/15 for a tibia fracture and returned to the facility on 02/28/15 with new orders. The DCS assessed Resident #4 on 04/22/15 and was found in stable condition.

2. On 04/28/15, the facility reported to the SSA that Resident #25 was found to have a black eye on 03/25/15. The incident was investigated and with the assistance of the SSD and DCS the source of the black eye was determined as a result of a resident to resident altercation and abuse was unsubstantiated.

3. On 04/22/15, one hundred twenty-six (126) residents were assessed by the ADCS, Nurse Manager, and Licensed Nurse to determine if any residents had an incident or accident or change in condition that would warrant physician notification and further intervention. One (1) resident was identified as having an incident, accident, or change of condition and the physician was notified by the nurse on 04/22/15. Additionally, the Nurse notified the RP and documented this in the clinical record. Nurses would additionally report incidents, accidents, or changes in condition to

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 383 the clinical administrative team. 4. On 04/22/15 the Corporate Administrative Nurses educated twenty-three (23) of thirty-eight (38) Nurses regarding timely notification to the physician related to resident incidents, accidents, or change in condition; care plan policies, evidence of assessments and care planning with immediate falls preventions interventions to meet the resident's needs; and falls procedures, immediate assessment by the Nurse after a resident's fall, notifications to the physician and RP, implementation of an immediate intervention by the Nurse, documentation of the fall in the clinical record by the Nurse, fall root cause investigation report initiated by the Nurse and reviewed by the DCS, and follow up by the IDT in the weekly falls meeting. Nurses were also trained related to reporting an incident, accident, or change in condition, to the resident ' s RP and documentation in the medical record to include the incident, accident, or change in condition, notifications to the physician, RP, and clinical administrative team, nurse's assessment, and interventions; evidence of assessment would include Situation, Background, Appearance, and Review (SBAR) sheet, Interdisciplinary Progress Note, and Neurological (neuro) checks sheet, and documentation of falls. Staff competencies were completed. Nursing staff not educated by midnight on 04/22/15 would not be allowed to work until they received training. Agency Nurses would be trained by the Corporate Administrative Nurses, DCS, Assistant DCS, or Nurse Manager prior to working their next shift. The DCS and ED would ensure staff that had not been educated were educated prior to working their next shift. The ED and DCS would monitor the daily schedule and highlight staff already trained. A	F 323		

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F 323	Continued From page 384 department manager would stand by the time clock at shift change to direct staff that needed education to the training. The IDT would monitor daily incidents and accidents. Notifications of accidents, incidents, or changes of condition would be reviewed for completion by the DCS, ADCS, or Nurse Manager, who would make notifications if not done. 5. An Ad-Hoc Quality Assurance/ Performance Improvement (QAPI) meeting was conducted on 04/22/15 to discuss facility policy and procedure (P&P) for falls, and notifications of incidents, accidents, or changes of condition; care plans as related to immediate falls interventions and revision status post fall, nursing assessment and documentation for falls; with no changes made. Also discussed the facility protocol related to shift relief and report; and additional avenues to attract new staff and maintaining current staff with a plan for performance improvement. 6. On 04/22/15, 126 residents were reviewed for fall risk with a fall risk assessment completed by the DCS and MDS Nurses who had previously been educated on 04/22/15, and care plans and Kardexes were also reviewed, with seventy-four (74) residents whose fall care plans were updated on 04/22/15. 7. On 04/22/15 the Corporate Administrative Nurses educated the DCS, ADCS, and Nurse Manager regarding evidence of assessment and care planning, with immediate falls prevention interventions to meet the resident's needs. On 04/22/15, thirty (30) of fifty-eight (58) CNAs and two (2) Agency CNAs were educated to review the Kardex for specific fall risk information.	F 323		

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F 323	Continued From page 385 8. Certified Medication Technician's (CMT) would be supervised by the Nurse they work with on the unit. The current resident census was reviewed by the ED and DCS to determine which residents required total care, assistance, or were independent with care. 9. On 04/22/15, 126 residents were assessed by Nurses using a visual and/or verbal nursing assessment that included vital signs to ensure there were no current physical or emotional distress or needs that were not met as related to inadequate staffing. One (1) resident was identified in physical distress and the Nurse timely notified the physician. 10. Current residents were reviewed for behaviors, on 05/12/15 and 05/13/15, by Corporate Administrative RNS and two (2) members of the IDT. Care plans were reviewed for sixty-six (66) residents with behaviors, with twenty (20) care plans updated, with one (1) resident placed on 1:1 supervision. 11. 101 of 149 staff and 10 agency staff were educated regarding resident behaviors and documentation, care planning and following the care plan, reporting maintenance issues, safe smoking policy, on 05/13/15 and 05/14/15 by the Corporate Administrative RNs. IDT will meet to ensure behaviors were documented and care planned, notification to the physician, and document on the 24 hour report. Residents with behaviors would be reviewed during the weekly IDT meeting beginning 05/12/15. The 24 hour report would be reviewed in the morning meeting. Forty-eight (48) staff not educated will not be allowed to work until they have been trained. No staff will be allowed to work after 05/14/15 until	F 323		

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they have been educated prior to the start of their shift. The ED or DCS would monitor the schedule and appoint a department manager to stand at the time clock to direct employees still needing education to the in-service.

12. QAPI meeting was held on 05/13/15 to review the P&P for care plans and behavior management, resident weights, skin assessments, ADLs, smoking, assistive devices related to lifts and shower bed, facility maintenance, pest control, housekeeping/ laundry, and staffing, falls, incidents/accidents, grievances, with no changes made. The facility's action plan for removal of the IJ was reviewed and tasks assigned, with department managers assigned to provide daily oversight along with the RDCS/ RVPO/ RDHC/ RCMC/Corporate Administrative RNs.

13. Beginning 05/15/15, residents with new falls and behaviors were reviewed by the Daily IDT team for completion of SBAR, assessment, notification, immediate interventions, and investigation with root cause analysis. Care plans and Kardexes were reviewed/updated with appropriate interventions. No issues were identified, and would be validated five (5) times weekly.

14. Beginning 05/12/15 weekly falls management meeting and weekly behavior management meeting occurred with IDT, with no issues identified. The IDT in the daily meeting reviewed the 24 hour report with no issues identified, and validated one (1) time weekly.

15. A weekly behavior meeting was held on 05/12/15 and 05/13/15 and discussed six (6)

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F 323	Continued From page 387 residents with resident to resident behaviors or sexual/ physical behaviors to ensure behaviors were documented, care planned, and interventions in place. 16. The IDT would review in the daily meeting incidents and accidents reports and the 24 hour report for investigation reports, nursing documentation in the clinical record, an SBAR, notifications to the physician and RP, and care plans with appropriate interventions. 17. On 04/30/15, one hundred twenty-four (124) residents were reviewed for appropriate transfer/lift method and updated the care plans and Kardexes, including Residents #4 and #34. The shower bed was removed from the facility and discarded. A new shower bed was ordered on 05/07/15. A shower bed located in the shed was inspected and discarded by Maintenance on 05/13/15. 18. The SSD completed safe smoking evaluations on fifteen (15) residents who smoke, on 05/13/15, with three (3) identified to require a smoking apron and two (2) referred to therapy for adaptive smoking equipment. Residents who smoke were given a copy of the facility's safe smoking rules on 05/13/15 and 05/14/15. 19. Room rounds were conducted by the ED, on 05/13/15, for incendiary smoking items, with any items found removed and maintained in a locked box at the nurse's station for supervised smoking times by facility staff. A list of residents who smoke and who require supervision or aprons would be kept in the locked box with the Kardexes.	F 323		

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F 323	Continued From page 388 20. On 05/12/15 Corporate Administrative Nurses made walking rounds to identify any maintenance/resident safety concerns. Identified concerns were given to the ED and Maintenance Director for prioritization and repair. On 05/13/15 The ED and Maintenance Director made facility rounds and reviewed the maintenance books at the nurse's stations to identify safety concerns. Safety concerns were addressed by the Maintenance Director on 05/13/15 and 05/14/15. The Maintenance Director was educated on 05/13/15 to check the maintenance books at each nurse's station five (5) times weekly and prioritize based on safety concerns. 21. Fifty-one (51) nursing staff and 10 agency staff were educated on 05/13/15 and 05/14/15 to observe shower beds for safety prior to use. If a shower bed was unsafe or non-functional, staff would immediately remove the equipment and notify maintenance. 22. QAPI monitoring, beginning 05/15/15 of the facility process for falls, smoking, assistive devices, lifts, shower beds, and facility maintenance. 23. Beginning 05/12/15 the IDT would round to observe for environment safety concerns in five (5) resident care areas and immediately addressed by maintenance, and validated five (5) times weekly. Maintenance books would be brought to the daily meeting to discuss concerns five (5) times weekly. 24. Beginning 05/13/15 training and return demonstration of five (5) nursing staff will be completed five (5) times weekly. Observations of five (5) residents during supervised smoking by a	F 323		

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member of the IDT five (5) times weekly. Rounds of five (5) resident rooms for incendiary items by a member of the IDT would be completed five (5) times weekly. Any issues would be brought to the daily meeting.

25. Five (5) residents would be observed, beginning 05/12/15, to ensure fall interventions were in place per the care plan would be completed by IDT five (5) times weekly.

26. On 05/13/15, Corporate Administrative RNs educated facility Administrative Staff on the regulations and P&P for staffing, pest control, housekeeping, and maintenance, with competencies completed. The ED would monitor the facility's process for notification, abuse, hiring, dignity, care plan revision, professional standards, assessments, behavior and falls management, incidents and accidents, smoking, call lights, pest control, and staffing.

27. Review of the 24 hour report, incident/ accident reports, in the daily meeting with the IDT; documentation in the clinical record included notification to the physician and new orders, and to the RP; the IDT made rounds in five (5) resident care areas to observe for maintenance and safety concerns; observations of five (5) residents during supervised smoking by the IDT; room rounds for five (5) residents to search for incendiary items by a member of the IDT, maintenance concerns were written in the maintenance books and taken to the daily meeting and prioritized for repair; observations of five (5) residents to ensure falls interventions were in place per the care plan by the IDT; call lights checked in resident rooms and bathrooms to ensure lights and sound; five (5) staff educated

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what to do if call light inoperable; resident care areas checked for no live pests; were validated five (5) times weekly.

28. Daily oversight since 04/22/15 on all shifts to ensure residents were safe and the plan of care was followed to meet resident needs, by the ED/ DCS/ RVPO/RDCS/Corporate Administrative Nurses.

29. The IDT would meet at least monthly to discuss facility action plan and ensure tasks were completed for the removal of the IJ, and QA monitoring completed according to the AOC during the IJ period, validated by the ED/RVPO/RDCS/Corporate Administrative RNs.

30. Per the Ad-Hoc QAPI meeting, on 05/15/15, QI monitoring would be done utilizing approved audit tool with oversight by the ED, beginning 05/16/15, five (5) resident interview; new resident/ family concerns; daily department head meeting to ensure new resident injuries or concerns were discussed; five (5) new employee files reviewed two (2) times weekly; residents with new falls or behaviors were reviewed in the daily meeting with IDT and care plans/ Kardexes reviewed and updated; review of the 24 hour report and the incident and accident reports in the daily meeting with IDT; review of the clinical record for timely notifications to the physician and RP; the IDT rounds in five (5) resident care areas to observe the environment for safety and maintenance concerns; observations of five (5) residents during supervised smoking; room rounds of five (5) residents for incendiary items; maintenance concerns listed in the maintenance book and taken to the daily meeting to discuss and prioritize repairs; observations of five (5) residents to

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F 323	Continued From page 391 ensure falls interventions were in place per the care plan by the IDT; five (5) resident rooms call lights checked to ensure they light at the door, nurse's station, and sound; five (5) staff education what to do if a call light was inoperable; five (5) times weekly; weekly falls and behavior management meetings occur with IDT one (1) time weekly. 31. The RVPO/RDCS/Corporate Administrative RNs would provide daily oversight of the ED and DCS in areas of falls, incidents, accidents, change in condition, sufficient staffing to meet resident needs, housekeeping and laundry, and pest control during the IJ period until removal. The State Survey Agency validated the removal of Immediate Jeopardy on 05/22/15 as follows: 1. Review of the facility's SBAR's, incident report, neuro checks, progress notes and physician orders, all dated 02/25/15, revealed Resident #4 had a fall on 02/25/15, the physician was notified on 02/25/15 with new orders received. The resident was transferred to a local hospital on 02/25/15 for a tibia fracture on 02/25/15, and returned to the facility on 02/28/15 with new orders. The DCS assessed Resident #4 on 04/22/15 and found the resident was stable. 2. Review of the facility investigation, dated 04/28/15, for Resident #25's black eye noted on 03/25/15, revealed the SSA was notified on 04/28/15, investigated, and followed up on 05/04/15. The investigation resulted in the cause of the injury from a resident to resident altercation. Interview with the DCS, on 05/20/15 at 2:04 PM, revealed she investigated Resident #25's black eye and the cause was determined to	F 323		

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F 323	Continued From page 392 be a resident to resident altercation. Observation, on 05/22/15 at 2:11 PM of Resident #25 revealed the resident was in his/her recliner with the TV on and staff sitting with him/her on a 1:1. 3. Review of one hundred twenty-six (126) resident assessments, completed by ADCS/Nurse Manager/Licensed Nurse, on 04/22/15, revealed residents were assessed for any incident or accident, or change in condition that warranted notification to the physician. One (1) resident was identified as experienced a change in condition, accident, or incident and the physician was notified on 04/22/15. 4. Review of in-service records, revealed twenty-three (23) nurses were educated by Corporate Administrative Registered Nurses regarding: timely notification to the physician related to incidents, accidents, and changes in condition; care plan policies; resident assessments, including SBAR, neuro checks; falls and immediate interventions; notification to the physician and RP; documentation of the fall in the clinical record; fall root cause investigation report. Staff competencies were completed. No staff had worked prior to them receiving the training. Review of staffing schedules revealed staff who had not yet been trained were not highlighted, which noted they required education. Review of facility records revealed notifications of incidents, accidents, and changes in condition were reviewed for completion by the DCS/ADCS/ Nurse Manager. Interview with the DCS and RDCS, on 05/04/15 at 4:18 PM, revealed twenty-three (23) nurses had been trained. Interview with RN #8, on 05/04/15 at 4:33 PM, with CNA #11, on 05/05/15 at 9:51 AM, with the UM, on 05/05/15 at 9:55 AM, CNA #14, on	F 323		

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F 323	Continued From page 393 05/05/15 at 10:03 AM, CNA #13, on 05/05/15 at 10:10 AM, revealed they had been educated on falls, notifications, Kardex and care plans. Interview, on 05/05/15 at 2:00 PM, with the DCS, ADCS, Nurse Manager, ED, Admissions Coordinator, DSS, MDS Director revealed they had all been trained on care plans, changes in condition, staff look at interventions for residents, the 24 hour report, falls, SBAR, incident reports, Kardex and care plans, notifications to the physician and family. 5. Review of a QAPI sign in sheet, dated 04/22/15, and agenda revealed the committee discussed the P&P for falls management, notifications of incidents, care plans, falls interventions, nursing assessments, shift to shift relief and report, with no changes made. Interview with the DCS, ADCS, Nurse Manager, ED, Admission Coordinator, DSS, MDS Director, on 05/05/15 at 2:00 PM, revealed QA would track and trend falls information to validate interventions and notifications were being completed. 6. Review of resident assessments for risk for falls, dated 04/22/15, for one hundred twenty-six (126) residents revealed seventy-four (74) residents were assessed by the ADCS as at risk for falls. Review of the Kardexes and Care Plans for the seventy-four (74) residents assessed at risk for falls revealed the Kardexes and care plans had been updated, on 04/22/15. Observation of room 107-A, on 05/05/15 at 1:26 PM, revealed the resident had falls interventions in place. Observation, on 05/05/15 at 1:30 PM, of room 112-A, revealed the resident's falls interventions were in place. Observation, on 05/05/15 at 1:30 PM, of Unsampled Resident Y	F 323		

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F 323	Continued From page 394 revealed the resident had falls interventions in place. Observation of Unsampled Resident O, on 05/05/15 at 2:52 PM, revealed the resident's falls interventions were in place. 7. Review of training records, dated 04/22/15, revealed thirty (30) CNAs and two (2) agency staff were educated on the Kardex and falls risk. The Corporate Administrative RNs educated the DCS/ADCS/Nurse Manager, on 04/22/15, regarding assessments, care plans, documentation of falls, and immediate falls interventions. Interview with CNA #6, on 05/05/15 at 10:12 AM, revealed he received training on the Kardex, falls, and notify the nurse if a resident had a change in condition. 8. Review of staff schedules revealed CMTs were scheduled to work with another nurse present on the unit. Review of a resident census revealed, on 04/22/15, the ED and DCS reviewed which residents required total care, assistance, or were independent with care. Observation, on 05/05/15 at 10:15 AM, revealed CMT/ CNA #11 on the 200 unit was supervised by LPN #1. 9. Review of assessments for one hundred twenty-six (126) residents, dated 04/22/15, revealed residents were assessed by the DCS, with vital signs taken. One (1) resident was identified in distress and the physician was notified at that time. 10. Review of current residents were assessed for behaviors by the Corporate Administrative Registered Nurses/Interdisciplinary Team, on 05/12/15 and 05/13/15, revealed sixty-four (64) residents with behaviors had their care plans reviewed, with nineteen (19) care plans updated.	F 323		

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F 323	Continued From page 395 One (1) resident was placed on 1:1 supervision, on 05/13/15. Interview with the RDCS, on 05/22/15, revealed sixty-four (64) residents were reviewed, and nineteen (19) actually had care plan interventions updated. 11. Record review of in-services conducted 05/13/15 and 05/14/15 revealed one hundred one (101) staff were educated by Corporate Administrative Registered Nurses on bathing, AM care, shaving, hair care, change in condition, notifications to physician and RP, assessments, linens and laundry, falls, behaviors, abuse, resident smoking and use of aprons. Observation on the IDT in daily morning meeting, on 05/22/15 at 9:05 AM, revealed specific residents and behaviors, the 24 hour report, with department heads noted an new orders or changes to the care plans. 12. Review of a QAPI sign in sheet, dated 05/13/15, and agenda revealed the P&P for care plans and behavior management were discussed with no changes made. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Staff Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS attended the QA meetings. 13. Review of audit tools revealed residents with new falls and behaviors were reviewed by the Interdisciplinary Team in the daily meeting for completion of the documentation, notifications, care plans and Kardexes. Observation, on 05/22/15 at 9:05 AM, of the IDT morning meeting revealed specific resident concerns were reviewed, 24 hour report and behaviors were discussed, and care plans reviewed. Interview, on 05/22/15 at 2:52 PM, with the DCS revealed	F 323		

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facility audits were reviewed in the daily meeting and any concerns discussed.

14. Review of the weekly falls meeting and behavior management meeting with the IDT, beginning 05/12/15, revealed meetings were conducted. Observation of the daily IDT meeting, on 05/22/15 at 9:05 AM, revealed the 24 hour report was discussed. Interview with the DCS, on 05/22/15 at 2:52 PM, revealed resident behaviors were reviewed in the behavior management meeting.

15. Review of weekly behavior meeting notes, dated 05/12/15 and 05/13/15, revealed six (6) residents with resident to resident behaviors or sexual/physical behaviors were reviewed for documentation, care plan interventions. Interview with the DCS, on 05/22/15 at 2:52 PM, revealed the behavior meeting reviewed and monitored residents with behaviors, notifications, interventions were in place, and possibility for more frequent monitoring.

16. Observation of the morning meeting, on 05/22/15 at 9:05 AM, revealed the IDT reviewed the 24 hour report, care plans, and specific resident concerns.

17. Review of facility assessments, dated 04/30/15, revealed one hundred twenty-four (124) residents were assessed for transfer/lift with Kardexes and care plans updated. Observation, on 05/22/15 at 2:20 PM, revealed no concerns with a broken shower bed in the 100 Unit shower room and lifts were functional.

18. Review of resident Safe Smoking Evaluations for fifteen (15) residents and completed by the

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F 323	Continued From page 397 SSD, on 05/13/15, revealed three (3) residents were identified to need a smoking apron. Review of the therapy screening tool revealed, and two (2) residents were referred to therapy. Observation, on 05/22/15 at 4:53 PM, revealed one (1) resident was smoking, used an apron, and staff assisted the resident to smoke. Interview with the DSS, on 05/22/15 at 2:52 PM, revealed she completed the resident smoking assessments and if the resident needed an apron. 19. Observation of the resident smoking area, on 05/22/15 at 4:53 PM, revealed eight (8) aprons hanging near the door, one (1) resident smoking with staff assistance, and wearing an apron. Observation of the smoking box on the 200 Unit, on 05/22/15 at 4:57 PM, revealed boxes of cigarettes for all residents of the facility; a list of residents who smoked and who required an apron. Interview with CNA #2, on 05/22/15 at 4:57 PM, revealed Central Supply and a staff from the 200 Unit cover the smoking times during the day; resident cigarettes and lighters should be kept in the smoking box which was kept locked in the medication room. 20. Review of rounding sheets, dated 05/12/15, revealed maintenance and environmental concerns were audited by Executive Director and Maintenance Director. Review of rounds completed by the ED and Maintenance Director, on 05/13/15, revealed maintenance books on each unit were reviewed for any maintenance issues, with concerns addressed on 05/13/15 and 05/14/15. Interview with the Maintenance Director, on 05/22/15 at 2:52 PM, revealed any maintenance issues should be listed in the maintenance book at each nurse's station, which	F 323		

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F 323	Continued From page 398 he will take to the morning meeting, and discuss what had been addressed on the maintenance concerns. 21. Review of in-service records, dated 05/13/15 and 05/14/15, revealed staff were educated on showers and beds. Interview, on 05/22/15 at 3:20 PM, with CNA #5 revealed she was educated not to use broken equipment or shower beds and to report to supervisor and maintenance if equipment/shower bed was broken. 22. Review of a QAPI sign in sheet, dated 05/15/15, audit tools, and agenda revealed monitoring of falls, smoking, assistive devices, lifts, shower beds, and maintenance occurred. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, Housekeeping Supervisor, and DSS revealed they attended the QA meetings. 23. Review of facility rounding sheets, dated 05/12/15, revealed the environment was observed, by Corporate Administrative Registered Nurses for maintenance needs. Observation of the morning meeting, on 05/22/15 at 9:05 AM, revealed the maintenance books were taken to the IDT meeting and reviewed. Interview with the Maintenance Director, on 05/22/15 at 2:52 PM, revealed he would take the maintenance books to the morning meetings. 24. Review of staff training records, beginning 05/13/15, revealed five (5) staff were trained with return demonstration for transfers. Review of the smoking list revealed residents who smoked were listed, with resident who required an apron and/or supervised smoking were identified. Review of	F 323		

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F 323	Continued From page 399 rounding sheets, beginning 05/13/15, revealed resident rooms were searched for incendiary smoking items by the Executive Director. Observation of the facility's smoking box on the 200 unit, on 05/22/15 at 4:57 PM, revealed cigarettes were stored for the entire facility, and contained a list of residents who smoked, with those who required an apron identified. Interview with CNA #2, on 05/22/15 at 4:57 PM, revealed the box should be locked in the med room and the box had the cigarettes and lighters for all residents who smoked in the facility. 25. Review of the facility's audit tool revealed, beginning 05/12/15, residents were observed to ensure fall interventions were in place per the care plan. Interview with the DCS, ADCS, UM, Medical Records, BOM, and DSS, on 05/22/15 at 2:52 PM, revealed audits were conducted every morning and looked for falls interventions compared to the care plan and discussed in morning meeting. 26. Review of in-service records, dated 05/13/15, revealed Administrative staff were trained on staffing, pest control, housekeeping and maintenance, and would be monitored by the ED. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS revealed they had been trained on staffing, pest control, housekeeping and maintenance, and any concerns of audits would be taken to the morning meeting. Interview with Resident #3 on 05/22/15 at 1:00 PM, revealed staffing had improved and were answering lights timely and the facility looked cleaner.	F 323		

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F 323	Continued From page 400 27. Observation of the daily morning meeting, on 05/22/15 at 9:05 AM, revealed review of the 24 hour report, notifications made and documented, new physician orders, maintenance concerns and books, pests, rounds and audits, call lights, care plans. Interview with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, MDS Coordinator, and DSS, on 05/22/15 at 2:52 PM, revealed they participate in the morning meeting and review the 24 hour report, notifications were made, maintenance books reviewed, physician orders, call lights, care plans, and audits/ round were reviewed in the morning meeting. 28. Interview, on 05/22/15 at 2:52 PM, with the DCS revealed facility concerns were reviewed in the morning meeting, including audits and rounding results, for department heads to address. She stated she (the DCS) or the ED would initial when concerns were resolved. Observation, on 05/22/15 at 9:05 AM, of the morning meeting revealed the DCS provided direction and asked clarifying questions related to information discussed with follow up items determined. 29. Review of sign in sheets, dated 04/22/15, 05/13/15, and 05/15/15, revealed QAPI meetings were held on those dates. Interview, with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS revealed they attended the QAPI meetings. Interview with the RDCS, on 05/22/15 at 5:05 PM, revealed the next QAPI meeting was scheduled for 06/17/15. Interview with the Medical Director, on 05/22/15 at 8:00 AM, revealed he was informed by the Executive Director of the resident care issues, attended the	F 323		

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F 323	Continued From page 401 QA meetings held by the facility and provided direction regarding corrective action plans that were developed to meet the needs of the residents. 30. Review of the QAPI sign in sheet, dated 05/15/15, and agenda revealed audit tools were approved for QA monitoring and discussed: resident interviews; resident/family concerns; morning meeting; new employee files; falls or behaviors reviewed; care plans and Kardexes update; review of the 24 hour report; notifications; maintenance rounds and book; supervised smoking; falls interventions in place; call lights; weekly falls; and, behavior management meetings. 31. Review of the sign in sheet for QAPI, dated 05/13/15, revealed the ED and DCS presented and reviewed falls, changes in condition, staffing, housekeeping, and laundry, and pest control, and would provide daily oversight.	F 323		
F 325 SS=J	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325		

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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 have an effective system to ensure residents at risk for weight loss had weights obtained in order to evaluate nutritional needs, and physician's orders and care plan interventions were in place for weight loss prevention for two (2) of forty-three (43) sampled residents (Residents #4 and #31).

Review of Resident #4's clinical record revealed the resident was at risk for altered nutrition and had an order, dated 02/28/15, for weekly weights and staff was to monitor the resident's food intake. Interview and record review revealed the resident was not weighed weekly per the physician's order. The resident weighed 97.8 pounds on 03/20/15 and the next weight obtained on 04/10/15 revealed a weight of 88.6 pounds, a significant weight loss of 9.4% in less than one month. Review of the resident's meal intake sheets revealed the resident's meal consumption was not recorded consistently.

Review of Resident #31's documented weights and meal intake records revealed the facility failed to obtain weights as ordered and did not routinely record meal consumption.

The facility's failure to have an effective system in place to maintain acceptable parameters of nutritional status through weight monitoring has caused or is likely to cause serious injury, harm, impairment or death to resident. The Immediate Jeopardy was identified on 04/22/15 and determined to exist on 04/10/15.

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F 325	Continued From page 403 An acceptable Allegation of Compliance (AOC) was received on 05/19 /15 alleging the Immediate Jeopardy was removed on 05/16/15. The State Survey Agency validated the Immediate Jeopardy was removed on 05/16/15 as alleged, prior to exit on 05/22/15. The scope and severity was lowered to an E while the facility monitors the implementation of the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes. The findings include: Review of the facility's policy regarding Weighing the Resident, dated 11/30/14, revealed at a minimum all residents would be weighed upon admission and monthly unless ordered otherwise by the physician or as directed by the weight committee, or if contraindicated by the resident's condition. When there was a significant variance from the previous recorded weight, the resident was to be re-weighed and a licensed nurse was to validate. Weights would be documented in the clinical record. Nursing would notify the physician of any significant weight change, consult with the Director of Dietary Services and or Dietitian, notify the Interdisciplinary Team in order to update the plan of care, and the weight committee would review residents with significant differences in weights. 1. Review of Resident #4's clinical record revealed the facility admitted the resident on 05/16/13 with diagnoses of Hypertension, Atrial Fibrillation, Chronic Obstructive Airway Disease, Congestive Heart Failure, Macular Degeneration, Rheumatoid Arthritis, Osteoporosis and an Open Wound Site. Review of the Quarterly Minimum Data Set (MDS) assessment, completed	F 325		

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F 325	Continued From page 404 03/09/15, revealed the facility assessed Resident #4 as rarely/never understood with a Brief Interview for Mental Status (BIMS) score of ninety-nine (99). Review of Resident #4's Comprehensive care plan, dated 03/02/15, revealed there was no care plan prior to 03/02/15 to address nutrition. The care plan dated 03/02/15 stated the resident was at risk for altered nutrition and hydration due to possible medical causes and or increase nutrition requirements and the resident would maintain adequate nutrition status and would maintain weight and have no unexplained significant weight changes and intake would be at least seventy-five percent (75%). The resident would receive a mechanical soft diet, supplements, and staff would monitor weight, laboratory values and intakes. Review of the physician's order, dated 02/28/15, revealed Resident #4's weights were to be obtained weekly. Review of the weight record revealed Resident #4 weighed ninety-seven (97) pounds on 01/19/15 and 01/28/15. On 02/17/15, the resident weighed 97.7 pounds and on 03/02/15 and 03/20/15 the resident weighed 97.8 pounds. There was no documented evidence that weights were obtained weekly from January through March 2015. Further review of Resident 4's weight record revealed a weight of 88.6 pounds on 04/10/15, 84.8 pounds on 04/17/15, and 84.1 pounds on 04/21/15. The resident experienced a 12.9 pound weight loss from 01/19/15 through 04/21/15. There was no documented evidence the facility staff re-weighed the resident on 04/10/15 as directed by the policy.	F 325		

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F 325	Continued From page 405 Review of the Dietitian notes, dated 03/20/15, revealed she was still waiting for weights this month and zero weights for February. Per record review there were no weights for the Dietitian to review, she stated she was waiting for weekly weights and there weren't any. Per nursing, the resident would benefit from moving to the dining room to eat with cues and assistance. Resident also had recent fracture to right tibia and presents with new pressure ulcer to ankle and foot; at this time wounds are unstageable. Recommend to move the resident to the dining room seating in order to increase intake. Review of the Dietitian notes, on 04/17/15, revealed the residents' current body weight was 84.8 pounds taken on 04/17/15. The resident had a seventeen (17) percent weight loss in the last 180 days and thirteen (13) percent weight loss in the last 90 days. Review of the Minimum Data Set (MDS) definition of significant weight loss revealed a 5% loss in 30 days, 7.5% in 90 days or 10% in 180 days was considered significant and the facility should not wait for the 180 day time frame to address the problem. Changes in 5% should prompt a thorough assessment of the resident's nutritional status. Interview with the Dietitian, on 04/17/15 at 11:05 AM, revealed Resident #4 had a decline in health with the development of pressure and hospital stays and weighed eighty-one (81) pounds. (without referencing her notes). She stated she was having a difficult time obtaining the resident's weights for evaluation so she was going to ask staff to weigh the resident for her today. Interview	F 325		

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with the CNA on duty revealed the weight had not been obtained. The Dietitian stated she obtained information from nursing regarding intakes because there were very few documented in the computer. She stated she changed the resident's meal to a pureed and ordered the resident to be fed; however this was inconsistently done, provided snacks and Speech Therapy was to evaluate the resident. The Dietitian went of maternity leave and refused follow-up interviews.

Interview with Certified Nursing Assistant (CNA) #1, on 04/16/15 at 9:00 AM, revealed she normally weighed residents in the lift; however, the lift was broken so she had not weighed Resident #4 in a while. She stated they could take the resident to another unit where they had a scale to weigh residents in a wheelchair. First, you had to take the wheelchair down there to weigh it; then come back and get the resident to weigh them in the wheelchair; so you could subtract the wheelchair weight. She stated that just took too much time and when she was going back and forth between the units, she was not available for the residents on her unit.

Interview with Licensed Practical Nurse (LPN) #2, on 04/20/15, revealed she was unable to find weekly weights on Resident #4. She stated the resident had sustained a weight loss and it was important to monitor the resident's weight to determine if the interventions put in place were working. She stated she was not aware the CNA's had not been weighing the resident, but knew the lift the aides used to weigh the residents was broken.

Interview with the previous Executive Director

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(ED) in charge at the time of Resident #4's weight loss, on 04/23/15 at 8:34 AM, revealed she was not aware Resident #4's weights were not obtained routinely. She stated it was the responsibility of nursing to ensure this was done. She stated the facility had a weight and wound meeting weekly and was not aware there were any issues with the facility's process in monitoring resident's weights.

Interview with the Director of Clinical Services (DCS), on 04/29/15 at 7:55 AM, revealed she was not aware of Resident #4's weight loss or that the weights were not obtained. She stated she was only employed by the facility for two (2) weeks and her last day was 04/17/15.
2. Review of the clinical record for Resident #31 revealed the facility admitted the resident on 08/11/14 with diagnoses of Gangrene Right Foot, Peripheral Vascular Disease, Coronary Artery Disease, and Diabetes Mellitus, A Right Below the Knee Amputation (RBKA) was completed on 12/01/14. The resident was re-admitted on 02/17/15 with diagnoses of Peripheral Vascular Disease (PVD), Diabetes Mellitus (DM), and a Left Above Knee Amputation (LAKA) completed on 02/11/15. The facility completed a Quarterly MDS on 02/17/15 and assessed the resident to have a BIMS of six (6) meaning the resident was not interviewable.

Review of the facility's care plan for Resident #31 for alteration in nutrition/hydration status, dated 08/15/14, revealed the resident had diagnoses of DM and CHF with interventions to monitor weight and intake. Review of the care plan for potential complications secondary to a coccyx pressure ulcer, revised 12/07/14, revealed an intervention of weekly weights while on the Nutritionally at

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F 325	Continued From page 408 Risk Program (NAR). The facility care plan for risk of dehydration related to diuretic use, dated 08/22/14, revealed an intervention to observe weights per order. The facility's care plan for risk of hypo/hyperglycemia, dated 08/22/14, revealed an intervention to encourage compliance with diet and observe PO (oral) intake. The nutritional care plan, revised 04/19/15, identified the resident had a progressive and significant weight loss of 21.8% over 180 days, with increased caloric needs due to a pressure ulcer. Review of a Dietary note, dated 01/19/15, revealed the resident's wound to his/her coccyx and all supplements in place were adequate to promote wound healing and prevent weight loss, and to monitor the resident's PO intake and weight changes. Review of the Physician Order Sheet (POS) for December 2014 revealed an order for weekly weights dated 12/11/14 and a 12/11/14 weight of 133.20 pounds. The resident, based on the care plan, was identified by the facility as a significant weight loss from 133.20 pounds to 102 pounds (-31.20 pounds) on 04/06/15. January 2015 POS revealed an order for weekly weights with no specific date. Review of the facility's weights for Resident #31, revealed in January 2015 the resident weighed one hundred twenty-seven (127) pounds on 01/05/15, one hundred nineteen (119) pounds on 01/16/15, and one hundred eighteen (118) pounds on 01/19/15. There was no documented evidence the facility re-weighed the resident on 01/16/15 to validate the weight loss as directed by the policy. The facility did not provide weekly weights for the week of 01/26/15. Review of Resident #31's weight record for	F 325		

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F 325	Continued From page 409 February 2015 revealed the resident weighed one hundred twenty-one (121) pounds on 02/08/15, and one hundred eleven (111) pounds on 02/25/15. The facility did not provide weekly weights for the weeks of 02/02/15 or 02/16/15. Review of a hospital Discharge Summary, dated 02/14/15, revealed the resident was admitted to the hospital on 02/06/15 and had a left AKA on 02/11/15. A Readmission MDS, dated 02/14/15, revealed the resident refused his/her weight, and had a left AKA. A quarterly Nutritional Review, dated 02/17/15, revealed the resident's food intake was 50-100%, had a Stage IV pressure ulcer to his/her coccyx, and received supplements. The weight noted was one hundred twenty-one (121) pounds. However, record review revealed the weight of 121 pounds was recorded on 02/08/15 prior to the resident's left AKA. There was no weights recorded after the resident's readmission. Review of a hospital Discharge Summary, dated 03/03/15, revealed the resident was admitted to the hospital on 02/26/15 after a fall, and discharged back to the facility on 03/03/15. Review of the Nutritional Evaluation, dated 03/06/15, revealed the resident would have weight fluctuations due to diuretic use and use of Remeron. The resident was noted with a pressure ulcer to his/her coccyx with increased nutritional needs related to aid in the healing of the pressure ulcer, and to monitor PO (oral) intake and weight changes. The facility did not provide a weight when the resident returned on 03/03/15, and did not provide a weekly weight for the week of 03/10/15. Review of a hospital History and Physical (H&P),	F 325		

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F 325	Continued From page 410 dated 03/16/15, revealed the resident was admitted on 03/15/15 with altered mental status, Urinary Tract Infection (UTI), and a pressure ulcer on the coccyx. Review of a facility Readmission MDS, dated 03/27/15, revealed the facility readmitted the resident from the hospital with UTI and pressure ulcer on his/her coccyx, and the resident's weight was one hundred seven (107) pounds. Review of Resident #31's weight record for April 2015 revealed a Re-admit Nutritional Evaluation, dated 04/03/15, that stated the resident weighed 107 pounds and his/her ideal body weight was 107 pounds +/- 10% for the amputation calculation. On 04/06/15, the resident weighed 102 pounds. Review of the facility Meal Intake Detail Report for Resident #31, dated 01/02/15 through 05/20/15, revealed the report had documented intakes for breakfast, lunch, dinner, and evening snack. The report had multiple missing entries for all months from 01/01/15 through 05/20/15, for all meals and evening snack, and multiple days without entries, for example breakfast for the month of January had twelve (12) intakes listed, with zero (0) entered for February and one (1) for May; zero (0) intakes listed for lunch in February, four (4) lunches in March, and zero (0) lunches in May. Observation of Resident #31, on 04/29/15 at 9:00 AM, revealed the resident ate breakfast independently in the dining room. The resident was seated in a wheelchair with a blanket over his/her lap. Observation, on 04/29/15 at 9:12 AM, revealed the resident was able to self-propel his/her wheelchair to his/her room and a second meal tray was served to the resident in his/her	F 325		

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F 325	Continued From page 411 room and the resident ate independently. Observation of the lunch meal, on 04/29/15 at 12:52 PM, revealed the resident was unhappy with the meal served, was offered and accepted an alternate at 1:05 PM. Observation of Resident #31 while being weighed, on 05/13/15 at 10:12 AM, revealed a weight of one hundred twelve (112) pounds. Observation of the lunch meal, on 05/15/15 at 1:12 PM, revealed the resident ate in the dining room independently and had eaten 90% of a sandwich and 50% of soup. Interview, on 04/30/15 at 1:40 PM, with Resident #31 revealed he/she had an area on the bottom that had gotten repeatedly better and the gotten worse again. The resident stated he/she had lost weight with the second leg amputation; however, the facility provided extra food. Interview, on 05/01/15 at 1:36 PM, with the Unit Manager (UM) revealed resident meal intakes should be documented for every meal every day. She stated agency CNAs did not have access to the Caretracker system (electronic documentation) and should use an Activities of Daily Living (ADL) tracking form. The UM stated Resident #31 did not transfer to her unit until after the resident had his/her second leg amputated. She further stated the resident had a UTI recently, and his/her last weight was one hundred seven (107) pounds. The UM further stated the resident had a current pressure ulcer. On 05/05/15 at 2:18 PM, interview with the Director of Clinical Services (DCS) revealed some residents had physician orders for weekly weights and were reviewed in the weekly weight meeting. She stated the Dietician was responsible to monitor residents for weight loss or	F 325		

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F 325	Continued From page 412 gain. The DCS stated when a resident was admitted by the facility, he/she should be weighed weekly for four (4) weeks. She stated if the physician ordered anything different the order would be in the chart and on the MAR and TAR. The DCS stated the day the resident weights were due, the nurse was responsible to ensure the CNAs obtained the resident's weight, and the nurse would document on the MAR/TAR. She stated the Dietician reviewed resident weights in the weekly weight meeting, and would discuss the resident's wounds; whether the resident had a loss or gain of weight; if supplements or medications were needed; or any other recommendations. Interview with the Interim Executive Director/Regional Vice President of Operations (ED/RVPO), on 05/05/15 at 3:05 PM, revealed the facility failed to accurately document Resident #31's weights. She stated the resident had a second amputation and had been in and out of hospital; however, if the information for the resident's weights were not documented then it would be difficult to validate what had occurred. Interview with CNA #2, on 05/13/15 at 10:34 AM, revealed all residents were weighed monthly with certain residents weighed weekly. She stated the aides were responsible to weigh the residents. The CNA stated Resident #31 was on another unit, transferred to the hospital, and then went to the 200 Unit. She revealed meal intake percentages eaten should be documented in the Caretracker every day for every resident. On 05/13/15 at 10:50 AM, interview with LPN #2 revealed Resident #31's weekly weights should be documented on the MAR. She stated the	F 325		

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F 325	Continued From page 413 CNAs were responsible to obtain the resident's weight, and inform the nurse so the nurse could document it on the MAR. The nurse stated a resident whose nutrition was not very good would have weekly weights. The LPN stated if the resident was not weighed weekly then the facility would not be able to track the resident's progress. Additionally, she stated the CNAs were responsible to document what percentage of the meal a resident ate, for every resident, for every meal. She stated the purpose of documenting the intakes was to assist in determining how much the resident ate, or if supplements or any changes were needed. Interview with Registered Dietician (RD) #2, on 05/15/15 at 9:36 AM, revealed she started as the RD, on 05/11/15. She stated when Resident #31 had the left AKA the Dietitian would have looked at the percentage in change of body weight and adjust the resident's ideal body weight (IBW) to the new range. She stated she completed a review on Resident #31 on 05/12/15 and she obtained the resident's weight from a quarterly admission note from 05/01/15. The RD stated Resident #31 had a weight loss that included the second amputation. She reported the resident would receive interventions, such as double entrees, as the resident ate well, per staff reports. The RD stated she was not aware how the resident had been eating from December 2014 through March 2015 as she did not have access to the resident's intake reports. On review of Resident #31's intake reports, the RD stated she had not seen the facility's meal intake reports. She further stated the intake report for Resident #31 was missing entries and she was unable to determine if there was an issue with the resident's intake. She further stated she was	F 325		

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F 325	Continued From page 414 unable to get an accurate assessment of a resident's regular intake. Upon review of Resident #31's weekly weights, the RD reported missing weights and she would not be able to determine if interventions were effective. She stated Resident #31 had increased nutritional needs to promote healing of a Stage 4 pressure ulcer, and needed protein to promote healing. She further stated if the resident's weights and intakes were not documented the resident could experience weight loss unrecognized by the facility or the wounds could worsen or not heal. The RD stated she evaluated if interventions were working by looking at the healing progress of a resident's wound, monitoring the resident's weights, and the overall condition of the resident. Continued interview with the DCS, on 05/20/15 at 2:04 PM, revealed Resident #31 had a physician order for weekly weights since 12/18/14; however, the facility did not have weekly weights for the resident. She stated the intake report since January 2015 for Resident #31 revealed intakes were not documented for every meal, every day. She stated the CNAs were responsible to document the resident's intake. The DCS stated the purpose of documenting the resident meal intake was to monitor how much the resident had eaten to determine if the resident received adequate nutrition and fluids to maintain his/her health. She further stated documented intakes also identified if medications and supplements, or food preferences were also needed. The DCS reported a resident's nutrition affected pressure ulcers and wounds. She stated wounds would not heal without proper nutrition. The DCS stated she could not determine if Resident #31 received proper nutrition for his/her wound healing based on the intake report since	F 325		

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F 325	Continued From page 415 January 2015, as there was no way to know how much the resident consumed. She stated she could not assess how to properly care for the resident with the documentation the facility had. The DCS stated Resident #31's weight documented for 02/08/15 could not have occurred, as the resident was in the hospital at that time and was unsure how the 02/08/15 weight was documented. The DCS stated based on the weights and intake reports the dietitian would not have a complete picture of Resident #31 related to his/her nutrition and would not have all the needed information to make an assessment. The DCS further stated Resident #31's weekly weights and meal intakes, the Dietitian would not be able to make recommendations when needed, such as medications and supplements, or evaluate if interventions were effective. Continued interview, on 05/21/15 at 8:23 AM, with the Interim ED revealed Resident #31's meal intakes were not documented on a daily basis. She stated she monitored resident's weights through the weekly weight meeting. She stated there were concerns that staff were not obtaining resident weights timely. The Interim ED stated the Dietician should have resident meal intake reports as well as their weights and nutrition was an overall part of a resident's wound healing process. The facility took the following actions to remove the Immediate Jeopardy on 05/16/15 as follows: 1. On 04/22/15, one hundred twenty-six (126) residents were assessed by the ADCS, Nurse Manager, and Licensed Nurse to determine if any residents had an incident or accident or change in	F 325		

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F 325	Continued From page 416 condition that would warrant physician notification and further intervention. One (1) resident was identified as having an incident, accident, or change of condition and the physician was notified by the nurse on 04/22/15. Additionally, the Nurse notified the RP and documented this in the clinical record. Nurses would additionally report incidents, accidents, or changes in condition to the clinical administrative team. 2. On 04/22/15 the Corporate Administrative Nurses educated twenty-three (23) of thirty-eight (38) Nurses regarding timely notification to the physician related to resident incidents, accidents, or change in condition; care plan policies, evidence of assessments and care planning with immediate falls preventions interventions to meet the resident's needs; and falls procedures, immediate assessment by the Nurse after a resident's fall, notifications to the physician and RP, implementation of an immediate intervention by the Nurse, documentation of the fall in the clinical record by the Nurse, fall root cause investigation report initiated by the Nurse and reviewed by the DCS, and follow up by the IDT in the weekly falls meeting. Nurses were also trained related to reporting an incident, accident, or change in condition, to the resident's RP and documentation in the medical record to include the incident, accident, or change in condition, notifications to the physician, RP, and clinical administrative team, nurse's assessment, and interventions; evidence of assessment would include Situation, Background, Appearance, and Review (SBAR) sheet, Interdisciplinary Progress Note, and Neurological (neuro) checks sheet, and documentation of falls. Staff competencies were completed. Nursing staff not educated by midnight on 04/22/15 would not be allowed to	F 325		

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F 325	Continued From page 417 work until they received training. Agency Nurses would be trained by the Corporate Administrative Nurses, DCS, Assistant DCS, or Nurse Manager prior to working their next shift. The DCS and ED would ensure staff that had not been educated were educated prior to working their next shift. The ED and DCS would monitor the daily schedule and highlight staff already trained. A department manager would stand by the time clock at shift change to direct staff that needed education to the training. The IDT would monitor daily incidents and accidents. Notifications of accidents, incidents, or changes of condition would be reviewed for completion by the DCS, ADCS, or Nurse Manager, who would make notifications if not done. 3. On 05/13/15 and 05/14/15 twenty-two (22) nurses were educated by the Corporate Administrative RNS to complete skin sweeps weekly and PRN, and complete residents' weights per physician order. 4. QAPI meeting was held on 05/13/15 to review the P&P for care plans and behavior management, resident weights, skin assessments, ADLs, smoking, assistive devices related to lifts and shower bed, facility maintenance, pest control, housekeeping/ laundry, and staffing, falls, incidents/accidents, grievances, with no changes made. The facility's action plan for removal of the IJ was reviewed and tasks assigned, with department managers assigned to provide daily oversight along with the RDCS/ RVPO/ RDHC/ RCMC/Corporate Administrative RNs. 5. The IDT would review in the daily meeting incidents and accidents reports and the 24 hour	F 325		

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F 325	Continued From page 418 report for investigation reports, nursing documentation in the clinical record, an SBAR, notifications to the physician and RP, and care plans with appropriate interventions. 6. The IDT would meet at least monthly to discuss facility action plan and ensure tasks were completed for the removal of the IJ, and QA monitoring completed according to the AOC during the IJ period, validated by the ED/RVPO/RDCS/Corporate Administrative RNs. 7. Per the Ad-Hoc QAPI meeting, on 05/15/15, QI monitoring would be done utilizing approved audit tool with oversight by the ED, beginning 05/16/15, review of the clinical record for timely notifications to the physician and RP. The State Survey Agency validated the removal of Immediate Jeopardy on 05/22/15 as follows: 1. Review of one hundred twenty-six (126) resident assessments, completed by Assistant DCS/Nurse Manager/Licensed Nurse, on 04/22/15, revealed residents were assessed for any incident or accident, or change in condition that warranted notification to the physician. One (1) resident was identified as experienced a change in condition, accident, or incident and the physician was notified on 04/22/15. 2. Review of in-service records, revealed twenty-three (23) nurses were educated by Corporate Administrative Registered Nurses regarding: timely notification to the physician related to incidents, accidents, and changes in condition; care plan policies; resident assessments, including SBAR, neuro checks; falls and immediate interventions; notification to	F 325		

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F 325	Continued From page 419 the physician and RP; documentation of the fall in the clinical record; fall root cause investigation report. Staff competencies were completed. No staff had worked prior to them receiving the training. Review of staffing schedules revealed staff who had not yet been trained were not highlighted, which noted they required education. Review of facility records revealed notifications of incidents, accidents, and changes in condition were reviewed for completion by the DCS/ADCS/ Nurse Manager. Interview with the DCS and RDCS, on 05/04/15 at 4:18 PM, revealed twenty-three (23) nurses had been trained. Interview with RN #8, on 05/04/15 at 4:33 PM, with CNA #11, on 05/05/15 at 9:51 AM, with the UM, on 05/05/15 at 9:55 AM, CNA #14, on 05/05/15 at 10:03 AM, CNA #13, on 05/05/15 at 10:10 AM, revealed they had been educated on falls, notifications, Kardex and care plans. Interview, on 05/05/15 at 2:00 PM, with the DCS, ADCS, Nurse Manager, ED, Admissions Coordinator, DSS, MDS Director revealed they had all been trained on care plans, changes in condition, staff look at interventions for residents, the 24 hour report, falls, SBAR, incident reports, Kardex and care plans, notifications to the physician and family. 3. Record review of in-services conducted on 05/13/15 and 05/14/15 revealed education provided for skin assessments, resident weights. Interview with CNA #7, on 05/22/15 at 8:05 AM, with RN #1, on 05/22/15 at 8:13 AM, with LPN #1, on 05/22/15 at 8:25 AM, with CNA #8, on 05/22/15 at 8:37 AM, revealed they had been trained on resident weights and skin assessments. Observation, on 05/22/15 at 3:30 PM, revealed Resident #34 skin assessment was performed by Registered Nurse #11 and no new	F 325		

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F 325	Continued From page 420 skin issues were identified and the documentation was completed as required. 4. Review of a QAPI sign in sheet, dated 05/13/15, and agenda revealed the P&P for care plans and behavior management were discussed with no changes made. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Staff Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS attended the QA meetings. 5. Observation of the morning meeting, on 05/22/15 at 9:05 AM, revealed the IDT reviewed the 24 hour report, care plans, and specific resident concerns. Interview with the Maintenance Director, DCS, Assistant DCS, UM, Schedule Coordinator, MDS Coordinator, and DSS, on 05/22/15 at 2:52 PM, revealed they participate in the morning meeting and review the 24 hour report, notifications were made, maintenance books reviewed, physician orders, call lights, care plans, and audits/ round were reviewed in the morning meeting. 6. Review of sign in sheets, dated 04/22/15, 05/13/15, and 05/15/15, revealed QAPI meetings were held on those dates. Interview, with the Maintenance Director, DCS, Assistant DCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, Business Office Manager, Housekeeping Supervisor, and DSS revealed they attended the QAPI meetings. Interview with the RDCS, on 05/22/15 at 5:05 PM, revealed the next QAPI meeting was scheduled for 06/17/15. Interview with the Medical Director, on 05/22/15 at 8:00 AM, revealed he was informed by the Executive Director of the resident care issues, attended the QA meetings held by the facility and	F 325		

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F 325	Continued From page 421 provided direction regarding corrective action plans that were developed to meet the needs of the residents. 7. Review of the QAPI sign in sheet, dated 05/15/15, and agenda revealed audit tools were approved for QA monitoring and discussed: resident interviews; resident/family concerns; morning meeting; new employee files; falls or behaviors reviewed; care plans and Kardexes update; review of the 24 hour report; notifications; maintenance rounds and book; supervised smoking; falls interventions in place; call lights; weekly falls; and, behavior management meetings.	F 325		
F 353 SS=L	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 personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. 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	F 353		

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F 353	Continued From page 422 duty. 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 have an effective system in place to ensure adequate staffing was available to meet the assessed needs of residents requiring assistance with toileting, incontinent care, at risk for falls and with pressure wounds. In addition, the facility failed to ensure adequate staffing to ensure resident's had a neat, clean environment, along with clean clothes and adequate linen supplies for eight (8) of forty-three (43) sampled residents (Residents #4, #6, #7, #9, #10, #11, #34, and #39). Interview with Certified Nursing Assistant (CNA) #15, on 04/22/15 at 12:05 AM, revealed she arrived for her 11:00 PM to 7:00 AM shift on 02/24/15, to find the previous shift CNA's, assigned to the 100 Unit, had already left the building. CNA #15 stated after she arrived to the unit she determined the only other staff present and working on the unit was Certified Medication Technician #16. CNA #15 stated she began checking on residents and heard Resident #4 hollering. She stated she went to the resident's room and found the resident on the floor, under the bed, with dried feces on the resident's bottom. The CNA stated the resident's right foot was black and the resident complained the foot hurt. She stated at the time she found Resident #4 on the floor, a nurse was not present on the unit, so	F 353		

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F 353	Continued From page 423 she informed Certified Medication Technician #16 of Resident #4's fall and together they cleaned the resident up and put the resident back to bed. She stated LPN #1 arrived later from another unit and went to the resident's room. Interview with Resident #6, on 04/16/15 at 10:45 AM, revealed he/she was left wet for seventeen hours (17) due to the facility not having enough staff to meet his/her needs. The resident stated he/she weighed 332 pounds and due to that it took at least two (2) staff members to get him/her cleaned up after an incontinent episode. Resident #6 indicated that he/she void on self and would remain "wet" during the entire night shift and would not get attended to until the day shift staff came on duty. Resident #6 went on to say that if he/she had an incontinent episode while up in the wheelchair, and requested to be changed, he/she had to wait until there was adequate staff available to change his/her brief, which at times took over an hour for there to be enough staff. Observation of Resident #7, on 04/16/15 at 3:37 PM, revealed the resident was seated on the floor in his/her bathroom, with pants down and stool on the resident's bottom and floor. No staff were present in the room at the time of this observation. Interview with Certified Nursing Assistant #36, on 04/16/15 at 3:43 PM, revealed there was not enough staff to tend to the residents' incontinent care needs on the unit. She stated the resident could get combative with care and would need more staff to tend to the resident at those times. She stated there were only three (3) aides on the unit for the second shift for the forty-five (45) to forty-eight (48) residents and	F 353		

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F 353	Continued From page 424 several were total care requiring the assistance of two. Observation, on 04/16/15 at 8:48 AM, revealed Resident #8's call light was not within reach and the room had a strong odor of urine. Resident #8's fitted sheet for their bariatric bed was thin and torn in various areas. The resident nails were long and had a black substance underneath them. The resident's mouth was full of unknown debris. Interview with Resident #8, on 04/22/15 at 9:20 AM, revealed he/she had felt like the management staff did not care and it did not do any good to complain. The resident stated he/she had activated the call light, again last night, due to being "wet" and wanted to be pulled up in the bed. The resident went on to say that staff answered the light and said told him/her they would be back, because they needed help. The resident said he/she fell back to sleep, woke up again and pushed the call light again. Resident #8 stated staff came back into his/her room and turned off the call light. "And none came back for a while." Interview with Resident #9, on 04/16/15 at 8:41 AM, revealed the resident had activated the call light thirty (30) minutes ago and wanted help with getting some cranberry juice and a brief changed. The resident stated it had been two weeks since he/she had taken a shower. Observation of Resident #9, on 04/17/15 at 10:40 AM, revealed the resident was lying on the bed with no covering over his/her body. The resident was noted to have an above the knee amputation. The resident was observed to be unshaven and his/her room had a strong odor of urine.	F 353		

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Interview with Resident #39, on 04/29/15 at 2:15 PM, revealed it routinely took a long time for staff to answer his/her call light and because the resident had waited so long for assistance they had urinated on themselves. The resident said he/she had held their urine as long as they could and it was very embarrassing to talk about wetting on themselves with the surveyor. The resident stated he/she was heavy and it took two (2) people to assist with toileting and because staff was not fast enough he/she had wet on himself/herself on many nights. The resident also said they were admitted in March and because of her impaired mobility and staffing issues he/she had only had their hair washed one time.

Interview with Certified Nursing Assistant (CNA) #1, on 04/17/15 at 10:55 AM, revealed she was assigned to provide care for Resident #9. The CNA stated when her shift started (on 04/17/15) there were only two (2) aides on the unit, and a third aide was to come in later. The CNA stated it was difficult to get residents up and ready for breakfast with only two aides on the unit. She stated she was also responsible for passing the breakfast trays and feeding the ten (10) residents that required total assistance. She went on to say that several residents needed the assistance of two (2) staff in order to get out of bed. She went on to say her duties also included providing incontinent care and dressing those residents that were to be gotten up. However, due to time constraints/staffing issues she was unable to proved ADL's for all the residents. The CNA indicated this would include not being able to ensure the residents were shaved, oral care was

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F 353	Continued From page 426 provided and the resident's hair may not be combed. Interview with Resident #10, on 04/15/15 at 9:25 AM, revealed the resident had many concerns with his/her nursing care, food service and linens provided by the facility. Interview with Certified Nursing Assistant (CNA) #7, on 04/15/15 at 9:10 AM, revealed she was normally assigned to one unit. She stated even though the schedule listed another CNA as working the unit with her that aide actually left and no replacement was provided. CNA #7 stated she was now responsible for sixteen residents and one of the residents was totally dependent on staff due to being quadriplegic. She stated there were several other residents which also required the assistance of two staff to check and change, toilet and transfer. The CNA stated she could not do this all by herself. Interviews with Certified Nursing Assistant's (CNA) #1, #8, and #32 on 04/30/15, revealed they had not checked or changed Resident #34 during the entire 7:00 AM-3:00 PM shift. Observation of the resident revealed the resident's brief was wet. Observation of Resident #34, on 05/13/15 at 2:15 PM, revealed the resident was in bed with a lunch tray in front of them on the over bed table with no staff present in the room. Continued observation revealed the resident had a paper napkin in the right hand and was observed to eat the paper napkin. The resident then picked up a butter knife and used it to eat pudding out of a dish that had	F 353		

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F 353	Continued From page 427 fallen over on to the resident's stomach. Review of the resident's care plan revealed the resident was at risk for aspiration. CNA #1 stated she knew the resident needed assistance with eating as part of the plan of care, but allowed the resident to feed themselves anyway. Interview with Licensed Practical Nurse (LPN) #5, on 04/30/15 at 2:40 PM, revealed residents were to be checked and changed every 2 hours and provided incontinent care and assisted with feeding. She stated she was unable to monitor the CNA's to determine if the residents care needs were provided as directed by the plan of care, because she had numerous responsibilities and tasks to do. The facility's failure to have an effective system in place to provide sufficient nursing staff and other related services that ensured the well-being of the residents and their environment has caused or is likely to cause serious injury, harm, impairment or death to resident. The Immediate Jeopardy was identified on 04/22/15 and determined to exist on 02/25/15. An acceptable Allegation of Compliance (AOC) was received on 05/19 /15 alleging the Immediate Jeopardy was removed on 05/16/15. The State Survey Agency validated the Immediate Jeopardy was removed on 05/16/15 as alleged, prior to exit on 05/22/15. The scope and severity was lowered to an F with remaining Substandard Quality of Care while the facility monitors the implementation of the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes.	F 353		

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F 353	Continued From page 428 The findings include: Review of the facility's policy regarding Staffing, dated 11/30/15, revealed staffing would be maintained by the facility in accordance with State and Federal requirements. The facility would have appropriate staff to provide for the needs of the residents at all times. Review of the facility's Resident Census and Conditions of Residents form, dated 04/14/15, revealed the facility had a census of one hundred and twenty-five (125) residents. Forty-five (45) of those residents were totally dependent on staff for bathing. Fifteen (15) residents were totally dependent on staff for dressing and toileting. Fourteen (14) residents were totally dependent on staff for eating. Seventeen (17) residents were totally dependent on staff for transferring. One hundred and five (105) residents required the assistance of one (1) or two (2) staff for dressing and toilet use. One hundred (100) residents required the assistance of one (1) or two (2) staff for transferring and ninety-two (92) required the assistance of one (1) or two (2) staff for eating. The facility assessed ninety (90) residents as occasionally or frequently incontinent of urine and fifty-seven (57) as incontinent of bowel. The facility assessed five (5) residents as independently ambulatory and nine (9) as bedfast all or most of the time, with eighty-five (85) in the chair most of the time. Review of the facility staffing schedule and Census List, dated 04/14/15, revealed the facility	F 353		

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F 353	Continued From page 429 had four (4) units called Unit 100 with a census of thirty-seven (37), Unit 200 with a census of fifty (50), Journey Home 1 had a census of sixteen (16) and Journey Home 2 had a census of twenty-five (25). Review of the Staffing Schedule, dated 02/24/15, for the 11:00 PM to 7:00 AM shift, revealed the Unit 100 had one (1) nurse and two (2) certified nursing assistants (CNA) scheduled to work and the 200 Unit had one (1) nurse and three (3) CNA's scheduled to work. The Journey Home 1 unit had one (1) nurse and one (1) CNA scheduled to work. The Journey Home 2 unit had one (1) nurse and one (1) CNA scheduled to work. Further review of the Staffing Schedule, revealed the staff scheduled to work the 100 Unit, on 02/25/15, for the 11:00 PM to 7:00 AM shift, were Licensed Practical Nurse (LPN) #8 and the Certified Nursing Assistants (CNA) were CNA/CMT #16 and CNA #15. Review of the Individual Timecard Report, dated 02/24/15-02/25/15, revealed LPN #7 and RN #8 were the nursing staff on the unit for the 3:00 PM to 11:00 PM shift. RN #8 clocked out at 11:12 PM and LPN #7 clocked out at 11:32 PM, which was prior to a nurse arriving on the unit to assume care of the residents. Further review of the Time Card Report, revealed LPN #8, who was listed on the staffing schedule and assigned to work the 100 Unit night shift, did not clock in for the 11:00 PM shift.	F 353		

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F 353	Continued From page 430 The Individual Timecard Report, dated 02/24/15-02/25/15, revealed CNA/CMT #16 clocked in at 11:02 PM and CNA #15 clocked in at 11:15 PM. Interview, on 04/21/15 at 11:25 PM, with CNA/CMT #16, revealed she was scheduled to work as a CMT and not as CNA on the night of 02/25/15. She stated Unit 100 actually had one (1) assigned CNA and one (1) assigned CMT working and no RN or LPN. She stated she would provide care to residents in between medication administration. Continued review of the Time Care report, dated 02/24/15-02/25/15, the three (3) CNA's, that worked the 100 Unit, on the 3:00 PM to 11:00 PM shift left at 11:00 PM, 10:56 PM and 10:57 PM; prior to the CNA/CMT #16 or CNA #15 arriving which prevented a shift to shift resident status report from occurring between them. Interview, on 04/17/15 at 10:05 AM, with the Unit Manager of the 200 Unit, revealed staffing for the 200 Unit should have consisted of five (5) CNAs per shift with one (1) CNA assigned to each hall, and one (1) CNA assigned to 15-minute checks of residents at risk for elopement and also to help out when needed. She stated that today (04/17/15) the 200 Unit was short of CNAs. She stated the unit had four (4) CNAs and one CNA in addition to be assigned to a hall would have to conduct 15-minute checks. She expressed to the ED her concern about the shortage of nursing staff.	F 353		

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On 04/27/15 at 9:50 AM, interview with Medical Records Coordinator revealed she also worked as the facility's Staffing Coordinator and had taken over that role in December 2014 or January 2015. She stated she followed the Master Schedule for the daily schedules. She reported all staff had a set schedule that did not change and would know if staff worked based on the Master Schedule. She stated if there were not enough staff to cover the scheduled shifts, then she would use the UM. The Medical Records stated she used the UM for coverage on 03/25/15.

She further stated there was no one else in the facility who assisted with staff schedules. She stated schedules were reviewed in the morning meeting and changes were made as needed. She stated that after she left for the day, if there were any changes made to the schedule, the on-call supervisor would handle any staff call ins and would make the changes to the schedule. The Medical Records Coordinator also stated the staff schedule for 03/25/15 would have been reviewed in the morning meeting with all Department Heads and Unit Managers on 03/25/15, which started at 9:00 AM.

She continued to state it would have been a group decision to put the UM on the schedule as staff. She reported she had put the UM on the schedule before she knew the UM would be on vacation. She further stated the UM's PTO time did not go through her (Medical Records); however, the UM's PTO went through the ED.

Interview with Unsampled Resident B, the President of the Resident Council, on 04/22/15 at

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F 353	Continued From page 432 2:31 PM, revealed he/she in Resident Council meetings he/she had brought to the attention of the facility the shortage of nursing aides on the Journey 2 Wing. He/she related on the day shift the facility was sometimes down to one (1) nursing aide on the wing, which meant it took longer for residents to get showers and changing's for incontinent residents. 1. Review of Resident #4's clinical record revealed the facility admitted the resident on 05/16/13 with diagnoses of Hypertension, Atrial Fibrillation, Chronic Obstructive Airway, Congestive Heart Failure, Macular Degeneration, Rheumatoid Arthritis, Osteoporosis and Open Wound Site. Review of Accident/Incident Report Form, dated 02/25/15, revealed Resident #4 sustained a fall from the bed and was found on the floor at 12:30 AM. The report form indicated the physician had not been contacted and the resident did not receive any treatment. Review of the Nursing Progress Note written, on 02/25/15 and timed at 6:00 AM, revealed Resident #4 was found on the floor by a CNA while performing rounds. Review of the Nursing Progress Note written, on 02/25/15 and timed at 4:30 PM, revealed nursing documented the right lower leg was swollen, warm, bruised and tender. Review of the Nursing Note written, on 02/25/15 at 4:30 PM, continued to state the first shift reported Resident #4 experienced a fall on the night shift and x-ray results were pending. The	F 353		

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F 353	Continued From page 433 X-ray results were positive for a right tibia fracture and the facility notified the nurse practitioner of the results and orders were received to transfer the resident to the hospital. Interview with Certified Nursing Assistant (CNA) #15, on 04/22/15 at 12:05 AM, revealed she arrived for her 11:00 PM to 7:00 AM shift on 02/24/15, to find the previous shift CNA's, assigned to the 100 unit, and had already left the building. CNA #15 stated after she arrived to the unit and determined the only other staff present and working on the unit was Certified Medication Technician #16. She stated she began checking on residents and heard Resident #4 hollering. She stated she went to the resident's room and found the resident on the floor, under the bed, with dried feces on the resident's bottom. She stated at no time was she alerted to the resident's fall by a bed alarm sounding and could not remember if the resident had a bed alarm device on the bed. The CNA stated the resident's right foot was black and the resident complained the foot hurt. She stated at the time she found Resident #4 on the floor, a nurse was not present on the unit, so she informed Certified Medication Technician #16 of Resident #4's fall and together they cleaned the resident up and put the resident back to bed. She stated each time she checked on the resident during the shift the right foot did not look good to her and the resident complained the foot hurt. She stated LPN #1 arrived later from another unit and went to the resident's room and believed he knew about the resident's condition. Interview with the Certified Medication Technician (CMT) #16, on 04/21/15 at 11:25 PM, revealed she was scheduled to work the medication cart	F 353		

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the night of 02/25/15. She stated when she arrived RN #8 and LPN #7, that worked the 3:00 PM to 11:00 PM shift, gave her report on the 100 Unit residents and left the building. She stated the scheduled nurse for the 100 Unit, did not report to work that night. CMT #16 stated CNA #15 told her she found Resident #4 on the floor and this occurred around 12:00 PM or a little after. She stated they both put the resident back to bed and cleaned feces off the resident's bottom. She stated after this she went back to her cart to pass medications and did not return to Resident #4's room during her shift.

Interview with Licensed Practical Nurse (LPN) #1, on 04/21/15 at 3:05 PM, revealed he was working on the 200 Unit when RN #1 notified him the 100 Unit did not have a nurse and Resident #4 had fallen. He stated RN #1 directed him to leave his assigned 200 Unit, which then would be without a licensed nurse, to go staff the 100 Unit, stated CMT #16 and CNA #15 had already put Resident #4 back to bed when he got to the unit. He stated his head to toe assessment, which he conducted sometime after 12:30 AM, consisted of him laying eyes on the resident. He stated he did not pull back the resident's covers to assess the resident's right lower leg. He stated he observed the resident moving all extremities, with the covers on, while in the bed, and to him this indicated the resident had not experienced an injury to the right lower leg.

Interview with Registered Nurse (RN) #1, on 04/21/15 at 11:20 PM, revealed if the 100 Unit did not have a nurse the night Resident #4 fell he probably did direct LPN #1 to leave his unit to go staff the 100 Unit. He stated the facility staffed the locked Dementia Unit with a CMT and CNA's

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F 353	Continued From page 435 when there was a staffing shortage so this was normal facility process when staffing was short. However, he said that if he was busy providing nursing care or involved in an emergency, such as a code, he would not be available to go to the locked Dementia unit or any other units staffed only by CMT's and CNA's in the building. He also stated since the incident happen on 02/25/15 he could not remember that far back to provide any additional information regarding what supervisory responsibilities he conducted. Interview with the Interim Director of Clinical Services (DCS), on 04/29/15 at 7:55 AM, revealed she was only employed by the facility for two (2) weeks and was not aware residents' needs were not being met. Interview with the previous facility Executive Director (ED) in charge at the time of Resident #4's fall, on 04/23/15 at 8:34 AM, revealed she had not been told that CMT #16 and CNA #15 had moved Resident #4 before a nurse assessed the resident for injuries. She stated she had determined the facility had a staffing shortage of (6) six to (8) eight CNA's and (2) two to (3) three nurses and was concerned. She stated she had notified upper management of the staffing issues and her concerns of not meeting the residents' needs, but nothing was done and that was one of the reasons she resigned. She stated the staff was not happy with the new corporate master staffing schedule and started coming and going as they pleased; however, she thought the Director of Clinical Services at the time had address some of the situations. She stated neither RN #1 nor her management staff called her to inform her of the staffing shortage, on the 100 Unit the night of 02/24/15-02/25/15, or that a	F 353		

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F 353	Continued From page 436 CMT had taken report from nursing staff and that the same nursing staff left prior to the next shift nurse assuming care of the residents in the building. 2. Review of Resident #6's clinical record revealed the facility admitted the resident on 11/14/13 with diagnoses of Toxic Encephalopathy, Sepsis, Bradycardia, Hypertension, Renal Insufficiency, Gastro-esophageal Reflux Disease, Neurogenic Bladder, and Seizures. Review of Resident #6's Quarterly Minimum Data Set (MDS) assessment, completed on 01/08/15, revealed a Brief Interview Mental Status (BIMS) exam was conducted and the resident scored a fourteen (14), indicating the resident was cognitively intact and interviewable. Review of the Comprehensive Care Plan for Resident #6 revealed the facility developed a care plan on 11/03/13, with updated goals and a target date for 07/09/15. The problem on the care plan stated Resident #6 was incontinent of bowel and bladder related to Urinary Tract Infection and Obesity. The goal stated the resident would show no evidence of skin breakdown related to incontinence through the next review. The approaches included direction for staff to assist with toileting needs as needed and on a consistent schedule to promote continence, and check frequently for incontinence. Observation of Resident #6, on 04/16/15 at 10:45 AM, revealed the resident was laying in a bariatric bed. The sheet underneath the resident was thin, frayed and contained holes. The resident's hair appeared uncombed and greasy. Observation of Resident #6, on 04/17/15 at 11:10AM, revealed	F 353		

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F 353	Continued From page 437 the resident's hair remained uncombed and greasy. Observation, on 04/17/15 at 11:05 AM, of Resident #6 revealed the window blinds had broken vanes, and the privacy curtain between the two (2) resident beds was torn partially off the track. A brown substance was observed between the top of the walls and the ceiling around the room. The bathroom door had a hole and a portable O2 concentrator was stored on the floor next to the dresser and television (TV). Continued observation of Resident #6, on 04/17/15 at 1:58 PM, on 04/27/15 at 10:51 AM, on 05/01/15 at 8:45 AM, on 05/05/15 at 1:28 PM, and on 05/13/15 at 9:19 AM, revealed the window blinds were broken and a portable O2 concentrator remained stored on the floor next to the dresser with the TV. Interview with Resident #6, on 04/16/15 at 10:45 AM, revealed he/she was left wet for seventeen hours (17) due to the facility not having enough staff to meet his/her needs. The resident stated he/she weighed 332 pounds and due to this it took at least two (2) staff members to get him/her cleaned up after an incontinent episode. Resident #6 said he/she would be wet during the night shift and would have to wait till the day shift staff came on to get cleaned up. Resident #6 stated if he/she had an incontinent episode while up in the wheelchair, and requested to be changed, he/she had to wait until there was adequate staff available to change his/her brief, which at times took over an hour for there to be enough staff. The resident stated maintenance was aware of the blinds, door and other issues in the room; however nothing had been done to correct them.	F 353		

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F 353	Continued From page 438 Interview with the Maintenance, on 05/14/15 at 10:20 AM, revealed he was the only person in the building that provided maintenance and up keep. He stated he performed rounds and made repairs but was unable to provide work orders or evidence of items repaired in resident's rooms. He stated he was unable to keep up with all the repairs in the building because he was just one person and there were not enough hours in the day to accomplish everything that needed to be fixed. Interview with Certified Nursing Assistant (CNA) #6, on 04/16/15 at 11:00 AM, revealed he was not able to complete all his assigned duties for twenty three residents that needed assistance with activities of daily living. He stated he had several residents that required total care. He stated the facility was short staffed and due to this those residents that required the assistance of two (2) to get up, turn and reposition or check and change, did not always have their needs met or if they were it was not timely. He stated if he was the only one working and he was giving a bath or assisting a resident he could not tend to his other assigned residents' needs. He stated some nurses answer call lights and some do not; which meant residents needs were not met timely. He stated he had complained about the staffing and not being able to meet the needs of his residents, but nothing had been done. Interview with the Director of Clinical Services (DCS), on 05/04/15 at 2:18 PM, revealed she did not start her employment with the facility until 04/20/15 and she was unaware of the staffing issue. She stated Resident #6's care plan was developed to direct the staff in relation to the resident's individualized care needs; and if it was	F 353		

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F 353	Continued From page 439 not followed the resident's needs were not met. She stated she expected staff to report environmental issues and if they were unable to complete their assigned tasks. She stated she had a lot of work to do to in relation to staffing and ensuring resident's needs were met. 3. Review of Resident #7's clinical record revealed the facility admitted the resident on 03/17/15, with diagnoses of Vascular Dementia, Cerebral Vascular Accident, Osteoarthritis of the Hip and Knee, Cocaine Abuse, and Hypertension. Review of Resident #7's Admission Minimum Data Set (MDS) assessment, completed on 03/25/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of ninety-nine (99) meaning the resident was rarely/never understood. Review of the Comprehensive Care Plan for Resident #7 revealed the facility developed a care plan on 03/26/15, with updated goals and a target date of 06/26/15. The problem on the care plan stated Resident #7 required assistance from staff with grooming and personal hygiene. The goal state the resident would not experience any skin conditions from incontinence. The approaches listed, directed staff to monitor the resident for signs of emotional distress with incontinence and to provide ongoing assessment of the resident's voiding patterns. In addition, Resident #7 had a plan of care for the potential for falls related to impaired mobility, unsafe decision making, poor safety awareness, and psychotropic drug use. The goal stated the resident would remain free from injuries related to fall through the next review. The approach for staff to follow stated staff was to anticipate and meet all needs.	F 353		

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F 353	Continued From page 440 Observation of Resident #7's room, on 04/16/15 at 1:50 PM, revealed a strong odor of urine and feces permeated the room. Observation of toilet bowl revealed a large amount of stool in the bowl. The resident was observed to be sitting in a straight backed chair bedside the bed. Observation of Resident #7, on 04/16/15 at 3:37 PM, revealed the resident was seated on the floor in his/her bathroom, with pants down and stool on the resident's bottom and floor. No staff was present in the room at the time of this observation. Interview with Certified Nursing Assistant #36, on 04/16/15 at 3:43 PM, revealed there was not enough staff to tend to the resident's incontinent care needs on the locked unit. She stated the resident could get combative with care and would need more staff to tend to the resident at those times. She stated there were only three (3) aides on the unit for the second shift for the forty-five (45) to forty-eight (48) residents and several were total care requiring the assistance of two. Interview with Licensed Practical Nurse (LPN) #1, 04/16/15 at 8:55 AM, revealed the Unit Manager was working as an aide performing the fifteen (15) minute checks on residents that were at risk for elopement. He stated the 200 Unit usually operated without enough staff. He stated at times they were short and no one was assigned to do the checks, and he would sign (15) minute check book for paper compliance, because he "knew who to keep an eye on collectively"; which meant he signed the book because he had seen the resident at some point while he was doing his daily nursing duties.	F 353		

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Interview with the Unit Manager, on 04/20/15 at 12:10 PM, revealed she was not able to conduct routine rounds to ensure residents were receiving the needed care and services. She stated the facility had a staffing shortage and due to the shortage she had to fill in and provide direct resident care as a floor nurse. She stated there were times the facility was unable to timely meet the needs of the residents.

4. Review of Resident #8's clinical record revealed the facility admitted the resident on 04/18/14, with diagnoses of Hypoxia, Respiratory Failure, Stage Three Renal Disease, Cerebral Vascular Accident, Congestive Heart Failure, Hypertension, Decubitus, and Toxic Metabolic Encephalopathy.

Review of Resident #8's Quarterly Minimum Data Set (MDS) assessment, completed on 03/25/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of fifteen (15) indicating the resident was cognitively intact and interviewable.

Review of the Comprehensive Care Plan for Resident #8 revealed the facility developed a care plan on 08/11/14, with updated goals and a target date for 05/24/15. The problem on the care plan stated Resident #8 had Impaired ability to perform own activities of daily living and self-mobility related to weakness, immobilization and Chronic Obstructive Pulmonary Disease. The goal stated the resident would improve self-care skills in at least one area of activities of daily living and mobility by next review on 05/24/15. The approaches listed stated staff was to provide assistance with activities of daily living, while

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promoting independence, promote dignity by assuring privacy and organize supplies by how or when they should be used and place within reach. The resident also had a care plan developed on 08/11/14 for urinary incontinence with updated goals and a target date for 05/24/15. The problem stated the resident was incontinent of urine and the goal stated the resident would have decreased episodes of urinary incontinence. The approaches stated staff would assist with toileting and provide incontinence device of resident's choice for dignity.

Interview with Resident #8, on 04/16/15 at 8:48 AM, revealed the resident had urinated on him/herself during the night. The resident said he/she was unable to reach the call light to ring for assistance and instead hollered for staff to come help him/her. The resident stated staff walked by and did not come into his/her room.

Observation, on 04/16/15 at 8:48 AM, revealed Resident #8's call light was not within reach, but was hanging on the wall behind and to the side of the resident's bed and the room had a strongodor of urine. Resident #8's fitted sheet for their bariatric bed was thin and torn in various areas. The resident nails were long and had a black substance underneath them. The resident's mouth was full of unknown debris.

Interview with Resident #8, on 04/22/15 at 9:20 AM, revealed he/she felt like the management staff did not care and it did not do any good to complain. The resident stated he/she put on their call light again last night because he/she was wet and wanted to be pulled up in the bed and the staff answered the light and said they would be back because they needed help. The resident

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F 353	Continued From page 443 said he/she fell back to sleep, woke up again and pushed the call light again and they turned if off again and did not come back for a while. Interview with Certified Nursing Assistant (CNA) #9, 04/22/15 at 9:15 AM, revealed she had seen ants in the bed with Resident #8 this morning during incontinent care. She stated she got the resident up out of the bed and removed the sheets. She stated it was difficult to meet the resident's needs and keep the room clean also. She stated the resident required the assistance of two and sometimes there was not enough staff to help with the resident's needs. Interview with Licensed Practical Nurse (LPN) #5, on 04/22/15 at 3:25 PM, revealed not all activities of daily living could be completed as the care plan directs staff to do when they were short staffed. She stated when she came into work most mornings the night shift aides were already gone. She stated the unit had about thirty-six (36) to thirty-seven (37) residents and most of the time they would only have 2 to 3 aides and she would be the only nurse working with a CMT that passed medications on one hall while she passed medications on the other hall. She stated the night shift would only have two (2) aides and one nurse and or a CMT most of the time. Interview with the Director of Clinical Services (DCS), on 05/04/15 at 2:18 PM, revealed she started her employment with the facility on 04/20/15 and was not aware of the staffing shortage in the facility. She stated the staffing shortage also hindered the ability of the supervisory nursing staff to determine if the residents needs were met. She stated Resident #8's care plan was developed to direct the staff in	F 353		

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F 353	Continued From page 444 relation to the resident's individualized care needs; and if it was not followed the resident's needs were not met. 5. Review of Resident #9's clinical record revealed the facility admitted the resident on 08/14/14, with diagnoses of Anemia, Coronary Artery Disease, Hypertension, Peripheral Vascular Disease, Traumatic Brain Injury, Anxiety, Depression, and Chronic Obstructive Pulmonary Disease and Dementia. Review of Resident #9's Sixty-day (60) scheduled Minimum Data Set (MDS) assessment, completed on 03/03/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of fifteen (15) indicating the resident was cognitively intact and interview. Review of the Comprehensive Care Plan for Resident #9 revealed the facility developed a care plan on 04/17/14, with updated goals and a target date for 06/03/15. The problem on the care plan stated Resident #9 had urinary incontinence related to impaired physical mobility, Right Above the Knee Amputation, Neurogenic Bladder and evidence of being incontinent of urine. The goal stated the resident would have no unrecognized Urinary Tract Infections or skin breakdown related to incontinence. The approaches listed for staff to implement were to place call light within reach at all times and to provide incontinence device of resident's choice for dignity. Interview with Resident #9, on 04/16/15 at 8:41 AM, revealed the resident had put on the call light thirty (30) minutes ago and wanted help with getting some cranberry juice and a brief changed. The resident stated it had been two weeks since	F 353		

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HURSTBOURNE CARE CENTRE AT STONY BROOK	2200 STONY BROOK DR LOUISVILLE, KY 40220

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F 353	Continued From page 445 he/she had taken a shower in the shower room. Observation of Resident #9, on 04/17/15 at 10:40 AM, revealed the resident was in the bed with no covering over their body. The resident's left leg was amputated above the knee, the resident's face was unshaven and the room had a strong odor of urine. Interview with Certified Nursing Assistant (CNA) #1, on 04/17/15 at 10:55 AM, revealed she was assigned to take care of Residents #4, #8 and #9 and when her shift started today there were just two (2) aides and the third aide did not come until 10:00 AM. She stated it was difficult to get residents up and ready for breakfast with only two aides on the unit. She stated she was also responsible for passing the breakfast trays and feeding the ten (10) residents that needed total assistance. She stated several residents needed the assistance of two (2) to get out of bed. She stated she changed the incontinent residents and dressed those that were gotten up, but due to time constraints and staffing she was not able to shave, provide oral, or comb the hair of all her residents. Interview with the Unit Manager, on 04/20/15 at 12:10 PM, and the Assistant Director of Clinical Services, on 04/20/15 at 2:35 PM, revealed they were not able to conduct routine rounds to ensure residents were receiving the needed care and services. They stated the facility had a staffing shortage and due to the shortage they had to fill in and provide direct resident care as a floor nurse. 6. Review of Resident #10's clinical record revealed the facility admitted the resident on	F 353		

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05/01/14, with diagnoses of Hypertension, Chronic Atrial Fibrillation, Quadriplegic, Neuropathy, Muscle Spasms, Gastro-esophageal Disease, Proteus Urinary Tract Infection, and Chronic Ileus resolved.

Review of Resident #10's Annual Minimum Data Set (MDS) assessment, completed on 02/03/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of fifteen (15) indicating the resident was cognitively intact and interviewable.

Review of the Comprehensive Care Plan for Resident #10 revealed the facility developed a care plan on 03/31/14, with updated goals and a target date for 05/03/15. The problem on the care plan stated Resident #10 was incontinent of bowel and bladder related to quadriplegia. The goal stated the resident would show no evidence of skin breakdown related to incontinence through the next review. The approaches listed stated staff would assist with toileting needs as needed and on a consistent schedule to promote continence and to check frequently for incontinence.

Interview with Resident #10, on 04/15/15 at 9:25 AM, revealed the resident had many concerns with nursing care, food service and linens provided by the facility. Resident #10 stated he/she was unable to move and was totally dependent upon staff for care; which required the assistance of two staff to turn and reposition when needed. The resident stated he/she was left wet all night long due to the facility not having enough staff and linens. The resident stated there were not enough sheets to change their bariatric bed and this delayed getting changed

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F 353	Continued From page 447 after incontinent care. The resident stated he/she had spoken with the staff regarding the issues; however they had yet to be resolved. Observation of Resident #10, on 04/15/15 at 9:25 AM, revealed the resident was laying on a bariatric bed with sheets that were thin, torn and tattered with pillows under both arms that had the stuffing protruding out. Interview with Certified Nursing Assistant (CNA) #7, on 04/15/15 at 9:10 AM, revealed she was normally assigned to Resident #10. She stated she worked by herself most of the time. She stated even though the schedule listed another aide as working the unit with her the aide actually left and said they were not coming back and no replacement was provided. CNA #7 stated she was now responsible for sixteen residents and Resident #10 was totally dependent on staff due to being a quadriplegic. She stated there were several other residents that also required the assistance of two staff to check and change, toilet and transfer and she could not do that by herself. She stated the nurses were not always available to assist her when needed. She stated Resident #10 had made complaints about not getting needs met and linen issues. CNA #7 stated she had also made complaints about these issues, but nothing had been done to correct them. Interview with the Unit Manager, on 04/20/15 at 12:10 PM, and the Assistant Director of Nursing, on 04/20/15 at 2:35 PM, revealed they were not able to conduct routine rounds to ensure residents were receiving the needed care and services. They stated the facility had a staffing shortage and due to the shortage they had to fill in and provide direct resident care as a floor	F 353		

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nurse.

7. Review of Resident #11's clinical record revealed the facility admitted the resident on 04/14/15, with diagnoses of Cerebral Palsy, Dysphagia, Anemia, Aphasia, Multiple Contractions and PICA (a disorder of persistently eating substances with no nutritional value such as dirt or paint).

Review of Resident #11's Admission Minimum Data Set (MDS) assessment, completed on 04/21/15, revealed a BIMS exam was not conducted due to the resident was rarely/never understood.

Review of the Admission Care Plan for Resident #11, revealed the facility developed a care plan on 04/14/15. The problem on the care plan stated the resident was at risk for falls. The goal stated the resident would not experience any injuries related to falls. The approaches provided direction for staff to assess the resident's cognitive status to determine their ability to ask for assistance and the resident's wheelchair would have a seat belt and a lap tray.

On 04/24/15, a Comprehensive Care Plan for Resident #11 was developed with updated goals and a target date for 07/24/15. The problem on the care plan stated Resident #11 had a potential for injury related to the restraint/enable, utilized a wheelchair tray to enhance self-initiated activities, interactions with peers and staff. The seat belt was used to assist with pelvic torso alignment. The goal stated the resident would remain free of restraint related complications as evidence by behavior control, contracture free, mobility maintained and skin remained intact through the

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next review. The approaches included direction for intellectually appropriate activities, apply restraint/enabler per order and staff to anticipate and meet the resident's needs, evaluate use of restraint/enabler per policy, provide check every thirty minutes and release every two hours, exercise and reposition as appropriate.

On 04/26/15 a Comprehensive Care Plan was developed with updated goals and a target date for 07/26/15. The problem on the care plan stated Resident #11 was at risk for falls related to Mental Retardation, Cerebral Palsy and Joint Contractor. The goal stated the resident would be free of any falls and would not experience any injuries related to falls. The approaches listed directed staff to provide the resident with a night light, monitor for change in condition that may warrant increased supervision/assistance and notify the physician.

Further review of the typed and printed plan of care revealed several handwritten notations were made with various dates. The first note was dated 04/25/15 (day before printed care plan was developed) that stated "Keep in view of staff when up in chair". Another hand written note dated 04/27/15 stated "Place on 15 minute checks", and another dated 04/28/15, stated "Keep resident with in a safe perimeter, arm's length away from any object that could assist with turning the wheelchair over."

Review of the Behavior Symptom Monitoring Flow Sheet, dated 04/21/15, revealed Resident #11 would sit in the floor to seek attention. There was a section on the form for interventions to be written; however, this area was blank.

Observation of Resident #11, on 04/23/15 at

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10:25 AM, revealed the resident was not in his/her wheelchair, but on the floor in the common area with no staff present. Licensed Practical Nurse (LPN) #5 observed Resident #11 on the floor and proceeded to assess the resident for injuries. LPN #5 requested CNA #1 to obtain Resident #11's tray for the wheelchair. LPN #5 finished her assessment, determined the resident had not sustained an injury and with the assistance of two other staff members, transferred the resident into the wheelchair.

Interview with Licensed Practical Nurse #5, on 04/23/15 at 10:25 AM, revealed she was the only nurse on the unit and it was difficult to monitor residents, supervise staff, pass medications, perform treatments, document assessments, answer phones and the numerous other duties for the unit. She stated the facility was aware of the staffing issue; however, nothing had been done to correct the issue. She stated Resident #11 needed constant supervision due to behaviors.

Observation, on 04/27/15 at 4:04 PM, revealed Resident #11 lived in room 117 in bed #2 and Unsampled Resident MM lived in bed #1. Observation of Resident #11 revealed he/she was on the floor in his/her room and next to bed #1. Resident #11 was observed reaching for the oxygen tubing that was connected to the Unsampled Resident MM's breathing tube. Observations also revealed Resident #11 had pulled off onto the floor, Unsampled Resident MM's air mattress pump, which was originally in place on the bed's foot board. Surveyors immediately gained the attention of LPN #7 and CNA #29, and they transferred the resident back into bed #2.

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F 353	Continued From page 451 Interview with LPN #7, on 04/27/15 at 4:05 PM, revealed the resident required constant supervision and was constantly putting things in his/her mouth. The LPN stated this incident was not the first time the resident had done this type of behavior. The LPN stated he had notified leadership of his concerns regarding the safety of the resident and others the resident may be around, but nothing had been done to resolve his concerns. Review of Resident #11's record revealed the resident sustained a non-injury fall from the wheelchair while using another resident to pull him/her self over, on 04/28/15 at 11:00 AM. Observation, on 04/29/15 at 1:50 PM, revealed Resident #11 was sitting in his/her wheelchair in the common area near the television when Resident #11 grabbed Unsampled Resident O causing Unsampled Resident O to scream out loud. Interview with Certified Nursing Assistant #3, on 04/29/15 at 1:55 PM, revealed Resident #11 grabs for other residents all the time and was unsure of how Unsampled Resident O, got next to Resident #11. Interview with Director of Clinical Services (DCS) on, 04/28/15 at 11:15 AM, revealed due to staffing the facility was not meeting the needs of all their residents. 8. Review of Resident #34's clinical record revealed the facility admitted the resident on 03/19/09, with diagnoses of Hypertension, Dementia and Cerebral Vascular Accident.	F 353		

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F 353	Continued From page 452 Review of Resident #34's Quarterly Minimum Data Set (MDS) assessment, completed on 02/21/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of ninety-nine (99), indicating the resident was rarely/never understood. Continued review of the MDS revealed the resident was totally dependent on staff for bed mobility, transferring, bathing, eating and personal hygiene. The MDS stated the resident was always incontinent of bowel and bladder. In addition, the MDS stated the resident had impairment in the range of motion to one side of the body. Review of the Comprehensive Care Plan for Resident #34 revealed the facility developed a care plan on 06/20/13, with updated goals and a target date for 08/26/15. The problem on the care plan stated the resident was always incontinent of bowel and bladder. The goal stated the resident would not experience any skin conditions or infections from incontinence. The approaches listed directed staff to provide incontinent care with each incontinent episode and assess skin daily for irritation and redness. Further review revealed the facility developed a care plan related to Aspiration, on 06/20/13, with updated goals and a target date for 08/26/15. The problem stated the resident was at risk for aspiration related to dysphagia secondary to a stroke and a history of Aspiration Pneumonia. The goal stated the resident would remain free of signs and symptoms of aspiration through next review. The approaches stated the staff was to observe the resident for choking or coughing before, during and after swallowing, observe for wet or gurgling sound after swallowing.	F 353		

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F 353	Continued From page 453 Observation of Resident #34, on 04/30/15 at 8:10 AM, 10:30 PM, 12:40 PM and 2:35 PM, revealed the resident was in a recliner in the common area on the 100 Unit with a lift pad underneath the resident. Interview with Certified Nursing Assistant #8, on 04/30/15 at 2:35 PM, revealed she had not checked or changed Resident #34. She stated assignments had changed throughout the day and she believed the resident had been gotten up by third shift staff. Interview with Certified Nursing Assistant #32, on 04/30/15 at 2:35 PM, revealed Resident #34 was already up when she arrived for duty and she had not checked the resident for incontinence at any time during the shift. Interview with Certified Nursing Assistant #1, on 04/30/15 at 2:40 PM, revealed she did not get the resident up or check and change the resident. Observation of Resident #34, on 04/30/15 at 2:55 PM, revealed CNA #1 and #8 were preparing to put Resident #8 back in the bed. Incontinent care was provided and revealed the resident had been incontinent of urine. Observation of Resident #34, on 05/13/15 at 2:15 PM, revealed the resident was in bed with a lunch tray in front of them on the over bed table and no staff present in the room. Continued observation revealed the resident had a paper napkin in the right hand. The resident took a bite of the napkin, chewed it and then swallowed and this was done three times. The resident then picked up a butter knife and used it to eat pudding out of a dish that	F 353		

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had fallen over on to the resident's stomach.

Interview with Certified Nursing Assistant (CNA) #1, on 05/13/15 at 2:18 PM, and said the resident was able to feed themselves if the tray was set up for them. The CNA stated she knew the resident needed assistance with eating as part of the plan of care, but allowed the resident to feed themselves anyway.

Interview with Licensed Practical Nurse (LPN) #5, on 04/30/15 at 2:40 PM, and 05/13/15 at 2:30 PM, revealed residents were to be checked and changed every 2 hours and provided incontinent care and assisted with feeding. She stated she was unable to monitor the CNA's to determine if the residents care needs were provided as directed by the plan of care, because she had numerous responsiblities and tasks to do.

9. Review of Resident #39's clinical record revealed the facility admitted the resident on 03/24/15, with diagnoses of General Weakness, Edema, Urinary Tract Infection, Bladder Spasms, Coronary Artery Disease, Seizures, Hypertension, Diabetes, Gastro-esophageal Reflux Disease, and Atrial Fibrillation.

Review of Resident #39's Annual Minimum Data Set (MDS) assessment, completed on 03/31/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of fifteen (15) meaning the resident was cognitively intact and interviewable.

Review of the Comprehensive Care Plan for Resident #39 revealed the facility developed a care plan on 04/01/15, with updated goals and a target date for 06/30/15. The problem on the care

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F 353	Continued From page 455 plan stated the resident had a decline in strength and endurance related to recent hospital stay and was now receiving assistance with activities of daily living. The goal stated the resident would have an increase in at least some of the activities of daily living and return to the highest level of function as possible and return home. The approaches stated the staff would provide assistance with activities of daily living as indicated, encourage the resident to be as independent as possible, and to be an assist of two with bed mobility, and transfers would be with a mechanical lift. In addition, the facility developed a plan of care on 04/01/15, with updated goals and target date for 06/30/15. The problem on the care plan stated the resident was occasionally incontinent of urine due to stress incontinence. The goal stated the resident would not experience any infections or skin conditions from incontinence. The approach stated staff would assist the resident to the bathroom or commode as needed. Observation on, 04/29/15 at 2:12 PM, revealed Resident #39's call light was illuminated and at 2:15 PM the Activity Assistant entered and immediately exited the room and the light was no longer illuminated. Interview with Resident #39, on 04/29/15 at 2:15 PM, revealed the Activity Assistant said she was going to find someone to help the resident. Resident #39 said routinely it took a long time for staff to answer his/her call light and because he/she had waited so long for assistance he/she had urinated on themselves. The resident said he/she had held their urine as long as they could and it was very embarrassing to talk about wetting on themselves with this surveyor. The	F 353		

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F 353	Continued From page 456 resident stated he/she was heavy and it took two (2) people to assist with toileting and because staff was not fast enough he/she had wet on himself/herself on many nights. The resident also said he/she was admitted in March and because of her impaired mobility and staffing issues he/she had only had their hair washed one time. Interview with Certified Nursing Assistant (CNA) #7, on 04/29/15 at 2:25 PM, revealed she was in Resident #10's room providing incontinent care when the activity assistant told her that Resident #39 needed her assistance. She stated she was the only aide working on the Journey two (2) Unit and would be back to take care of Resident #39 when she finished with Resident #10. Interview with Registered Nurse #8, on 04/16/15 at 3:45 PM, revealed the facility had a staffing shortage and when there were only two (2) Certified Nursing Assistants for the unit; call lights did not always get answered timely. He stated the usual staffing pattern was for the 100 Unit to have only two (2) CNA's on duty. He stated the schedule would say there were four (4) CNA's on the unit, but that was not the reality. He called this scheduling process "Ghost Staffing". He also stated employees were chronically late to work. He said if there were four (4) CNA's on the unit it would take five to six minutes to answer call lights; however, if there were only two CNA's then it could take twenty (25) to thirty (30) minutes to answer. Observation and interview, on 04/17/15 at 12:45 PM, revealed the Assistant Business Office Manager conducted 15-minute checks of residents at risk for elopement on the 200 Unit. She stated that within the past few days prior to	F 353		

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F 353	Continued From page 457 04/17/15, the Executive Director (ED) had requested she fill in and conduct 15-minute checks until a CNA arrived for duty. She related that on 04/17/15, the 200 Unit had three (3) CNAs working when there should have been four (4) CNAs, one (1) for each hallway plus one (1) CNA to conduct 15-minute checks. Interview, on 04/17/15 at 10:05 AM, with the Unit Manager of the 200 Unit, revealed staffing for the 200 Unit should have consisted of five (5) CNAs per shift with one (1) CNA assigned to each hall, and one (1) CNA assigned to 15-minute checks of residents at risk for elopement and also to help out when needed. She stated that today (04/17/15) the 200 Unit was short of CNAs. She stated the unit had four (4) CNAs and one CNA in addition to be assigned to a hall would have to conduct 15-minute checks. She expressed to the ED her concern about the shortage of nursing staff. Interview with Unsampled Resident B, the President of the Resident Council, on 04/22/15 at 2:31 PM, revealed he/she in Resident Council meetings he/she had brought to the attention of the facility the shortage of nursing aides on the Journey 2 Wing. He/she related on the day shift the facility was sometimes down to one (1) nursing aide on the wing, which meant it took longer for residents to get showers and changings for incontinent residents. Interview with CNA's #2 and #3, on 04/17/15 at 2:50 PM, revealed CNA #2 did not have time to shave Unsampled Resident J during her shift because of the staffing shortage and trying to accomplish other tasks. Both CNA's stated the unit normally was staffed with four (4) certified nursing assistants and another staff member that	F 353		

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F 353	Continued From page 458 conducted the fifteen (15) minute safety checks for the unit. However, the unit had not been staffed with that number of employees for some time. Interview with the Assistant Director of Clinical Servies (ADCS), on 04/20/15 at 2:35 PM, revealed the facility had a staffing shortage that prevented the facility from providing all the necessary activities of daily living to meet the needs of the residents. She stated washing resident faces; shaving and bathing were just a few of the tasks that were unable to be completed on a daily basis. She stated she was unable to complete her ADCS duties because she had been working as a floor nurse and aide due to staffing shortages. Interview with the Director of Clinical Services (DCS), on 05/04/15 at 2:18 PM, revealed she had determined the facility had a certified nursing assistant shortage of about sixteen (16) to eighteen (18) and about five (5) to six (6) licensed nursing staff. She stated this prevented the facility from meeting the needs of its residents. Interview with the Interim ED, on 05/21/15 at 8:23 AM, revealed she had identified there were some issues with the facility meeting the needs of its residents. The facility took the following actions to remove the Immediate Jeopardy on 05/16/15 as follows: 1. The facility notified Resident #4's physician, of a fall that occurred on 02/25/15 with new orders	F 353		

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given to the nurse. The resident transferred to a local hospital on 02/25/15 for a tibia fracture and returned to the facility on 02/28/15 with new orders. The DCS assessed Resident #4 on 04/22/15 and was found in stable condition.

2. On 04/22/15, one hundred twenty-six (126) residents were assessed by the ADCS, Nurse Manager, and Licensed Nurse to determine if any residents had an incident or accident or change in condition that would warrant physician notification and further intervention. One (1) resident was identified as having an incident, accident, or change of condition and the physician was notified by the nurse on 04/22/15. Additionally, the Nurse notified the RP and documented this in the clinical record. Nurses would additionally report incidents, accidents, or changes in condition to the clinical administrative team.

3. On 04/22/15 the Corporate Administrative Nurses educated twenty-three (23) of thirty-eight (38) Nurses regarding timely notification to the physician related to resident incidents, accidents, or change in condition; care plan policies, evidence of assessments and care planning with immediate falls preventions interventions to meet the resident's needs; and falls procedures, immediate assessment by the Nurse after a resident's fall, notifications to the physician and RP, implementation of an immediate intervention by the Nurse, documentation of the fall in the clinical record by the Nurse, fall root cause investigation report initiated by the Nurse and reviewed by the DCS, and follow up by the IDT in the weekly falls meeting. Nurses were also trained related to reporting an incident, accident, or change in condition, to the resident ' s RP and documentation in the medical record to include

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F 353	Continued From page 460 the incident, accident, or change in condition, notifications to the physician, RP, and clinical administrative team, nurse's assessment, and interventions; evidence of assessment would include Situation, Background, Appearance, and Review (SBAR) sheet, Interdisciplinary Progress Note, and Neurological (neuro) checks sheet, and documentation of falls. Staff competencies were completed. Nursing staff not educated by midnight on 04/22/15 would not be allowed to work until they received training. Agency Nurses would be trained by the Corporate Administrative Nurses, DCS, Assistant DCS, or Nurse Manager prior to working their next shift. The DCS and ED would ensure staff that had not been educated were educated prior to working their next shift. The ED and DCS would monitor the daily schedule and highlight staff already trained. A department manager would stand by the time clock at shift change to direct staff that needed education to the training. The IDT would monitor daily incidents and accidents. Notifications of accidents, incidents, or changes of condition would be reviewed for completion by the DCS, ADCS, or Nurse Manager, who would make notifications if not done. 4. An Ad-Hoc Quality Assurance/ Performance Improvement (QAPI) meeting was conducted on 04/22/15 to discuss facility policy and procedure (P&P) for falls, and notifications of incidents, accidents, or changes of condition; care plans as related to immediate falls interventions and revision status post fall, nursing assessment and documentation for falls; with no changes made. Also discussed the facility protocol related to shift relief and report; and additional avenues to attract new staff and maintaining current staff with a plan for performance improvement.	F 353		

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F 353	Continued From page 461 5. On 04/22/15, 126 residents were reviewed for fall risk with a fall risk assessment completed by the DCS and MDS Nurses who had previously been educated on 04/22/15, and care plans and Kardexes were also reviewed, with seventy-four (74) residents whose fall care plans were updated on 04/22/15. 6. On 04/22/15 the Corporate Administrative Nurses educated the DCS, ADCS, and Nurse Manager regarding evidence of assessment and care planning, with immediate falls prevention interventions to meet the resident's needs. On 04/22/15, thirty (30) of fifty-eight (58) CNAs and two (2) Agency CNAs were educated to review the Kardex for specific fall risk information. 7. Certified Medication Technician's (CMT) would be supervised by the Nurse they work with on the unit. The current resident census was reviewed by the ED and DCS to determine which residents required total care, assistance, or were independent with care. 8. On 04/22/15, 126 residents were assessed by Nurses using a visual and/or verbal nursing assessment that included vital signs to ensure there were no current physical or emotional distress or needs that were not met as related to inadequate staffing. One (1) resident was identified in physical distress and the Nurse timely notified the physician. 9. On 04/22/15, The Corporate Administrative Nurses educated twenty-three (23) of thirty-eight (38) Nurses, thirty (30) of fifty-eight (58) CNAs, and two (2) Agency CNAs related to staffing, to notify the ED, DCS, or ADCS for any staff call	F 353		

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outs. The ED, DCS, ADCS, or Scheduler would attempt to replace the staff member who called out by calling on facility staff to stay over or come into work. If staffing needs could not be met the ED, DCS, ADCS could mandate staff currently working. Staff were educated on waiting for their relief to arrive prior to leaving the facility, and to give shift report to oncoming staff, that would include resident status, falls that occurred, and any new interventions. Staff competencies were completed.

10. On 04/28/15, the facility reported to the SSA that Resident #25 was found to have a black eye on 03/25/15. The incident was investigated and with the assistance of the SSD and DCS the source of the black eye was determined as a result of a resident to resident altercation and abuse was unsubstantiated.

11. One hundred twenty-one (121) residents were assessed by a nurse for suspicious injuries on 05/12/15 and 05/13/15. No suspicious injuries were found.

12. Current residents with BIMS Scores of twelve (12) or higher were interviewed by the ED, on 05/12/15 and 05/13/15, about their safety.

13. Staff in Nursing, Dietary, Housekeeping and Laundry, and Therapy were interviewed by the ED/Assistant ED on 05/12/15, 05/13/15, and 05/14/15. Two (2) new allegations of abuse/neglect that required reporting to the SSA were reported on 05/14/15.

14. The Corporate Administrative RNs educated 107 of 149 staff and fourteen (14) agency staff on abuse and neglect and injuries of unknown origin

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F 353	Continued From page 463 from 05/09/15 through 05/14/15 with competency. Forty-two (42) staff not educated as of 05/14/15 will not be allowed to work without having been educated prior to the start of their shift. Agency staff will be educated prior to working their next shift. Staff, through the use of a Performance Improvement tool, staff were aware of the types of abuse, injuries of unknown origin, and when and whom to report to. Forty- two (42) staff not educated as of 05/14/15 15. One hundred twelve (112) of 112 employee personnel files were reviewed by the Regional Director of HR (RDHR), facility HR, and BOM to ensure files were complete with criminal background checks, nurse aide abuse registry checks, and abuse training. The RDHR corrected discrepancies on 05/13/15. Ongoing reviews of five (5) new employee files would occur twice weekly. 16. The ED or DCS would review all allegations of abuse, complete the 24 hour report, investigation, and five (5) day report. 17. The QAPI Committee met on 05/13/15 and reviewed the Policy and Procedures (P&P) for abuse with no changes made. 18. The Regional Director of Clinical Services (RDCS) reviewed potential reportable events were completed on 04/21/15 through 04/24/15, 04/26/15 through 04/29/15, 05/01/15, 05/04/15, 05/06/15, 05/09/15, and on 05/11/15 with no issues identified. On 05/14/15 the RDCS reviewed abuse allegations and investigations for the last ninety (90) days for timely reporting, investigation, and resolution.	F 353		

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F 353	Continued From page 464 19. An Ad-Hoc QAPI Committee meeting on 05/15/15 discussed ongoing quality improvement monitoring for abuse and neglect reporting beginning 05/16/15 using an approved audit tool and included: a. Five (5) resident interviews on 05/12/15 and ongoing five (5) times weekly. b. Skins sweeps on 05/08/15, 05/12/15, 05/13/15 completed by a nurse and reviewed by RDCS, Corporate Administrative RNs, DCS, ADCS, or Nurse Manager for any suspicious injuries, of five (5) residents, five (5) times a week. c. Beginning 04/21/15 and ongoing the RDCS, RVPO, RDHR will review new allegations of abuse and neglect for timely reporting, investigation, and resolution once a week. d. On 05/15/15 and ongoing new resident and family concerns would be reviewed by the ED, RDCS, RCPO, RDHR, or Corporate Administrative RNs for resolution five (5) times a week. e. On 05/12/15 an ongoing Daily Department Head Meeting led by the ED and DCS would be attended by Corporate Administrative RN, RDCS, RVPO, or RDHR to ensure new resident injuries or concerns were discussed five (5) times weekly. 20. Current residents were reviewed for behaviors, on 05/12/15 and 05/13/15, by Corporate Administrative RNS and two (2) members of the IDT. Care plans were reviewed for sixty-six (66) residents with behaviors, with twenty (20) care plans updated, with one (1) resident placed on 1:1 supervision.	F 353		

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F 353	Continued From page 465 21. 101 of 149 staff and 10 agency staff were educated regarding resident behaviors and documentation, care planning and following the care plan, reporting maintenance issues, safe smoking policy, on 05/13/15 and 05/14/15 by the Corporate Administrative RNs. IDT will meet to ensure behaviors were documented and care planned, notification to the physician, and document on the 24 hour report. Residents with behaviors would be reviewed during the weekly IDT meeting beginning 05/12/15. The 24 hour report would be reviewed in the morning meeting. Forty-eight (48) staff not educated will not be allowed to work until they have been trained. No staff will be allowed to work after 05/14/15 until they have been educated prior to the start of their shift. The ED or DCS would monitor the schedule and appoint a department manager to stand at the time clock to direct employees still needing education to the in-service. 22. QAPI meeting was held on 05/13/15 to review the P&P for care plans and behavior management, resident weights, skin assessments, ADLs, smoking, assistive devices related to lifts and shower bed, facility maintenance, pest control, housekeeping/ laundry, and staffing, falls, incidents/accidents, grievances, with no changes made. The facility's action plan for removal of the IJ was reviewed and tasks assigned, with department managers assigned to provide daily oversight along with the RDCS/ RVPO/ RDHC/ RCMC/Corporate Administrative RNs. 23. Beginning 05/15/15, residents with new falls and behaviors were reviewed by the Daily IDT team for completion of SBAR, assessment,	F 353		

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F 353	Continued From page 466 notification, immediate interventions, and investigation with root cause analysis. Care plans and Kardexes were reviewed/updated with appropriate interventions. No issues were identified, and would be validated five (5) times weekly. 24. Beginning 05/12/15 weekly falls management meeting and weekly behavior management meeting occurred with IDT, with no issues identified. The IDT in the daily meeting reviewed the 24 hour report with no issues identified, and validated one (1) time weekly. 25. An Ad-Hoc QAPI meeting held on 05/15/15 for ongoing QI monitoring of the facility process for abuse and neglect reporting is done, and call lights, beginning 05/16/15 using an approved audit tool. Any issues identified in audits were addressed and ongoing plans developed. 26. A weekly behavior meeting was held on 05/12/15 and 05/13/15 and discussed six (6) residents with resident to resident behaviors or sexual/ physical behaviors to ensure behaviors were documented, care planned, and interventions in place. 27. On 05/13/15 and 05/14/15 twenty-two (22) nurses were educated by the Corporate Administrative RNS to complete skin sweeps weekly and PRN, and complete residents' weights per physician order. 28. The IDT would review in the daily meeting incidents and accidents reports and the 24 hour report for investigation reports, nursing documentation in the clinical record, an SBAR, notifications to the physician and RP, and care	F 353		

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F 353	Continued From page 467 plans with appropriate interventions. 29. On 04/30/15, one hundred twenty-four (124) residents were reviewed for appropriate transfer/lift method and updated the care plans and Kardexes, including Residents #4 and #34. The shower bed was removed from the facility and discarded. A new shower bed was ordered on 05/07/15. A shower bed located in the shed was inspected and discarded by Maintenance on 05/13/15. 30. The SSD completed safe smoking evaluations on fifteen (15) residents who smoke, on 05/13/15, with three (3) identified to require a smoking apron and two (2) referred to therapy for adaptive smoking equipment. Residents who smoke were given a copy of the facility's safe smoking rules on 05/13/15 and 05/14/15. 31. Room rounds were conducted by the ED, on 05/13/15, for incendiary smoking items, with any items found removed and maintained in a locked box at the nurse's station for supervised smoking times by facility staff. A list of residents who smoke and who require supervision or aprons would be kept in the locked box with the Kardexes. 32. On 05/12/15 Corporate Administrative Nurses made walking rounds to identify any maintenance/resident safety concerns. Identified concerns were given to the ED and Maintenance Director for prioritization and repair. On 05/13/15 The ED and Maintenance Director made facility rounds and reviewed the maintenance books at the nurse's stations to identify safety concerns. Safety concerns were addressed by the Maintenance Director on 05/13/15 and 05/14/15.	F 353		

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F 353	Continued From page 468 The Maintenance Director was educated on 05/13/15 to check the maintenance books at each nurse's station five (5) times weekly and prioritize based on safety concerns. 33. Fifty-one (51) nursing staff and 10 agency staff were educated on 05/13/15 and 05/14/15 to observe shower beds for safety prior to use. If a shower bed was unsafe or non-functional, staff would immediately remove the equipment and notify maintenance. 34. QAPI monitoring, beginning 05/15/15 of the facility process for falls, smoking, assistive devices, lifts, shower beds, and facility maintenance. 35. Beginning 05/12/15 the IDT would round to observe for environment safety concerns in five (5) resident care areas and immediately addressed by maintenance, and validated five (5) times weekly. Maintenance books would be brought to the daily meeting to discuss concerns five (5) times weekly. 36. Beginning 05/13/15 training and return demonstration of five (5) nursing staff will be completed five (5) times weekly. Observations of five (5) residents during supervised smoking by a member of the IDT five (5) times weekly. Rounds of five (5) resident rooms for incendiary items by a member of the IDT would be completed five (5) times weekly. Any issues would be brought to the daily meeting. 37. Five (5) residents would be observed, beginning 05/12/15, to ensure fall interventions were in place per the care plan would be completed by IDT five (5) times weekly.	F 353		

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HURSTBOURNE CARE CENTRE AT STONY BROOK	2200 STONY BROOK DR LOUISVILLE, KY 40220

(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 469 38. Resident call lights were checked for function on 05/12/15 for Resident #7, #5, #12, Unsampled Residents Z, and AA. Unsampled Resident M no longer resided in the facility. Resident #12's call light was found not to light at the desk or the door. 39. On 05/12/15, one hundred twenty-four (124) residents call lights were checked for function and twenty-two (22) rooms were found to not light at the desk, one (1) room did not light at the desk or door, and two (2) rooms did not light at the desk or door, or sound. The ED was notified of the three (3) resident rooms, on 05/13/15, that had call lights that did not work. All six (6) residents of the three (3) rooms were put on fifteen (15) minute safety checks. On 05/13/15 an outside contractor initiated maintenance to ensure functionality and made repairs on 05/13/15 with an additional room repaired on 05/14/15 of a call light that would not turn off. The annunciator system at the nurse's station on the 200 unit was repaired, on 05/14/15. 40. Twelve (12) nursing staff working 11:00 PM to 7:00 AM on 05/12/15 were educated on the call light P&P on 005/09/15 through 05/12/15 with competencies. The 11:00 PM to 7:00 AM staff working on 05/12/15 were re-educated on the facility's P&P for an inoperable call light system, on 05/13/15, and the six (6) residents were placed on fifteen (15) minute safety checks until the call lights were functional. Hand bells were also given to the six (6) residents on 05/13/15. 41. One hundred and one (101) of 149 staff were educated on 05/09/15 through 05/14/15 on the facility's call light P&P and what to do if there was	F 353		

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F 353	Continued From page 470 an inoperable call light, and use the pest sightings book at the nurse's station. Forty-eight (48) staff not educated by 05/14/15 would not be allowed to work until they had been educated prior to the start of their shift. 42. On 05/11/15, pest control service evaluated the facility and rendered services on 05/13/15, with another visit on 05/14/15. Pest control would visit monthly and as needed. As of 05/15/15 live pests in the facility had been eliminated. 43. Walking rounds were conducted by Corporate Administrative Nurses, on 05/12/15, to look for pests, with none seen. One hundred twenty-one (121) residents were assessed by skin sweeps, with no pest bites evident. No pests were observed in resident beds or rooms. 44. Beginning 05/14/15 rounds were completed by IDT Monday through Friday with no pest issues identified. 45. An Ad-Hoc QAPI meeting, held on 05/14/15, related to QI monitoring of the facility's process for pest control would be completed by the ED/RVPO one (1) time monthly that pest control visits occurred monthly. Beginning 05/15/15 resident care areas would be checked to ensure there were no live pests five (5) times weekly. 46. On 05/12/15 and 05/13/15, housekeeping rounds were completed by the ED and Housekeeping Supervisor for facility cleanliness and odors, with areas needing cleaning were cleaned on 05/12/15 through 05/15/15. 47. On 05/13/15, Corporate Administrative RNs educated facility Administrative Staff on the	F 353		

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F 353	Continued From page 471 regulations and P&P for staffing, pest control, housekeeping, and maintenance, with competencies completed. The ED would monitor the facility's process for notification, abuse, hiring, dignity, care plan revision, professional standards, assessments, behavior and falls management, incidents and accidents, smoking, call lights, pest control, and staffing. 48. New employee files would be reviewed by the ED or Corporate Administrative Nurses for completeness two (2) times weekly. 49. Review of the 24 hour report, incident/ accident reports, in the daily meeting with the IDT; documentation in the clinical record included notification to the physician and new orders, and to the RP; the IDT made rounds in five (5) resident care areas to observe for maintenance and safety concerns; observations of five (5) residents during supervised smoking by the IDT; room rounds for five (5) residents to search for incendiary items by a member of the IDT, maintenance concerns were written in the maintenance books and taken to the daily meeting and prioritized for repair; observations of five (5) residents to ensure falls interventions were in place per the care plan by the IDT; call lights checked in resident rooms and bathrooms to ensure lights and sound; five (5) staff educated what to do if call light inoperable; resident care areas checked for no live pests; were validated five (5) times weekly. 50. Daily oversight since 04/22/15 on all shifts to ensure residents were safe and the plan of care was followed to meet resident needs, by the ED/ DCS/ RVPO/RDCS/Corporate Administrative Nurses.	F 353		

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F 353	Continued From page 472 51. The IDT would meet at least monthly to discuss facility action plan and ensure tasks were completed for the removal of the IJ, and QA monitoring completed according to the AOC during the IJ period, validated by the ED/RVPO/RDCS/Corporate Administrative RNs. 52. Per the Ad-Hoc QAPI meeting, on 05/15/15, QI monitoring would be done utilizing approved audit tool with oversight by the ED, beginning 05/16/15, five (5) resident interview; new resident/ family concerns; daily department head meeting to ensure new resident injuries or concerns were discussed; five (5) new employee files reviewed two (2) times weekly; residents with new falls or behaviors were reviewed in the daily meeting with IDT and care plans/ Kardexes reviewed and updated; review of the 24 hour report and the incident and accident reports in the daily meeting with IDT; review of the clinical record for timely notifications to the physician and RP; the IDT rounds in five (5) resident care areas to observe the environment for safety and maintenance concerns; observations of five (5) residents during supervised smoking; room rounds of five (5) residents for incendiary items; maintenance concerns listed in the maintenance book and taken to the daily meeting to discuss and prioritize repairs; observations of five (5) residents to ensure falls interventions were in place per the care plan by the IDT; five (5) resident rooms call lights checked to ensure they light at the door, nurse's station, and sound; five (5) staff education what to do if a call light was inoperable; five (5) times weekly; weekly falls and behavior management meetings occur with IDT one (1) time weekly.	F 353		

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53. Linen rounds were completed, on 05/13/15, by the ED/ Housekeeping Supervisor/Department Managers to ensure PAR levels and available resident laundry, with areas of concern addressed by the Housekeeping Supervisor at that time.

54. The RVPO/RDCS/Corporate Administrative RNs would provide daily oversight of the ED and DCS in areas of falls, incidents, accidents, change in condition, sufficient staffing to meet resident needs, housekeeping and laundry, and pest control during the IJ period until removal.

55. Grievances were reviewed, on 05/13/15, by the ED/SSD/DCS back to 05/1/15 for any areas requiring additional follow up, which was handled by 05/15/15.

56. Resident #39's hair was washed and combed, shaved and care provided, sheets changed, privacy curtain provided.

57. On 05/12/15 rounds were completed by the DCS/ADCS/ Nurse Managers, and Corporate Administrative Nurses to identify residents who needed additional grooming or incontinent care; bed linens checked to ensure they were clean and pest free; call lights checked to ensure they were within resident reach and answered timely; resident's skin observed to ensure free from pests; and privacy curtains in place. Additional grooming was provided to residents requiring it, and one (1) resident room was identified to need a privacy curtain on 05/13/15.

58. On 05/13/15 and 05/14/15, nursing staff and ten (10) agency staff were educated on incontinent care, bathing, shaving, washing

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F 353	Continued From page 474 resident's hair, with those not trained would not allowed to work until trained prior to the start of their shift. 59. On 05/13/15 and 05/14/15, 101 of 149 staff and ten (10) agency staff were educated to notify housekeeping when privacy curtains were needed; report pest sightings in the pest sightings book; any pests noticed on residents should be reported immediately to the nurse supervisor/DCS/ADCS for completion of a skin assessment; resident privacy. Forty-eight (48) staff not educated will be trained prior to working their next scheduled shift. 60. A QAPI meeting was held, on 05/13/15, to discuss the facility's P&P for incontinent care, resident privacy, shaving, AM care, with no changes made. 61. Daily rounds were conducted by department managers and corporate administration Monday through Friday to identify any issues with resident incontinent care, privacy, shaving and AM care, with any issues identified discussed in the daily IDT meeting and resolved with further Ad-Hoc education. 62. An Ad-Hoc QAPI meeting, on 05/15/15, discussed QI monitoring would be completed beginning 05/16/15 for: beginning 05/12/15 observations of five (5) residents to ensure they were shaven, hair combed, provided incontinent care, privacy curtains were clean, bed linens were clean, rooms/bed/residents were free from pests, privacy provided for care, call lights in reach and answered timely, would be conducted five (5) times weekly.	F 353		

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The State Survey Agency validated the removal of Immediate Jeopardy on 05/22/15 as follows:

1. Review of the facility's SBAR's, incident report, neuro checks, progress notes and physician orders, all dated 02/25/15, revealed Resident #4 had a fall on 02/25/15, the physician was notified on 02/25/15 with new orders received. The resident was transferred to a local hospital on 02/25/15 for a tibia fracture on 02/25/15, and returned to the facility on 02/28/15 with new orders. The DCS assessed Resident #4 on 04/22/15 and found the resident was stable.

2. Review of one hundred twenty-six (126) resident assessments, completed by ADCS/Nurse Manager/Licensed Nurse, on 04/22/15, revealed residents were assessed for any incident or accident, or change in condition that warranted notification to the physician. One (1) resident was identified as experienced a change in condition, accident, or incident and the physician was notified on 04/22/15.

3. Review of in-service records, revealed twenty-three (23) nurses were educated by Corporate Administrative Registered Nurses regarding: timely notification to the physician related to incidents, accidents, and changes in condition; care plan policies; resident assessments, including SBAR, neuro checks; falls and immediate interventions; notification to the physician and RP; documentation of the fall in the clinical record; fall root cause investigation report. Staff competencies were completed. No staff had worked prior to them receiving the training. Review of staffing schedules revealed staff who had not yet been trained were not highlighted, which noted they required education.

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F 353	Continued From page 476 Review of facility records revealed notifications of incidents, accidents, and changes in condition were reviewed for completion by the DCS/ADCS/ Nurse Manager. Interview with the DCS and RDCS, on 05/04/15 at 4:18 PM, revealed twenty-three (23) nurses had been trained. Interview with RN #8, on 05/04/15 at 4:33 PM, with CNA #11, on 05/05/15 at 9:51 AM, with the UM, on 05/05/15 at 9:55 AM, CNA #14, on 05/05/15 at 10:03 AM, CNA #13, on 05/05/15 at 10:10 AM, revealed they had been educated on falls, notifications, Kardex and care plans. Interview, on 05/05/15 at 2:00 PM, with the DCS, ADCS, Nurse Manager, ED, Admissions Coordinator, DSS, MDS Director revealed they had all been trained on care plans, changes in condition, staff look at interventions for residents, the 24 hour report, falls, SBAR, incident reports, Kardex and care plans, notifications to the physician and family. 4. Review of a QAPI sign in sheet, dated 04/22/15, and agenda revealed the committee discussed the P&P for falls management, notifications of incidents, care plans, falls interventions, nursing assessments, shift to shift relief and report, with no changes made. Interview with the DCS, ADCS, Nurse Manager, ED, Admission Coordinator, DSS, MDS Director, on 05/05/15 at 2:00 PM, revealed QA would track and trend falls information to validate interventions and notifications were being completed. 5. Review of resident assessments for risk for falls, dated 04/22/15, for one hundred twenty-six (126) residents revealed seventy-four (74) residents were assessed by the ADCS as at risk for falls. Review of the Kardexes and Care Plans	F 353		

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F 353	Continued From page 477 for the seventy-four (74) residents assessed at risk for falls revealed the Kardexes and care plans had been updated, on 04/22/15. Observation of room 107-A, on 05/05/15 at 1:26 PM, revealed the resident had falls interventions in place. Observation, on 05/05/15 at 1:30 PM, of room 112-A, revealed the resident's falls interventions were in place. Observation, on 05/05/15 at 1:30 PM, of Unsampled Resident Y revealed the resident had falls interventions in place. Observation of Unsampled Resident O, on 05/05/15 at 2:52 PM, revealed the resident's falls interventions were in place. 6. Review of training records, dated 04/22/15, revealed thirty (30) CNAs and two (2) agency staff were educated on the Kardex and falls risk. The Corporate Administrative RNs educated the DCS/ADCS/Nurse Manager, on 04/22/15, regarding assessments, care plans, documentation of falls, and immediate falls interventions. Interview with CNA #6, on 05/05/15 at 10:12 AM, revealed he received training on the Kardex, falls, and notify the nurse if a resident had a change in condition. 7. Review of staff schedules revealed CMTs were scheduled to work with another nurse present on the unit. Review of a resident census revealed, on 04/22/15, the ED and DCS reviewed which residents required total care, assistance, or were independent with care. Observation, on 05/05/15 at 10:15 AM, revealed CMT/ CNA #11 on the 200 unit was supervised by LPN #1. 8. Review of assessments for one hundred twenty-six (126) residents, dated 04/22/15, revealed residents were assessed by the DCS, with vital signs taken. One (1) resident was	F 353		

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F 353	Continued From page 478 identified in distress and the physician was notified at that time. 9. Review of in-service records, dated 04/22/15, revealed twenty-three (23) nurses, thirty (30) CNAs, and two (2) agency staff were educated who to call when they call out and how the shift may be covered to ensure adequate staffing, shift report. Staff competencies were completed. Interview, on 05/04/15 at 4:00 PM, with the RDCS and Interim ED, revealed twenty-three (23) nurses were educated on staffing. Interview with LPN #1, on 05/05/15 at 9:45 AM, revealed he had been trained on what to do and who to call if calling in, and call in to the ED, DCS, or ADCS; stated he had to go through training before he was allowed to work. Interview, on 05/05/15 at 9:51 AM, with CNA #11 revealed she had been educated on staffing, to call the ED, DCS, or ADCS, and had to be trained prior to working. Interview with the UM, on 05/05/15 at 9:55 AM, revealed she was educated on staffing and the ED, DCS, or ADCS should be called if staff were to call in. Interview with CNA #6, on 05/05/15 at 10:12 AM, revealed he could only call the ED, DCS, or ADCS if he could not come in to work and he was to wait for the next shift before leaving. 10. Review of the facility investigation, dated 04/28/15, for Resident #25's black eye noted on 03/25/15, revealed the SSA was notified on 04/28/15, investigated, and followed up on 05/04/15. The investigation resulted in the cause of the injury from a resident to resident altercation. Interview with the DCS, on 05/20/15 at 2:04 PM, revealed she investigated Resident #25's black eye and the cause was determined to be a resident to resident altercation. Observation,	F 353		

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F 353	Continued From page 479 on 05/22/15 at 2:11 PM of Resident #25 revealed the resident was in his/her recliner with the TV on and staff sitting with him/her on a 1:1. 11. Review of skin sweeps, dated 05/12/15 and 05/13/15, for one hundred twenty-one (121) residents revealed no suspicious injuries were identified. Interview with the RDCS, on 05/22/15 at 8:59 AM, revealed all residents skin were assessed for any injuries that did not have reasonable cause. Observation of Resident #25, on 05/05/15 at 2:11 PM, Unsampled Resident KK, on 05/05/15 at 2:11 PM, Resident #8, on 05/22/15 at 4:20 PM, Resident #6, on 05/05/15 at 2:26 PM, revealed no concerns with new or unknown injuries. 12. Review of resident interview questionnaire, dated 05/12/15 and 05/13/15, revealed residents with a BIMS Score of twelve (12) or more were interviewed by the Executive Director about their safety, no concerns identified. Interview with the DCS, on 05/22/15 at 2:52 PM, revealed residents were interviewed about their safety with no concerns identified. Interview with Resident #8, on 05/22/15 at 4:20 PM, revealed the resident felt safe in the facility. 13. Review of staff questionnaires, dated 05/12/15 and 05/13/15, revealed staff were interviewed by the ED to determine if any staff member had witnessed abuse or neglect. Review of two (2) facility reports to the SSA revealed the reports were made on 05/14/15. Interview with the DCS, on 05/22/15 at 2:52 PM, revealed staff were interviewed about abuse. She stated two (2) new additional reports were made and investigations were begun.	F 353		

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F 353	Continued From page 480 14. Review of in-service records, dated 05/09/15 through 05/14/15, revealed one hundred one (107) staff and fourteen (14) agency staff were educated on abuse and neglect and injury of unknown origin, with staff competencies completed. Interview with CNA #7, on 05/22/15 at 8:05 AM, RN #6, on 05/22/15 at 8:13 AM, with Housekeeper, on 05/22/15 at 8:20 AM, with LPN #1, on 05/22/15 at 8:25 AM, CNA #8, on 05/22/15 at 8:37 AM, had been trained on abuse and neglect, could name the types of abuse, and who and when to report. Interview, on 05/22/15 at 2:52 PM, with the DCS, Maintenance Director, ADCS, UM, Staffing Coordinator, Medical Records, MDS Coordinator, Housekeeping Supervisor, revealed they had been trained on abuse. 15. Review of one hundred twelve (112) employee file audits, dated 05/13/15, revealed employee files were audited by the Regional Director of Human Resources by the Regional Director of Clinical Services for criminal background checks, nurse aide abuse registry, OIG checks, and telephone reference checks with no discrepancies corrected. Review of the QAPI meeting, held on 05/15/15, five (5) new employee files would be reviewed for completeness, twice a week. Review of five (5) new employee files, dated 05/15/15 and 05/20/15, revealed they were complete with criminal checks, nurse aide abuse registry, OIG checks, and reference checks. 16. Review of the facility abuse allegation investigations, revealed complete investigations and five day follow up. Interview with the RDCS, on 05/22/15 at 12:07 PM, revealed allegations were reviewed for investigation and follow up.	F 353		

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F 353	Continued From page 481 17. Review of a QAPI sign in sheet, dated 05/13/15, revealed review of the P&P for abuse with no changes made. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, ADCS, UM, Staffing Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS had all been trained on abuse, and staff trained on abuse. 18. Review of facility investigations , dated 04/21/15 through 04/24/15, 04/26/15 through 04/29/15, 05/01/15, 05/04/15, 05/06/15, 05/09/15, 05/11/15, revealed incidents were reviewed by the RDCS for regulatory compliance and timeliness with no issues identified. Review of the investigations audit for the last thirty (30) days, dated 05/14/15, revealed the investigations were reviewed for timely reporting, investigation, and resolution. Interview with the RDCS, on 05/22/15 at 12:07 PM, revealed she completed the review of investigations with no concerns. 19. Review of the sign in sheet and agenda for QAPI meeting, dated 05/15/15, revealed monitoring of abuse and neglect reporting: resident interviews, dated 05/12/15, 05/13/15, 05/15/15, 05/16/15, 05/18/15, 05/19/15, would be completed for five (5) residents five (5) times weekly; skin sweeps, dated 05/08/15, 05/12/15, 05/13/15, and would be conducted for five (5) residents five (5) times a week; beginning 05/15/15 resident and family concerns would be reviewed five (5) times weekly; beginning 05/12/15 and on 05/15/15, 05/18/15, 05/19/15, 05/20/15, daily meeting would discuss new resident injuries or concerns five (5) times weekly; and use of an abuse audit tool for abuse reporting beginning on 05/15/15. Observation of the daily meeting, on 05/22/15 at 9:05 AM,	F 353		

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NAME OF PROVIDER OR SUPPLIER
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STREET ADDRESS, CITY, STATE, ZIP CODE
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LOUISVILLE, KY 40220

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F 353	Continued From page 482 revealed specific residents were discussed in regard to specific resident concerns. Interview with the DCS, on 05/22/15 at 2:52 PM, revealed residents were discussed in the morning meeting for specific concerns and plan. 20. Review of current residents were assessed for behaviors by the Corporate Administrative Registered Nurses/Interdisciplinary Team, on 05/12/15 and 05/13/15, revealed sixty-four (64) residents with behaviors had their care plans reviewed, with nineteen (19) care plans updated. One (1) resident was placed on 1:1 supervision, on 05/13/15. Interview with the RDCS, on 05/22/15, revealed sixty-four (64) residents were reviewed, and nineteen (19) actually had care plan interventions updated. 21. Record review of in-services conducted 05/13/15 and 05/14/15 revealed one hundred one (101) staff were educated by Corporate Administrative Registered Nurses on bathing, AM care, shaving, hair care, change in condition, notifications to physician and RP, assessments, linens and laundry, falls, behaviors, abuse, resident smoking and use of aprons. Observation on the IDT in daily morning meeting, on 05/22/15 at 9:05 AM, revealed specific residents and behaviors, the 24 hour report, with department heads noted an new orders or changes to the care plans. 22. Review of a QAPI sign in sheet, dated 05/13/15, and agenda revealed the P&P for care plans and behavior management were discussed with no changes made. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Staff Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping	F 353		

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F 353	Continued From page 483 Supervisor, and DSS attended the QA meetings. 23. Review of audit tools revealed residents with new falls and behaviors were reviewed by the Interdisciplinary Team in the daily meeting for completion of the documentation, notifications, care plans and Kardexes. Observation, on 05/22/15 at 9:05 AM, of the IDT morning meeting revealed specific resident concerns were reviewed, 24 hour report and behaviors were discussed, and care plans reviewed. Interview, on 05/22/15 at 2:52 PM, with the DCS revealed facility audits were reviewed in the daily meeting and any concerns discussed. 24. Review of the weekly falls meeting and behavior management meeting with the IDT, beginning 05/12/15, revealed meetings were conducted. Observation of the daily IDT meeting, on 05/22/15 at 9:05 AM, revealed the 24 hour report was discussed. Interview with the DCS, on 05/22/15 at 2:52 PM, revealed resident behaviors were reviewed in the behavior management meeting. 25. Review of the sign in sheet for an Ad-Hoc QAPI meeting, dated 05/15/15, and audit tools revealed abuse and neglect reporting was monitored by the QA. 26. Review of weekly behavior meeting notes, dated 05/12/15 and 05/13/15, revealed six (6) residents with resident to resident behaviors or sexual/physical behaviors were reviewed for documentation, care plan interventions. Interview with the DCS, on 05/22/15 at 2:52 PM, revealed the behavior meeting reviewed and monitored residents with behaviors, notifications, interventions were in place, and possibility for	F 353		

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F 353	Continued From page 484 more frequent monitoring. 27. Record review of in-services conducted on 05/13/15 and 05/14/15 revealed education provided for skin assessments, resident weights. Interview with CNA #7, on 05/22/15 at 8:05 AM, with RN #1, on 05/22/15 at 8:13 AM, with LPN #1, on 05/22/15 at 8:25 AM, with CNA #8, on 05/22/15 at 8:37 AM, revealed they had been trained on resident weights and skin assessments. Observation, on 05/22/15 at 3:30 PM, revealed Resident #34 skin assessment was performed by Registered Nurse #11 and no new skin issues were identified and the documentation was completed as required. 28. Observation of the morning meeting, on 05/22/15 at 9:05 AM, revealed the IDT reviewed the 24 hour report, care plans, and specific resident concerns. 29. Review of facility assessments, dated 04/30/15, revealed one hundred twenty-four (124) residents were assessed for transfer/lift with Kardexes and care plans updated. Observation, on 05/22/15 at 2:20 PM, revealed no concerns with a broken shower bed in the 100 Unit shower room and lifts were functional. 30. Review of resident Safe Smoking Evaluations for fifteen (15) residents and completed by the SSD, on 05/13/15, revealed three (3) residents were identified to need a smoking apron. Review of the therapy screening tool revealed, and two (2) residents were referred to therapy. Observation, on 05/22/15 at 4:53 PM, revealed one (1) resident was smoking, used an apron, and staff assisted the resident to smoke. Interview with the DSS, on 05/22/15 at 2:52 PM,	F 353		

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F 353	Continued From page 485 revealed she completed the resident smoking assessments and if the resident needed an apron. 31. Observation of the resident smoking area, on 05/22/15 at 4:53 PM, revealed eight (8) aprons hanging near the door, one (1) resident smoking with staff assistance, and wearing an apron. Observation of the smoking box on the 200 Unit, on 05/22/15 at 4:57 PM, revealed boxes of cigarettes for all residents of the facility; a list of residents who smoked and who required an apron. Interview with CNA #2, on 05/22/15 at 4:57 PM, revealed Central Supply and a staff from the 200 Unit cover the smoking times during the day; resident cigarettes and lighters should be kept in the smoking box which was kept locked in the medication room. 32. Review of rounding sheets, dated 05/12/15, revealed maintenance and environmental concerns were audited by Executive Director and Maintenance Director. Review of rounds completed by the ED and Maintenance Director, on 05/13/15, revealed maintenance books on each unit were reviewed for any maintenance issues, with concerns addressed on 05/13/15 and 05/14/15. Interview with the Maintenance Director, on 05/22/15 at 2:52 PM, revealed any maintenance issues should be listed in the maintenance book at each nurse's station, which he will take to the morning meeting, and discuss what had been addressed on the maintenance concerns. 33. Review of in-service records, dated 05/13/15 and 05/14/15, revealed staff were educated on showers and beds. Interview, on 05/22/15 at 3:20 PM, with CNA #5 revealed she was educated not	F 353		

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F 353	Continued From page 486 to use broken equipment or shower beds and to report to supervisor and maintenance if equipment/shower bed was broken. 34. Review of a QAPI sign in sheet, dated 05/15/15, audit tools, and agenda revealed monitoring of falls, smoking, assistive devices, lifts, shower beds, and maintenance occurred. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, Housekeeping Supervisor, and DSS revealed they attended the QA meetings. 35. Review of facility rounding sheets, dated 05/12/15, revealed the environment was observed, by Corporate Administrative Registered Nurses for maintenance needs. Observation of the morning meeting, on 05/22/15 at 9:05 AM, revealed the maintenance books were taken to the IDT meeting and reviewed. Interview with the Maintenance Director, on 05/22/15 at 2:52 PM, revealed he would take the maintenance books to the morning meetings. 36. Review of staff training records, beginning 05/13/15, revealed five (5) staff were trained with return demonstration for transfers. Review of the smoking list revealed residents who smoked were listed, with resident who required an apron and/or supervised smoking were identified. Review of rounding sheets, beginning 05/13/15, revealed resident rooms were searched for incendiary smoking items by the Executive Director. Observation of the facility's smoking box on the 200 unit, on 05/22/15 at 4:57 PM, revealed cigarettes were stored for the entire facility, and contained a list of residents who smoked, with those who required an apron identified. Interview	F 353		

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F 353	Continued From page 487 with CNA #2, on 05/22/15 at 4:57 PM, revealed the box should be locked in the med room and the box had the cigarettes and lighters for all residents who smoked in the facility. 37. Review of the facility's audit tool revealed, beginning 05/12/15, residents were observed to ensure fall interventions were in place per the care plan. Interview with the DCS, ADCS, UM, Medical Records, BOM, and DSS, on 05/22/15 at 2:52 PM, revealed audits were conducted every morning and looked for falls interventions compared to the care plan and discussed in morning meeting. 38. Record review of resident call light audit, dated 05/12/15, revealed Residents #7, #5, #12, Unsampled Resident Z and AA call lights were checked for function, with Resident #12's call light was found to not light at the desk or the door. 39. Record review of call light audits, completed on 05/12/15, found one hundred twenty-four (124) resident call lights were checked for functionality, with twenty-two (22) rooms found that call lights did not light at the desk, one (1) room did not light at the desk or the door, and two (2) rooms did not light at the desk, the door, or sound. Six (6) residents in the three (3) rooms that call lights did not work, were placed on fifteen (15) minute checks and given a hand bell. Record review of the call light work order, dated 05/13/15, revealed the call lights for the six (6) residents were repaired by an outside contractor on 05/13/15 and another call light was repaired on 05/14/15 that would not turn off; the annunciator on the 200 Unit was repaired at the nurse's desk on 05/15/15. Observation, on 05/22/15 at 2:03 PM, of room 18 revealed the call light functional at the	F 353		

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F 353	Continued From page 488 door, desk and sounding. Observation, on 05/22/15 at 2:15 PM, on the 200 Unit of two (2) nurse's stations revealed each desk had a new call light system installed on the wall behind the desk. Interview with the RDCS, on 05/22/15 at 12:07 PM and 05/22/15 at 3:42 PM, revealed call lights were repaired on 05/13/15 and 05/14/15, and the 200 Unit annunciators were repaired, and then moved to the wall behind each nurse's station. The six (6) residents were given hand bells on 05/13/15 and placed on fifteen (15) minute safety checks. Review of fifteen (15) minute check sheets revealed residents were checked on every fifteen minutes until call light was repaired. Interview with DCS on 05/22/15 at 5:30 PM, revealed she had call bells purchased and given to residents. 40. Review of in-service training records, dated 05/09/15 through 05/12/15, revealed twelve (12) nursing staff working the 11:00 PM through 7:00 AM shift on 05/12/15 were re-educated on 05/13/15 on what to do if the call lights were inoperable and the six (6) residents identified with inoperable call lights were placed on fifteen (15) minute checks. Interview, on 05/22/15 at 3:42 PM, with the RDCS revealed staff working on 05/12/15 and 05/13/15 were educated on the call lights not working for the six (6) residents and conduct fifteen (15) minute safety checks and were provided hand bells. Observation on 05/21/15 at 11:10 AM, revealed a hand bell was rung and the Medical Records Coordinator answered the hand bell immediately upon hearing it ring. 41. Record review of in-services conducted 05/13/15 and 05/14/15 revealed 101 of 149 staff were educated on providing call lights and what	F 353		

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F 353	Continued From page 489 to do if not working, and answering call lights timely. Interview, on 05/22/15 at 8:05 AM, with CNA #7, on 05/22/15 at 8:13 AM with RN #1, on 05/22/15 at 8:25 AM with LPN #1, revealed they had been trained on call lights and knew what to do if a resident's call light did not work. Interview, on 05/22/15 at 2:52 PM, with the DCS, ADCS, UM, Medical Records, and Staffing Coordinator revealed staff were trained on call lights, answering call lights, and what to do if call lights were not functioning. Observation, on 05/22/15 at 1:58 PM, of room 106 revealed the call light was functional at the door, at the desk, and sounded. 42. Review of the pest control company invoice, dated 05/13/15 and 05/14/15 revealed services were provided to the interior and exterior of the facility. Review of the pest control contract revealed services would be provided to the facility monthly and as needed. Interview with the Maintenance Director, on 05/22/15 at 2:52 PM, revealed the new pest control company had begun services inside and outside of the facility. Observation of the Sub acute 1 nurse's station, on 05/22/15 at 2:03 PM, revealed the maintenance book also contained the pest sightings book. Observation of Sub acute 2 nurse's station, on 05/22/15 at 2:07 PM, revealed the maintenance book also included the pest sightings log. Observation of room 215, on 05/22/15 at 2:09 PM, revealed no pests were seen. Observation of the 100 Unit nutrition room, on 05/22/15 2:20 PM, revealed no pests were seen. Observation, on 05/22/15 at 5:20 PM, of the kitchen revealed no pests were seen. Interview with the Dietary Director, on 05/22/15 at 2:52 PM, revealed the kitchen did not currently have pests.	F 353		

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F 353	Continued From page 490 43. Review of facility rounding sheets, dated 05/12/15, revealed no pests were observed. One hundred twenty-one (121) residents were assessed via skin sweeps on 05/12/15 and 05/13/15 with no pest bites evident, and no pests documented in resident beds or rooms. Interview with the DCS, ADCS, UM, MDS Director, on 05/22/15 at 2:52 PM, revealed residents were assessed via skin sweeps, and no concerns. Interview with Resident #24 on 05/22/15 at 4:30 PM, revealed no pests were in his/her room. 44. Review of rounding records, dated 05/14/15 through 05/21/15, revealed no concerns identified with pests. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, Central Supply, and DSS revealed daily rounds occurred with no concerns of pests. Interview with Resident #8 on 05/22/15 at 2:00 PM, revealed no pests were in his/her room. 45. Review of the Ad-Hoc sign in sheet, dated 05/15/15, and agenda, and audit tools revealed monitoring of the facility's pest control would be completed by the QA. Review of rounding records, dated 05/14/15 through 05/21/15, revealed no live pests were seen. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, Central Supply, and DSS revealed daily rounds occurred with no concerns of pests. 46. Review of rounding sheets, dated 05/12/15 and 05/13/15, revealed the ED and Housekeeping Supervisor observed the facility for cleanliness. Interview with the Housekeeping Supervisor, on 05/22/15 at 2:52 PM, revealed he conducted rounds for cleanliness of the facility, including linens, resident rooms, shower rooms,	F 353		

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F 353	Continued From page 491 trash, webs and pests, and privacy curtains. Interview with Resident #10 on 05/22/15 at 12:30 PM, revealed no concerns with linens. 47. Review of in-service records, dated 05/13/15, revealed Administrative staff were trained on staffing, pest control, housekeeping and maintenance, and would be monitored by the ED. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS revealed they had been trained on staffing, pest control, housekeeping and maintenance, and any concerns of audits would be taken to the morning meeting. Interview with Resident #3 on 05/22/15 at 1:00 PM, revealed staffing had improved and were answering lights timely and the facility looked cleaner. 48. Review of audits for employee files revealed they were audited twice per week by the Executive Director/RDHR/RVPO/RDCS or Corporate Administrative Nurse. 49. Observation of the daily morning meeting, on 05/22/15 at 9:05 AM, revealed review of the 24 hour report, notifications made and documented, new physician orders, maintenance concerns and books, pests, rounds and audits, call lights, care plans. Interview with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, MDS Coordinator, and DSS, on 05/22/15 at 2:52 PM, revealed they participate in the morning meeting and review the 24 hour report, notifications were made, maintenance books reviewed, physician orders, call lights, care plans, and audits/ round were reviewed in the morning meeting.	F 353		

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F 353	Continued From page 492 50. Interview, on 05/22/15 at 2:52 PM, with the DCS revealed facility concerns were reviewed in the morning meeting, including audits and rounding results, for department heads to address. She stated she (the DCS) or the ED would initial when concerns were resolved. Observation, on 05/22/15 at 9:05 AM, of the morning meeting revealed the DCS provided direction and asked clarifying questions related to information discussed with follow up items determined. 51. Review of sign in sheets, dated 04/22/15, 05/13/15, and 05/15/15, revealed QAPI meetings were held on those dates. Interview, with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS revealed they attended the QAPI meetings. Interview with the RDCS, on 05/22/15 at 5:05 PM, revealed the next QAPI meeting was scheduled for 06/17/15. Interview with the Medical Director, on 05/22/15 at 8:00 AM, revealed he was informed by the Executive Director of the resident care issues, attended the QA meetings held by the facility and provided direction regarding corrective action plans that were developed to meet the needs of the residents. 52. Review of the QAPI sign in sheet, dated 05/15/15, and agenda revealed audit tools were approved for QA monitoring and discussed: resident interviews; resident/family concerns; morning meeting; new employee files; falls or behaviors reviewed; care plans and Kardexes update; review of the 24 hour report; notifications; maintenance rounds and book; supervised smoking; falls interventions in place; call lights;	F 353		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 493 weekly falls; and, behavior management meetings. 53. Review of facility linen rounds, dated 05/13/15, revealed resident laundry available for use and linen PAR levels were observed. Observation, on 05/22/15 at 2:05 PM, of the linen closet on Journey Home 1 revealed adequate numbers of linens, wash cloths and towels, pillows, and gowns. Observation of the linen closet on the 200 Unit, on 05/22/15 at 2:15 PM, revealed adequate linens, gowns, towels, washcloths, pillows, blankets and clothing protectors. Interview with the Housekeeping Supervisor, on 05/22/15 at 2:52 PM, revealed he completed rounds three (3) times a day and checked the linen closets for adequate supplies. Observation, on 05/22/15 at 2:00 PM, revealed Resident #4's linens on the bed were clean, neat and were not torn, tattered or frayed. 54. Review of the sign in sheet for QAPI, dated 05/13/15, revealed the ED and DCS presented and reviewed falls, changes in condition, staffing, housekeeping, and laundry, and pest control, and would provide daily oversight. 55. Review of grievance audit, dated 05/13/15, revealed grievances were reviewed since 05/01/15 and resolved by 05/15/15. Interviews on 05/22/15 with Resident #3 at 2:10 PM, Resident #8 at 2:00 PM, and Resident #10 at 12:30 PM, revealed the issues and concerns they had regarding linens, pests, environment repairs and answering call lights were resolved. 56. Review of rounds , dated 05/12/15, revealed Resident #39 was groomed and had clean linens.	F 353		

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F 353	Continued From page 494 57. Review of the facility rounds, dated 05/12/15, revealed residents were observed to identify residents grooming, incontinent care, bed linens, pests, call lights in reach, and privacy curtains in place. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Staffing Coordinator, BOM, Central Supply, Housekeeping Supervisor, and DSS revealed daily rounds were completed to identify resident grooming needs and care, linens, pests, call lights in reach, and privacy curtains in place. Interviews with Resident #3, #8 and #10 on 05/22/15, revealed the issues and concerns they had regarding linens, pests, environment repairs and answering call lights had improved. 58. Review of in-service records, dated 05/13/15 and 05/14/15, revealed nursing staff and ten (10) agency staff were educated on incontinent care, bathing, shaving, and hair care. Interview, on 05/22/15 at 2:52 PM, with the DCS, ADCS, UM, and Staffing Coordinator revealed staff were trained on grooming, incontinent care, shaving, and bathing. Interview with CNA #31, on 05/22/15 at 8:10 AM, revealed she received training on incontinent care, bathing, shaving, hair care, reporting pest, broken equipment, fall prevention, lifts, reporting change in condition, and answering call lights, abuse, resident laundry and linens. 59. Review of in-service records, dated 05/13/15 and 05/14/15, revealed one hundred one (101) staff and ten (10) agency staff were educated on privacy curtains; using the pest sightings book; resident privacy. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, Staffing Coordinator, Central Supply and Housekeeping Supervisor revealed they were trained on privacy curtains, resident privacy, and	F 353		

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F 353	Continued From page 495 pests. Interview with Housekeeper #1, on 05/22/15 at 8:20 AM, revealed she received training on cleaning resident rooms, privacy curtains, reporting pests and broken equipment. Interview with Registered Nurse #11, on 05/22/15 at 8:10 AM, revealed she was educated on abuse, falls, physician orders, dignity, grievances, infection control, call lights, and reporting pests and maintenance issues. 60. Review of QAPI sign in sheet, dated 05/13/15, revealed incontinent care, resident privacy, shaving and AM care P&P were reviewed. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Staffing Coordinator, MDS Director, Housekeeping Supervisor, and DSS attended the QA meetings. 61. Review of rounding sheets revealed residents were observed by staff to identify any issues with grooming, incontinent care, privacy, shaving and AM care. Interview, on 05/22/15 at 2:52 PM with the DCS, ADCS, UM, Staffing Coordinator, Medical Records, BOM, MDS Director, Central Supply, Housekeeping Supervisor, and DSS revealed they conducted rounds to assess residents grooming, privacy, shaved, and care. 62. Review of a QAPI sign in sheet, dated 05/15/15, revealed residents would be observed to ensure they were shaved, hair combed, incontinent care, privacy curtains and bed linens in place and clean, residents and environment free from pests, resident privacy, and call lights. On 05/22/15 at 2:52 PM, interview with the Maintenance Director, DCS, ADCS, UM, Staffing Coordinator, MDS Director, Housekeeping Supervisor, and DSS attended the QA meetings. Interview with Resident #8, on 05/22/15 at 4:20	F 353		

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F 353	Continued From page 496 PM, Resident #6, on 05/05/15 at 2:26 PM, Resident #24, on 05/22/15 at 8:07 AM, revealed the issues they had with not getting shaved, hair washed and combed, incontinent care provided, bed linens without tears, an environment free from pests, and call lights answered timely had improved. Observation of Resident #43, on 05/22/15 at 8:00 AM, revealed two staff were using a lift to transfer the resident into a wheelchair and then proceeded to shave the resident.	F 353		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community	F 356		

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F 356	Continued From page 497 standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. 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 ensure the posted information regarding the total number and actual hours worked by licensed and unlicensed nursing staff, accurately reflected the number of staff for each shift and hours worked. The findings include: Review of the facility's policy titled, "Staffing", dated 11/30/14, revealed staffing would be maintained by the facility in accordance with State and Federal requirements. The facility would have appropriate staff to provide for the needs of the residents at all times. Interview with the Staffing Coordinator, on 04/20/15 at 11:10 AM, revealed the facility's process was for her to post the Daily Nursing Staffing Form information, containing the numbers and hours of the licensed and unlicensed nursing staff each day in the front lobby. She stated she used the facility's master schedule which listed the staff who were scheduled to work on each specific day to	F 356		

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F 356	Continued From page 498 prepare the sheet for the posting and to calculate the number of hours. However, she stated after she posted the Form, the unit schedules always changed due to staffing shortages and no one was assigned to change the numbers on the posted Form when she was not in the building. She stated if the numbers were different when she came back to work and she had time, she updated the Daily Nursing Staffing Form to reflect the number of staff who worked the previous day. Review of the Daily Nursing Staffing Form, dated 02/24/15, revealed it was a report of all nursing staff directly responsible for resident care. Continued review revealed the definition of "directly responsible" for resident care was provided on the form and defined as responsible for resident care which included, but was not limited to, as assisting with Activities of Daily Living (ADLs), giving medications or notifying the Physician of a change in a resident's condition. Further review of the daily staffing form, dated 02/24/15, revealed on 02/24/15, the facility's census was one hundred and twenty-six (126) residents with four (4) licensed nurses, one (1) of which was LPN #8, and seven (7) Certified Nursing Assistants (CNA's) listed as on duty for the facility's 11:00 PM to 7:00 AM shift. However, review of the Time Card Report document, dated 02/24/15, revealed LPN #8, who was listed on the staffing schedule and assigned to work the 100 Unit for the 11:00 PM to 7:00 AM shift, no documented evidence LPN #8 clocked in for work in at 11:00 PM. This left the 100 Unit without coverage by a licensed nurse. Continued interview with the Staffing Coordinator,	F 356		

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F 356	Continued From page 499 on 04/20/15 at 11:10 AM, revealed the facility strived to get staff to come into work on time and to staff the facility according to the policy. The Staffing Coordinator revealed however, the facility was experiencing a staffing shortage and did not have enough staff to cover all the shifts. She stated the facility's management staff was "stepping up" to work as floor staff to try and meet the residents needs. The Staffing Coordinator stated no one else came into work on the 11:00 PM to 7:00 PM shift on 02/24/15 to take the place of LPN #8 who did not show up for work. She stated she apparently missed updating the Daily Nursing Staffing Form on 02/24/15. Interview, on 04/21/15 at 11:25 PM with CNA/Certified Medication Technician (CMT) #16, revealed she was scheduled to work as a CMT passing residents' medications on the 100 Unit on 02/24/15 on the night shift, 11:00 PM to 7:00 AM, and not as CNA. She stated on 02/24/15, Unit 100 had one (1) assigned CNA and one (1) assigned CMT, herself working and no Registered Nurse (RN) or LPN. CNA/CMT #16 revealed she had provided care to some residents in between performing medication administration and her other CMT tasks; however, was not working as a CNA on nigh shift on 02/24/15 as that was not her assigned duty. Interview with the Executive Director/Regional Vice President of Operations, on 04/22/15 at 8:34 AM, revealed she was not aware the Daily Nursing Staffing Forms did not reflect the actual nursing staff numbers and hours as required for posting. She stated she was not aware LPN #8, who was listed on the staffing schedule and	F 356		

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F 356	Continued From page 500 assigned to work the 100 Unit on night shift on 02/24/15, had not clocked in for work at 11:00 PM and had not worked the shift. She stated she did not remember receiving any calls from the facility notifying her of a staffing shortage on 02/24/15 or 02/25/15.	F 356		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. 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 ensure resident meals were delivered at a palatable temperature according to the resident's taste for two (2) of forty-three (43) sampled residents (Residents #10 and #20). The facility failed to serve trays to Resident #10 and #20 which were at a palatable temperature, and observation of a test tray revealed food was served at temperatures below the acceptable parameters. The findings include: Review of the facility's policy, "Tray Service", not dated, revealed at point of service, food should be palatable for any resident to eat. Per the Policy, at point of service to the resident, food	F 364		

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F 364	Continued From page 501 should be flavorful, warm enough, but not too hot to scald or burn residents and not too cold so it would not be palatable. The policy did not specify what temperatures should be when served to the resident. 1. Observation of the breakfast meal service, on 04/15/15 at 8:30 AM, revealed residents were seated at tables in the dining area and staff were taking trays from two (2) carts and delivering them to residents at the tables and to residents' rooms. Continued observation revealed not all breakfast trays were served when staff started picking up dirty trays and putting them in an empty cart, leaving some trays on the meal carts unserved. Observation revealed the last tray was served from the last meal cart at 9:05 AM, approximately thirty-five (35) minutes after the first trays were served. Observation of the lunch meal service, on 04/15/15 at 12:37 PM, revealed residents were seated at tables in the dining area when one (1) dietary meal cart was delivered. Continued observation revealed staff started tray delivery to residents and the second meal cart was delivered to the unit at 12:40 PM. Observation at 12:50 PM, revealed residents' meal trays were still being served, with fourteen (14) residents waiting to be served at various tables while other residents were eating. Observation at 1:05 PM, twenty-eight minutes later, revealed fifteen (15) residents' lunch meal trays remained on the cart. Further observation revealed the last meal tray was served at 1:20 PM, forty-three (43) minutes from the time the first tray was served from the first meal cart. Observation of a test tray's food	F 364		

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F 364	Continued From page 502 temperatures was performed by the Dietary Manager at 1:20 PM, after the last resident's meal tray was delivered, to determine the temperature of the food served on the last meal trays served. Per observation and interview at 1:22 PM, the Director of Dietary stated the temperature for the Chicken Parmesan served was at 125.2 degrees Fahrenheit and the mashed potatoes temperatures was at 125.6 degrees Fahrenheit, which were both below the temperature the food should be served at to be palatable for the residents as stated in the policy. Interview with the Director of Dietary, on 04/15/15 at 1:22 PM, revealed the facility's policy stated food should be palatable according to the resident's taste at the point of service. He stated this meant the point of service for food temperature should be according to the resident's likes or dislikes for food temperatures. 2. Review of Resident #10's clinical record revealed the facility admitted the resident on 05/01/14, with diagnoses of Quadriplegic, Neuropathy, Muscle Spasms and Gastro-esophageal Disease. Review of the Annual Minimum Data Set (MDS) Assessment, dated 02/03/15, revealed the facility assessed Resident #10 to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15), indicating the resident was cognitively intact and interviewable. Interview with Resident #10, on 04/15/15 at 9:25 AM, revealed the resident's food was ice cold when it was served. Resident #10 stated he/she	F 364		

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F 364	Continued From page 503 needed to be fed and due to the facility's staffing shortage his/her meals were usually cold by the time the staff got around to feeding the resident. Per interview, Resident #10 had complained about the food served being cold; however, nothing had been done to resolve the issue and the food was still being served cold. 3. Review of Resident #20's clinical record revealed the facility admitted the resident on 02/10/15, with diagnoses which included Anemia and Dementia. Review of the Annual MDS Assessment, dated 02/24/15, revealed the facility assessed Resident #20 to have a BIMS score of fifteen (15) out of fifteen (15) indicating the resident was cognitively intact and interviewable. Interview with Resident #20, on 04/16/15 at 9:11 AM, revealed the resident's breakfast meal was cold when served. Per interview, the resident's meals were routinely served cold. Resident #20 stated the meals were served cold due to the short staffing and there was not enough people to deliver the trays. Further interview revealed Resident #20 had complained about the food being served cold before, but nothing was ever done to resolve the issue and the resident's food was still being served cold. Interview, on 04/17/15 at 2:50 PM, with Certified Nursing Assistants (CNA's) #2 and #3, revealed it was difficult to serve residents' meal trays for about forty-eight (48) residents timely and try to assist residents who needed feeding, without some of the residents food getting cold. Per interview, the facility was short staffed most days	F 364		

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F 364	Continued From page 504	F 364		
	and on those days meal service was slower and residents' food got cold. They stated the facility was aware of the staffing and cold food issues, but nothing had been done to improve the situation.			
	Interview with the Director of Dietary, on 04/15/15 at 10:15 AM, revealed he made rounds daily to speak to residents about their meals. He stated however, he was not aware residents were served meals which were cold.			
	Interview with the previous Interim Director of Clinical Services (IDCS), on 04/29/15 at 7:55 AM, revealed she was not aware of any meal service issues. She stated she was only employed by the facility for two (2) weeks with her last day being 04/17/15.			
	Interview with the previous Executive Director (ED), on 04/23/15 at 8:34 AM, revealed she was not aware residents received cold food during their meals. Per interview, it was the responsibility of nursing staff to ensure meals were served timely. She stated the facility had a staffing shortage and believed this was the underlying issue to the problem of cold food being served to residents. Further interview revealed she requested approval to hire agency staff; however, as of her resignation on 04/17/15, she had yet to receive the approval to hire agency staff to cover.			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	Continued From page 505 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined that the facility failed to store, prepare and serve food under sanitary conditions. Observations on 04/21/15 and 05/22/15 revealed cleaning fluids and employee personal items were stored among food sources; the floor was soiled and sticky; pipes without insulation; three (3) soiled rolling carts and two (2) buckets containing soiled mop heads and soiled rags were stored in direct contact with the ice machine; peeling paint and rough surfaces with large areas of black and brown substances were on the walls behind the three compartment sink and dishwasher; an opening was present in the wall around the pipe leading to the dishwasher; the dishwashing area contained fruit flies and numerous small brown bugs; chipped paint with a dried brown substance and particles of debris on the baseboard; two (2) small rolling carts with glasses of ice water by the steam table and a large open trash can was in direct contact with racks of glasses. In addition, a worker prepared sandwiches on a table directly under the open serving window that had chipped and flaking paint	F 371		

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F 371	Continued From page 506 along the edges. The findings include: Review of the facility's policy titled, "Maintenance Policy and Procedures", dated 11/30/14, revealed the facility's physical plant and equipment would be maintained through a program of preventive maintenance and prompt action to identify areas/items in need of repair. The maintenance procedures included the Director of Environmental Services would follow all policies regarding routine periodic maintenance, perform daily rounds of the building to ensure the plant was maintained to be free of hazards and in proper physical condition, and all employees reported physical plant areas or equipment in need of repair or service to their supervisor. Review of the facility's Sanitation and Infection Control Pest Control policy, undated, revealed the Dining Services Department should be free of all insects. Review of two (2) letters presented by the Dietary Manager both dated 04/23/15, revealed the facility did not have records on file of either the Daily Cleaning Assignment Sheet or the Detail Cleaning Schedule on file, and did not have records on file of submitted Maintenance Requests. Review of a letter presented by the District Director of Nutrition Services, dated 04/24/15, revealed on either 10/13/14 or 10/14/14, she made rounds in the facility's kitchen and identified the need of repairs to tile and/or grout in the dishwashing area, damaged dry wall present, and recommended replacement of the piping	F 371		

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F 371	Continued From page 507 insulation. Observation of the kitchen, on 04/21/15 at 2:42 PM, revealed rubber gloves and one pair of oven mitts lying on a steel rack next to a container of germicidal ultra-bleach in the Chemical Storage Room. The corner of the floor behind the steel rack was covered with brownish particles, grayish dusty web-like substances, chewing gum wrappers, and a used dish/wash cloth. The dishwashing area and oven area had wall molding torn away from the wall, and seven (7) ceiling ventilation vents covered with a black substance. A leaf was stuck in one of the ceiling ventilation vents. The floor underneath the Pellet Warmer was covered with grease and black dirty substances. The wall molding was detached from the wall exposing the insides of the wall, and there was a buildup of brownish crusty substance on the wall and floor behind the steamer. In the Uploading and Wash-Out Area (where equipment was sprayed down), a section of the wall molding was missing. The insulation on pipes throughout the kitchen was torn off in various places, and holes in the wall had exposed pipes. The ice scoop for the ice machine was stored in a holder mounted on the wall directly above a wall-mounted fire extinguisher. Continued observation, on 04/21/15 at 2:42 PM, revealed numerous small brown bugs crawling in and out of a hole in the wall behind the dishwashing machine. A piece of vinyl had been screwed over the hole in the wall. The top seal of the garbage disposal was corroded with a rusty substance and leaked water, which dropped onto the floor. Three (3) holes were in the wall under the three compartment sink, and one (1) hole in the wall behind the warmer. The ceiling had	F 371		

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F 371	Continued From page 508 cracks and peeling plaster. A single unit metal refrigerator door was found stored in the walk-in freezer. Continued observation, on 04/21/15 at 2:56 PM, revealed a personal beverage in a plastic glass sitting on the counter belonging to a dietary worker in the work station where she was making sandwiches for the residents. A red plastic bucket filled with soapy water sat next to a large uncovered metal bowl that contained dozens of cookies. The top of the convection oven was covered with a black greasy substance that had a grayish fluffy substance stuck to it. The oil in the fryer was dark in color and the oil was gummed up on the walls and had sediment on the bottom. Interview, on 04/28/15 at 9:41 AM, with the Dietary Manager (DM) that works through a contract company, revealed he was responsible for the daily operations of the kitchen. He stated he reported to the District Manager and to the facility's Executive Director (ED). Issues with the kitchen were reported to the ED during daily morning meetings. There was no written report routinely used. He followed the contractor and the facility's policy and procedures or whichever one was more stringent. The system used to monitor kitchen cleaning tasks included utilizing a work flow sheet, which listed all duties for the entire shift. Each worker knew what tasks needed to be done by reviewing the work flow sheet. He checked kitchen sanitation four or five (4-5) times daily through visual inspection. For sanitation and infection control reasons, dietary workers were not to eat or drink while preparing or serving food. Any equipment issues would verbally be reported directly to the Maintenance Director (MD) or in morning meetings. He stated	F 371		

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F 371	Continued From page 509 there was no written system of reporting concerns with the kitchen. The DM stated there was not a breakdown in the system he used to run the kitchen. Months ago he reported to maintenance and the ED the need for repairs of the physical environment, and nothing was done. He was informed that repairs could not be completed because the facility did not have the funds. He stated that pipes not having insulation meant the boilers would lose energy and had to work harder, and that the sanitation of kitchen related to infection control and an unclean kitchen could result in cross contamination or foodborne illnesses. Interview on 04/28/15 on 10:14 AM with the contracted District Manager for Dietary Services, revealed the overall operation of the dietary department was the responsibility of the contracted DM. He related the contracted dietary services handled the food and the physical equipment and maintenance was the responsibility of the facility. He stated the DM had informed him that there were issues with floor tiles, holes in the walls, and lack of insulation on pipes. He stated the DM reported the issues to the facility's Maintenance Department and ED; however the issues were not addressed. Further, the previous MD was made aware of the issues in January or February 2015, and he was not sure if the current MD knew that repairs were needed in the kitchen. Regarding cleanliness of the kitchen, a Weekly Cycle Cleaning list is use to monitor tasks that have been completed. The dietary workers were suppose to sign off on the list as cleaning tasks were completed, however, staff had not been signing off on the list and he did not know the reason why they did not follow protocol. He stated the cleanliness of the kitchen	F 371		

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F 371	Continued From page 510 was important because if not maintained foodborne illnesses could be a consequence. Interview with the contracted District Director of Nutrition (DDN), on 04/21/15 at 2:42 PM, revealed she requested a work order several months ago to have the wall molding replaced in the Uploading and Wash-Out Area. She could not produce the work order request, and related she would have to look for it. The DDN stated related she saw no problem with storing dirty mop heads and dirty rags in containers next to the ice machine and ice scoop provided there was a lid on the buckets. Additionally, maintenance cleaned the vents and she believed the Maintenance Department had a rotating schedule for cleaning the vents. 2. Review of the facility's Cleaning Schedule for Dietary, dated 05/22/15, was reviewed and contained a check-off list for documentation of cleaning. Review of the facility's Laundry policy, undated, revealed housekeeping would provide clean mop heads for use in the dietary department. Soiled mop heads would be placed in specified/designated containers for the laundry department to clean. Observation of the Kitchen, on 05/22/15 at 5:10 PM, revealed the Stock Room floor was soiled around the edges and the floor had a sticky substance on it. The ice machine had a white dried substance in the corners of the door on the outside. On one side of the ice machine, three (3) small soiled rolling carts were stored in direct contact with the machine. On the other side of the ice machine, there were two (2) buckets with unsealed lids in direct contact with the ice	F 371		

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F 371	Continued From page 511 machine. One bucket contained soiled mop heads and the other contained soiled rags. The serving window in the kitchen was open and the ledge of the window was observed to have chipped peeling paint. Air was noted to be flowing from the dining room into the kitchen. Directly under the ledge, was a food preparation table with pimento cheese sandwiches assembled in various stages of preparation. Continued observation on 05/22/15 at 5:14 PM, revealed the walls behind and around the dishwasher and the three compartment sink had flaking paint with rough raised surfaces. Additionally observed on the walls were crevices and areas of brownish/black substances. The wall below the dishwasher, contained the same substances. There was an opening around the pipe coming through the wall and jagged pieces of wall board were noted. Further observation revealed the area under the dishwasher had particles of brown and tan debris. The baseboard in the dishwasher area had chipped paint, dust-like particles and dried substances. Several fruit flies were observed in the dishwasher area. Interview with the DM, on 05/22/15 at 2:53 PM, revealed insect lights and insect traps were placed in the kitchen. He stated he knew when there were problems in the kitchen and there were no problems in the kitchen, at this time. Continued observation on 05/22/15 at 5:20 PM, revealed the food steamer was located atop a metal table with a shelf. The metal shelf and legs had a build-up of paint with blackish soiling in the crevices and brown particles of debris were noted on the shelf. There were two (2) small rolling carts by the steam table holding glasses of water	F 371		

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F 371	Continued From page 512 ready for the evening meal. These carts holding glasses of drinking water were in direct contact with a large open trash can. Further interview with the DM, on 05/22/15 at 5:10 PM, revealed all of the dietary staff received training on infection control and cross contamination. He stated the soiled carts and mop/rag containers should not be stored next to the ice machine and they were infection control/cross-contamination issues. He stated that the service window was kept open to the dining room to allow for equalization of air pressure to prevent the exit door on the 200 Hall from being difficult to open. He indicated the facility was aware of the problem with the air pressure. The DM stated employees followed the cleaning schedule. He stated he sent a work order to maintenance when repairs were needed in the kitchen. He revealed that work orders were not requested for the unequal air pressure in the kitchen, work orders were not requested for the window ledge paint to be repainted, nor were work orders submitted to request the walls behind the dishwasher and the three compartment sink be repaired. The DM stated the holes in the wall were filled; however, the whole wall was not repaired and he believed the brown/black substance was mold of some sort. He stated the stock room floor was sticky due to an earlier spill of tea and the floor needed to be mopped.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission	F 441		

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F 441	Continued From page 513 of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to	F 441		

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F 441	Continued From page 514 maintain infection control program data for evaluation in order to monitor its program for effectiveness and to prevent direct and indirect transmission of potential microorganisms for six (6) of forty-three (43) sampled residents (#3, #5, #7, #8, #22, #24). The findings include: The facility did not provide a policy related to an Infection Control Program for the facility. Interview on 04/24/15 at 11:31 AM, with the Director of Clinical Services (DCS), revealed the facility had no policy in writing related to an Infection Control Program. 1. Review of Resident #5's clinical record revealed the facility admitted the resident on 03/13/15 with diagnoses of Altered Mental Status, Parkinson's, Hypertension (HTN) , Gastro Esophageal Reflux Disease (GERD), and Chest Pain. Review of Resident #5's Significant Change Minimum Data Set (MDS) assessment, completed on 04/25/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of ninety-nine (99), meaning the resident was rarely/never understood. Observation of Resident #5, on 04/16/15 at 3:30 PM, revealed the resident was living in a semi-private room with Unsampled Resident M. Observation revealed Resident #5's mattress was	F 441		

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F 441	Continued From page 515 laying directly on the floor and the resident was laying on top of the mattress. Next to the mattress was a blue vinyl mat with two (2) torn areas. The resident had food debris on his/her clothes and on the mattress. Interview with Certified Nursing Assistant (CNA) #3, on 04/15/15 at 2:50 PM, revealed Resident #5 fell out of the bed so many times that the decision was made to put the mattress on the floor to prevent falls. He stated a fall mat was placed next to the mattress; now the resident rolls over onto the mat and sometimes onto the floor. He stated the torn areas on the mat could pose an infection control risk. Interview with Licensed Practical Nurse (LPN) #1, on 04/15/15 at 3:10 PM revealed putting the resident's mattress on the floor was a fall prevention intervention. He stated the resident kept falling out of the bed and onto the floor. The LPN said the resident needed frequent supervision to promote safety and putting the mattress on the floor helped to prevent fall injuries. He stated there was an infection control issue with the torn areas on the mat and the potential for cleaning fluids to get on the mattress when housekeeping cleaned the floor. 2. Review of Resident #7's clinical record revealed the facility admitted the resident on 03/17/15, with diagnoses of Vascular Dementia, Cerebral Vascular Accident (CVA), Hypertension (HTN), Cocaine Abuse, and Osteoarthritis of the Hip and Knee.	F 441		

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F 441	Continued From page 516 Review of Resident #7's Admission MDS assessment, completed on 03/25/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of ninety-nine (99), meaning the resident was rarely/never understood. Observation, on 04/16/15 at 11:07 AM, of Resident #7's room revealed seven (7) pairs of briefs stored on top of the heating/AC unit, and one (1) pair of briefs was stuck in the heating/AC's control panel. Observation of Resident #7, on 04/16/15 at 3:37 PM, revealed the resident was seated on the floor in his/her bathroom, with pants down and stool on the resident's bottom and floor. No staff was present in the room at the time of this observation. 3. Review of Resident #8's clinical record revealed the facility admitted the resident on 04/18/14, with diagnoses of Hypoxia, Respiratory Failure, Stage Three Renal Disease, Cerebral Vascular Accident (CVA), Congestive Heart Failure (CHF), Hypertension (HTN), Decubitus, and Toxic Metabolic Encephalopathy. Review of Resident #8's Quarterly MDS assessment, completed on 03/25/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of fifteen (15), meaning the resident was cognitively intact and interviewable.	F 441		

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F 441	Continued From page 517	F 441		

Observation, on 04/16/15 at 8:48 AM, and 04/17/15 at 10:55 AM, revealed Resident #8's nebulizer mask, which was dated 04/13/15, was in an easter basket that contained a bottle of PeriGuard ointment and a plastic trash bag.

Interview with Assistant Director of Clinical Services (ADCS), on 04/20/15 at 2:35 PM, revealed the nebulizer tubing should have been placed in a plactic bag instead of the Easter basket for infection control and cross contamination reasons.

4. Review of Resident #3's clinical record revealed the facility admitted the resident on 07/27/12, with diagnoses of Chronic Pain, Cerebral Vascular Accident (CVA), Anxiety, and Depression.

Review of Resident #3's Quarterly MDS assessment, completed on 02/17/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of thirteen (13), meaning the resident was cognitively intact and interviewable.

Observation of Resident #3's shared closet space with Resident #18, on 04/14/15 at 1:15 PM, revealed the right side of the closet contained numerous folded and unfolded items of clothing on the closet floor.

Interview with Resident #3, on 04/14/15 at 1:15

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F 441	Continued From page 518 PM, revealed the resident had complained to the facility staff about the laundry staff throwing her roommate's (Resident #18) clean clothes on the floor in their closet; however, nothing had been done to rectify her complaint and the clothes were still on the floor. Resident #3 stated Resident #18 was blind and required total care by staff and he/she was advocating for Resident #18. Interview with the Housekeeping Director, on 05/15/15 at 1:45 PM, revealed putting clean clothes on the floor was an infection control issue if the resident wore them after being on the floor. 5. Review of Resident #22's clinical record revealed the facility admitted the resident on 06/27/12, with diagnoses of Anemia, Coronary Artery Disease (CAD), Hypertension (HTN), Gastro Esophageal Reflux Disease (GERD), Diabetes Mellitus (DM), Hyperlipidemia, Osteoporosis, Non-Alzheimer's Dementia, Manic Depression, and Cataracts. Review of Resident #22's Admission MDS assessment, completed on 03/20/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of ninety-nine (99), meaning the resident was rarely/never understood. Observation, on 04/17/15 at 3:20 PM, revealed feces on the floor and toilet in the Resident #22's room. Feces were smeared across the bathroom floor and was on and running down the toilet seat. There was an upward facing feces filled brief in the bathroom garbage can, feces on the sheet in the middle of Resident 22's bed, and track marks of feces from the bathroom through the bedroom	F 441		

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F 441	Continued From page 519 and into the hallway. 6. Review of Resident #24's clinical record revealed the facility admitted the resident on 06/27/12, with diagnoses of Anemia, Neurogenic Bladder, Urinary Tract Infection (UTI), Quadriplegia, Anxiety, Depression, Chronic Pain and Pressure Ulcers. Review of Resident #24's Annual MDS assessment, completed on 05/10/15, revealed a BIMS exam was conducted and the facility assessed the resident with a score of fifteen (15), meaning the resident was cognitively intact and interviewable. Observation of Resident #24's room, on 04/21/15 at 4:45 PM, revealed a denture cup was on the night stand and inside the cup was a clear liquid and resident #24's dentures. Continued observation revealed the sides of the container contained an unknown black substance. Interview with CNA #9, on 04/22/15 at 9:15 AM, revealed she did not know what the black substance in Resident #24's denture cup was; however, she stated it was due to staff not changing the water in the cup often enough. Interview with Resident #24, on 04/21/15 at 4:45 PM, revealed there were ants everywhere in his/her room last week and the ants were all over and inside the cup that contained his/her dentures.	F 441		

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	Interview with the ADCS, on 04/24/15 at 10:05 AM, revealed she was the designated Infection Control Nurse; however, since the facility had a staffing shortage, and she had been working as an aide, she had not been able to perform the infection control duties. She stated she believed the previous Director of Nursing took over those responsiblities and had the infection control book in her office.			
	Interview with the DCS, on 04/24/15 at 11:31 AM, revealed the infection control book that contained surveillance data which included incidents, resident infection tracking and actions taken was no where to be found in the facility. She stated she was unable to provide evidence of the actions taken by the facility regarding infection prevention activities.			
F 463 SS=K	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH	F 463		
	The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.			
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to have an effective system in place to ensure the resident call system was working for three of four units (100 Unit, 200			

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F 463	Continued From page 521 Unit and the Journey 1 Unit) effecting three (3) of forty-three (43) sampled residents, (Residents #5, #7, #12) and seven (7) of thirty-nine (3) unsampled residents, Unsampled Residents M, T, AA, CC in order to notify staff of their needs. Additionally, the call system panel located at the nursing station had buttons missing and others that did not work for three (3) of forty-three (43) sampled residents (Resident #12, #26 and #31) and eight (8) of thirty-nine (39) Unsampled Residents (Unsampled Residents E, AA, GG, HH, II, JJ, KK, and LL, on two (2) of four (4) units (100 Unit and 200 Unit). Observations, on 04/28/15 at 1:35 PM, of call lights on the 200 Unit did not activate the call light located above the door of the rooms for Resident #5, Resident #7, Resident #12, Unsampled Resident M, Unsampled Resident T, Unsampled Resident AA and Unsampled Resident CC. Observation revealed at this time these residents did not have an alternate method of contacting the staff for assistance. Buttons were missing on the call light panel at Nurses Station #1 for Unsampled Residents E, GG, HH, Resident #31, Unsampled Residents II, JJ, KK and LL and at Nurses Station #2, for Resident #26, Unsampled Resident AA, and Resident #12. The facility's audit of resident rooms on all four units, dated 05/12/15 conducted by the Medical Records Coordinator, Social Services Director, Social Services Assistant, and the Central Supply Clerk revealed 41 call lights that did not illuminate and/or make an audible sound when the call button was pressed. Call light buttons on the panel box did not make an audible sound or illuminate or were not labeled.	F 463		

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F 463	Continued From page 522	F 463		

The facility's failure to have an effective system in place to ensure the resident call system in residents' rooms and at the nurse's stations control panel was operational for residents to notify staff of their needs has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 05/12/15 and determined to exist on 04/28/15.

The facility provided an acceptable Allegation of Compliance (AOC) on 05/19/15, which alleged removal of the Immediate Jeopardy on 05/16/15. The State Survey Agency verified Immediate Jeopardy was removed on 05/16/15 as alleged prior to exit on 05/22/15.

The findings include:

Review of the facility's policy and procedure, Maintenance, effective date 11/30/14, revealed the facility's physical plant and equipment would be maintained through a program of preventive maintenance and prompt action to identify areas/items in need of repair. The Director of Environmental Services would follow all policies regarding routine periodic maintenance and perform daily rounds of the building to ensure the plant was free of hazards and in proper physical condition. The Maintenance Repair Request form would be utilized to report items needing maintenance assistance.

Observation, on 04/28/15 at 11:14 AM, revealed Resident #7's call light did not activate when the button was pushed by the resident, at 11:20 AM the surveryor pushed the button and the call light did not activate. At 11:23 AM, the call light box was noted to be pulled from the wall and the call light would sporatically activate on and off above

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F 463	Continued From page 523 the door and at the nurses station. Observation, on 04/28/15 at 1:35 PM, of the call lights on the 200 Unit revealed the call light button did not activate the call light located above the door in the rooms for Resident #5, Resident #7, Resident #12, Unsampled Resident M, Unsampled Resident T, Unsampled Resident AA and Unsampled Resident CC. Observations further revealed these residents did not have an alternate means to notify staff. Observation on 04/28/15 at 1:35 PM conducted with the Unit Manager revealed the call light control panel at Nurse's Station 1 was missing buttons (these lighted with the room number when the call light button was pressed in the room to alert the nurse at the nurse's station that the light was on even if it did not illuminate at the resident's door) for Unsampled Resident E, Unsampled Resident GG, Unsampled Resident HH, Resident #31, Unsampled Resident II, Unsampled Resident JJ, and Unsampled Resident KK; and at Nurse's Station 2 for Resident #26, Unsampled Resident LL, Resident #12, and Unsampled Resident AA. Review of the facility's audit of resident rooms conducted on 05/12/15 by the Medical Records Coordinator, Social Services Director, Social Services Assistant, and the Central Supply Clerk revealed the Journey 1 Unit: rooms 16, 18, 19, 22, 23, 24, 25, and 27 panel lights did not illuminate. The Journey 2 Unit: room 28 the call light would not turn off; room 29 and room 30 the panel light did not illuminate; room 31 the panel	F 463		

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F 463	Continued From page 524 light was not labeled with a room number; room 32 the panel light did not illuminate; room 33 the panel light was not labeled; room 34 and room 36 the panel light did not illuminate; room 35 the panel light was not labeled; rooms 38, 39 and 40 the panel light did not illuminate. The 100 Unit: room 101 the panel light did not illuminate; rooms 104, 106, and 107 the panel light was not labeled; rooms 108, 109 the panel light did not illuminate; room 110 the light did not illuminate at the door or the panel; room 112 and two other lights (not identified) were not labeled; room 115 was not labeled; room 116 the panel light did not illuminate; room 117 the light did not illuminate at the door or the panel. The 200 Unit: rooms 201, 203, 204, 205, 207, and 208 panel lights were not labeled; room 221 the panel light did not illuminate; room 225 the panel light did not illuminate and the room light did not work; rooms 215 and 216 the panel light did not illuminate; and room 217 the panel light was not labeled. Interview with Registered Nurse (RN) #10, on 04/28/15 at 1:35 PM, revealed the call light system on the 200 Unit was working as far as she knew. She stated the light on the outside of the resident room would light up when the call light button was pulled and it would light up at the nurse's station. She related that the nursing staff did not test the call light system to ensure it was working unless there was an obvious problem and then maintenance would be called and the problem logged in the Maintenance Log located at the nurse's station. She related that she had never seen maintenance test the system. However, observations, on 04/28/15 at 1:35 PM, of the call lights on the 200 Unit revealed the call light button did not activate the call light located above the door in six (6) rooms.	F 463		

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F 463	Continued From page 525 Interview, on 04/28/15 at 2:28 PM, with the Unit 100 Manager revealed she had no knowledge that some of the lights above resident doors were not working. She stated that some of the lights on the control panel at the nurse's station did not work. When nursing staff at the nurse's station heard an audible call, they would have to get up and visually look down each hall to see which light was on over the door. The Unit 100 Manager stated it was a long time ago that she verbally mentioned to the Maintenance Director that some of the lights at the control panel did not work. She could not remember how long ago it was that she mentioned her concern to the Maintenance Director. Interview, on 04/22/15 at 10:22 AM, with the Maintenance Director revealed repairs needed on a unit should be documented in the Maintenance Log kept at each nurse's station. He checked the Maintenance Log daily to see what needed repaired. Interview via telephone, on 04/22/15 at 2:22 PM, with the former Maintenance Director revealed he was an employee of the facility from approximately May 2014 to 03/23/15 or 03/24/15. He stated that during his employment the Maintenance Department consisted of himself and an assistant. He related that to keep track of what repairs needed to be completed, a Maintenance Request Log was kept at each nurse's station, and he kept mental notes of what needed to be done. Review of the Facility Monthly Tour Quality Assurance Round Sheet, dated 02/10/15, 03/10/15, and 04/10/15, revealed the	F 463		

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F 463	Continued From page 526 Maintenance Director conducted monthly checks of call lights, lights, and bathrooms. The Facility Monthly Tour Quality Assurance Round Sheet stated the the form was to be completed before the 10th of every month and turned in to the Executive Director. The Facility Monthly Tour Quality Assurance Round Sheets, dated 02/10/15, 03/10/15, and 04/10/15, documented the Maintenance Director checked the call lights, lights, and bathrooms for rooms 100 thru 119, rooms 10 thru 27, rooms 28 thru 40, and rooms 200 thru 225. The form, dated 02/10/15, 03/10/15, 04/10/15, had each category for each room checked indicating all items were "ok". Each Facility Monthly Tour Quality Assurance Round Sheet was dated and signed as being completed by the Maintenance Director. Interview, on 05/05/15 at 2:30 PM, with the Interim Executive Director/Vice President of Operations (ED/RVPO) revealed the facility's system for ensuring an operational call light system was through observation and quarterly maintenance checks. She related any staff could make observations of the call light system. Staff who found call lights not working should fill out a maintenance request form so that maintenance could make repairs. She stated the facility had a company that also checked the call light system; however, she did not know the name of the company and would have to check to ascertain if a contract existed. However, the ED/RVPO did not provide any evidence the call light system had been checked. She was not aware that some call lights were not working, and explained that a work order should have been submitted and the problem presented at the morning meetings. Interview, on 05/15/15 at 10:50 AM, with the	F 463		

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F 463	Continued From page 527 Electronics Field Supervisor for Call Light System Repair revealed the facility had called his company on 05/14/15 to inspect the call light system and this was his first visit to the facility. He stated that upon inspection of the call light system, he found that the system in the 200 Unit had originally been wired incorrectly. He stated the direct circuit (DC) and alternating circuit (AC) was wired opposite of what it should have been, and the system had fried itself. He stated the system was installed in the 1980's to 1990's and was no longer compatible with current technology. The supervisor stated the company had not been to this facility before today and the system would have to be replaced. The facility took the following actions to remove the Immediate Jeopardy on 05/16/15 as follows: 1. Resident call lights were checked for function on 05/12/15 for Resident #7, #5, #12, Unsampled Residents Z, and AA. Unsampled Resident M no longer resided in the facility. Resident #12's call light was found not to light at the desk or the door. 2. On 05/12/15, one hundred twenty-four (124) residents call lights were checked for function and twenty-two (22) rooms were found to not light at the desk, one (1) room did not light at the desk or door, and two (2) rooms did not light at the desk or door, or sound. The ED was notified of the three (3) resident rooms, on 05/13/15, that had call lights that did not work. All six (6) residents of the three (3) rooms were put on fifteen (15) minute safety checks. On 05/13/15 an outside contractor initiated maintenance to ensure functionality and made repairs on 05/13/15 with an additional room repaired on	F 463		

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05/14/15 of a call light that would not turn off. The annunciator system at the nurse's station on the 200 unit was repaired, on 05/14/15.

3. Twelve (12) nursing staff working 11:00 PM to 7:00 AM on 05/12/15 were educated on the call light P&P on 005/09/15 through 05/12/15 with competencies. The 11:00 PM to 7:00 AM staff working on 05/12/15 were re-educated on the facility's P&P for an inoperable call light system, on 05/13/15, and the six (6) residents were placed on fifteen (15) minute safety checks until the call lights were functional. Hand bells were also given to the six (6) residents on 05/13/15.

4. One hundred and one (101) of 149 staff were educated on 05/09/15 through 05/14/15 on the facility's call light P&P and what to do if there was an inoperable call light, and use the pest sightings book at the nurse's station. Forty-eight (48) staff not educated by 05/14/15 would not be allowed to work until they had been educated prior to the start of their shift.

5. On 05/13/15, Corporate Administrative RNs educated facility Administrative Staff on the regulations and P&P for staffing, pest control, housekeeping, and maintenance, with competencies completed. The ED would monitor the facility's process for notification, abuse, hiring, dignity, care plan revision, professional standards, assessments, behavior and falls management, incidents and accidents, smoking, call lights, pest control, and staffing.

6. Review of the 24 hour report, incident/ accident reports, in the daily meeting with the IDT; documentation in the clinical record included notification to the physician and new orders, and

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F 463	Continued From page 529 to the RP; the IDT made rounds in five (5) resident care areas to observe for maintenance and safety concerns; observations of five (5) residents during supervised smoking by the IDT; room rounds for five (5) residents to search for incendiary items by a member of the IDT, maintenance concerns were written in the maintenance books and taken to the daily meeting and prioritized for repair; observations of five (5) residents to ensure falls interventions were in place per the care plan by the IDT; call lights checked in resident rooms and bathrooms to ensure lights and sound; five (5) staff educated what to do if call light inoperable; resident care areas checked for no live pests; were validated five (5) times weekly. 7. The IDT would meet at least monthly to discuss facility action plan and ensure tasks were completed for the removal of the IJ, and QA monitoring completed according to the AOC during the IJ period, validated by the ED/RVPO/RDCS/Corporate Administrative RNs. 8. Per the Ad-Hoc QAPI meeting, on 05/15/15, QI monitoring would be done utilizing approved audit tool with oversight by the ED, beginning 05/16/15, five (5) resident interview; new resident/ family concerns; daily department head meeting to ensure new resident injuries or concerns were discussed; five (5) new employee files reviewed two (2) times weekly; residents with new falls or behaviors were reviewed in the daily meeting with IDT and care plans/ Kardexes reviewed and updated; review of the 24 hour report and the incident and accident reports in the daily meeting with IDT; review of the clinical record for timely notifications to the physician and RP; the IDT rounds in five (5) resident care areas to observe	F 463		

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F 463	Continued From page 530 the environment for safety and maintenance concerns; observations of five (5) residents during supervised smoking; room rounds of five (5) residents for incendiary items; maintenance concerns listed in the maintenance book and taken to the daily meeting to discuss and prioritize repairs; observations of five (5) residents to ensure falls interventions were in place per the care plan by the IDT; five (5) resident rooms call lights checked to ensure they light at the door, nurse's station, and sound; five (5) staff education what to do if a call light was inoperable; five (5) times weekly; weekly falls and behavior management meetings occur with IDT one (1) time weekly. The State Survey Agency validated the removal of Immediate Jeopardy on 05/22/15 as follows: 1. Record review of resident call light audit, dated 05/12/15, revealed Residents #7, #5, #12, Unsampled Resident Z and AA call lights were checked for function, with Resident #12's call light was found to not light at the desk or the door. 2. Record review of call light audits, completed on 05/12/15, found one hundred twenty-four (124) resident call lights were checked for functionality, with twenty-two (22) rooms found that call lights did not light at the desk, one (1) room did not light at the desk or the door, and two (2) rooms did not light at the desk, the door, or sound. Six (6) residents in the three (3) rooms that call lights did not work, were placed on fifteen (15) minute checks and given a hand bell. Record review of the call light work order, dated 05/13/15, revealed the call lights for the six (6) residents were repaired by an outside contractor on 05/13/15 and another call light was repaired on 05/14/15 that	F 463		

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would not turn off; the annunciator on the 200 Unit was repaired at the nurse's desk on 05/15/15. Observation, on 05/22/15 at 2:03 PM, of room 18 revealed the call light functional at the door, desk and sounding. Observation, on 05/22/15 at 2:15 PM, on the 200 Unit of two (2) nurse's stations revealed each desk had a new call light system installed on the wall behind the desk. Interview with the RDCS, on 05/22/15 at 12:07 PM and 05/22/15 at 3:42 PM, revealed call lights were repaired on 05/13/15 and 05/14/15, and the 200 Unit annunciators were repaired, and then moved to the wall behind each nurse's station. The six (6) residents were given hand bells on 05/13/15 and placed on fifteen (15) minute safety checks. Review of fifteen (15) minute check sheets revealed residents were checked on every fifteen minutes until call light was repaired. Interview with DCS on 05/22/15 at 5:30 PM, revealed she had call bells purchased and given to residents.

3. Review of in-service training records, dated 05/09/15 through 05/12/15, revealed twelve (12) nursing staff working the 11:00 PM through 7:00 AM shift on 05/12/15 were re-educated on 05/13/15 on what to do if the call lights were inoperable and the six (6) residents identified with inoperable call lights were placed on fifteen (15) minute checks. Interview, on 05/22/15 at 3:42 PM, with the RDCS revealed staff working on 05/12/15 and 05/13/15 were educated on the call lights not working for the six (6) residents and conduct fifteen (15) minute safety checks and were provided hand bells. Observation on 05/21/15 at 11:10 AM, revealed a hand bell was rung and the Medical Records Coordinator answered the hand bell immediately upon hearing it ring.

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F 463	Continued From page 532 4. Record review of in-services conducted 05/13/15 and 05/14/15 revealed 101 of 149 staff were educated on providing call lights and what to do if not working, and answering call lights timely. Interview, on 05/22/15 at 8:05 AM, with CNA #7, on 05/22/15 at 8:13 AM with RN #1, on 05/22/15 at 8:25 AM with LPN #1, revealed they had been trained on call lights and knew what to do if a resident's call light did not work. Interview, on 05/22/15 at 2:52 PM, with the DCS, ADCS, UM, Medical Records, and Staffing Coordinator revealed staff were trained on call lights, answering call lights, and what to do if call lights were not functioning. Observation, on 05/22/15 at 1:58 PM, of room 106 revealed the call light was functional at the door, at the desk, and sounded. 5. Review of in-service records, dated 05/13/15, revealed Administrative staff were trained on maintenance and would be monitored by the ED. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS revealed they had been trained on maintenance and any concerns of audits would be taken to the morning meeting. 6. Observation of the daily morning meeting, on 05/22/15 at 9:05 AM, revealed maintenance concerns and books, audits, and call lights. Interview with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, MDS Coordinator, and DSS, on 05/22/15 at 2:52 PM, revealed they participate in the morning meeting and review the maintenance books and call lights audits/round.	F 463		

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F 463	Continued From page 533 7. Review of sign in sheets, dated 04/22/15, 05/13/15, and 05/15/15, revealed QAPI meetings were held on those dates. Interview, with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS revealed they attended the QAPI meetings. Interview with the RDCS, on 05/22/15 at 5:05 PM, revealed the next QAPI meeting was scheduled for 06/17/15. Interview with the Medical Director, on 05/22/15 at 8:00 AM, revealed he was informed by the Executive Director of the resident care issues, attended the QA meetings held by the facility and provided direction regarding corrective action plans that were developed to meet the needs of the residents. 8. Review of the QAPI sign in sheet, dated 05/15/15, and agenda revealed audit tools were approved for QA monitoring and discussed: maintenance rounds and book and call lights.	F 463		
F 469 SS=L	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to have a effective system in place to provide an effective pest control program to ensure resident	F 469		

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F 469	Continued From page 534 rooms, beds, belongings, common areas, kitchen, grounds and bodies remained pest free, in two (2) of two (2) units (Unit 100 and Journey 1 Unit) for four (4) of forty-three (43) sampled residents (Residents #8, #24, #33 and #36) and one (1) of thirty-nine (39) Unsampled Residents (DD). Resident and staff interviews revealed the facility had an ant problem with ants crawling on the walls in residents' rooms, in residents' beds, on the residents' bodies, and out of electrical outlets in residents' rooms. Interview with Resident #8, Resident #24, and Unsampled Resident DD revealed ants crawling in the bed with the residents, on their arms, faces and bodies. The residents had to be cleaned by staff, sheets changed, and/or room changed due to the ant problem. Resident #24 had to scream for help due to the ants crawling on his/her body. Resident #24 further stated they were deathly afraid of spiders and observations of the resident's room revealed spider webs behind the head of the bed and over the closet door. Observations of the common areas and offices revealed spiders in the corner of a picture window, ants crawling on desks, dead bugs in the window sill and gnats in the shower room, the kitchen had brown bugs crawling in and out of an opening in the wall. Interview with staff revealed Administration was informed numerous times of the pest control problem. The facility's failure to have an effective system in place to ensure resident rooms, beds and bodies were free of pests has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 04/22/15 and determined to exist on 04/19/15.	F 469		

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The facility provided an acceptable Allegation of Compliance (AOC) on 05/19/15, which alleged removal of the Immediate Jeopardy on 05/16/15. The scope and severity was lowered to an L while the facility monitors the implementation of the Plan of Correction and the facility's Quality Assurance monitors the effectiveness of the systemic changes. The State Survey Agency verified Immediate Jeopardy was removed on 05/16/15 as alleged prior to exit on 05/22/15.

The findings include:

A facility pest control policy was requested and not provided. The contract company that provided the facility with housekeeping, laundry, and dietary services provided a Sanitation and Infection Control Pest Control policy. Review of the undated policy revealed the Dining Services Department should be free of all insects.

Review of the pest control contract, dated 09/11/13, revealed the pest control service would provide services on a weekly basis at a compensation rate of $56.00 weekly.

Review of the pest control service tickets obtained from the pest control company for January 2015 to April 2015 revealed services were provided on an intermittent and sporadic basis rather than the contracted weekly basis as identified in the facility and pest control company contract. A service ticket was created on 01/07/15 and limited services provided to the facility on 01/13/15; a service ticket was created on 01/22/15 and limited services were provided

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F 469	Continued From page 536 on 01/27/15; a service ticket was created on 01/30/15 and limited services provided on 02/02/15; a service ticket was created on 02/27/15 and limited services provided on 03/04/15; and a service ticket was created on 04/03/15 and limited service provided on 04/06/15. Interview, on 04/27/15 at 1:45 PM, with Unsampled Resident DD, whom the facility had assessed with a Brief Interview Mental Status (BIMS) score of fifteen (15) indicating the resident was cognitively intact and interviewable, revealed three to four weeks ago he/she was removed from Room 17, because ants were in the room, crawling in the bed and on his/her arms. Interview with Family Member #1, on 04/22/15 at 4:18 PM, revealed there had been ants coming out of the electrical outlet in Resident #33's room. Due to the ants in the room, a nurse (later identified as RN #10) moved Resident #33 to another room without notification of the Clinical Services Director and the family member. Interview with Unsampled Resident B, the President of the Resident Council, on 04/22/15 at 2:31 PM, revealed he/she had recently noticed gnats in the shower room on Journey 2 Unit, and that he/she planned to bring the issue to the Resident Council in the next meeting held the first Wednesday of each month. Observation, on 04/22/15 at 3:23 PM, in the Account/Manager's Office, revealed ants were	F 469		

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F 469	Continued From page 537 crawling across the office desk. Observation, on 04/17/15 at 12:30 PM, revealed a black spider hanging from a web in the corner of a picture window on the west hallway adjacent to the 200 Unit. Observation, on 04/20/15 at 8:59 AM, on a tour of the facility's grounds revealed a wasp nest, with larvae attached to the gutter in the corner of the building next to an entrance/exit door to the Activity Room. Further observation, on 04/21/15 at 2:42 PM, of the kitchen revealed numerous small brown bugs crawling in and out of a hole in the wall behind the dishwashing machine. A piece of vinyl had been screwed over the hole in the wall. Observation of the hallway adjacent to the 200 Unit, on 04/17/15 at 12:30 PM, revealed a window screen in the common area on Journey 2 Unit was pushed out at the bottom and the window seal was covered with a grayish fluffy substance and small dead brown bugs. Observation of the Journey Home 1 Unit, on 05/13/15 at 8:20 AM, revealed dead and alive spiders and other unknown bugs were hanging in webs from the ceiling and attached to the light fixtures. Observation, on 05/13/15 at 10:39 AM, revealed	F 469		

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F 469	Continued From page 538 ants were crawling in the heating/air conditioning vent in Resident Resident #30's room. Interview with Resident #30 whom the facility had assessed with a Brief Interview Mental Status (BIMS) score of twelve (12) indicating the resident was cognitively intact and interviewable, revealed the ants had been coming in through the vent for awhile. On 04/22/15 at 9:15 AM, observation of Resident #8's room revealed the resident was sitting in their wheelchair beside the bed in the middle of the room. Observation of the wall beside the bed revealed ants were crawling on the wall and inside the baskets and bin that was on the floor next to the bed. Continued observation and interview with Certified Nursing Assistant (CNA) #9 revealed she removed baskets and bins that were on the other side of the bed by the wall and window and said there were ants crawling inside the baskets, bin and on the wall. Observation revealed the baskets and bins had numerous dead ants and live ants crawling amongst the items. CNA #9 removed the baskets and bins from Resident #8's room and took them to the shower room and emptied the contents of the baskets and bin. The items found inside were; ten (10) soft drink cans, dirty clothing, a tin foil food container with debris inside, boxes of briefs, and a lift pad. Interview, on 04/22/15 at 9:20 AM, with Resident #8 whom the facility had assessed with a BIMS score of fifteen (15) which meant the resident was cognitively intact and interviewable, revealed he/she had ants crawling in the bed with him/her and the staff cleaned them off of his/her body and removed the sheets from the bed. Resident #8	F 469		

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F 469	Continued From page 539 stated he/she felt like the management staff did not care and that it did not do any good to complain. Interview with Certified Nursing Assistant (CNA) #9, on 04/22/15 at 9:15 AM, revealed she had seen ants in the bed with Resident #8 this morning during incontinent care. She stated she got the resident up out of the bed and removed the sheets. She said she had not informed her supervisor yet, but the process was for her to write her findings in the maintenance book for management to address. Interview with Licensed Practical Nurse (LPN) #5, on 04/22/15 at 3:25 PM, revealed she was aware of the ant infestation; however, the facility had yet to take care of the issue. Observation of Resident #24's room, on 04/21/15 at 4:45 PM, revealed ants were crawling on the bedside table and inside packaging that contained supplies to change Resident #24's dressings. Spiders and spider webs were observed above the closet doors and behind the head of the resident's bed on the walls close to the floor. Observation of a denture cup on Resident #24's night stand revealed the inside of the cup contained dentures, a clear liquid and the sides of the container contained an unknown black substance. Interview with CNA #7, 04/15/15 at 9:10 AM, revealed staff heard Resident #24 screaming for help from their room. The CNA stated when staff went into the resident's room they found ants crawling on the resident and in the resident's bed.	F 469		

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F 469	Continued From page 540 The CNA stated the resident was a quadriplegic and staff had to use the lift to remove the resident from the bed in order to remove the ants from the resident's body and the bed. Interview, on 04/21/15 at 4:45 PM, with Resident #24 whom the facility had assessed with a BIMS score of fifteen (15) which meant the resident was cognitively intact and interviewable, revealed the resident had an ant crawling on their pillow that morning. Resident #24 stated ants had been crawling on him/her last week and that was when he/she was screaming for help. The resident stated staff had to get him/her out of the bed using the lift equipment in order to remove the ants from the bed and his/her body. The resident stated then again on 04/19/15 ants were crawling on his/her face. Resident #24 said he/she was afraid the ants would crawl up into their nose and ears or even get into their wounds and private area. The resident continued to state they were deathly afraid of spiders. Resident #24 stated he/she did see someone outside his/her window spraying for bugs, but no one had been into the resident's room to address the ant issue. Resident #24 stated the ants were every where in the room and they were all over and inside the denture cup that contained his/her dentures. Further interview with Resident #24, on 05/14/15 at 8:00 AM, revealed the resident had an unknown flying bug, land on him/her last night, while in the bed. Interview with LPN #24, on 04/22/15 at 3:25 PM, revealed she had found ants on Resident #24 this morning and was on duty last week when the resident was found with numerous ants in the bed	F 469		

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and all over the body. She stated she had not seen pest control in the building for some time now. She stated the facility leadership had been made aware of the pest infestation.

Interview with Unit Manager (UM), on 04/21/15 at 3:25 PM, revealed Resident #24 was found with ants on them and in their bed. She said the resident was cleaned up, and pest control called; however, she was unaware there were additional incidents and residents with pests in their bed and on their bodies.

Observation of Resident #36, on 04/29/15 at 9:55 AM, revealed the resident was sitting in a wheelchair beside the bed with food debris on his/her face and clothing. A urinal containing a yellow liquid was observed on the night stand beside the bed. The opening of the urinal had an unknown food substance adhered to it which had several small black bugs stuck in the unknown substance.

Observation of Resident #36, on 04/29/15 at 10:35 AM, revealed the resident's urinal contained a yellow liquid previously observed on the night stand beside the bed remained. The opening of the urinal still contained an unknown food substance with the several small black bugs stuck in the unknown substance.

Observation of Resident #36, on 04/29/15 at 12:53 PM, revealed the urinal containing a yellow liquid previously observed on the night stand beside the bed remained. The opening of the

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F 469	Continued From page 542 urinal still contained the unknown food substance with the several small black bugs stuck in the unknown substance. Observation, on 04/29/15 at 3:00 PM, of Resident #36's room, revealed ants crawling up the wall behind the bed, and unknown insects flying around left over food from lunch sitting on the bedside table. Interview, on 04/29/15 at 3:00 PM, with Resident #36 whom the facility had assessed with a BIMS score of fourteen (14) indicating the resident was interviewable, revealed the gnats had been flying around the room prior to 04/29/15 and the resident was not sure how long ants had been in the room. Resident stated he/she had not seen pest control in the building or his/her room. Interview via telephone, on 04/23/15 at 1:40 PM, with the former Maintenance Director, revealed he informed the Administrator each time the staff reported pest sightings to him; however, he was unable to recall pest sighting dates he had reported to the Administrator. He stated he was not aware of a time when the facility was provided pest control services in February or March of 2015. He stated he believed pest control services were not provided to the facility due to nonpayment. Interview via telephone, on 04/22/15 at 3:23 PM, with the Secretary/Treasurer and part Owner of the facility's contracted pest control services revealed her company had provided pest control services to the facility for approximately five (5)	F 469		

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F 469	Continued From page 543 years, and the billing was forwarded to the facility's corporation for payment. She related the facility's corporation had a history of not paying for billed services on time, and oftentimes became delinquent in payments. In the past, her company had let the facility go without payments and continued pest control services. Continued interview via telephone with the Secretary/Treasurer and part Owner of the contracted pest control service company, on 05/13/15 at 2:31 PM, revealed in September 2013 the facility entered into a contract for weekly pest control services at a rate of $56.00 per week. She called the facility's corporation numerous times toward the end of 2014 in an attempt to get them to pay their bills. On 01/09/15, she informed the corporate office that pest control services would no longer be provided. Although her company had not been paid, she continued weekly services to the facility throughout the month of January 2015. Her company received a small payment and provided one week of service in February; which took place on 02/02/15. Then did not provide service for the remainder of February 2015 due to nonpayment. Her company received another payment and services were provided for one week in March and that was on 03/04/15. Services stopped again due to nonpayment and resumed in April 2015 and a weekly visit occurred on 04/06/15. The Secretary/Treasurer and part Owner of the pest control company stated the facility's payments were delinquent in the amount of $290.00. She related when the pest control company was at the facility on 02/02/15, 03/04/15 and 04/03/15 they treated the facility for fruit flies,	F 469		

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F 469	Continued From page 544 gnats, and ants which was a partial services. Interview, on 04/22/15 at 10:22 AM, with the Maintenance Director, revealed the pest control company for the facility started providing weekly services three week ago, and the pest control technician had been attempting to get the ant problem under control. Interview with the pest control company's Service Technician at the facility, on 04/29/15 at 12:45 PM, revealed he was present to set out gel bait in the baseboards and crevices and bait traps under the AC/Heating units in the residents' rooms. He stated he treated the resident rooms, common areas, kitchen, and the outside grounds. He stated gel bait and bait traps were the standard treatment provided for resident rooms. He related that 04/29/15 was his third visit to the facility since the facility resumed payment of their billings. The Service Technician stated he placed a Pest Control Binder at every nurse's station so that if a nurse noticed a pest problem, it could be documented in the Pest Control Binder. On each visit, he checked the Pest Control Binder. He stated it would be approximately another two weeks before he could get the ant problem under control. Review of pest control binders revealed no evidence of pest sightings were documented. Interview with Executive Director (ED) on 05/11/15 at 8:18 AM, revealed she resigned as of 04/17/15. She stated she was aware of one report of a resident that had ants on them, but did not remember their name, just that they were in room 111. The ED stated having ants on residents was an infection control issue. The ED stated she remembered the pest control company provided services on 04/06/15, but was not sure	F 469		

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what/where they treated. She stated the pest control services were on hold for a period of time due to non-payment beginning in January of 2015. She stated the facility had weekly services at first, then went to monthly services, and was not sure of the timeframe when the services changed frequency. She stated she believed arrangements were made with the pest control company for payments to made every 60 days, instead of 30 days, in order to resume services, but was unsure of when those arrangements were made because the corporation made them.

Interview with the Interim Executive Director/Vice President of Operations (ED/RVPO), on 05/05/15 at 3:55 PM, revealed the facility's pest control policy entailed routine basic monthly services and call-in if needed. She stated the facility's contract with the pest control company consisted of a monthly rate and a different rate if the facility requested weekly services. She stated the treatment of pest in resident rooms was limited as only bait could be used. She related the pest control company had been to the facility; however was not sure if it was a routine visit or if they were called to treat a specific pest control problem. She stated if staff noticed a problem with pest the staff member should call maintenance and maintenance in turn would contact the pest control company.

She related that she was not aware of any current problems with pests; however, she knew of a prior issue with ants in a resident's room. She stated a family member who wanted to know why her parent had been moved due to ants in the room, complained about the move and that was how she became aware of ants in a resident's room. She stated the outcome to residents in the

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event of the facility not having pest control services could result in the increase of pest in the building, and if in the kitchen could result in sanitation issues.

The facility took the following actions to remove the Immediate Jeopardy on 05/16/15 as follows:

1. 101 of 149 staff and 10 agency staff were educated regarding maintenance issues on 05/13/15 and 05/14/15 by the Corporate Administrative RNs. Forty-eight (48) staff not educated will not be allowed to work until they have been trained. No staff will be allowed to work after 05/14/15 until they have been educated prior to the start of their shift. The ED or DCS would monitor the schedule and appoint a department manager to stand at the time clock to direct employees still needing education to the in-service.

2. QAPI meeting was held on 05/13/15 to review the P&P for facility maintenance and pest control with no changes made. The facility's action plan for removal of the IJ was reviewed and tasks assigned, with department managers assigned to provide daily oversight along with the RDCS/ RVPO/ RDHC/ RCMC/Corporate Administrative RNs.

3. On 05/12/15 Corporate Administrative Nurses made walking rounds to identify any maintenance/resident safety concerns. Identified concerns were given to the ED and Maintenance Director for prioritization and repair. On 05/13/15 The ED and Maintenance Director made facility rounds and reviewed the maintenance books at the nurse's stations to identify safety concerns. Safety concerns were addressed by the

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F 469	Continued From page 547 Maintenance Director on 05/13/15 and 05/14/15. The Maintenance Director was educated on 05/13/15 to check the maintenance books at each nurse's station five (5) times weekly and prioritize based on safety concerns. 4. QAPI monitoring, beginning 05/15/15 of the facility process for facility maintenance. 5. Beginning 05/12/15 the IDT would round to observe for environment safety concerns in five (5) resident care areas and immediately addressed by maintenance, and validated five (5) times weekly. Maintenance books would be brought to the daily meeting to discuss concerns five (5) times weekly. 6. One hundred and one (101) of 149 staff were educated on 05/09/15 through 05/14/15 on the use of the pest sightings book at the nurse's station. Forty-eight (48) staff not educated by 05/14/15 would not be allowed to work until they had been educated prior to the start of their shift. 7. On 05/11/15, pest control service evaluated the facility and rendered services on 05/13/15, with another visit on 05/14/15. Pest control would visit monthly and as needed. As of 05/15/15 live pests in the facility had been eliminated. 8. Walking rounds were conducted by Corporate Administrative Nurses, on 05/12/15, to look for pests, with none seen. One hundred twenty-one (121) residents were assessed by skin sweeps, with no pest bites evident. No pests were observed in resident beds or rooms. 9. Beginning 05/14/15 rounds were completed by IDT Monday through Friday with no pest issues	F 469		

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F 469	Continued From page 548 identified. 10. An Ad-Hoc QAPI meeting, held on 05/14/15, related to QI monitoring of the facility's process for pest control would be completed by the ED/RVPO one (1) time monthly that pest control visits occurred monthly. Beginning 05/15/15 resident care areas would be checked to ensure there were no live pests five (5) times weekly. 11. On 05/12/15 and 05/13/15, housekeeping rounds were completed by the ED and Housekeeping Supervisor for facility cleanliness and odors, with areas needing cleaning were cleaned on 05/12/15 through 05/15/15. 12. On 05/13/15, Corporate Administrative RNs educated facility Administrative Staff on the regulations and P&P for pest control, housekeeping, and maintenance, with competencies completed. The ED would monitor the facility's process for pest control. 13. Review of the 24 hour report, incident/ accident reports, in the daily meeting with the IDT. The IDT will make rounds in five (5) resident care areas to observe for maintenance and safety concerns; ensure maintenance concerns are written in the maintenance books and taken to the daily meeting and prioritized for repair; resident care areas checked for no live pests; validated five (5) times weekly. 14. Daily oversight since 04/22/15 on all shifts to ensure residents were safe and the plan of care was followed to meet resident needs, by the ED/ DCS/ RVPO/RDCS/Corporate Administrative Nurses.	F 469		

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F 469	Continued From page 549 15. The IDT would meet at least monthly to discuss facility action plan and ensure tasks were completed for the removal of the IJ, and QA monitoring completed according to the AOC during the IJ period, validated by the ED/RVPO/RDCS/Corporate Administrative RNs. 16. Per the Ad-Hoc QAPI meeting, on 05/15/15, QI monitoring would be done utilizing approved audit tool with oversight by the ED. Beginning 05/16/15, five (5) resident interviews; review new resident/ family concerns; IDT rounds in five (5) resident care areas to observe the environment for safety and maintenance concerns; and, maintenance concerns listed in the maintenance book and taken to the daily meeting to discuss and prioritize repairs. 17. The RVPO/RDCS/Corporate Administrative RNs would provide daily oversight of the ED and DCS in areas of pest control during the IJ period until removal. 18. On 05/12/15 rounds were completed by the DCS/ADCS/ Nurse Managers, and Corporate Administrative Nurses to observe resident's skin to ensure free from pests. 19. On 05/13/15 and 05/14/15, 101 of 149 staff and ten (10) agency staff were educated to report pest sightings in the pest sightings book; any pests noticed on residents should be reported immediately to the nurse supervisor/DCS/ADCS for completion of a skin assessment; and resident privacy. Forty-eight (48) staff not educated will be trained prior to working their next scheduled shift. 20. An Ad-Hoc QAPI meeting, on 05/15/15, discussed QI monitoring would be completed	F 469		

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F 469	Continued From page 550 beginning 05/16/15 for: beginning 05/12/15 observations of five (5) residents to ensure rooms/bed/residents were free from pests and would be conducted five (5) times weekly. The State Survey Agency validated the removal of Immediate Jeopardy on 05/22/15 as follows: 1. Record review of in-services conducted 05/13/15 and 05/14/15 revealed one hundred one (101) staff were educated by Corporate Administrative Registered Nurses on maintenance issues 2. Review of a QAPI sign in sheet, dated 05/13/15, and agenda revealed the P&P for facility maintenance and pest control were discussed with no changes made. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Staff Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS attended the QA meetings. 3. Review of rounding sheets, dated 05/12/15, revealed maintenance and environmental concerns were audited by Executive Director and Maintenance Director. Review of rounds completed by the ED and Maintenance Director, on 05/13/15, revealed maintenance books on each unit were reviewed for any maintenance issues, with concerns addressed on 05/13/15 and 05/14/15. Interview with the Maintenance Director, on 05/22/15 at 2:52 PM, revealed any maintenance issues should be listed in the maintenance book at each nurse's station, which he will take to the morning meeting, and discuss what had been addressed on the maintenance concerns.	F 469		

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F 469	Continued From page 551 4. Review of a QAPI sign in sheet, dated 05/15/15, audit tools, and agenda revealed maintenance occurred. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, Housekeeping Supervisor, and DSS revealed they attended the QA meetings. 5. Review of facility rounding sheets, dated 05/12/15, revealed the environment was observed, by Corporate Administrative Registered Nurses for maintenance needs. Observation of the morning meeting, on 05/22/15 at 9:05 AM, revealed the maintenance books were taken to the IDT meeting and reviewed. Interview with the Maintenance Director, on 05/22/15 at 2:52 PM, revealed he would take the maintenance books to the morning meetings. 6. Record review of in-services conducted 05/13/15 and 05/14/15 revealed 101 of 149 staff were educated on the use of the pest sigthings book at the nurse's station. Interview, on 05/22/15 at 8:05 AM, with CNA #7, on 05/22/15 at 8:13 AM with RN #1, on 05/22/15 at 8:25 AM with LPN #1, revealed they had been trained on the process. 7. Review of the pest control company invoice, dated 05/13/15 and 05/14/15 revealed services were provided to the interior and exterior of the facility. Review of the pest control contract revealed services would be provided to the facility monthly and as needed. Interview with the Maintenance Director, on 05/22/15 at 2:52 PM, revealed the new pest control company had begun services inside and outside of the facility.	F 469		

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F 469	Continued From page 552 Observation of the Sub acute 1 nurse's station, on 05/22/15 at 2:03 PM, revealed the maintenance book also contained the pest sightings book. Observation of Sub acute 2 nurse's station, on 05/22/15 at 2:07 PM, revealed the maintenance book also included the pest sightings log. Observation of room 215, on 05/22/15 at 2:09 PM, revealed no pests were seen. Observation of the 100 Unit nutrition room, on 05/22/15 2:20 PM, revealed no pests were seen. Observation, on 05/22/15 at 5:20 PM, of the kitchen revealed no pests were seen. Interview with the Dietary Director, on 05/22/15 at 2:52 PM, revealed the kitchen did not currently have pests. 8. Review of facility rounding sheets, dated 05/12/15, revealed no pests were observed. One hundred twenty-one (121) residents were assessed via skin sweeps on 05/12/15 and 05/13/15 with no pest bites evident, and no pests documented in resident beds or rooms. Interview with the DCS, ADCS, UM, MDS Director, on 05/22/15 at 2:52 PM, revealed residents were assessed via skin sweeps, and no concerns. Interview with Resident #24 on 05/22/15 at 4:30 PM, revealed no pests were in his/her room. 9. Review of rounding records, dated 05/14/15 through 05/21/15, revealed no concerns identified with pests. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, Central Supply, and DSS revealed daily rounds occurred with no concerns of pests. Interview with Resident #8 on 05/22/15 at 2:00 PM, revealed no pests were in his/her room. 10. Review of the Ad-Hoc sign in sheet, dated 05/15/15, and agenda, and audit tools revealed	F 469		

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F 469	Continued From page 553 monitoring of the facility's pest control would be completed by the QA. Review of rounding records, dated 05/14/15 through 05/21/15, revealed no live pests were seen. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, Central Supply, and DSS revealed daily rounds occurred with no concerns of pests. 11. Review of rounding sheets, dated 05/12/15 and 05/13/15, revealed the ED and Housekeeping Supervisor observed the facility for cleanliness. Interview with the Housekeeping Supervisor, on 05/22/15 at 2:52 PM, revealed he conducted rounds for cleanliness of the facility, including linens, resident rooms, shower rooms, trash, webs and pests, and privacy curtains. Interview with Resident #10 on 05/22/15 at 12:30 PM, revealed no concerns with linens. 12. Review of in-service records, dated 05/13/15, revealed Administrative staff were trained on staffing, pest control, housekeeping and maintenance, and would be monitored by the ED. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS revealed they had been trained on staffing, pest control, housekeeping and maintenance, and any concerns of audits would be taken to the morning meeting. Interview with Resident #3 on 05/22/15 at 1:00 PM, revealed staffing had improved and were answering lights timely and the facility looked cleaner. 13. Observation of the daily morning meeting, on 05/22/15 at 9:05 AM, revealed review of the 24 hour report, notifications made and documented,	F 469		

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F 469	Continued From page 554 maintenance concerns and books, pests, rounds and audits. Interview with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, MDS Coordinator, and DSS, on 05/22/15 at 2:52 PM, revealed they participate in the morning meeting and review the 24 hour report, notifications were made, maintenance books reviewed, and audits/ round were reviewed in the morning meeting. 14. Interview, on 05/22/15 at 2:52 PM, with the DCS revealed facility concerns were reviewed in the morning meeting, including audits and rounding results, for department heads to address. She stated she (the DCS) or the ED would initial when concerns were resolved. Observation, on 05/22/15 at 9:05 AM, of the morning meeting revealed the DCS provided direction and asked clarifying questions related to information discussed with follow up items determined. 15. Review of sign in sheets, dated 04/22/15, 05/13/15, and 05/15/15, revealed QAPI meetings were held on those dates. Interview, with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS revealed they attended the QAPI meetings. Interview with the RDCS, on 05/22/15 at 5:05 PM, revealed the next QAPI meeting was scheduled for 06/17/15. Interview with the Medical Director, on 05/22/15 at 8:00 AM, revealed he was informed by the Executive Director of the resident care issues, attended the QA meetings held by the facility and provided direction regarding corrective action plans that were developed to meet the needs of the residents.	F 469		

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16. Review of the QAPI sign in sheet, dated 05/15/15, and agenda revealed audit tools were approved for QA monitoring and discussed: resident interviews; resident/family concerns; morning meeting; new employee files; falls or behaviors reviewed; care plans and Kardexes update; review of the 24 hour report; notifications; maintenance rounds and book; supervised smoking; falls interventions in place; call lights; weekly falls; and, behavior management meetings.

17. Review of the sign in sheet for QAPI, dated 05/13/15, revealed the ED and DCS presented and reviewed pest control and would provide daily oversight.

18. Review of the facility rounds, dated 05/12/15, revealed residents were observed to identify residents pests. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Staffing Coordinator, BOM, Central Supply, Housekeeping Supervisor, and DSS revealed daily rounds were completed to identify pests. Interviews with Resident #3, #8 and #10 on 05/22/15, revealed the issues and concerns they had regarding pests and environment repairs had improved.

19. Review of in-service records, dated 05/13/15 and 05/14/15, revealed one hundred one (101) staff and ten (10) agency staff were educated on using the pest sightings book. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, Staffing Coordinator, Central Supply and Housekeeping Supervisor revealed they were trained on pests. Interview with Housekeeper #1, on 05/22/15 at 8:20 AM,

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F 469	Continued From page 556 revealed she received training on cleaning resident rooms, reporting pests and broken equipment. Interview with Registered Nurse #11, on 05/22/15 at 8:10 AM, revealed she was educated on reporting pests and maintenance issues. 20. Review of a QAPI sign in sheet, dated 05/15/15, revealed residents would be observed to ensure residents and environment free from pests. On 05/22/15 at 2:52 PM, interview with the Maintenance Director, DCS, ADCS, UM, Staffing Coordinator, MDS Director, Housekeeping Supervisor, and DSS attended the QA meetings. Interview with Resident #8, on 05/22/15 at 4:20 PM, Resident #6, on 05/05/15 at 2:26 PM, Resident #24, on 05/22/15 at 8:07 AM, revealed the issues they had with an environment of pests had improved.	F 469		
F 490 SS=L	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and 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 interview and record review, it was determined the facility's Executive Director failed to effectively and efficiently utilize policies and procedures developed to meet the needs of the residents related to failure to provide adequate supervision to prevent accidents/incidents,	F 490		

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investigate potential abuse, assess and monitor residents after an injury, ensure a safe, clean, pest free environment, maintain an adequate supply of bed/bath linens, ensure residents' dignity was maintained, ensure sufficient staffing to meet the residents' care needs, and ensure residents' physicians and responsible parties were notified of changes in residents' condition. (Refer to F157, F225, F226, F241, F280, F282, F254, F309, F323, F353, F463, F469, F490, F514 and F520)

Immediate Jeopardy was identified on 04/22/15 and determined to exist on 02/25/15. On 02/25/15 at approximately 12:30 AM, Resident #4 was found on the floor by a Certified Nursing Assistant (CNA) while performing rounds. Interview and record review revealed no documented evidence the resident's physician was notified at the time of the fall, there was no documented evidence the resident was assessed and monitored after the fall, and there was no evidence interventions were implemented to prevent recurrence. An x-ray was obtained at 4:30 PM (16 hours after the incident) and the resident was diagnosed with a right tibia fracture.

Immediate Jeopardy was identified on 04/21/15 and determined to exist on 04/19/15. Observations revealed ants in the facility. Observation and interview with Resident #24 on 04/21/15 revealed ants in the resident's room. Interview with Resident #24 revealed on 04/19/15 ants were in the bed and crawling all over his/her body. The resident was scared and had to scream out for staff to help him/her.

Immediate Jeopardy was identified on 05/12/15

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and determined to exist on 03/25/15. Record review and interview revealed on 03/25/15 during the 7:00 AM-3:00 PM shift, Registered Nurse (RN) #6 noted Resident #25's right eye was swollen and bruised on the side with a small cut. The resident had a history of wandering into other resident rooms, both male and female. Interview and record review revealed the resident's eye injury was not assessed or monitored. There was no documented assessment of the injury until 04/24/15, thirty (30) days after the bruising was identified. The facility could not provide any evidence the physician or responsible party were notified or that the incident was reported or investigated until 04/28/15 (thirty-four [34]days after the incident) after surveyor intervention.

Immediate Jeopardy was identified on 05/12/15 and determined to exist on 04/28/15. Observation, interview and record review revealed the facility failed to ensure the resident call system was functional for Residents #5, #7, #12 and Unsampled Residents M, T, Z, AA, CC, GG, HH, II, JJ, KK, and LL in order to notify staff of their needs. The facility failed to provide the residents with an alternate means of notifying staff. Additionally, the call system panel located at the nursing station had buttons missing and others that did not work.

The facility's failure to have an effective system in place to ensure the Executive Director effectively and efficiently implement policies, procedures, and resources to ensure residents assessed needs were met, along with building maintenance and pest control, has caused or is likely to cause serious injury, harm, impairment or death.

An acceptable Allegation of Compliance (AOC)

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was received on 05/19/15 alleging the Immediate Jeopardy was removed on 05/16/15. The State Survey Agency validated the Immediate Jeopardy was removed on 05/16/15 as alleged, prior to exit on 05/22/15. The scope and severity was lowered to an F while the facility monitors the implementation of the Plan of Correction and the facility's Quality Assurance monitors the effectiveness of the systemic changes.

The findings include:

Review of the Executive Director's job description, not dated and blank, revealed the primary purpose of the Executive Director was to direct the day-to-day functions of the facility in accordance with current federal, state and local standards, guidelines, and regulations that govern nursing facilities to ensure that the highest degree of quality care could be provided to the residents at all times. The Executive Director was responsible for hiring a sufficient number of qualified staff to carry out the facility's programs and services; maintain and guide the implementation of facility policies and procedures in compliance with state, federal and other regulatory guidelines; support and guide the facility's quality improvement process; ensure a safe, clean and comfortable environment for residents; ensure that residents are treated with respect and compassion; adhere to facility policies and participate in quality improvement; and, maintain resident confidentiality of all resident care information, including protected health information.

1. Reference F157, F309 and F323

Review of the facility's policy regarding Resident

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F 490	Continued From page 560 Incident/Accident Reports, dated 11/30/14, revealed it was the policy of the company that resident incidents/accidents were recorded, reviewed, and trended through Quality Assurance and Performance Improvement process in order to, as much as possible, provide for resident, staff, and visitor safety. Any happening not consistent with routine operations of the facility or care of a resident may warrant the completion of an incident report. Following the nursing assessment, the physician would be notified of any noted or suspected injury, and would implement appropriate interventions. The event, along with the assessment, physician and other required notifications would be documented in the clinical record. Resident's family or legal representatives would be notified of the incident. On 02/25/15 at approximately 12:30 AM, Resident #4 sustained a fall. Interview and record review revealed the fall was documented at 6:00 AM on 02/25/15; however, there was no documented evidence the resident's physician was notified at the time of the fall and there was no evidence the resident received a complete nursing assessment, which included the lower extremities, after the fall until 4:30 PM on 02/25/15 when nursing documented the right lower leg was swollen, warm, bruised and tender. An x-ray was ordered and the resident was diagnosed with a right tibia fracture. On 02/26/15, with no time of incident, Resident #31 sustained a fall when attempting to self-transfer from the wheelchair (w/c) to the bed. The resident's fall resulted in small skin tears to his/her arms and swelling to the left eye with a hematoma to the left side of the face. The resident was transferred to a local hospital on	F 490		

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F 490	Continued From page 561 02/26/15 and diagnosed with a Contusion, Bilateral Frontal Lobe Hemorrhage, and Mild Subarachnoid Hemorrhage and returned to the facility on 03/03/15. Interview and record review revealed the facility failed to conduct an investigation of the fall on 02/26/15 which resulted in a hematoma. Review of the clinical record for Resident #25 revealed the resident wandered and had socially and sexually inappropriate behaviors. On 03/25/15 during the 7:00 AM-3:00 PM shift, Registered Nurse (RN) #6 noted the Resident #25's right eye was swollen and bruised on the side with a small cut. Interview with Resident #29, on 04/27/15 at 11:40 AM, revealed Resident #25 had wandered into his/her room and tried to get into Unsampled Resident A's bed. Resident #29 stated he/she "busted" the resident in the jaw a couple of times to get the resident out of the room. Interview revealed staff was aware of the altercation; however, there was no documented evidence the facility investigated Resident #25's injury/incident until 04/28/15 after surveyor intervention. Due to the lack of a timely investigation, there was no evidence of increased monitoring/supervision related to this resident to resident altercation to prevent recurrence. In addition, interview and record review revealed the resident's eye injury was not assessed or monitored. There was no documented assessment of the injury until 04/24/15, thirty (30) days after the bruising was identified. 2. Reference F225 and F226 Review of the facility's policy regarding Resident Abuse-Injuries of Unknown Origin, dated 11/30/14, revealed injuries of unknown origin also included bruises with no known cause. The	F 490		

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F 490	Continued From page 562 Executive Director (ED) and Director of Clinical Services (DCS) should be notified immediately, and the responsible party (RP) and physician should also be notified. The ED, DCS, or designee should begin a documented investigation of the cause of the injury and that would include interviews with the resident, all staff involved, or anyone who may help with the investigation. All injuries of unknown origin should be reported to the state agencies. Review of the facility's policy regarding Resident Abuse, revised 01/01/12, revealed all reported events, including bruises, would be investigated by the Director of Clinical Services (DCS), and forwarded to the Executive Director (ED) who was also the facility's Abuse Coordinator. All incidents of abuse should be reported immediately to the Clinical Nurse in Charge, DCS, and ED. The Abuse Coordinator was responsible to report the incident to the appropriate officials. The facility should investigate all reports of suspected abuse. The Abuse Coordinator should be notified and the Clinical Nurse in Charge or DCS should perform and document a thorough nursing assessment and notify the physician. The facility investigation should include statements from the victim, suspects, and all possible witnesses that included other employees. On 03/25/15 Resident #25 was found with an eye injury that the facility did not evaluate, obtain treatment, investigate, or report. 3. Reference F241 Review of the facility's policy regarding AM Care, dated 11/30/14, revealed Clinical Services	F 490		

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personnel would offer AM care each day to ensure resident's overall comfort, cleanliness, good grooming, and general well-being. Residents who were capable of performing their own personal care would be encouraged to do so. Showers, baths, and shampoos would be scheduled at least weekly and more often if needed.

Review of the facility's policy regarding Call Lights, dated 11/30/14, revealed all lights will be answered promptly by all staff regardless of assignment.

Interview with Resident #24 and Resident #8 revealed the facility failed to toilet residents timely as to not cause embarrassment from urinary accidents, provide incontinent care and check/change to ensure residents did not remain in wet briefs for extended periods or in urine stained sheets. In addition, interview revealed the residents had ants in their beds and crawling on their bodies. Interviews with Resident #8 revealed he/she was mad and felt the staff did not care and Resident #24 was scared and had to scream out for staff to help him/her.

4. Reference F280 and F282

Review of the facility's policy regarding Care Plans, dated 11/30/14, revealed an interdisciplinary plan of care would be established for every resident and updated in accordance with the state and federal regulatory requirements and on an as needed basis. Goals must be measurable and objective. The facility must develop a comprehensive Care Plan for each resident that included measurable objectives and timetables to meet the resident's medical,

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F 490	Continued From page 564 nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. Observation, interview, and record review revealed the facility failed to ensure resident care plans were revised after an accident or incident; such as a fall or resident to resident altercation for four (4) residents. Observation, interview, and record review revealed the facility failed to ensure staff followed the resident's care plans of sixteen (16) residents. 5. Reference F353 Review of the facility policy regarding Staffing, dated 11/30/15 revealed staffing would be maintained by the facility in accordance with State and Federal requirements. The facility would have appropriate staff to provide for the needs of the residents at all times. Observation, interview, and record review revealed the facility failed to ensure adequate staffing was available to meet the assessed needs of residents and to ensure resident's had a neat, clean environment, along with clean clothes and adequate linen supplies. 6. Reference F254 Review of the contract company's (housekeeping, laundry, and dietary services) policy, Linen Par System, not dated, revealed flat sheets, fitted sheets, blankets, pillowcases, wash cloths, and bath towels needed to have a three (3) Par Level, meaning three (3) of each item was needed in inventory per resident.	F 490		

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F 490	Continued From page 565 Observation and interview revealed the facility failed to ensure an adequate number of pillows, sheets, blankets, towels, wash clothes, bath blankets, clothing protectors, and pillow cases, that were in good condition, were available to provide resident care. 7. Reference F463 Review of the facility's Maintenance Policy and Procedures, effective date 11/30/14, revealed the facility's physical plant and equipment would be maintained through a program of preventive maintenance and prompt action to identify areas/items in need of repair. The maintenance procedures included the Director of Environmental Services would follow all policies regarding routine periodic maintenance, perform daily rounds of the building to ensure the plant was maintained to be free of hazards and in proper physical condition, and all employees reported physical plant areas or equipment in need of repair or service to their supervisor. Observation and interview revealed the resident call light system did not work effectively in six (6) resident rooms with no alternative method of contacting the staff for assistance provided to these residents. In addition, buttons were missing on the call light panel at Nurses Station #1 for eight (8) residents and at Nurses Station #2, for three (3) residents. After surveyor intervention, the facility conducted an audit and identified forty-one (41) call lights that did not illuminate and/or make an audible sound when the call button was pressed. 8. Reference F469	F 490		

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F 490	Continued From page 566 Review of the facility's Sanitation and Infection Control Pest Control policy, undated, revealed the Dining Services Department should be free of all insects. Review of the facility's policy regarding Pest Control, dated 11/30/14, revealed the facility would maintain a pest control program, which included inspection, reporting, and prevention. Treatment would be rendered as required to control pests and vermin. Any unusual occurrence or sighting of insects would be reported immediately to the Supervisor. Proper action would be taken. Interview with residents and staff revealed the facility had an ant problem with ants crawling on the walls in residents' rooms, in residents' beds, on the residents' bodies, and out of electrical outlets in residents' rooms. Observations of the common areas and offices revealed spiders in the corner of a picture window, ants crawling on desks, dead bugs in the window sill and gnats in the shower room, the kitchen had brown bugs crawling in and out of an opening in the wall. Interview with staff revealed Administration was informed numerous times of the pest control problem. Interview with the Owner/Operator of the Pest Control Company revealed the facility was notified on 01/09/15 that the company was placing the facility's services on hold for non-payment of services; however, continued to provide a partial service one time a month instead of the weekly services. Interview with the previous Executive Director (ED), on 04/23/15 at 8:35 AM, and on 05/11/15 at	F 490		

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F 490	Continued From page 567 8:18 AM, revealed she resigned as of 04/17/15. She stated the underlying issue to the facility's inability to meet the needs of the resident was related to the staffing shortage. She stated she had requested approval for the use of agency staff until they could hire additional nursing staff; however, she had not received approval as 04/17/15 and that was one of the reasons she put in her resignation, among others. She stated the corporation was using an agency to staff the Director of Clinical Services position and during her time at the facility she worked with six (6) Directors' of Clinical Services. She stated she was unable to ensure staff followed policy and procedures due to having only one Unit Manager, when she normally had three (3), and one (1) Assistant Director of Clinical Services and the Director of Clinical Services position was not stable. She stated staff came and went as they pleased and she was not able to control the schedule to ensure staff was always available to meet the needs of the resident. She stated the budgetary processes and contracts with Housekeeping and the Dietary Corporation contributed to the facility's inability to meet the needs of the residents. She stated she had made the corporation aware of the facility's issues; however, nothing was done to resolve them. Interview with the Interim Executive Director/Regional Vice President of Operations (as of 04/17/15), on 04/28/15 at 9:40 AM, and on 05/21/15 at 8:25AM, revealed the previous Executive Director resigned as of 04/17/15 for personal reasons. She stated she made routine rounds of the facility prior to assuming the role as Interim Executive Director and was aware of the staffing shortage. Continued interview revealed she was not aware of the facility's pest infestation	F 490		

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F 490	Continued From page 568 issues, call lights not working or that staff were unable to answer timely, or that a resident obtained a wound caused by a brace. She stated she was also not aware the shower bed did not have all the metal pins to maintain the bed rails in the up position, linen par levels were not adequate, or of the environmental repairs that needed to take place. She stated not following the facility's policies and procedures regarding these issues affected the facility's ability to provide the resident's assessed care needs. The facility took the following actions to remove the Immediate Jeopardy on 05/16/15 as follows: 1. The facility notified Resident #4's physician, of a fall that occurred on 02/25/15 with new orders given to the nurse. The resident transferred to a local hospital on 02/25/15 for a tibia fracture and returned to the facility on 02/28/15 with new orders. The DCS assessed Resident #4 on 04/22/15 and was found in stable condition. 2. On 04/22/15, one hundred twenty-six (126) residents were assessed by the ADCS, Nurse Manager, and Licensed Nurse to determine if any residents had an incident or accident or change in condition that would warrant physician notification and further intervention. One (1) resident was identified as having an incident, accident, or change of condition and the physician was notified by the nurse on 04/22/15. Additionally, the Nurse notified the RP and documented this in the clinical record. Nurses would additionally report incidents, accidents, or changes in condition to the clinical administrative team. 3. On 04/22/15 the Corporate Administrative	F 490		

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F 490	Continued From page 569 Nurses educated twenty-three (23) of thirty-eight (38) Nurses regarding timely notification to the physician related to resident incidents, accidents, or change in condition; care plan policies, evidence of assessments and care planning with immediate falls preventions interventions to meet the resident's needs; and falls procedures, immediate assessment by the Nurse after a resident's fall, notifications to the physician and RP, implementation of an immediate intervention by the Nurse, documentation of the fall in the clinical record by the Nurse, fall root cause investigation report initiated by the Nurse and reviewed by the DCS, and follow up by the IDT in the weekly falls meeting. Nurses were also trained related to reporting an incident, accident, or change in condition, to the resident ' s RP and documentation in the medical record to include the incident, accident, or change in condition, notifications to the physician, RP, and clinical administrative team, nurse's assessment, and interventions; evidence of assessment would include Situation, Background, Appearance, and Review (SBAR) sheet, Interdisciplinary Progress Note, and Neurological (neuro) checks sheet, and documentation of falls. Staff competencies were completed. Nursing staff not educated by midnight on 04/22/15 would not be allowed to work until they received training. Agency Nurses would be trained by the Corporate Administrative Nurses, DCS, Assistant DCS, or Nurse Manager prior to working their next shift. The DCS and ED would ensure staff that had not been educated were educated prior to working their next shift. The ED and DCS would monitor the daily schedule and highlight staff already trained. A department manager would stand by the time clock at shift change to direct staff that needed education to the training. The IDT would monitor	F 490		

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F 490	Continued From page 570 daily incidents and accidents. Notifications of accidents, incidents, or changes of condition would be reviewed for completion by the DCS, ADCS, or Nurse Manager, who would make notifications if not done. 4. An Ad-Hoc Quality Assurance/ Performance Improvement (QAPI) meeting was conducted on 04/22/15 to discuss facility policy and procedure (P&P) for falls, and notifications of incidents, accidents, or changes of condition; care plans as related to immediate falls interventions and revision status post fall, nursing assessment and documentation for falls; with no changes made. Also discussed the facility protocol related to shift relief and report; and additional avenues to attract new staff and maintaining current staff with a plan for performance improvement. 5. On 04/22/15, 126 residents were reviewed for fall risk with a fall risk assessment completed by the DCS and MDS Nurses who had previously been educated on 04/22/15, and care plans and Kardexes were also reviewed, with seventy-four (74) residents whose fall care plans were updated on 04/22/15. 6. On 04/22/15 the Corporate Administrative Nurses educated the DCS, ADCS, and Nurse Manager regarding evidence of assessment and care planning, with immediate falls prevention interventions to meet the resident's needs. On 04/22/15, thirty (30) of fifty-eight (58) CNAs and two (2) Agency CNAs were educated to review the Kardex for specific fall risk information. 7. Certified Medication Technician's (CMT) would be supervised by the Nurse they work with on the unit. The current resident census was reviewed	F 490		

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F 490	Continued From page 571 by the ED and DCS to determine which residents required total care, assistance, or were independent with care. 8. On 04/22/15, 126 residents were assessed by Nurses using a visual and/or verbal nursing assessment that included vital signs to ensure there were no current physical or emotional distress or needs that were not met as related to inadequate staffing. One (1) resident was identified in physical distress and the Nurse timely notified the physician. 9. On 04/22/15, The Corporate Administrative Nurses educated twenty-three (23) of thirty-eight (38) Nurses, thirty (30) of fifty-eight (58) CNAs, and two (2) Agency CNAs related to staffing, to notify the ED, DCS, or ADCS for any staff call outs. The ED, DCS, ADCS, or Scheduler would attempt to replace the staff member who called out by calling on facility staff to stay over or come into work. If staffing needs could not be met the ED, DCS, ADCS could mandate staff currently working. Staff were educated on waiting for their relief to arrive prior to leaving the facility, and to give shift report to oncoming staff, that would include resident status, falls that occurred, and any new interventions. Staff competencies were completed. 10. On 04/28/15, the facility reported to the SSA that Resident #25 was found to have a black eye on 03/25/15. The incident was investigated and with the assistance of the SSD and DCS the source of the black eye was determined as a result of a resident to resident altercation and abuse was unsubstantiated. 11. One hundred twenty-one (121) residents were	F 490		

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F 490	Continued From page 572	F 490		

assessed by a nurse for suspicious injuries on 05/12/15 and 05/13/15. No suspicious injuries were found.

12. Current residents with BIMS Scores of twelve (12) or higher were interviewed by the ED, on 05/12/15 and 05/13/15, about their safety.

13. Staff in Nursing, Dietary, Housekeeping and Laundry, and Therapy were interviewed by the ED/Assistant ED on 05/12/15, 05/13/15, and 05/14/15. Two (2) new allegations of abuse/neglect that required reporting to the SSA were reported on 05/14/15.

14. The Corporate Administrative RNs educated 107 of 149 staff and fourteen (14) agency staff on abuse and neglect and injuries of unknown origin from 05/09/15 through 05/14/15 with competency. Forty-two (42) staff not educated as of 05/14/15 will not be allowed to work without having been educated prior to the start of their shift. Agency staff will be educated prior to working their next shift. Staff, through the use of a Performance Improvement tool, staff were aware of the types of abuse, injuries of unknown origin, and when and whom to report to. Forty- two (42) staff not educated as of 05/14/15

15. One hundred twelve (112) of 112 employee personnel files were reviewed by the Regional Director of HR (RDHR), facility HR, and BOM to ensure files were complete with criminal background checks, nurse aide abuse registry checks, and abuse training. The RDHR corrected discrepancies on 05/13/15. Ongoing reviews of five (5) new employee files would occur twice weekly.

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F 490	Continued From page 573 16. The ED or DCS would review all allegations of abuse, complete the 24 hour report, investigation, and five (5) day report. 17. The QAPI Committee met on 05/13/15 and reviewed the Policy and Procedures (P&P) for abuse with no changes made. 18. The Regional Director of Clinical Services (RDCS) reviewed potential reportable events were completed on 04/21/15 through 04/24/15, 04/26/15 through 04/29/15, 05/01/15, 05/04/15, 05/06/15, 05/09/15, and on 05/11/15 with no issues identified. On 05/14/15 the RDCS reviewed abuse allegations and investigations for the last ninety (90) days for timely reporting, investigation, and resolution. 19. An Ad-Hoc QAPI Committee meeting on 05/15/15 discussed ongoing quality improvement monitoring for abuse and neglect reporting beginning 05/16/15 using an approved audit tool and included: a. Five (5) resident interviews on 05/12/15 and ongoing five (5) times weekly. b. Skins sweeps on 05/08/15, 05/12/15, 05/13/15 completed by a nurse and reviewed by RDCS, Corporate Administrative RNs, DCS, ADCS, or Nurse Manager for any suspicious injuries, of five (5) residents, five (5) times a week. c. Beginning 04/21/15 and ongoing the RDCS, RVPO, RDHR will review new allegations of abuse and neglect for timely reporting, investigation, and resolution once a week. d. On 05/15/15 and ongoing new resident and	F 490		

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F 490	Continued From page 574 family concerns would be reviewed by the ED, RDCS, RCPO, RDHR, or Corporate Administrative RNs for resolution five (5) times a week. e. On 05/12/15 an ongoing Daily Department Head Meeting led by the ED and DCS would be attended by Corporate Administrative RN, RDCS, RVPO, or RDHR to ensure new resident injuries or concerns were discussed five (5) times weekly. 20. Current residents were reviewed for behaviors, on 05/12/15 and 05/13/15, by Corporate Administrative RNS and two (2) members of the IDT. Care plans were reviewed for sixty-six (66) residents with behaviors, with twenty (20) care plans updated, with one (1) resident placed on 1:1 supervision. 21. 101 of 149 staff and 10 agency staff were educated regarding resident behaviors and documentation, care planning and following the care plan, reporting maintenance issues, safe smoking policy, on 05/13/15 and 05/14/15 by the Corporate Administrative RNs. IDT will meet to ensure behaviors were documented and care planned, notification to the physician, and document on the 24 hour report. Residents with behaviors would be reviewed during the weekly IDT meeting beginning 05/12/15. The 24 hour report would be reviewed in the morning meeting. Forty-eight (48) staff not educated will not be allowed to work until they have been trained. No staff will be allowed to work after 05/14/15 until they have been educated prior to the start of their shift. The ED or DCS would monitor the schedule and appoint a department manager to stand at the time clock to direct employees still needing education to the in-service.	F 490		

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F 490	Continued From page 575 22. QAPI meeting was held on 05/13/15 to review the P&P for care plans and behavior management, resident weights, skin assessments, ADLs, smoking, assistive devices related to lifts and shower bed, facility maintenance, pest control, housekeeping/ laundry, and staffing, falls, incidents/accidents, grievances, with no changes made. The facility's action plan for removal of the IJ was reviewed and tasks assigned, with department managers assigned to provide daily oversight along with the RDCS/ RVPO/ RDHC/ RCMC/Corporate Administrative RNs. 23. Beginning 05/15/15, residents with new falls and behaviors were reviewed by the Daily IDT team for completion of SBAR, assessment, notification, immediate interventions, and investigation with root cause analysis. Care plans and Kardexes were reviewed/updated with appropriate interventions. No issues were identified, and would be validated five (5) times weekly. 24. Beginning 05/12/15 weekly falls management meeting and weekly behavior management meeting occurred with IDT, with no issues identified. The IDT in the daily meeting reviewed the 24 hour report with no issues identified, and validated one (1) time weekly. 25. An Ad-Hoc QAPI meeting held on 05/15/15 for ongoing QI monitoring of the facility process for abuse and neglect reporting is done, and call lights, beginning 05/16/15 using an approved audit tool. Any issues identified in audits were addressed and ongoing plans developed.	F 490		

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26. A weekly behavior meeting was held on 05/12/15 and 05/13/15 and discussed six (6) residents with resident to resident behaviors or sexual/ physical behaviors to ensure behaviors were documented, care planned, and interventions in place.

27. On 05/13/15 and 05/14/15 twenty-two (22) nurses were educated by the Corporate Administrative RNS to complete skin sweeps weekly and PRN, and complete residents' weights per physician order.

28. The IDT would review in the daily meeting incidents and accidents reports and the 24 hour report for investigation reports, nursing documentation in the clinical record, an SBAR, notifications to the physician and RP, and care plans with appropriate interventions.

29. On 04/30/15, one hundred twenty-four (124) residents were reviewed for appropriate transfer/lift method and updated the care plans and Kardexes, including Residents #4 and #34. The shower bed was removed from the facility and discarded. A new shower bed was ordered on 05/07/15. A shower bed located in the shed was inspected and discarded by Maintenance on 05/13/15.

30. The SSD completed safe smoking evaluations on fifteen (15) residents who smoke, on 05/13/15, with three (3) identified to require a smoking apron and two (2) referred to therapy for adaptive smoking equipment. Residents who smoke were given a copy of the facility's safe smoking rules on 05/13/15 and 05/14/15.

31. Room rounds were conducted by the ED, on

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F 490	Continued From page 577 05/13/15, for incendiary smoking items, with any items found removed and maintained in a locked box at the nurse's station for supervised smoking times by facility staff. A list of residents who smoke and who require supervision or aprons would be kept in the locked box with the Kardexes. 32. On 05/12/15 Corporate Administrative Nurses made walking rounds to identify any maintenance/resident safety concerns. Identified concerns were given to the ED and Maintenance Director for prioritization and repair. On 05/13/15 The ED and Maintenance Director made facility rounds and reviewed the maintenance books at the nurse's stations to identify safety concerns. Safety concerns were addressed by the Maintenance Director on 05/13/15 and 05/14/15. The Maintenance Director was educated on 05/13/15 to check the maintenance books at each nurse's station five (5) times weekly and prioritize based on safety concerns. 33. Fifty-one (51) nursing staff and 10 agency staff were educated on 05/13/15 and 05/14/15 to observe shower beds for safety prior to use. If a shower bed was unsafe or non-functional, staff would immediately remove the equipment and notify maintenance. 34. QAPI monitoring, beginning 05/15/15 of the facility process for falls, smoking, assistive devices, lifts, shower beds, and facility maintenance. 35. Beginning 05/12/15 the IDT would round to observe for environment safety concerns in five (5) resident care areas and immediately addressed by maintenance, and validated five (5)	F 490		

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times weekly. Maintenance books would be brought to the daily meeting to discuss concerns five (5) times weekly.

36. Beginning 05/13/15 training and return demonstration of five (5) nursing staff will be completed five (5) times weekly. Observations of five (5) residents during supervised smoking by a member of the IDT five (5) times weekly. Rounds of five (5) resident rooms for incendiary items by a member of the IDT would be completed five (5) times weekly. Any issues would be brought to the daily meeting.

37. Five (5) residents would be observed, beginning 05/12/15, to ensure fall interventions were in place per the care plan would be completed by IDT five (5) times weekly.

38. Resident call lights were checked for function on 05/12/15 for Resident #7, #5, #12, Unsampled Residents Z, and AA. Unsampled Resident M no longer resided in the facility. Resident #12's call light was found not to light at the desk or the door.

39. On 05/12/15, one hundred twenty-four (124) residents call lights were checked for function and twenty-two (22) rooms were found to not light at the desk, one (1) room did not light at the desk or door, and two (2) rooms did not light at the desk or door, or sound. The ED was notified of the three (3) resident rooms, on 05/13/15, that had call lights that did not work. All six (6) residents of the three (3) rooms were put on fifteen (15) minute safety checks. On 05/13/15 an outside contractor initiated maintenance to ensure functionality and made repairs on 05/13/15 with an additional room repaired on

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F 490	Continued From page 579 05/14/15 of a call light that would not turn off. The annunciator system at the nurse's station on the 200 unit was repaired, on 05/14/15. 40. Twelve (12) nursing staff working 11:00 PM to 7:00 AM on 05/12/15 were educated on the call light P&P on 005/09/15 through 05/12/15 with competencies. The 11:00 PM to 7:00 AM staff working on 05/12/15 were re-educated on the facility's P&P for an inoperable call light system, on 05/13/15, and the six (6) residents were placed on fifteen (15) minute safety checks until the call lights were functional. Hand bells were also given to the six (6) residents on 05/13/15. 41. One hundred and one (101) of 149 staff were educated on 05/09/15 through 05/14/15 on the facility's call light P&P and what to do if there was an inoperable call light, and use the pest sightings book at the nurse's station. Forty-eight (48) staff not educated by 05/14/15 would not be allowed to work until they had been educated prior to the start of their shift. 42. On 05/11/15, pest control service evaluated the facility and rendered services on 05/13/15, with another visit on 05/14/15. Pest control would visit monthly and as needed. As of 05/15/15 live pests in the facility had been eliminated. 43. Walking rounds were conducted by Corporate Administrative Nurses, on 05/12/15, to look for pests, with none seen. One hundred twenty-one (121) residents were assessed by skin sweeps, with no pest bites evident. No pests were observed in resident beds or rooms. 44. Beginning 05/14/15 rounds were completed by IDT Monday through Friday with no pest	F 490		

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F 490	Continued From page 580 issues identified. 45. An Ad-Hoc QAPI meeting, held on 05/14/15, related to QI monitoring of the facility's process for pest control would be completed by the ED/RVPO one (1) time monthly that pest control visits occurred monthly. Beginning 05/15/15 resident care areas would be checked to ensure there were no live pests five (5) times weekly. 46. On 05/12/15 and 05/13/15, housekeeping rounds were completed by the ED and Housekeeping Supervisor for facility cleanliness and odors, with areas needing cleaning were cleaned on 05/12/15 through 05/15/15. 47. On 05/13/15, Corporate Administrative RNs educated facility Administrative Staff on the regulations and P&P for staffing, pest control, housekeeping, and maintenance, with competencies completed. The ED would monitor the facility's process for notification, abuse, hiring, dignity, care plan revision, professional standards, assessments, behavior and falls management, incidents and accidents, smoking, call lights, pest control, and staffing. 48. New employee files would be reviewed by the ED or Corporate Administrative Nurses for completeness two (2) times weekly. 49. Review of the 24 hour report, incident/ accident reports, in the daily meeting with the IDT; documentation in the clinical record included notification to the physician and new orders, and to the RP; the IDT made rounds in five (5) resident care areas to observe for maintenance and safety concerns; observations of five (5) residents during supervised smoking by the IDT;	F 490		

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F 490	Continued From page 581 room rounds for five (5) residents to search for incendiary items by a member of the IDT, maintenance concerns were written in the maintenance books and taken to the daily meeting and prioritized for repair; observations of five (5) residents to ensure falls interventions were in place per the care plan by the IDT; call lights checked in resident rooms and bathrooms to ensure lights and sound; five (5) staff educated what to do if call light inoperable; resident care areas checked for no live pests; were validated five (5) times weekly. 50. Daily oversight since 04/22/15 on all shifts to ensure residents were safe and the plan of care was followed to meet resident needs, by the ED/ DCS/ RVPO/RDCS/Corporate Administrative Nurses. 51. The IDT would meet at least monthly to discuss facility action plan and ensure tasks were completed for the removal of the IJ, and QA monitoring completed according to the AOC during the IJ period, validated by the ED/RVPO/RDCS/Corporate Administrative RNs. 52. Per the Ad-Hoc QAPI meeting, on 05/15/15, QI monitoring would be done utilizing approved audit tool with oversight by the ED, beginning 05/16/15, five (5) resident interview; new resident/ family concerns; daily department head meeting to ensure new resident injuries or concerns were discussed; five (5) new employee files reviewed two (2) times weekly; residents with new falls or behaviors were reviewed in the daily meeting with IDT and care plans/ Kardexes reviewed and updated; review of the 24 hour report and the incident and accident reports in the daily meeting with IDT; review of the clinical record for timely	F 490		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HURSTBOURNE CARE CENTRE AT STONY BROOK	2200 STONY BROOK DR LOUISVILLE, KY 40220

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F 490	Continued From page 582 notifications to the physician and RP; the IDT rounds in five (5) resident care areas to observe the environment for safety and maintenance concerns; observations of five (5) residents during supervised smoking; room rounds of five (5) residents for incendiary items; maintenance concerns listed in the maintenance book and taken to the daily meeting to discuss and prioritize repairs; observations of five (5) residents to ensure falls interventions were in place per the care plan by the IDT; five (5) resident rooms call lights checked to ensure they light at the door, nurse's station, and sound; five (5) staff education what to do if a call light was inoperable; five (5) times weekly; weekly falls and behavior management meetings occur with IDT one (1) time weekly. 53. Linen rounds were completed, on 05/13/15, by the ED/ Housekeeping Supervisor/Department Managers to ensure PAR levels and available resident laundry, with areas of concern addressed by the Housekeeping Supervisor at that time. 54. The RVPO/RDCS/Corporate Administrative RNs would provide daily oversight of the ED and DCS in areas of falls, incidents, accidents, change in condition, sufficient staffing to meet resident needs, housekeeping and laundry, and pest control during the IJ period until removal. 55. Grievances were reviewed, on 05/13/15, by the ED/SSD/DCS back to 05/1/15 for any areas requiring additional follow up, which was handled by 05/15/15. 56. Resident #39's hair was washed and combed, shaved and care provided, sheets changed,	F 490		

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F 490	Continued From page 583 privacy curtain provided. 57. On 05/12/15 rounds were completed by the DCS/ADCS/ Nurse Managers, and Corporate Administrative Nurses to identify residents who needed additional grooming or incontinent care; bed linens checked to ensure they were clean and pest free; call lights checked to ensure they were within resident reach and answered timely; resident's skin observed to ensure free from pests; and privacy curtains in place. Additional grooming was provided to residents requiring it, and one (1) resident room was identified to need a privacy curtain on 05/13/15. 58. On 05/13/15 and 05/14/15, nursing staff and ten (10) agency staff were educated on incontinent care, bathing, shaving, washing resident's hair, with those not trained would not allowed to work until trained prior to the start of their shift. 59. On 05/13/15 and 05/14/15, 101 of 149 staff and ten (10) agency staff were educated to notify housekeeping when privacy curtains were needed; report pest sightings in the pest sightings book; any pests noticed on residents should be reported immediately to the nurse supervisor/DCS/ADCS for completion of a skin assessment; resident privacy. Forty-eight (48) staff not educated will be trained prior to working their next scheduled shift. 60. A QAPI meeting was held, on 05/13/15, to discuss the facility's P&P for incontinent care, resident privacy, shaving, AM care, with no changes made. 61. Daily rounds were conducted by department	F 490		

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F 490	Continued From page 584 managers and corporate administration Monday through Friday to identify any issues with resident incontinent care, privacy, shaving and AM care, with any issues identified discussed in the daily IDT meeting and resolved with further Ad-Hoc education. 62. An Ad-Hoc QAPI meeting, on 05/15/15, discussed QI monitoring would be completed beginning 05/16/15 for: beginning 05/12/15 observations of five (5) residents to ensure they were shaven, hair combed, provided incontinent care, privacy curtains were clean, bed linens were clean, rooms/bed/residents were free from pests, privacy provided for care, call lights in reach and answered timely, would be conducted five (5) times weekly. The State Survey Agency validated the removal of Immediate Jeopardy on 05/22/15 as follows: 1. Review of the facility's SBAR's, incident report, neuro checks, progress notes and physician orders, all dated 02/25/15, revealed Resident #4 had a fall on 02/25/15, the physician was notified on 02/25/15 with new orders received. The resident was transferred to a local hospital on 02/25/15 for a tibia fracture on 02/25/15, and returned to the facility on 02/28/15 with new orders. The DCS assessed Resident #4 on 04/22/15 and found the resident was stable. 2. Review of one hundred twenty-six (126) resident assessments, completed by ADCS/Nurse Manager/Licensed Nurse, on 04/22/15, revealed residents were assessed for any incident or accident, or change in condition that warranted notification to the physician. One (1) resident was identified as experienced a change in condition, accident, or incident and the	F 490		

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F 490	Continued From page 585 physician was notified on 04/22/15. 3. Review of in-service records, revealed twenty-three (23) nurses were educated by Corporate Administrative Registered Nurses regarding: timely notification to the physician related to incidents, accidents, and changes in condition; care plan policies; resident assessments, including SBAR, neuro checks; falls and immediate interventions; notification to the physician and RP; documentation of the fall in the clinical record; fall root cause investigation report. Staff competencies were completed. No staff had worked prior to them receiving the training. Review of staffing schedules revealed staff who had not yet been trained were not highlighted, which noted they required education. Review of facility records revealed notifications of incidents, accidents, and changes in condition were reviewed for completion by the DCS/ADCS/ Nurse Manager. Interview with the DCS and RDCS, on 05/04/15 at 4:18 PM, revealed twenty-three (23) nurses had been trained. Interview with RN #8, on 05/04/15 at 4:33 PM, with CNA #11, on 05/05/15 at 9:51 AM, with the UM, on 05/05/15 at 9:55 AM, CNA #14, on 05/05/15 at 10:03 AM, CNA #13, on 05/05/15 at 10:10 AM, revealed they had been educated on falls, notifications, Kardex and care plans. Interview, on 05/05/15 at 2:00 PM, with the DCS, ADCS, Nurse Manager, ED, Admissions Coordinator, DSS, MDS Director revealed they had all been trained on care plans, changes in condition, staff look at interventions for residents, the 24 hour report, falls, SBAR, incident reports, Kardex and care plans, notifications to the physician and family. 4. Review of a QAPI sign in sheet, dated	F 490		

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04/22/15, and agenda revealed the committee discussed the P&P for falls management, notifications of incidents, care plans, falls interventions, nursing assessments, shift to shift relief and report, with no changes made. Interview with the DCS, ADCS, Nurse Manager, ED, Admission Coordinator, DSS, MDS Director, on 05/05/15 at 2:00 PM, revealed QA would track and trend falls information to validate interventions and notifications were being completed.

5. Review of resident assessments for risk for falls, dated 04/22/15, for one hundred twenty-six (126) residents revealed seventy-four (74) residents were assessed by the ADCS as at risk for falls. Review of the Kardexes and Care Plans for the seventy-four (74) residents assessed at risk for falls revealed the Kardexes and care plans had been updated, on 04/22/15. Observation of room 107-A, on 05/05/15 at 1:26 PM, revealed the resident had falls interventions in place. Observation, on 05/05/15 at 1:30 PM, of room 112-A, revealed the resident's falls interventions were in place. Observation, on 05/05/15 at 1:30 PM, of Unsampled Resident Y revealed the resident had falls interventions in place. Observation of Unsampled Resident O, on 05/05/15 at 2:52 PM, revealed the resident's falls interventions were in place.

6. Review of training records, dated 04/22/15, revealed thirty (30) CNAs and two (2) agency staff were educated on the Kardex and falls risk. The Corporate Administrative RNs educated the DCS/ADCS/Nurse Manager, on 04/22/15, regarding assessments, care plans, documentation of falls, and immediate falls interventions. Interview with CNA #6, on 05/05/15

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at 10:12 AM, revealed he received training on the Kardex, falls, and notify the nurse if a resident had a change in condition.

7. Review of staff schedules revealed CMTs were scheduled to work with another nurse present on the unit. Review of a resident census revealed, on 04/22/15, the ED and DCS reviewed which residents required total care, assistance, or were independent with care. Observation, on 05/05/15 at 10:15 AM, revealed CMT/ CNA #11 on the 200 unit was supervised by LPN #1.

8. Review of assessments for one hundred twenty-six (126) residents, dated 04/22/15, revealed residents were assessed by the DCS, with vital signs taken. One (1) resident was identified in distress and the physician was notified at that time.

9. Review of in-service records, dated 04/22/15, revealed twenty-three (23) nurses, thirty (30) CNAs, and two (2) agency staff were educated who to call when they call out and how the shift may be covered to ensure adequate staffing, shift report. Staff competencies were completed. Interview, on 05/04/15 at 4:00 PM, with the RDCS and Interim ED, revealed twenty-three (23) nurses were educated on staffing. Interview with LPN #1, on 05/05/15 at 9:45 AM, revealed he had been trained on what to do and who to call if calling in, and call in to the ED, DCS, or ADCS; stated he had to go through training before he was allowed to work. Interview, on 05/05/15 at 9:51 AM, with CNA #11 revealed she had been educated on staffing, to call the ED, DCS, or ADCS, and had to be trained prior to working. Interview with the UM, on 05/05/15 at 9:55 AM, revealed she was educated on staffing and the

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F 490	Continued From page 588 ED, DCS, or ADCS should be called if staff were to call in. Interview with CNA #6, on 05/05/15 at 10:12 AM, revealed he could only call the ED, DCS, or ADCS if he could not come in to work and he was to wait for the next shift before leaving. 10. Review of the facility investigation, dated 04/28/15, for Resident #25's black eye noted on 03/25/15, revealed the SSA was notified on 04/28/15, investigated, and followed up on 05/04/15. The investigation resulted in the cause of the injury from a resident to resident altercation. Interview with the DCS, on 05/20/15 at 2:04 PM, revealed she investigated Resident #25's black eye and the cause was determined to be a resident to resident altercation. Observation, on 05/22/15 at 2:11 PM of Resident #25 revealed the resident was in his/her recliner with the TV on and staff sitting with him/her on a 1:1. 11. Review of skin sweeps, dated 05/12/15 and 05/13/15, for one hundred twenty-one (121) residents revealed no suspicious injuries were identified. Interview with the RDCS, on 05/22/15 at 8:59 AM, revealed all residents skin were assessed for any injuries that did not have reasonable cause. Observation of Resident #25, on 05/05/15 at 2:11 PM, Unsampled Resident KK, on 05/05/15 at 2:11 PM, Resident #8, on 05/22/15 at 4:20 PM, Resident #6, on 05/05/15 at 2:26 PM, revealed no concerns with new or unknown injuries. 12. Review of resident interview questionnaire, dated 05/12/15 and 05/13/15, revealed residents with a BIMS Score of twelve (12) or more were interviewed by the Executive Director about their safety, no concerns identified. Interview with the	F 490		

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F 490	Continued From page 589 DCS, on 05/22/15 at 2:52 PM, revealed residents were interviewed about their safety with no concerns identified. Interview with Resident #8, on 05/22/15 at 4:20 PM, revealed the resident felt safe in the facility. 13. Review of staff questionnaires, dated 05/12/15 and 05/13/15, revealed staff were interviewed by the ED to determine if any staff member had witnessed abuse or neglect. Review of two (2) facility reports to the SSA revealed the reports were made on 05/14/15. Interview with the DCS, on 05/22/15 at 2:52 PM, revealed staff were interviewed about abuse. She stated two (2) new additional reports were made and investigations were begun. 14. Review of in-service records, dated 05/09/15 through 05/14/15, revealed one hundred one (107) staff and fourteen (14) agency staff were educated on abuse and neglect and injury of unknown origin, with staff competencies completed. Interview with CNA #7, on 05/22/15 at 8:05 AM, RN #6, on 05/22/15 at 8:13 AM, with Housekeeper, on 05/22/15 at 8:20 AM, with LPN #1, on 05/22/15 at 8:25 AM, CNA #8, on 05/22/15 at 8:37 AM, had been trained on abuse and neglect, could name the types of abuse, and who and when to report. Interview, on 05/22/15 at 2:52 PM, with the DCS, Maintenance Director, ADCS, UM, Staffing Coordinator, Medical Records, MDS Coordinator, Housekeeping Supervisor, revealed they had been trained on abuse. 15. Review of one hundred twelve (112) employee file audits, dated 05/13/15, revealed employee files were audited by the Regional Director of Human Resources by the Regional Director of Clinical Services for criminal	F 490		

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background checks, nurse aide abuse registry, OIG checks, and telephone reference checks with no discrepancies corrected. Review of the QAPI meeting, held on 05/15/15, five (5) new employee files would be reviewed for completeness, twice a week. Review of five (5) new employee files, dated 05/15/15 and 05/20/15, revealed they were complete with criminal checks, nurse aide abuse registry, OIG checks, and reference checks.

16. Review of the facility abuse allegation investigations, revealed complete investigations and five day follow up. Interview with the RDCS, on 05/22/15 at 12:07 PM, revealed allegations were reviewed for investigation and follow up.

17. Review of a QAPI sign in sheet, dated 05/13/15, revealed review of the P&P for abuse with no changes made. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, ADCS, UM, Staffing Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS had all been trained on abuse, and staff trained on abuse.

18. Review of facility investigations , dated 04/21/15 through 04/24/15, 04/26/15 through 04/29/15, 05/01/15, 05/04/15, 05/06/15, 05/09/15, 05/11/15, revealed incidents were reviewed by the RDCS for regulatory compliance and timeliness with no issues identified. Review of the investigations audit for the last thirty (30) days, dated 05/14/15, revealed the investigations were reviewed for timely reporting, investigation, and resolution. Interview with the RDCS, on 05/22/15 at 12:07 PM, revealed she completed the review of investigations with no concerns.

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F 490	Continued From page 591 19. Review of the sign in sheet and agenda for QAPI meeting, dated 05/15/15, revealed monitoring of abuse and neglect reporting: resident interviews, dated 05/12/15, 05/13/15, 05/15/15, 05/16/15, 05/18/15, 05/19/15, would be completed for five (5) residents five (5) times weekly; skin sweeps, dated 05/08/15, 05/12/15, 05/13/15, and would be conducted for five (5) residents five (5) times a week; beginning 05/15/15 resident and family concerns would be reviewed five (5) times weekly; beginning 05/12/15 and on 05/15/15, 05/18/15, 05/19/15, 05/20/15, daily meeting would discuss new resident injuries or concerns five (5) times weekly; and use of an abuse audit tool for abuse reporting beginning on 05/15/15. Observation of the daily meeting, on 05/22/15 at 9:05 AM, revealed specific residents were discussed in regard to specific resident concerns. Interview with the DCS, on 05/22/15 at 2:52 PM, revealed residents were discussed in the morning meeting for specific concerns and plan. 20. Review of current residents were assessed for behaviors by the Corporate Administrative Registered Nurses/Interdisciplinary Team, on 05/12/15 and 05/13/15, revealed sixty-four (64) residents with behaviors had their care plans reviewed, with nineteen (19) care plans updated. One (1) resident was placed on 1:1 supervision, on 05/13/15. Interview with the RDCS, on 05/22/15, revealed sixty-four (64) residents were reviewed, and nineteen (19) actually had care plan interventions updated. 21. Record review of in-services conducted 05/13/15 and 05/14/15 revealed one hundred one (101) staff were educated by Corporate Administrative Registered Nurses on bathing, AM	F 490		

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care, shaving, hair care, change in condition, notifications to physician and RP, assessments, linens and laundry, falls, behaviors, abuse, resident smoking and use of aprons. Observation on the IDT in daily morning meeting, on 05/22/15 at 9:05 AM, revealed specific residents and behaviors, the 24 hour report, with department heads noted an new orders or changes to the care plans.

22. Review of a QAPI sign in sheet, dated 05/13/15, and agenda revealed the P&P for care plans and behavior management were discussed with no changes made. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Staff Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS attended the QA meetings.

23. Review of audit tools revealed residents with new falls and behaviors were reviewed by the Interdisciplinary Team in the daily meeting for completion of the documentation, notifications, care plans and Kardexes. Observation, on 05/22/15 at 9:05 AM, of the IDT morning meeting revealed specific resident concerns were reviewed, 24 hour report and behaviors were discussed, and care plans reviewed. Interview, on 05/22/15 at 2:52 PM, with the DCS revealed facility audits were reviewed in the daily meeting and any concerns discussed.

24. Review of the weekly falls meeting and behavior management meeting with the IDT, beginning 05/12/15, revealed meetings were conducted. Observation of the daily IDT meeting, on 05/22/15 at 9:05 AM, revealed the 24 hour report was discussed. Interview with the DCS, on 05/22/15 at 2:52 PM, revealed resident behaviors

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were reviewed in the behavior management meeting.

25. Review of the sign in sheet for an Ad-Hoc QAPI meeting, dated 05/15/15, and audit tools revealed abuse and neglect reporting was monitored by the QA.

26. Review of weekly behavior meeting notes, dated 05/12/15 and 05/13/15, revealed six (6) residents with resident to resident behaviors or sexual/physical behaviors were reviewed for documentation, care plan interventions. Interview with the DCS, on 05/22/15 at 2:52 PM, revealed the behavior meeting reviewed and monitored residents with behaviors, notifications, interventions were in place, and possibility for more frequent monitoring.

27. Record review of in-services conducted on 05/13/15 and 05/14/15 revealed education provided for skin assessments, resident weights. Interview with CNA #7, on 05/22/15 at 8:05 AM, with RN #1, on 05/22/15 at 8:13 AM, with LPN #1, on 05/22/15 at 8:25 AM, with CNA #8, on 05/22/15 at 8:37 AM, revealed they had been trained on resident weights and skin assessments. Observation, on 05/22/15 at 3:30 PM, revealed Resident #34 skin assessment was performed by Registered Nurse #11 and no new skin issues were identified and the documentation was completed as required.

28. Observation of the morning meeting, on 05/22/15 at 9:05 AM, revealed the IDT reviewed the 24 hour report, care plans, and specific resident concerns.

29. Review of facility assessments, dated

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F 490	Continued From page 594 04/30/15, revealed one hundred twenty-four (124) residents were assessed for transfer/lift with Kardexes and care plans updated. Observation, on 05/22/15 at 2:20 PM, revealed no concerns with a broken shower bed in the 100 Unit shower room and lifts were functional. 30. Review of resident Safe Smoking Evaluations for fifteen (15) residents and completed by the SSD, on 05/13/15, revealed three (3) residents were identified to need a smoking apron. Review of the therapy screening tool revealed, and two (2) residents were referred to therapy. Observation, on 05/22/15 at 4:53 PM, revealed one (1) resident was smoking, used an apron, and staff assisted the resident to smoke. Interview with the DSS, on 05/22/15 at 2:52 PM, revealed she completed the resident smoking assessments and if the resident needed an apron. 31. Observation of the resident smoking area, on 05/22/15 at 4:53 PM, revealed eight (8) aprons hanging near the door, one (1) resident smoking with staff assistance, and wearing an apron. Observation of the smoking box on the 200 Unit, on 05/22/15 at 4:57 PM, revealed boxes of cigarettes for all residents of the facility; a list of residents who smoked and who required an apron. Interview with CNA #2, on 05/22/15 at 4:57 PM, revealed Central Supply and a staff from the 200 Unit cover the smoking times during the day; resident cigarettes and lighters should be kept in the smoking box which was kept locked in the medication room. 32. Review of rounding sheets, dated 05/12/15, revealed maintenance and environmental concerns were audited by Executive Director and	F 490		

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F 490	Continued From page 595 Maintenance Director. Review of rounds completed by the ED and Maintenance Director, on 05/13/15, revealed maintenance books on each unit were reviewed for any maintenance issues, with concerns addressed on 05/13/15 and 05/14/15. Interview with the Maintenance Director, on 05/22/15 at 2:52 PM, revealed any maintenance issues should be listed in the maintenance book at each nurse's station, which he will take to the morning meeting, and discuss what had been addressed on the maintenance concerns. 33. Review of in-service records, dated 05/13/15 and 05/14/15, revealed staff were educated on showers and beds. Interview, on 05/22/15 at 3:20 PM, with CNA #5 revealed she was educated not to use broken equipment or shower beds and to report to supervisor and maintenance if equipment/shower bed was broken. 34. Review of a QAPI sign in sheet, dated 05/15/15, audit tools, and agenda revealed monitoring of falls, smoking, assistive devices, lifts, shower beds, and maintenance occurred. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, Housekeeping Supervisor, and DSS revealed they attended the QA meetings. 35. Review of facility rounding sheets, dated 05/12/15, revealed the environment was observed, by Corporate Administrative Registered Nurses for maintenance needs. Observation of the morning meeting, on 05/22/15 at 9:05 AM, revealed the maintenance books were taken to the IDT meeting and reviewed. Interview with the Maintenance Director, on 05/22/15 at 2:52 PM,	F 490		

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F 490	Continued From page 596 revealed he would take the maintenance books to the morning meetings. 36. Review of staff training records, beginning 05/13/15, revealed five (5) staff were trained with return demonstration for transfers. Review of the smoking list revealed residents who smoked were listed, with resident who required an apron and/or supervised smoking were identified. Review of rounding sheets, beginning 05/13/15, revealed resident rooms were searched for incendiary smoking items by the Executive Director. Observation of the facility's smoking box on the 200 unit, on 05/22/15 at 4:57 PM, revealed cigarettes were stored for the entire facility, and contained a list of residents who smoked, with those who required an apron identified. Interview with CNA #2, on 05/22/15 at 4:57 PM, revealed the box should be locked in the med room and the box had the cigarettes and lighters for all residents who smoked in the facility. 37. Review of the facility's audit tool revealed, beginning 05/12/15, residents were observed to ensure fall interventions were in place per the care plan. Interview with the DCS, ADCS, UM, Medical Records, BOM, and DSS, on 05/22/15 at 2:52 PM, revealed audits were conducted every morning and looked for falls interventions compared to the care plan and discussed in morning meeting. 38. Record review of resident call light audit, dated 05/12/15, revealed Residents #7, #5, #12, Unsampled Resident Z and AA call lights were checked for function, with Resident #12's call light was found to not light at the desk or the door. 39. Record review of call light audits, completed	F 490		

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F 490	Continued From page 597 on 05/12/15, found one hundred twenty-four (124) resident call lights were checked for functionality, with twenty-two (22) rooms found that call lights did not light at the desk, one (1) room did not light at the desk or the door, and two (2) rooms did not light at the desk, the door, or sound. Six (6) residents in the three (3) rooms that call lights did not work, were placed on fifteen (15) minute checks and given a hand bell. Record review of the call light work order, dated 05/13/15, revealed the call lights for the six (6) residents were repaired by an outside contractor on 05/13/15 and another call light was repaired on 05/14/15 that would not turn off; the annunciator on the 200 Unit was repaired at the nurse's desk on 05/15/15. Observation, on 05/22/15 at 2:03 PM, of room 18 revealed the call light functional at the door, desk and sounding. Observation, on 05/22/15 at 2:15 PM, on the 200 Unit of two (2) nurse's stations revealed each desk had a new call light system installed on the wall behind the desk. Interview with the RDCS, on 05/22/15 at 12:07 PM and 05/22/15 at 3:42 PM, revealed call lights were repaired on 05/13/15 and 05/14/15, and the 200 Unit annunciators were repaired, and then moved to the wall behind each nurse's station. The six (6) residents were given hand bells on 05/13/15 and placed on fifteen (15) minute safety checks. Review of fifteen (15) minute check sheets revealed residents were checked on every fifteen minutes until call light was repaired. Interview with DCS on 05/22/15 at 5:30 PM, revealed she had call bells purchased and given to residents. 40. Review of in-service training records, dated 05/09/15 through 05/12/15, revealed twelve (12) nursing staff working the 11:00 PM through 7:00 AM shift on 05/12/15 were re-educated on	F 490		

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F 490	Continued From page 598 05/13/15 on what to do if the call lights were inoperable and the six (6) residents identified with inoperable call lights were placed on fifteen (15) minute checks. Interview, on 05/22/15 at 3:42 PM, with the RDCS revealed staff working on 05/12/15 and 05/13/15 were educated on the call lights not working for the six (6) residents and conduct fifteen (15) minute safety checks and were provided hand bells. Observation on 05/21/15 at 11:10 AM, revealed a hand bell was rung and the Medical Records Coordinator answered the hand bell immediately upon hearing it ring. 41. Record review of in-services conducted 05/13/15 and 05/14/15 revealed 101 of 149 staff were educated on providing call lights and what to do if not working, and answering call lights timely. Interview, on 05/22/15 at 8:05 AM, with CNA #7, on 05/22/15 at 8:13 AM with RN #1, on 05/22/15 at 8:25 AM with LPN #1, revealed they had been trained on call lights and knew what to do if a resident's call light did not work. Interview, on 05/22/15 at 2:52 PM, with the DCS, ADCS, UM, Medical Records, and Staffing Coordinator revealed staff were trained on call lights, answering call lights, and what to do if call lights were not functioning. Observation, on 05/22/15 at 1:58 PM, of room 106 revealed the call light was functional at the door, at the desk, and sounded. 42. Review of the pest control company invoice, dated 05/13/15 and 05/14/15 revealed services were provided to the interior and exterior of the facility. Review of the pest control contract revealed services would be provided to the facility monthly and as needed. Interview with the Maintenance Director, on 05/22/15 at 2:52 PM, revealed the new pest control company had	F 490		

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F 490	Continued From page 599 begun services inside and outside of the facility. Observation of the Sub acute 1 nurse's station, on 05/22/15 at 2:03 PM, revealed the maintenance book also contained the pest sightings book. Observation of Sub acute 2 nurse's station, on 05/22/15 at 2:07 PM, revealed the maintenance book also included the pest sightings log. Observation of room 215, on 05/22/15 at 2:09 PM, revealed no pests were seen. Observation of the 100 Unit nutrition room, on 05/22/15 2:20 PM, revealed no pests were seen. Observation, on 05/22/15 at 5:20 PM, of the kitchen revealed no pests were seen. Interview with the Dietary Director, on 05/22/15 at 2:52 PM, revealed the kitchen did not currently have pests. 43. Review of facility rounding sheets, dated 05/12/15, revealed no pests were observed. One hundred twenty-one (121) residents were assessed via skin sweeps on 05/12/15 and 05/13/15 with no pest bites evident, and no pests documented in resident beds or rooms. Interview with the DCS, ADCS, UM, MDS Director, on 05/22/15 at 2:52 PM, revealed residents were assessed via skin sweeps, and no concerns. Interview with Resident #24 on 05/22/15 at 4:30 PM, revealed no pests were in his/her room. 44. Review of rounding records, dated 05/14/15 through 05/21/15, revealed no concerns identified with pests. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, Central Supply, and DSS revealed daily rounds occurred with no concerns of pests. Interview with Resident #8 on 05/22/15 at 2:00 PM, revealed no pests were in his/her room. 45. Review of the Ad-Hoc sign in sheet, dated	F 490		

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F 490	Continued From page 600 05/15/15, and agenda, and audit tools revealed monitoring of the facility's pest control would be completed by the QA. Review of rounding records, dated 05/14/15 through 05/21/15, revealed no live pests were seen. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, Central Supply, and DSS revealed daily rounds occurred with no concerns of pests. 46. Review of rounding sheets, dated 05/12/15 and 05/13/15, revealed the ED and Housekeeping Supervisor observed the facility for cleanliness. Interview with the Housekeeping Supervisor, on 05/22/15 at 2:52 PM, revealed he conducted rounds for cleanliness of the facility, including linens, resident rooms, shower rooms, trash, webs and pests, and privacy curtains. Interview with Resident #10 on 05/22/15 at 12:30 PM, revealed no concerns with linens. 47. Review of in-service records, dated 05/13/15, revealed Administrative staff were trained on staffing, pest control, housekeeping and maintenance, and would be monitored by the ED. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS revealed they had been trained on staffing, pest control, housekeeping and maintenance, and any concerns of audits would be taken to the morning meeting. Interview with Resident #3 on 05/22/15 at 1:00 PM, revealed staffing had improved and were answering lights timely and the facility looked cleaner. 48. Review of audits for employee files revealed they were audited twice per week by the	F 490		

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F 490	Continued From page 601 Executive Director/RDHR/RVPO/RDCS or Corporate Administrative Nurse. 49. Observation of the daily morning meeting, on 05/22/15 at 9:05 AM, revealed review of the 24 hour report, notifications made and documented, new physician orders, maintenance concerns and books, pests, rounds and audits, call lights, care plans. Interview with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, MDS Coordinator, and DSS, on 05/22/15 at 2:52 PM, revealed they participate in the morning meeting and review the 24 hour report, notifications were made, maintenance books reviewed, physician orders, call lights, care plans, and audits/ round were reviewed in the morning meeting. 50. Interview, on 05/22/15 at 2:52 PM, with the DCS revealed facility concerns were reviewed in the morning meeting, including audits and rounding results, for department heads to address. She stated she (the DCS) or the ED would initial when concerns were resolved. Observation, on 05/22/15 at 9:05 AM, of the morning meeting revealed the DCS provided direction and asked clarifying questions related to information discussed with follow up items determined. 51. Review of sign in sheets, dated 04/22/15, 05/13/15, and 05/15/15, revealed QAPI meetings were held on those dates. Interview, with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS revealed they attended the QAPI meetings. Interview with the RDCS, on 05/22/15 at 5:05 PM, revealed the next QAPI meeting was scheduled for 06/17/15. Interview with the	F 490		

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F 490	Continued From page 602 Medical Director, on 05/22/15 at 8:00 AM, revealed he was informed by the Executive Director of the resident care issues, attended the QA meetings held by the facility and provided direction regarding corrective action plans that were developed to meet the needs of the residents. 52. Review of the QAPI sign in sheet, dated 05/15/15, and agenda revealed audit tools were approved for QA monitoring and discussed: resident interviews; resident/family concerns; morning meeting; new employee files; falls or behaviors reviewed; care plans and Kardexes update; review of the 24 hour report; notifications; maintenance rounds and book; supervised smoking; falls interventions in place; call lights; weekly falls; and, behavior management meetings. 53. Review of facility linen rounds, dated 05/13/15, revealed resident laundry available for use and linen PAR levels were observed. Observation, on 05/22/15 at 2:05 PM, of the linen closet on Journey Home 1 revealed adequate numbers of linens, wash cloths and towels, pillows, and gowns. Observation of the linen closet on the 200 Unit, on 05/22/15 at 2:15 PM, revealed adequate linens, gowns, towels, washcloths, pillows, blankets and clothing protectors. Interview with the Housekeeping Supervisor, on 05/22/15 at 2:52 PM, revealed he completed rounds three (3) times a day and checked the linen closets for adequate supplies. Observation, on 05/22/15 at 2:00 PM, revealed Resident #4's linens on the bed were clean, neat and were not torn, tattered or frayed. 54. Review of the sign in sheet for QAPI, dated	F 490		

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F 490	Continued From page 603 05/13/15, revealed the ED and DCS presented and reviewed falls, changes in condition, staffing, housekeeping, and laundry, and pest control, and would provide daily oversight. 55. Review of grievance audit, dated 05/13/15, revealed grievances were reviewed since 05/01/15 and resolved by 05/15/15. Interviews on 05/22/15 with Resident #3 at 2:10 PM, Resident #8 at 2:00 PM, and Resident #10 at 12:30 PM, revealed the issues and concerns they had regarding linens, pests, environment repairs and answering call lights were resolved. 56. Review of rounds , dated 05/12/15, revealed Resident #39 was groomed and had clean linens. 57. Review of the facility rounds, dated 05/12/15, revealed residents were observed to identify residents grooming, incontinent care, bed linens, pests, call lights in reach, and privacy curtains in place. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Staffing Coordinator, BOM, Central Supply, Housekeeping Supervisor, and DSS revealed daily rounds were completed to identify resident grooming needs and care, linens, pests, call lights in reach, and privacy curtains in place. Interviews with Resident #3, #8 and #10 on 05/22/15, revealed the issues and concerns they had regarding linens, pests, environment repairs and answering call lights had improved. 58. Review of in-service records, dated 05/13/15 and 05/14/15, revealed nursing staff and ten (10) agency staff were educated on incontinent care, bathing, shaving, and hair care. Interview, on 05/22/15 at 2:52 PM, with the DCS, ADCS, UM,	F 490		

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and Staffing Coordinator revealed staff were trained on grooming, incontinent care, shaving, and bathing. Interview with CNA #31, on 05/22/15 at 8:10 AM, revealed she received training on incontinent care, bathing, shaving, hair care, reporting pest, broken equipment, fall prevention, lifts, reporting change in condition, and answering call lights, abuse, resident laundry and linens.

59. Review of in-service records, dated 05/13/15 and 05/14/15, revealed one hundred one (101) staff and ten (10) agency staff were educated on privacy curtains; using the pest sightings book; resident privacy. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, Staffing Coordinator, Central Supply and Housekeeping Supervisor revealed they were trained on privacy curtains, resident privacy, and pests. Interview with Housekeeper #1, on 05/22/15 at 8:20 AM, revealed she received training on cleaning resident rooms, privacy curtains, reporting pests and broken equipment. Interview with Registered Nurse #11, on 05/22/15 at 8:10 AM, revealed she was educated on abuse, falls, physician orders, dignity, grievances, infection control, call lights, and reporting pests and maintenance issues.

60. Review of QAPI sign in sheet, dated 05/13/15, revealed incontinent care, resident privacy, shaving and AM care P&P were reviewed. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Staffing Coordinator, MDS Director, Housekeeping Supervisor, and DSS attended the QA meetings.

61. Review of rounding sheets revealed residents were observed by staff to identify any issues with grooming, incontinent care, privacy, shaving and

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F 490	Continued From page 605 AM care. Interview, on 05/22/15 at 2:52 PM with the DCS, ADCS, UM, Staffing Coordinator, Medical Records, BOM, MDS Director, Central Supply, Housekeeping Supervisor, and DSS revealed they conducted rounds to assess residents grooming, privacy, shaved, and care. 62. Review of a QAPI sign in sheet, dated 05/15/15, revealed residents would be observed to ensure they were shaved, hair combed, incontinent care, privacy curtains and bed linens in place and clean, residents and environment free from pests, resident privacy, and call lights. On 05/22/15 at 2:52 PM, interview with the Maintenance Director, DCS, ADCS, UM, Staffing Coordinator, MDS Director, Housekeeping Supervisor, and DSS attended the QA meetings. Interview with Resident #8, on 05/22/15 at 4:20 PM, Resident #6, on 05/05/15 at 2:26 PM, Resident #24, on 05/22/15 at 8:07 AM, revealed the issues they had with not getting shaved, hair washed and combed, incontinent care provided, bed linens without tears, an environment free from pests, and call lights answered timely had improved. Observation of Resident #43, on 05/22/15 at 8:00 AM, revealed two staff were using a lift to transfer the resident into a wheelchair and then proceeded to shave the resident.	F 490		
F 493 SS=L	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is	F 493		

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F 493	Continued From page 606 licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's policies, it was determined the Governing Body failed to assure the facility was administered in a manner to implement policy and procedures to meet the needs of the residents and environment; failed to ensure adequate staffing was available at all times to provide residents with basic care and services to maintain their pyschosocial wellbeing and promote the health and safety of each resident. The facility failed to have a Governing Body who was legally responsible for establishing and implementing policies and procedures regarding the dat-to-day managment and operation of the facility; and the governing body failed to monitor the facility operations to ensure residents were clean, safe and free of bodily pests. (Refer to F157, F225, F226, F241, F280, F282, F254, F309, F323, F353, F463, F469, F490, F514 and F520) Immediate Jeopardy was identified on 04/22/15 and determined to exist on 02/25/15. On 02/25/15 at approximately 12:30 AM, Resident #4 was found on the floor by a Certified Nursing Assistant (CNA) while performing rounds. Interview and record review revealed no documented evidence the resident's physician was notified at the time of the fall, there was no documented evidence the resident was assessed and monitored after the fall, and there was no evidence interventions were implemented to	F 493		

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F 493	Continued From page 607 prevent recurrence. An x-ray was obtained at 4:30 PM (16 hours after the incident) and the resident was diagnosed with a right tibia fracture. Immediate Jeopardy was identified on 04/21/15 and determined to exist on 04/19/15. Observations revealed ants in the facility. Observation and interview with Resident #24 on 04/21/15 revealed ants in the resident's room. Interview with Resident #24 revealed on 04/19/15 ants were in the bed and crawling all over his/her body. The resident was scared and had to scream out for staff to help him/her. Immediate Jeopardy was identified on 05/12/15 and determined to exist on 03/25/15. Record review and interview revealed on 03/25/15 during the 7:00 AM-3:00 PM shift, Registered Nurse (RN) #6 noted Resident #25's right eye was swollen and bruised on the side with a small cut. The resident had a history of wandering into other resident rooms, both male and female. Interview and record review revealed the resident's eye injury was not assessed or monitored. There was no documented assessment of the injury until 04/24/15, thirty (30) days after the bruising was identified. The facility could not provide any evidence the physician or responsible party were notified or that the incident was reported or investigated until 04/28/15 (thirty-four [34]days after the incident) after surveyor intervention. Immediate Jeopardy was identified on 05/12/15 and determined to exist on 04/28/15. Observation, interview and record review revealed the facility failed to ensure the resident call system was functional for Residents #5, #7, #12 and Unsampled Residents M, T, Z, AA, CC, GG, HH, II, JJ, KK, and LL in order to notify staff	F 493		

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F 493	Continued From page 608 of their needs. The facility failed to provide the residents with an alternate means of notifying staff. Additionally, the call system panel located at the nursing station had buttons missing and others that did not work. The facility's failure to have an identified governing body in place to assure the facility was administered in a manner that promoted, protected and enhanced the health and safety of each resident and provided assessed needs, along with building maintenance and pest control, has caused or is likely to cause serious injury, harm, impairment or death. An acceptable Allegation of Compliance (AOC) was received on 05/19/15 alleging the Immediate Jeopardy was removed on 05/16/15. The State Survey Agency validated the Immediate Jeopardy was removed on 05/16/15 as alleged, prior to exit on 05/22/15. The scope and severity was lowered to an F while the facility monitors the implementation of the Plan of Correction and the facility's Quality Assurance monitors the effectiveness of the systemic changes. The findings include: The facility did not provide a policy related to the Governing Body. Interview on 05/13/15 at 1:20 PM, with the Corporate Director of Clinical Services, revealed the facility had no policy in writing related to a Governing Body. Interview with the Interim Executive Director/ Regional Vice President of Operations (as of 04/20/15), on 05/13/15 at 11:30 AM, revealed the	F 493		

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facility's governing body consisted of the facility's Unit Managers and the Executive Director. She stated the Executive Director oversees the governing body.

Interview with the previous Executive Director (ED), on 04/23/15 at 8:35 AM, and on 05/11/15 at 8:18 AM, revealed she was aware of the facility's inability to meet the needs of the resident and this was directly related to the staffing shortage. Per intervieew, she had requested approval for the use of agency staff; however, she had not received approval as 04/17/15 and that was one of the reasons she put in her resignation on 04/17/15. Per interview, Management positions at the facility was not stable. She stated she had worked with six (6) Directors' of Clinical Services and the Corporation was utilizing Agency staff for this position. Interview further revealed she had made the Corporation aware of the facility's issues; however, nothing was done to resolve them.

Interview with the Interim Executive Director/ Regional Vice President of Operations (as of 04/17/15), on 05/21/15 at 8:25 AM, revealed she made routine rounds of the facility prior to assuming the role as Interim Director and was aware of the staffing shortage. However, she was not aware of the facility's pest infestation issues, call lights not working, or the other care issues identified and the environmental repairs that needed to take place.

The facility took the following actions to remove the Immediate Jeopardy on 05/16/15 as follows:

1. The facility notified Resident #4's physician, of

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F 493	Continued From page 610 a fall that occurred on 02/25/15 with new orders given to the nurse. The resident transferred to a local hospital on 02/25/15 for a tibia fracture and returned to the facility on 02/28/15 with new orders. The DCS assessed Resident #4 on 04/22/15 and was found in stable condition. 2. On 04/22/15, one hundred twenty-six (126) residents were assessed by the ADCS, Nurse Manager, and Licensed Nurse to determine if any residents had an incident or accident or change in condition that would warrant physician notification and further intervention. One (1) resident was identified as having an incident, accident, or change of condition and the physician was notified by the nurse on 04/22/15. Additionally, the Nurse notified the RP and documented this in the clinical record. Nurses would additionally report incidents, accidents, or changes in condition to the clinical administrative team. 3. On 04/22/15 the Corporate Administrative Nurses educated twenty-three (23) of thirty-eight (38) Nurses regarding timely notification to the physician related to resident incidents, accidents, or change in condition; care plan policies, evidence of assessments and care planning with immediate falls preventions interventions to meet the resident's needs; and falls procedures, immediate assessment by the Nurse after a resident's fall, notifications to the physician and RP, implementation of an immediate intervention by the Nurse, documentation of the fall in the clinical record by the Nurse, fall root cause investigation report initiated by the Nurse and reviewed by the DCS, and follow up by the IDT in the weekly falls meeting. Nurses were also trained related to reporting an incident, accident,	F 493		

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F 493	Continued From page 611 or change in condition, to the resident ' s RP and documentation in the medical record to include the incident, accident, or change in condition, notifications to the physician, RP, and clinical administrative team, nurse's assessment, and interventions; evidence of assessment would include Situation, Background, Appearance, and Review (SBAR) sheet, Interdisciplinary Progress Note, and Neurological (neuro) checks sheet, and documentation of falls. Staff competencies were completed. Nursing staff not educated by midnight on 04/22/15 would not be allowed to work until they received training. Agency Nurses would be trained by the Corporate Administrative Nurses, DCS, Assistant DCS, or Nurse Manager prior to working their next shift. The DCS and ED would ensure staff that had not been educated were educated prior to working their next shift. The ED and DCS would monitor the daily schedule and highlight staff already trained. A department manager would stand by the time clock at shift change to direct staff that needed education to the training. The IDT would monitor daily incidents and accidents. Notifications of accidents, incidents, or changes of condition would be reviewed for completion by the DCS, ADCS, or Nurse Manager, who would make notifications if not done. 4. An Ad-Hoc Quality Assurance/ Performance Improvement (QAPI) meeting was conducted on 04/22/15 to discuss facility policy and procedure (P&P) for falls, and notifications of incidents, accidents, or changes of condition; care plans as related to immediate falls interventions and revision status post fall, nursing assessment and documentation for falls; with no changes made. Also discussed the facility protocol related to shift relief and report; and additional avenues to attract	F 493		

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new staff and maintaining current staff with a plan for performance improvement.

5. On 04/22/15, 126 residents were reviewed for fall risk with a fall risk assessment completed by the DCS and MDS Nurses who had previously been educated on 04/22/15, and care plans and Kardexes were also reviewed, with seventy-four (74) residents whose fall care plans were updated on 04/22/15.

6. On 04/22/15 the Corporate Administrative Nurses educated the DCS, ADCS, and Nurse Manager regarding evidence of assessment and care planning, with immediate falls prevention interventions to meet the resident's needs. On 04/22/15, thirty (30) of fifty-eight (58) CNAs and two (2) Agency CNAs were educated to review the Kardex for specific fall risk information.

7. Certified Medication Technician's (CMT) would be supervised by the Nurse they work with on the unit. The current resident census was reviewed by the ED and DCS to determine which residents required total care, assistance, or were independent with care.

8. On 04/22/15, 126 residents were assessed by Nurses using a visual and/or verbal nursing assessment that included vital signs to ensure there were no current physical or emotional distress or needs that were not met as related to inadequate staffing. One (1) resident was identified in physical distress and the Nurse timely notified the physician.

9. On 04/22/15, The Corporate Administrative Nurses educated twenty-three (23) of thirty-eight (38) Nurses, thirty (30) of fifty-eight (58) CNAs,

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and two (2) Agency CNAs related to staffing, to notify the ED, DCS, or ADCS for any staff call outs. The ED, DCS, ADCS, or Scheduler would attempt to replace the staff member who called out by calling on facility staff to stay over or come into work. If staffing needs could not be met the ED, DCS, ADCS could mandate staff currently working. Staff were educated on waiting for their relief to arrive prior to leaving the facility, and to give shift report to oncoming staff, that would include resident status, falls that occurred, and any new interventions. Staff competencies were completed.

10. On 04/28/15, the facility reported to the SSA that Resident #25 was found to have a black eye on 03/25/15. The incident was investigated and with the assistance of the SSD and DCS the source of the black eye was determined as a result of a resident to resident altercation and abuse was unsubstantiated.

11. One hundred twenty-one (121) residents were assessed by a nurse for suspicious injuries on 05/12/15 and 05/13/15. No suspicious injuries were found.

12. Current residents with BIMS Scores of twelve (12) or higher were interviewed by the ED, on 05/12/15 and 05/13/15, about their safety.

13. Staff in Nursing, Dietary, Housekeeping and Laundry, and Therapy were interviewed by the ED/Assistant ED on 05/12/15, 05/13/15, and 05/14/15. Two (2) new allegations of abuse/neglect that required reporting to the SSA were reported on 05/14/15.

14. The Corporate Administrative RNs educated

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107 of 149 staff and fourteen (14) agency staff on abuse and neglect and injuries of unknown origin from 05/09/15 through 05/14/15 with competency. Forty-two (42) staff not educated as of 05/14/15 will not be allowed to work without having been educated prior to the start of their shift. Agency staff will be educated prior to working their next shift. Staff, through the use of a Performance Improvement tool, staff were aware of the types of abuse, injuries of unknown origin, and when and whom to report to. Forty- two (42) staff not educated as of 05/14/15

15. One hundred twelve (112) of 112 employee personnel files were reviewed by the Regional Director of HR (RDHR), facility HR, and BOM to ensure files were complete with criminal background checks, nurse aide abuse registry checks, and abuse training. The RDHR corrected discrepancies on 05/13/15. Ongoing reviews of five (5) new employee files would occur twice weekly.

16. The ED or DCS would review all allegations of abuse, complete the 24 hour report, investigation, and five (5) day report.

17. The QAPI Committee met on 05/13/15 and reviewed the Policy and Procedures (P&P) for abuse with no changes made.

18. The Regional Director of Clinical Services (RDCS) reviewed potential reportable events were completed on 04/21/15 through 04/24/15, 04/26/15 through 04/29/15, 05/01/15, 05/04/15, 05/06/15, 05/09/15, and on 05/11/15 with no issues identified. On 05/14/15 the RDCS reviewed abuse allegations and investigations for the last ninety (90) days for timely reporting,

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F 493	Continued From page 615 investigation, and resolution. 19. An Ad-Hoc QAPI Committee meeting on 05/15/15 discussed ongoing quality improvement monitoring for abuse and neglect reporting beginning 05/16/15 using an approved audit tool and included: a. Five (5) resident interviews on 05/12/15 and ongoing five (5) times weekly. b. Skins sweeps on 05/08/15, 05/12/15, 05/13/15 completed by a nurse and reviewed by RDCS, Corporate Administrative RNs, DCS, ADCS, or Nurse Manager for any suspicious injuries, of five (5) residents, five (5) times a week. c. Beginning 04/21/15 and ongoing the RDCS, RVPO, RDHR will review new allegations of abuse and neglect for timely reporting, investigation, and resolution once a week. d. On 05/15/15 and ongoing new resident and family concerns would be reviewed by the ED, RDCS, RCPO, RDHR, or Corporate Administrative RNs for resolution five (5) times a week. e. On 05/12/15 an ongoing Daily Department Head Meeting led by the ED and DCS would be attended by Corporate Administrative RN, RDCS, RVPO, or RDHR to ensure new resident injuries or concerns were discussed five (5) times weekly. 20. Current residents were reviewed for behaviors, on 05/12/15 and 05/13/15, by Corporate Administrative RNS and two (2) members of the IDT. Care plans were reviewed for sixty-six (66) residents with behaviors, with	F 493		

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F 493	Continued From page 616 twenty (20) care plans updated, with one (1) resident placed on 1:1 supervision. 21. 101 of 149 staff and 10 agency staff were educated regarding resident behaviors and documentation, care planning and following the care plan, reporting maintenance issues, safe smoking policy, on 05/13/15 and 05/14/15 by the Corporate Administrative RNs. IDT will meet to ensure behaviors were documented and care planned, notification to the physician, and document on the 24 hour report. Residents with behaviors would be reviewed during the weekly IDT meeting beginning 05/12/15. The 24 hour report would be reviewed in the morning meeting. Forty-eight (48) staff not educated will not be allowed to work until they have been trained. No staff will be allowed to work after 05/14/15 until they have been educated prior to the start of their shift. The ED or DCS would monitor the schedule and appoint a department manager to stand at the time clock to direct employees still needing education to the in-service. 22. QAPI meeting was held on 05/13/15 to review the P&P for care plans and behavior management, resident weights, skin assessments, ADLs, smoking, assistive devices related to lifts and shower bed, facility maintenance, pest control, housekeeping/ laundry, and staffing, falls, incidents/accidents, grievances, with no changes made. The facility's action plan for removal of the IJ was reviewed and tasks assigned, with department managers assigned to provide daily oversight along with the RDCS/ RVPO/ RDHC/ RCMC/Corporate Administrative RNs. 23. Beginning 05/15/15, residents with new falls	F 493		

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and behaviors were reviewed by the Daily IDT team for completion of SBAR, assessment, notification, immediate interventions, and investigation with root cause analysis. Care plans and Kardexes were reviewed/updated with appropriate interventions. No issues were identified, and would be validated five (5) times weekly.

24. Beginning 05/12/15 weekly falls management meeting and weekly behavior management meeting occurred with IDT, with no issues identified. The IDT in the daily meeting reviewed the 24 hour report with no issues identified, and validated one (1) time weekly.

25. An Ad-Hoc QAPI meeting held on 05/15/15 for ongoing QI monitoring of the facility process for abuse and neglect reporting is done, and call lights, beginning 05/16/15 using an approved audit tool. Any issues identified in audits were addressed and ongoing plans developed.

26. A weekly behavior meeting was held on 05/12/15 and 05/13/15 and discussed six (6) residents with resident to resident behaviors or sexual/ physical behaviors to ensure behaviors were documented, care planned, and interventions in place.

27. On 05/13/15 and 05/14/15 twenty-two (22) nurses were educated by the Corporate Administrative RNS to complete skin sweeps weekly and PRN, and complete residents' weights per physician order.

28. The IDT would review in the daily meeting incidents and accidents reports and the 24 hour report for investigation reports, nursing

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HURSTBOURNE CARE CENTRE AT STONY BROOK	2200 STONY BROOK DR LOUISVILLE, KY 40220

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F 493	Continued From page 618 documentation in the clinical record, an SBAR, notifications to the physician and RP, and care plans with appropriate interventions. 29. On 04/30/15, one hundred twenty-four (124) residents were reviewed for appropriate transfer/lift method and updated the care plans and Kardexes, including Residents #4 and #34. The shower bed was removed from the facility and discarded. A new shower bed was ordered on 05/07/15. A shower bed located in the shed was inspected and discarded by Maintenance on 05/13/15. 30. The SSD completed safe smoking evaluations on fifteen (15) residents who smoke, on 05/13/15, with three (3) identified to require a smoking apron and two (2) referred to therapy for adaptive smoking equipment. Residents who smoke were given a copy of the facility's safe smoking rules on 05/13/15 and 05/14/15. 31. Room rounds were conducted by the ED, on 05/13/15, for incendiary smoking items, with any items found removed and maintained in a locked box at the nurse's station for supervised smoking times by facility staff. A list of residents who smoke and who require supervision or aprons would be kept in the locked box with the Kardexes. 32. On 05/12/15 Corporate Administrative Nurses made walking rounds to identify any maintenance/resident safety concerns. Identified concerns were given to the ED and Maintenance Director for prioritization and repair. On 05/13/15 The ED and Maintenance Director made facility rounds and reviewed the maintenance books at the nurse's stations to identify safety concerns.	F 493		

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Safety concerns were addressed by the Maintenance Director on 05/13/15 and 05/14/15. The Maintenance Director was educated on 05/13/15 to check the maintenance books at each nurse's station five (5) times weekly and prioritize based on safety concerns.

33. Fifty-one (51) nursing staff and 10 agency staff were educated on 05/13/15 and 05/14/15 to observe shower beds for safety prior to use. If a shower bed was unsafe or non-functional, staff would immediately remove the equipment and notify maintenance.

34. QAPI monitoring, beginning 05/15/15 of the facility process for falls, smoking, assistive devices, lifts, shower beds, and facility maintenance.

35. Beginning 05/12/15 the IDT would round to observe for environment safety concerns in five (5) resident care areas and immediately addressed by maintenance, and validated five (5) times weekly. Maintenance books would be brought to the daily meeting to discuss concerns five (5) times weekly.

36. Beginning 05/13/15 training and return demonstration of five (5) nursing staff will be completed five (5) times weekly. Observations of five (5) residents during supervised smoking by a member of the IDT five (5) times weekly. Rounds of five (5) resident rooms for incendiary items by a member of the IDT would be completed five (5) times weekly. Any issues would be brought to the daily meeting.

37. Five (5) residents would be observed, beginning 05/12/15, to ensure fall interventions

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were in place per the care plan would be completed by IDT five (5) times weekly.

38. Resident call lights were checked for function on 05/12/15 for Resident #7, #5, #12, Unsampled Residents Z, and AA. Unsampled Resident M no longer resided in the facility. Resident #12's call light was found not to light at the desk or the door.

39. On 05/12/15, one hundred twenty-four (124) residents call lights were checked for function and twenty-two (22) rooms were found to not light at the desk, one (1) room did not light at the desk or door, and two (2) rooms did not light at the desk or door, or sound. The ED was notified of the three (3) resident rooms, on 05/13/15, that had call lights that did not work. All six (6) residents of the three (3) rooms were put on fifteen (15) minute safety checks. On 05/13/15 an outside contractor initiated maintenance to ensure functionality and made repairs on 05/13/15 with an additional room repaired on 05/14/15 of a call light that would not turn off. The annunciator system at the nurse's station on the 200 unit was repaired, on 05/14/15.

40. Twelve (12) nursing staff working 11:00 PM to 7:00 AM on 05/12/15 were educated on the call light P&P on 005/09/15 through 05/12/15 with competencies. The 11:00 PM to 7:00 AM staff working on 05/12/15 were re-educated on the facility's P&P for an inoperable call light system, on 05/13/15, and the six (6) residents were placed on fifteen (15) minute safety checks until the call lights were functional. Hand bells were also given to the six (6) residents on 05/13/15.

41. One hundred and one (101) of 149 staff were

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F 493	Continued From page 621 educated on 05/09/15 through 05/14/15 on the facility's call light P&P and what to do if there was an inoperable call light, and use the pest sightings book at the nurse's station. Forty-eight (48) staff not educated by 05/14/15 would not be allowed to work until they had been educated prior to the start of their shift. 42. On 05/11/15, pest control service evaluated the facility and rendered services on 05/13/15, with another visit on 05/14/15. Pest control would visit monthly and as needed. As of 05/15/15 live pests in the facility had been eliminated. 43. Walking rounds were conducted by Corporate Administrative Nurses, on 05/12/15, to look for pests, with none seen. One hundred twenty-one (121) residents were assessed by skin sweeps, with no pest bites evident. No pests were observed in resident beds or rooms. 44. Beginning 05/14/15 rounds were completed by IDT Monday through Friday with no pest issues identified. 45. An Ad-Hoc QAPI meeting, held on 05/14/15, related to QI monitoring of the facility's process for pest control would be completed by the ED/RVPO one (1) time monthly that pest control visits occurred monthly. Beginning 05/15/15 resident care areas would be checked to ensure there were no live pests five (5) times weekly. 46. On 05/12/15 and 05/13/15, housekeeping rounds were completed by the ED and Housekeeping Supervisor for facility cleanliness and odors, with areas needing cleaning were cleaned on 05/12/15 through 05/15/15.	F 493		

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F 493	Continued From page 622 47. On 05/13/15, Corporate Administrative RNs educated facility Administrative Staff on the regulations and P&P for staffing, pest control, housekeeping, and maintenance, with competencies completed. The ED would monitor the facility's process for notification, abuse, hiring, dignity, care plan revision, professional standards, assessments, behavior and falls management, incidents and accidents, smoking, call lights, pest control, and staffing. 48. New employee files would be reviewed by the ED or Corporate Administrative Nurses for completeness two (2) times weekly. 49. Review of the 24 hour report, incident/ accident reports, in the daily meeting with the IDT; documentation in the clinical record included notification to the physician and new orders, and to the RP; the IDT made rounds in five (5) resident care areas to observe for maintenance and safety concerns; observations of five (5) residents during supervised smoking by the IDT; room rounds for five (5) residents to search for incendiary items by a member of the IDT, maintenance concerns were written in the maintenance books and taken to the daily meeting and prioritized for repair; observations of five (5) residents to ensure falls interventions were in place per the care plan by the IDT; call lights checked in resident rooms and bathrooms to ensure lights and sound; five (5) staff educated what to do if call light inoperable; resident care areas checked for no live pests; were validated five (5) times weekly. 50. Daily oversight since 04/22/15 on all shifts to ensure residents were safe and the plan of care was followed to meet resident needs, by the ED/	F 493		

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F 493	Continued From page 623 DCS/ RVPO/RDCS/Corporate Administrative Nurses. 51. The IDT would meet at least monthly to discuss facility action plan and ensure tasks were completed for the removal of the IJ, and QA monitoring completed according to the AOC during the IJ period, validated by the ED/RVPO/RDCS/Corporate Administrative RNs. 52. Per the Ad-Hoc QAPI meeting, on 05/15/15, QI monitoring would be done utilizing approved audit tool with oversight by the ED, beginning 05/16/15, five (5) resident interview; new resident/ family concerns; daily department head meeting to ensure new resident injuries or concerns were discussed; five (5) new employee files reviewed two (2) times weekly; residents with new falls or behaviors were reviewed in the daily meeting with IDT and care plans/ Kardexes reviewed and updated; review of the 24 hour report and the incident and accident reports in the daily meeting with IDT; review of the clinical record for timely notifications to the physician and RP; the IDT rounds in five (5) resident care areas to observe the environment for safety and maintenance concerns; observations of five (5) residents during supervised smoking; room rounds of five (5) residents for incendiary items; maintenance concerns listed in the maintenance book and taken to the daily meeting to discuss and prioritize repairs; observations of five (5) residents to ensure falls interventions were in place per the care plan by the IDT; five (5) resident rooms call lights checked to ensure they light at the door, nurse's station, and sound; five (5) staff education what to do if a call light was inoperable; five (5) times weekly; weekly falls and behavior management meetings occur with IDT one (1)	F 493		

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F 493	Continued From page 624 time weekly. 53. Linen rounds were completed, on 05/13/15, by the ED/ Housekeeping Supervisor/Department Managers to ensure PAR levels and available resident laundry, with areas of concern addressed by the Housekeeping Supervisor at that time. 54. The RVPO/RDCS/Corporate Administrative RNs would provide daily oversight of the ED and DCS in areas of falls, incidents, accidents, change in condition, sufficient staffing to meet resident needs, housekeeping and laundry, and pest control during the IJ period until removal. 55. Grievances were reviewed, on 05/13/15, by the ED/SSD/DCS back to 05/1/15 for any areas requiring additional follow up, which was handled by 05/15/15. 56. Resident #39's hair was washed and combed, shaved and care provided, sheets changed, privacy curtain provided. 57. On 05/12/15 rounds were completed by the DCS/ADCS/ Nurse Managers, and Corporate Administrative Nurses to identify residents who needed additional grooming or incontinent care; bed linens checked to ensure they were clean and pest free; call lights checked to ensure they were within resident reach and answered timely; resident's skin observed to ensure free from pests; and privacy curtains in place. Additional grooming was provided to residents requiring it, and one (1) resident room was identified to need a privacy curtain on 05/13/15. 58. On 05/13/15 and 05/14/15, nursing staff and	F 493		

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F 493	Continued From page 625 ten (10) agency staff were educated on incontinent care, bathing, shaving, washing resident's hair, with those not trained would not allowed to work until trained prior to the start of their shift. 59. On 05/13/15 and 05/14/15, 101 of 149 staff and ten (10) agency staff were educated to notify housekeeping when privacy curtains were needed; report pest sightings in the pest sightings book; any pests noticed on residents should be reported immediately to the nurse supervisor/DCS/ADCS for completion of a skin assessment; resident privacy. Forty-eight (48) staff not educated will be trained prior to working their next scheduled shift. 60. A QAPI meeting was held, on 05/13/15, to discuss the facility's P&P for incontinent care, resident privacy, shaving, AM care, with no changes made. 61. Daily rounds were conducted by department managers and corporate administration Monday through Friday to identify any issues with resident incontinent care, privacy, shaving and AM care, with any issues identified discussed in the daily IDT meeting and resolved with further Ad-Hoc education. 62. An Ad-Hoc QAPI meeting, on 05/15/15, discussed QI monitoring would be completed beginning 05/16/15 for: beginning 05/12/15 observations of five (5) residents to ensure they were shaven, hair combed, provided incontinent care, privacy curtains were clean, bed linens were clean, rooms/bed/residents were free from pests, privacy provided for care, call lights in reach and answered timely, would be conducted five (5)	F 493		

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times weekly.

The State Survey Agency validated the removal of Immediate Jeopardy on 05/22/15 as follows:

1. Review of the facility's SBAR's, incident report, neuro checks, progress notes and physician orders, all dated 02/25/15, revealed Resident #4 had a fall on 02/25/15, the physician was notified on 02/25/15 with new orders received. The resident was transferred to a local hospital on 02/25/15 for a tibia fracture on 02/25/15, and returned to the facility on 02/28/15 with new orders. The DCS assessed Resident #4 on 04/22/15 and found the resident was stable.

2. Review of one hundred twenty-six (126) resident assessments, completed by ADCS/Nurse Manager/Licensed Nurse, on 04/22/15, revealed residents were assessed for any incident or accident, or change in condition that warranted notification to the physician. One (1) resident was identified as experienced a change in condition, accident, or incident and the physician was notified on 04/22/15.

3. Review of in-service records, revealed twenty-three (23) nurses were educated by Corporate Administrative Registered Nurses regarding: timely notification to the physician related to incidents, accidents, and changes in condition; care plan policies; resident assessments, including SBAR, neuro checks; falls and immediate interventions; notification to the physician and RP; documentation of the fall in the clinical record; fall root cause investigation report. Staff competencies were completed. No staff had worked prior to them receiving the training. Review of staffing schedules revealed

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staff who had not yet been trained were not highlighted, which noted they required education. Review of facility records revealed notifications of incidents, accidents, and changes in condition were reviewed for completion by the DCS/ADCS/ Nurse Manager. Interview with the DCSand RDCS, on 05/04/15 at 4:18 PM, revealed twenty-three (23) nurses had been trained. Interview with RN #8, on 05/04/15 at 4:33 PM, with CNA #11, on 05/05/15 at 9:51 AM, with the UM, on 05/05/15 at 9:55 AM, CNA #14, on 05/05/15 at 10:03 AM, CNA #13, on 05/05/15 at 10:10 AM, revealed they had been educated on falls, notifications, Kardex and care plans. Interview, on 05/05/15 at 2:00 PM, with the DCS, ADCS, Nurse Manager, ED, Admissions Coordinator, DSS, MDS Director revealed they had all been trained on care plans, changes in condition, staff look at interventions for residents, the 24 hour report, falls, SBAR, incident reports, Kardex and care plans, notifications to the physician and family.

4. Review of a QAPI sign in sheet, dated 04/22/15, and agenda revealed the committee discussed the P&P for falls management, notifications of incidents, care plans, falls interventions, nursing assessments, shift to shift relief and report, with no changes made. Interview with the DCS, ADCS, Nurse Manager, ED, Admission Coordinator, DSS, MDS Director, on 05/05/15 at 2:00 PM, revealed QA would track and trend falls information to validate interventions and notifications were being completed.

5. Review of resident assessments for risk for falls, dated 04/22/15, for one hundred twenty-six (126) residents revealed seventy-four (74)

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F 493	Continued From page 628 residents were assessed by the ADCS as at risk for falls. Review of the Kardexes and Care Plans for the seventy-four (74) residents assessed at risk for falls revealed the Kardexes and care plans had been updated, on 04/22/15. Observation of room 107-A, on 05/05/15 at 1:26 PM, revealed the resident had falls interventions in place. Observation, on 05/05/15 at 1:30 PM, of room 112-A, revealed the resident's falls interventions were in place. Observation, on 05/05/15 at 1:30 PM, of Unsampled Resident Y revealed the resident had falls interventions in place. Observation of Unsampled Resident O, on 05/05/15 at 2:52 PM, revealed the resident's falls interventions were in place. 6. Review of training records, dated 04/22/15, revealed thirty (30) CNAs and two (2) agency staff were educated on the Kardex and falls risk. The Corporate Administrative RNs educated the DCS/ADCS/Nurse Manager, on 04/22/15, regarding assessments, care plans, documentation of falls, and immediate falls interventions. Interview with CNA #6, on 05/05/15 at 10:12 AM, revealed he received training on the Kardex, falls, and notify the nurse if a resident had a change in condition. 7. Review of staff schedules revealed CMTs were scheduled to work with another nurse present on the unit. Review of a resident census revealed, on 04/22/15, the ED and DCS reviewed which residents required total care, assistance, or were independent with care. Observation, on 05/05/15 at 10:15 AM, revealed CMT/ CNA #11 on the 200 unit was supervised by LPN #1. 8. Review of assessments for one hundred twenty-six (126) residents, dated 04/22/15,	F 493		

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F 493	Continued From page 629 revealed residents were assessed by the DCS, with vital signs taken. One (1) resident was identified in distress and the physician was notified at that time. 9. Review of in-service records, dated 04/22/15, revealed twenty-three (23) nurses, thirty (30) CNAs, and two (2) agency staff were educated who to call when they call out and how the shift may be covered to ensure adequate staffing, shift report. Staff competencies were completed. Interview, on 05/04/15 at 4:00 PM, with the RDCS and Interim ED, revealed twenty-three (23) nurses were educated on staffing. Interview with LPN #1, on 05/05/15 at 9:45 AM, revealed he had been trained on what to do and who to call if calling in, and call in to the ED, DCS, or ADCS; stated he had to go through training before he was allowed to work. Interview, on 05/05/15 at 9:51 AM, with CNA #11 revealed she had been educated on staffing, to call the ED, DCS, or ADCS, and had to be trained prior to working. Interview with the UM, on 05/05/15 at 9:55 AM, revealed she was educated on staffing and the ED, DCS, or ADCS should be called if staff were to call in. Interview with CNA #6, on 05/05/15 at 10:12 AM, revealed he could only call the ED, DCS, or ADCS if he could not come in to work and he was to wait for the next shift before leaving. 10. Review of the facility investigation, dated 04/28/15, for Resident #25's black eye noted on 03/25/15, revealed the SSA was notified on 04/28/15, investigated, and followed up on 05/04/15. The investigation resulted in the cause of the injury from a resident to resident altercation. Interview with the DCS, on 05/20/15 at 2:04 PM, revealed she investigated Resident	F 493		

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F 493	Continued From page 630 #25's black eye and the cause was determined to be a resident to resident altercation. Observation, on 05/22/15 at 2:11 PM of Resident #25 revealed the resident was in his/her recliner with the TV on and staff sitting with him/her on a 1:1. 11. Review of skin sweeps, dated 05/12/15 and 05/13/15, for one hundred twenty-one (121) residents revealed no suspicious injuries were identified. Interview with the RDCS, on 05/22/15 at 8:59 AM, revealed all residents skin were assessed for any injuries that did not have reasonable cause. Observation of Resident #25, on 05/05/15 at 2:11 PM, Unsampled Resident KK, on 05/05/15 at 2:11 PM, Resident #8, on 05/22/15 at 4:20 PM, Resident #6, on 05/05/15 at 2:26 PM, revealed no concerns with new or unknown injuries. 12. Review of resident interview questionnaire, dated 05/12/15 and 05/13/15, revealed residents with a BIMS Score of twelve (12) or more were interviewed by the Executive Director about their safety, no concerns identified. Interview with the DCS, on 05/22/15 at 2:52 PM, revealed residents were interviewed about their safety with no concerns identified. Interview with Resident #8, on 05/22/15 at 4:20 PM, revealed the resident felt safe in the facility. 13. Review of staff questionnaires, dated 05/12/15 and 05/13/15, revealed staff were interviewed by the ED to determine if any staff member had witnessed abuse or neglect. Review of two (2) facility reports to the SSA revealed the reports were made on 05/14/15. Interview with the DCS, on 05/22/15 at 2:52 PM, revealed staff were interviewed about abuse. She stated two (2) new additional reports were made and	F 493		

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	185289		C 05/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HURSTBOURNE CARE CENTRE AT STONY BROOK	2200 STONY BROOK DR LOUISVILLE, KY 40220

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F 493	Continued From page 631 investigations were begun. 14. Review of in-service records, dated 05/09/15 through 05/14/15, revealed one hundred one (107) staff and fourteen (14) agency staff were educated on abuse and neglect and injury of unknown origin, with staff competencies completed. Interview with CNA #7, on 05/22/15 at 8:05 AM, RN #6, on 05/22/15 at 8:13 AM, with Housekeeper, on 05/22/15 at 8:20 AM, with LPN #1, on 05/22/15 at 8:25 AM, CNA #8, on 05/22/15 at 8:37 AM, had been trained on abuse and neglect, could name the types of abuse, and who and when to report. Interview, on 05/22/15 at 2:52 PM, with the DCS, Maintenance Director, ADCS, UM, Staffing Coordinator, Medical Records, MDS Coordinator, Housekeeping Supervisor, revealed they had been trained on abuse. 15. Review of one hundred twelve (112) employee file audits, dated 05/13/15, revealed employee files were audited by the Regional Director of Human Resources by the Regional Director of Clinical Services for criminal background checks, nurse aide abuse registry, OIG checks, and telephone reference checks with no discrepancies corrected. Review of the QAPI meeting, held on 05/15/15, five (5) new employee files would be reviewed for completeness, twice a week. Review of five (5) new employee files, dated 05/15/15 and 05/20/15, revealed they were complete with criminal checks, nurse aide abuse registry, OIG checks, and reference checks. 16. Review of the facility abuse allegation investigations, revealed complete investigations and five day follow up. Interview with the RDCS, on 05/22/15 at 12:07 PM, revealed allegations	F 493		

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F 493	Continued From page 632	F 493		

were reviewed for investigation and follow up.

17. Review of a QAPI sign in sheet, dated 05/13/15, revealed review of the P&P for abuse with no changes made. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, ADCS, UM, Staffing Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS had all been trained on abuse, and staff trained on abuse.

18. Review of facility investigations , dated 04/21/15 through 04/24/15, 04/26/15 through 04/29/15, 05/01/15, 05/04/15, 05/06/15, 05/09/15, 05/11/15, revealed incidents were reviewed by the RDCS for regulatory compliance and timeliness with no issues identified. Review of the investigations audit for the last thirty (30) days, dated 05/14/15, revealed the investigations were reviewed for timely reporting, investigation, and resolution. Interview with the RDCS, on 05/22/15 at 12:07 PM, revealed she completed the review of investigations with no concerns.

19. Review of the sign in sheet and agenda for QAPI meeting, dated 05/15/15, revealed monitoring of abuse and neglect reporting: resident interviews, dated 05/12/15, 05/13/15, 05/15/15, 05/16/15, 05/18/15, 05/19/15, would be completed for five (5) residents five (5) times weekly; skin sweeps, dated 05/08/15, 05/12/15, 05/13/15, and would be conducted for five (5) residents five (5) times a week; beginning 05/15/15 resident and family concerns would be reviewed five (5) times weekly; beginning 05/12/15 and on 05/15/15, 05/18/15, 05/19/15, 05/20/15, daily meeting would discuss new resident injuries or concerns five (5) times weekly; and use of an abuse audit tool for abuse

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F 493	Continued From page 633 reporting beginning on 05/15/15. Observation of the daily meeting, on 05/22/15 at 9:05 AM, revealed specific residents were discussed in regard to specific resident concerns. Interview with the DCS, on 05/22/15 at 2:52 PM, revealed residents were discussed in the morning meeting for specific concerns and plan. 20. Review of current residents were assessed for behaviors by the Corporate Administrative Registered Nurses/Interdisciplinary Team, on 05/12/15 and 05/13/15, revealed sixty-four (64) residents with behaviors had their care plans reviewed, with nineteen (19) care plans updated. One (1) resident was placed on 1:1 supervision, on 05/13/15. Interview with the RDCS, on 05/22/15, revealed sixty-four (64) residents were reviewed, and nineteen (19) actually had care plan interventions updated. 21. Record review of in-services conducted 05/13/15 and 05/14/15 revealed one hundred one (101) staff were educated by Corporate Administrative Registered Nurses on bathing, AM care, shaving, hair care, change in condition, notifications to physician and RP, assessments, linens and laundry, falls, behaviors, abuse, resident smoking and use of aprons. Observation on the IDT in daily morning meeting, on 05/22/15 at 9:05 AM, revealed specific residents and behaviors, the 24 hour report, with department heads noted an new orders or changes to the care plans. 22. Review of a QAPI sign in sheet, dated 05/13/15, and agenda revealed the P&P for care plans and behavior management were discussed with no changes made. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS,	F 493		

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F 493	Continued From page 634 ADCS, UM, Staff Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS attended the QA meetings. 23. Review of audit tools revealed residents with new falls and behaviors were reviewed by the Interdisciplinary Team in the daily meeting for completion of the documentation, notifications, care plans and Kardexes. Observation, on 05/22/15 at 9:05 AM, of the IDT morning meeting revealed specific resident concerns were reviewed, 24 hour report and behaviors were discussed, and care plans reviewed. Interview, on 05/22/15 at 2:52 PM, with the DCS revealed facility audits were reviewed in the daily meeting and any concerns discussed. 24. Review of the weekly falls meeting and behavior management meeting with the IDT, beginning 05/12/15, revealed meetings were conducted. Observation of the daily IDT meeting, on 05/22/15 at 9:05 AM, revealed the 24 hour report was discussed. Interview with the DCS, on 05/22/15 at 2:52 PM, revealed resident behaviors were reviewed in the behavior management meeting. 25. Review of the sign in sheet for an Ad-Hoc QAPI meeting, dated 05/15/15, and audit tools revealed abuse and neglect reporting was monitored by the QA. 26. Review of weekly behavior meeting notes, dated 05/12/15 and 05/13/15, revealed six (6) residents with resident to resident behaviors or sexual/physical behaviors were reviewed for documentation, care plan interventions. Interview with the DCS, on 05/22/15 at 2:52 PM, revealed the behavior meeting reviewed and monitored	F 493		

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F 493	Continued From page 635 residents with behaviors, notifications, interventions were in place, and possibility for more frequent monitoring. 27. Record review of in-services conducted on 05/13/15 and 05/14/15 revealed education provided for skin assessments, resident weights. Interview with CNA #7, on 05/22/15 at 8:05 AM, with RN #1, on 05/22/15 at 8:13 AM, with LPN #1, on 05/22/15 at 8:25 AM, with CNA #8, on 05/22/15 at 8:37 AM, revealed they had been trained on resident weights and skin assessments. Observation, on 05/22/15 at 3:30 PM, revealed Resident #34 skin assessment was performed by Registered Nurse #11 and no new skin issues were identified and the documentation was completed as required. 28. Observation of the morning meeting, on 05/22/15 at 9:05 AM, revealed the IDT reviewed the 24 hour report, care plans, and specific resident concerns. 29. Review of facility assessments, dated 04/30/15, revealed one hundred twenty-four (124) residents were assessed for transfer/lift with Kardexes and care plans updated. Observation, on 05/22/15 at 2:20 PM, revealed no concerns with a broken shower bed in the 100 Unit shower room and lifts were functional. 30. Review of resident Safe Smoking Evaluations for fifteen (15) residents and completed by the SSD, on 05/13/15, revealed three (3) residents were identified to need a smoking apron. Review of the therapy screening tool revealed, and two (2) residents were referred to therapy. Observation, on 05/22/15 at 4:53 PM, revealed one (1) resident was smoking, used an apron,	F 493		

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and staff assisted the resident to smoke.
Interview with the DSS, on 05/22/15 at 2:52 PM, revealed she completed the resident smoking assessments and if the resident needed an apron.

31. Observation of the resident smoking area, on 05/22/15 at 4:53 PM, revealed eight (8) aprons hanging near the door, one (1) resident smoking with staff assistance, and wearing an apron. Observation of the smoking box on the 200 Unit, on 05/22/15 at 4:57 PM, revealed boxes of cigarettes for all residents of the facility; a list of residents who smoked and who required an apron. Interview with CNA #2, on 05/22/15 at 4:57 PM, revealed Central Supply and a staff from the 200 Unit cover the smoking times during the day; resident cigarettes and lighters should be kept in the smoking box which was kept locked in the medication room.

32. Review of rounding sheets, dated 05/12/15, revealed maintenance and environmental concerns were audited by Executive Director and Maintenance Director. Review of rounds completed by the ED and Maintenance Director, on 05/13/15, revealed maintenance books on each unit were reviewed for any maintenance issues, with concerns addressed on 05/13/15 and 05/14/15. Interview with the Maintenance Director, on 05/22/15 at 2:52 PM, revealed any maintenance issues should be listed in the maintenance book at each nurse's station, which he will take to the morning meeting, and discuss what had been addressed on the maintenance concerns.

33. Review of in-service records, dated 05/13/15 and 05/14/15, revealed staff were educated on

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showers and beds. Interview, on 05/22/15 at 3:20 PM, with CNA #5 revealed she was educated not to use broken equipment or shower beds and to report to supervisor and maintenance if equipment/shower bed was broken.

34. Review of a QAPI sign in sheet, dated 05/15/15, audit tools, and agenda revealed monitoring of falls, smoking, assistive devices, lifts, shower beds, and maintenance occurred. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, Housekeeping Supervisor, and DSS revealed they attended the QA meetings.

35. Review of facility rounding sheets, dated 05/12/15, revealed the environment was observed, by Corporate Administrative Registered Nurses for maintenance needs. Observation of the morning meeting, on 05/22/15 at 9:05 AM, revealed the maintenance books were taken to the IDT meeting and reviewed. Interview with the Maintenance Director, on 05/22/15 at 2:52 PM, revealed he would take the maintenance books to the morning meetings.

36. Review of staff training records, beginning 05/13/15, revealed five (5) staff were trained with return demonstration for transfers. Review of the smoking list revealed residents who smoked were listed, with resident who required an apron and/or supervised smoking were identified. Review of rounding sheets, beginning 05/13/15, revealed resident rooms were searched for incendiary smoking items by the Executive Director. Observation of the facility's smoking box on the 200 unit, on 05/22/15 at 4:57 PM, revealed cigarettes were stored for the entire facility, and

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F 493	Continued From page 638 contained a list of residents who smoked, with those who required an apron identified. Interview with CNA #2, on 05/22/15 at 4:57 PM, revealed the box should be locked in the med room and the box had the cigarettes and lighters for all residents who smoked in the facility. 37. Review of the facility's audit tool revealed, beginning 05/12/15, residents were observed to ensure fall interventions were in place per the care plan. Interview with the DCS, ADCS, UM, Medical Records, BOM, and DSS, on 05/22/15 at 2:52 PM, revealed audits were conducted every morning and looked for falls interventions compared to the care plan and discussed in morning meeting. 38. Record review of resident call light audit, dated 05/12/15, revealed Residents #7, #5, #12, Unsampled Resident Z and AA call lights were checked for function, with Resident #12's call light was found to not light at the desk or the door. 39. Record review of call light audits, completed on 05/12/15, found one hundred twenty-four (124) resident call lights were checked for functionality, with twenty-two (22) rooms found that call lights did not light at the desk, one (1) room did not light at the desk or the door, and two (2) rooms did not light at the desk, the door, or sound. Six (6) residents in the three (3) rooms that call lights did not work, were placed on fifteen (15) minute checks and given a hand bell. Record review of the call light work order, dated 05/13/15, revealed the call lights for the six (6) residents were repaired by an outside contractor on 05/13/15 and another call light was repaired on 05/14/15 that would not turn off; the annunciator on the 200 Unit was repaired at the nurse's desk on	F 493		

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F 493	Continued From page 639 05/15/15. Observation, on 05/22/15 at 2:03 PM, of room 18 revealed the call light functional at the door, desk and sounding. Observation, on 05/22/15 at 2:15 PM, on the 200 Unit of two (2) nurse's stations revealed each desk had a new call light system installed on the wall behind the desk. Interview with the RDCS, on 05/22/15 at 12:07 PM and 05/22/15 at 3:42 PM, revealed call lights were repaired on 05/13/15 and 05/14/15, and the 200 Unit annunciators were repaired, and then moved to the wall behind each nurse's station. The six (6) residents were given hand bells on 05/13/15 and placed on fifteen (15) minute safety checks. Review of fifteen (15) minute check sheets revealed residents were checked on every fifteen minutes until call light was repaired. Interview with DCS on 05/22/15 at 5:30 PM, revealed she had call bells purchased and given to residents. 40. Review of in-service training records, dated 05/09/15 through 05/12/15, revealed twelve (12) nursing staff working the 11:00 PM through 7:00 AM shift on 05/12/15 were re-educated on 05/13/15 on what to do if the call lights were inoperable and the six (6) residents identified with inoperable call lights were placed on fifteen (15) minute checks. Interview, on 05/22/15 at 3:42 PM, with the RDCS revealed staff working on 05/12/15 and 05/13/15 were educated on the call lights not working for the six (6) residents and conduct fifteen (15) minute safety checks and were provided hand bells. Observation on 05/21/15 at 11:10 AM, revealed a hand bell was rung and the Medical Records Coordinator answered the hand bell immediately upon hearing it ring. 41. Record review of in-services conducted	F 493		

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F 493	Continued From page 640 05/13/15 and 05/14/15 revealed 101 of 149 staff were educated on providing call lights and what to do if not working, and answering call lights timely. Interview, on 05/22/15 at 8:05 AM, with CNA #7, on 05/22/15 at 8:13 AM with RN #1, on 05/22/15 at 8:25 AM with LPN #1, revealed they had been trained on call lights and knew what to do if a resident's call light did not work. Interview, on 05/22/15 at 2:52 PM, with the DCS, ADCS, UM, Medical Records, and Staffing Coordinator revealed staff were trained on call lights, answering call lights, and what to do if call lights were not functioning. Observation, on 05/22/15 at 1:58 PM, of room 106 revealed the call light was functional at the door, at the desk, and sounded. 42. Review of the pest control company invoice, dated 05/13/15 and 05/14/15 revealed services were provided to the interior and exterior of the facility. Review of the pest control contract revealed services would be provided to the facility monthly and as needed. Interview with the Maintenance Director, on 05/22/15 at 2:52 PM, revealed the new pest control company had begun services inside and outside of the facility. Observation of the Sub acute 1 nurse's station, on 05/22/15 at 2:03 PM, revealed the maintenance book also contained the pest sightings book. Observation of Sub acute 2 nurse's station, on 05/22/15 at 2:07 PM, revealed the maintenance book also included the pest sightings log. Observation of room 215, on 05/22/15 at 2:09 PM, revealed no pests were seen. Observation of the 100 Unit nutrition room, on 05/22/15 2:20 PM, revealed no pests were seen. Observation, on 05/22/15 at 5:20 PM, of the kitchen revealed no pests were seen. Interview with the Dietary Director, on 05/22/15 at 2:52 PM, revealed the kitchen did not currently	F 493		

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F 493	Continued From page 641 have pests. 43. Review of facility rounding sheets, dated 05/12/15, revealed no pests were observed. One hundred twenty-one (121) residents were assessed via skin sweeps on 05/12/15 and 05/13/15 with no pest bites evident, and no pests documented in resident beds or rooms. Interview with the DCS, ADCS, UM, MDS Director, on 05/22/15 at 2:52 PM, revealed residents were assessed via skin sweeps, and no concerns. Interview with Resident #24 on 05/22/15 at 4:30 PM, revealed no pests were in his/her room. 44. Review of rounding records, dated 05/14/15 through 05/21/15, revealed no concerns identified with pests. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, Central Supply, and DSS revealed daily rounds occurred with no concerns of pests. Interview with Resident #8 on 05/22/15 at 2:00 PM, revealed no pests were in his/her room. 45. Review of the Ad-Hoc sign in sheet, dated 05/15/15, and agenda, and audit tools revealed monitoring of the facility's pest control would be completed by the QA. Review of rounding records, dated 05/14/15 through 05/21/15, revealed no live pests were seen. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, Central Supply, and DSS revealed daily rounds occurred with no concerns of pests. 46. Review of rounding sheets, dated 05/12/15 and 05/13/15, revealed the ED and Housekeeping Supervisor observed the facility for cleanliness. Interview with the Housekeeping Supervisor, on 05/22/15 at 2:52 PM, revealed he	F 493		

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HURSTBOURNE CARE CENTRE AT STONY BROOK

STREET ADDRESS, CITY, STATE, ZIP CODE
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LOUISVILLE, KY 40220

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F 493	Continued From page 642 conducted rounds for cleanliness of the facility, including linens, resident rooms, shower rooms, trash, webs and pests, and privacy curtains. Interview with Resident #10 on 05/22/15 at 12:30 PM, revealed no concerns with linens. 47. Review of in-service records, dated 05/13/15, revealed Administrative staff were trained on staffing, pest control, housekeeping and maintenance, and would be monitored by the ED. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS revealed they had been trained on staffing, pest control, housekeeping and maintenance, and any concerns of audits would be taken to the morning meeting. Interview with Resident #3 on 05/22/15 at 1:00 PM, revealed staffing had improved and were answering lights timely and the facility looked cleaner. 48. Review of audits for employee files revealed they were audited twice per week by the Executive Director/RDHR/RVPO/RDCS or Corporate Administrative Nurse. 49. Observation of the daily morning meeting, on 05/22/15 at 9:05 AM, revealed review of the 24 hour report, notifications made and documented, new physician orders, maintenance concerns and books, pests, rounds and audits, call lights, care plans. Interview with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, MDS Coordinator, and DSS, on 05/22/15 at 2:52 PM, revealed they participate in the morning meeting and review the 24 hour report, notifications were made, maintenance books reviewed, physician orders, call lights, care plans, and audits/ round	F 493		

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F 493	Continued From page 643	F 493		

were reviewed in the morning meeting.

50. Interview, on 05/22/15 at 2:52 PM, with the DCS revealed facility concerns were reviewed in the morning meeting, including audits and rounding results, for department heads to address. She stated she (the DCS) or the ED would initial when concerns were resolved. Observation, on 05/22/15 at 9:05 AM, of the morning meeting revealed the DCS provided direction and asked clarifying questions related to information discussed with follow up items determined.

51. Review of sign in sheets, dated 04/22/15, 05/13/15, and 05/15/15, revealed QAPI meetings were held on those dates. Interview, with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS revealed they attended the QAPI meetings. Interview with the RDCS, on 05/22/15 at 5:05 PM, revealed the next QAPI meeting was scheduled for 06/17/15. Interview with the Medical Director, on 05/22/15 at 8:00 AM, revealed he was informed by the Executive Director of the resident care issues, attended the QA meetings held by the facility and provided direction regarding corrective action plans that were developed to meet the needs of the residents.

52. Review of the QAPI sign in sheet, dated 05/15/15, and agenda revealed audit tools were approved for QA monitoring and discussed: resident interviews; resident/family concerns; morning meeting; new employee files; falls or behaviors reviewed; care plans and Kardexes update; review of the 24 hour report; notifications;

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F 493	Continued From page 644 maintenance rounds and book; supervised smoking; falls interventions in place; call lights; weekly falls; and, behavior management meetings. 53. Review of facility linen rounds, dated 05/13/15, revealed resident laundry available for use and linen PAR levels were observed. Observation, on 05/22/15 at 2:05 PM, of the linen closet on Journey Home 1 revealed adequate numbers of linens, wash cloths and towels, pillows, and gowns. Observation of the linen closet on the 200 Unit, on 05/22/15 at 2:15 PM, revealed adequate linens, gowns, towels, washcloths, pillows, blankets and clothing protectors. Interview with the Housekeeping Supervisor, on 05/22/15 at 2:52 PM, revealed he completed rounds three (3) times a day and checked the linen closets for adequate supplies. Observation, on 05/22/15 at 2:00 PM, revealed Resident #4's linens on the bed were clean, neat and were not torn, tattered or frayed. 54. Review of the sign in sheet for QAPI, dated 05/13/15, revealed the ED and DCS presented and reviewed falls, changes in condition, staffing, housekeeping, and laundry, and pest control, and would provide daily oversight. 55. Review of grievance audit, dated 05/13/15, revealed grievances were reviewed since 05/01/15 and resolved by 05/15/15. Interviews on 05/22/15 with Resident #3 at 2:10 PM, Resident #8 at 2:00 PM, and Resident #10 at 12:30 PM, revealed the issues and concerns they had regarding linens, pests, environment repairs and answering call lights were resolved. 56. Review of rounds , dated 05/12/15, revealed	F 493		

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F 493	Continued From page 645 Resident #39 was groomed and had clean linens. 57. Review of the facility rounds, dated 05/12/15, revealed residents were observed to identify residents grooming, incontinent care, bed linens, pests, call lights in reach, and privacy curtains in place. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Staffing Coordinator, BOM, Central Supply, Housekeeping Supervisor, and DSS revealed daily rounds were completed to identify resident grooming needs and care, linens, pests, call lights in reach, and privacy curtains in place. Interviews with Resident #3, #8 and #10 on 05/22/15, revealed the issues and concerns they had regarding linens, pests, environment repairs and answering call lights had improved. 58. Review of in-service records, dated 05/13/15 and 05/14/15, revealed nursing staff and ten (10) agency staff were educated on incontinent care, bathing, shaving, and hair care. Interview, on 05/22/15 at 2:52 PM, with the DCS, ADCS, UM, and Staffing Coordinator revealed staff were trained on grooming, incontinent care, shaving, and bathing. Interview with CNA #31, on 05/22/15 at 8:10 AM, revealed she received training on incontinent care, bathing, shaving, hair care, reporting pest, broken equipment, fall prevention, lifts, reporting change in condition, and answering call lights, abuse, resident laundry and linens. 59. Review of in-service records, dated 05/13/15 and 05/14/15, revealed one hundred one (101) staff and ten (10) agency staff were educated on privacy curtains; using the pest sightings book; resident privacy. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS,	F 493		

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F 493	Continued From page 646 Staffing Coordinator, Central Supply and Housekeeping Supervisor revealed they were trained on privacy curtains, resident privacy, and pests. Interview with Housekeeper #1, on 05/22/15 at 8:20 AM, revealed she received training on cleaning resident rooms, privacy curtains, reporting pests and broken equipment. Interview with Registered Nurse #11, on 05/22/15 at 8:10 AM, revealed she was educated on abuse, falls, physician orders, dignity, grievances, infection control, call lights, and reporting pests and maintenance issues. 60. Review of QAPI sign in sheet, dated 05/13/15, revealed incontinent care, resident privacy, shaving and AM care P&P were reviewed. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Staffing Coordinator, MDS Director, Housekeeping Supervisor, and DSS attended the QA meetings. 61. Review of rounding sheets revealed residents were observed by staff to identify any issues with grooming, incontinent care, privacy, shaving and AM care. Interview, on 05/22/15 at 2:52 PM with the DCS, ADCS, UM, Staffing Coordinator, Medical Records, BOM, MDS Director, Central Supply, Housekeeping Supervisor, and DSS revealed they conducted rounds to assess residents grooming, privacy, shaved, and care. 62. Review of a QAPI sign in sheet, dated 05/15/15, revealed residents would be observed to ensure they were shaved, hair combed, incontinent care, privacy curtains and bed linens in place and clean, residents and environment free from pests, resident privacy, and call lights. On 05/22/15 at 2:52 PM, interview with the Maintenance Director, DCS, ADCS, UM, Staffing	F 493		

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F 493	Continued From page 647 Coordinator, MDS Director, Housekeeping Supervisor, and DSS attended the QA meetings. Interview with Resident #8, on 05/22/15 at 4:20 PM, Resident #6, on 05/05/15 at 2:26 PM, Resident #24, on 05/22/15 at 8:07 AM, revealed the issues they had with not getting shaved, hair washed and combed, incontinent care provided, bed linens without tears, an environment free from pests, and call lights answered timely had improved. Observation of Resident #43, on 05/22/15 at 8:00 AM, revealed two staff were using a lift to transfer the resident into a wheelchair and then proceeded to shave the resident.	F 493		
F 514 SS=J	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policies it was determined the facility	F 514		

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F 514	Continued From page 648 failed to have an effective system to ensure residents' clinical records were complete and accurate. This failure affected three (3) of forty-three sampled residents (Residents #4, #25, and #31). On 02/25/15 at approximately 12:30 AM, Resident #4 sustained a fall. Interview and record review revealed the fall was documented at 6:00 AM on 02/25/15; however, there was no documented evidence the resident's physician was notified at the time of the fall and there was no evidence the resident received a complete nursing assessment, which included the lower extremities, after the fall until 4:30 PM on 02/25/15 when nursing documented the right lower leg was swollen, warm, bruised and tender. An x-ray was ordered and the resident was diagnosed with a right tibia fracture. Resident #4 had an immobilizer applied for stabilization on 02/25/15 with staff to observe skin under the immobilizer for signs and symptoms of redness or breakdown. However, review of the nursing documentation revealed no evidence the skin under the immobilizer was assessed daily or during showers or at bath time. There was no documented evidence on the MAR or TAR to observe the skin under the immobilizer. In addition, the resident was to have weekly weights obtained; however, there was no documented evidence the weights were obtained routinely. (Refer to F309, F314, and F325) On 03/25/15 during the 7:00 AM-3:00 PM shift, Registered Nurse (RN) #6 noted the Resident #25's right eye was swollen and bruised on the side with a small cut. Interview and record review revealed the resident's eye injury was not assessed or monitored. There was no	F 514		

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F 514	Continued From page 649	F 514		

documented assessment of the injury until 04/24/15, thirty (30) days after the bruising was identified. (Refer to F309)

In addition, the facility failed to assess resident #31's pressure areas routinely to identify progressive skin breakdown and prevent unstageable wounds from developing. The resident was to have weekly weights obtained and meal intake monitored. However, there was no documented evidence the weights and meal intake were obtained/monitored routinely. (Refer to F314 and F325)

The facility's failure to have an effective system in place to ensure residents' clinical records were complete and accurate has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 04/22/15 and was determined to exist on 02/25/15.

An acceptable Allegation of Compliance (AOC) was received on 05/19/15 alleging the Immediate Jeopardy was removed on 05/16/15. The State Survey Agency validated the Immediate Jeopardy was removed on 05/16/15 as alleged, prior to exit on 05/22/15. The scope and severity was lowered to an D while the facility monitors the implementation of the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes.

The findings include:

Review of the facility's policy regarding Resident Incident/Accident Reports, dated 11/30/14, revealed any happening not consistent with routine operations of the facility or care of a

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resident may warrant the completion of an incident report. Following a nursing assessment, the physician would be notified of any noted or suspected injury, and would implement appropriate interventions.

Review of the facility's blank Situation, Background, Appearance, Review (SBAR) Communication Form, dated 2014, revealed the Situation of the incident, Background of the resident's care, Resident's Evaluation, the Appearance of the resident, and Review and Notification to the physician, and also to the responsible party (RP) was to be documented.

Review of the facility's policy regarding Skin Evaluations, dated 11/30/14, revealed a Licensed Nurse would complete a total body evaluation on each resident weekly, paying particular attention to any skin tears, bruises, stasis ulcers, rashes, pressure ulcers, lesion, abrasions, reddened areas and skin problems. A Licensed Nurse would document the observation on the Weekly Skin Integrity Review form. The evaluating nurse must date and sign each review.

1. Review of Resident #4's clinical record revealed the facility admitted the resident on 05/16/13 with diagnoses of Hypertension, Atrial Fibrillation, Chronic Obstructive Airway, Congestive Heart Failure, Macular Degeneration, Rheumatoid Arthritis, Osteoporosis and Open Wound Site.

Review of an Accident/Incident Report Form, dated 02/25/15, revealed Resident #4 sustained a fall from the bed and was found on the floor at 12:30 AM.

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F 514	Continued From page 651 Review of the Nursing Progress Note written, on 02/25/15 and timed at 6:00 AM, revealed Resident #4 was found on the floor by a Certified Nursing Assistant while performing rounds. Further review of the resident's clinical record revealed nursing no documented evidence Resident #4's lower extremities were assessed or monitored after the fall occurred. The Nursing Progress Note written on 02/25/15 at 4:30 PM, revealed nursing documented the right lower leg was swollen, warm, bruised and tender. Record review revealed an xray was obtained and the resident was diagnosed with a right tibia fracture. Interview with Licensed Practical Nurse (LPN) #1, on 04/21/15 at 3:05 PM, revealed he was not the assigned nurse for the 100 Unit but was notified by Registered Nurse (RN) #1 that Resident #4 had fallen. Per interview, he documented he performed a head to toe assessment at 6:00 AM on 02/25/15 and believed this covered him for the whole shift. LPN #1 stated neuro-checks were started on Resident #4; however, record review revealed LPN #1 only completed three (3) neuro-checks on Resident #4 and documented five (5) times the resident refused assessment. Interview with RN #1, on 04/21/15 at 11:20 PM, revealed he did not remember if he assessed Resident #4 the night of the fall. He stated since he was not the nurse on the unit he did not make any nursing documentation in the medical record or contact the physician and family regarding the fall. Interview with Director of Clinical Services (employed as of 04/20/15), on 04/24/15 at 1:05 PM, revealed nursing did not document nursing assessments regarding Resident #4's fall. Per	F 514		

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F 514	Continued From page 652 interview, injuries would not be detected and treatment would not be provided timely, if nursing assessments were not completed. Further review of the clinical record for Resident #4 revealed after the resident was diagnosed with a fractured right tibia after the 02/25/15 and an immobilizer was applied for stabilization on 02/25/15. Review of the Comprehensive Care Plan for Resident #4 revealed the facility developed a plan of care on 03/10/15 with updated goals and a target date for 06/09/15. The problem on the care plan stated the resident sustained a tibial/fibula fracture to the right leg on 02/25/15 and an immobilizer for stablization was also placed on the same date. The approaches listed directed staff to maintain the immobilizer per physician orders and observe skin under the immobilizer for signs and symptoms of redness or breakdown. However, review of the nursing documentation revealed no evidence the skin under the immobilizer was assessed. There was no documented evidence on the MAR or TAR to observe the skin under the immobilizer. Review of the Wound Physician's documentation, dated 04/03/15, revealed Resident #4 had new unstageable wounds to the right lower extremity after having a brace for a fracture. Interview with the LPN #5, on 04/23/15 at 2:55 PM, revealed she was unable to find the Certified Nursing Assistants' (CNAs) pink sheets containing any noted skin issues or any other nursing documentation related the wound on the back of Resident #4's right leg. Interview further	F 514		

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F 514	Continued From page 653 revealed the resident's skin should have been assessed underneath the immobilizer daily to monitor for skin breakdown by nursing; however, that was not done. Interview with the Assistant Director of Clinical Services, on 04/24/15 at 10:05 AM, revealed every resident was required to have a skin assessment every week. Per interview, if a resident had a brace, nursing staff should be assessing the skin under the brace. However there was not documented evidence this assessment was completed. Further review of the clinical record for Resident #4 revealed a physician's order, dated 02/28/15, for weekly weights to be obtained. However, review of the weight record for Resident #4 revealed weekly weights were not routinely documented from January through March 2015. Further review revealed the resident experienced a thirteen (13) pound weight loss from 01/19/15 through 04/17/15. Interview with LPN #2, on 04/20/15, revealed she was unable to find weekly weights on Resident #4. 2. Review of the clinical record for Resident #25, revealed the facility admitted the resident on 12/30/14 with a diagnosis of Vascular Dementia. Review of Resident #25's care plan revealed a care plan for risk of falls, dated 01/08/15, included an intervention to monitor the resident for change in condition that may warrant an increase in supervision or assistance, and notify the physician. Continued review of Resident #25's clinical record	F 514		

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F 514	Continued From page 654 revealed on 03/25/15 from 7:00 AM through 3:00 PM, a nurse's note by RN # 6 stating the resident's right eye was swollen and bruised on the side with a small cut. A skin assessment was completed by RN #6; however, she did not document the resident's eye injury. Record review revealed the right eye bruising and cut were not assessed until 04/24/15, thirty (30) days after the bruising was identified. Interview, on 04/27/15 at 11:42 PM, with RN #1 revealed he worked with Resident #25 on third shift. He stated was made aware of the injury through report but could not remember who told him. The RN stated the nurse on duty at the time of the incident should have assessed the resident, completed an SBAR, notified the physician and RP, and completed neuro checks for 24 hours. However, record review revealed no evidence this documentation was completed. Interview with RN #6, on 04/23/15 at 1:15 PM and on 04/24/15 at 1:24 PM, revealed no one completed an SBAR or any other documentation, which should have been completed by the shift which the incident occurred. Interview with the Unit Manager (UM), on 04/24/15 at 9:35 AM, revealed when she returned from vacation, she assessed Resident #25 and saw bruising; however, she did not document her assessment. The UM stated the nurse should have also completed an SBAR on resident #25. On 04/28/15 at 8:35 AM, interview with the DCS revealed for Resident #25's injury she would expect to find an SBAR, incident report, and neuro checks since the injury occurred on the head, and physician and family notifications in the	F 514		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HURSTBOURNE CARE CENTRE AT STONY BROOK	2200 STONY BROOK DR LOUISVILLE, KY 40220

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F 514	Continued From page 655 resident's clinical record. However, the facility was not able to provide evidence of the completion of a SBAR, notifications or neurological (neuro) checks for Resident #25 that would have occurred at the time of the black eye was identified on 03/25/15. 3. Review of Resident #31's clinical record revealed the facility admitted the resident on 08/11/14, and readmitted the resident on 03/27/15 with diagnoses which included Above Knee Amputation (AKA), Below Knee Amputation (BKA), Diabetes Mellitus (DM), Peripheral Vascular Disease (PVD), and Pressure Ulcer. Review of the Comprehensive Care Plan for risk of skin breakdown, dated 08/22/14, revealed interventions included perform skin assessments per facility policy, wound consult weekly, and assist to turn and reposition. Review of the Wound Physician's documentation, dated 01/09/15, revealed Resident #31, complained of pain in the buttock area and staff reported the resident was noted to be pulling at the dressings in that area. Review of the Wound Physician's note on 01/23/15 revealed the Coccyx wound had necrotic tissue. On 01/30/15, the Wound Care Physician noted the Coccyx wound was now a Stage Three (3) Pressure Ulcer. On 04/03/16, the Wound Physician noted the Coccyx wound as a Stage Four (4) Pressure Ulcer. Review of Resident #31's clinical record revealed a Physician Order Sheet for December 2014 and March 2015, for weekly skin assessments to be performed. However, review of the medical record revealed the facility did not consistently	F 514		

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F 514	Continued From page 656 perform skin/wound assessments per the physician's order and as required by the facility's policy. Review of the weekly skin assessments for Resident #31, for January 2015 revealed the resident had an open area to his/her coccyx on 01/05/15 and 01/12/15, but the skin assessments failed to reveal any measurements, or description of the open area on the coccyx. The facility was unable to provide weekly skin assessments for Resident #31 for the weeks of 01/19/15, 01/26/15, 02/16/15, 02/23/15, 03/30/15 or 04/06/15. Interview with LPN #2, on 05/13/15 at 10:50 AM, revealed the nurses should document what they see during the skin assessment. On 05/01/15 at 1:36 PM, interview with the UM revealed resident skin assessments should be completed weekly. However, per interview, the skin assessments were not documented for Resident #31. Interview, on 05/04/15 at 2:18 PM, with the Director of Clinical services (DCS) revealed weekly skin assessments should be completed for Resident #31 to identify any changes in his/her skin and any skin breakdown. Continued interview with the DCS, on 05/20/15 at 2:04 PM, revealed the facility did not have documentation of the skin assessments for Resident #31. Interview with the Interim Executive Director/Regional Vice President of Operations (ED/RVPO), on 05/05/15 at 3:05 PM, revealed	F 514		

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F 514	Continued From page 657 the staff failed to document skin assessments for Resident #31. Further review of the clinical record for Resident #31 revealed a care plan for alteration in nutrition/hydration status, dated 08/15/14, with interventions to monitor weight and intake. The nutritional care plan, revised 04/19/15, identified the resident had a progressive and significant weight loss of 21.8% over 180 days, with an intervention of weekly weights while on the Nutritionally at Risk (NAR). Review of the Physician Order Sheet (POS) for January 2015 revealed an order for weekly weights. Review of the facility's January weight record for Resident #31, revealed no documented weight for the week of 01/26/15. Review of the February 2015 revealed no documented weight for the weeks of 02/02/15 or 02/16/15. Review of the March 2015 weight record revealed no documented weekly weight for the week of 03/03/15 or 03/10/15. On 05/13/15 at 10:50 AM, interview with LPN #2 revealed Resident #31's weekly weights should be documented on the MAR. She stated the CNAs were responsible to obtain the resident's weight, and inform the nurse so the nurse could document it on the MAR. On 05/05/15 at 2:18 PM, interview with the Director of Clinical Services (DCS) revealed the day the resident weights were due, the nurse was responsible to ensure the CNAs obtained the resident's weight, and the nurse would document on the MAR/TAR.	F 514		

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F 514	Continued From page 658 Continued interview with the DCS, on 05/20/15 at 2:04 PM, revealed Resident #31 had a physician order for weekly weights since 12/18/14; however, the facility did not have weekly weights for the resident. Interview with the Interim Executive Director/Regional Vice President of Operations (ED/RVPO), on 05/05/15 at 3:05 PM, revealed the facility failed to accurately document Resident #31's weights. Review of the facility Meal Intake Detail Report for Resident #31, dated 01/02/15 through 05/20/15, revealed multiple missing entries from 01/01/15 through 05/20/15, for all meals and evening snack, and multiple days without entries. Interview with CNA #2, on 05/13/15 at 10:34 AM, revealed meal intake percentages eaten should be documented in the Caretracker every day for every resident. However, review of the Caretracker revealed this process was not being completed. Continued interview on 05/13/15 at 10:50 AM, with LPN #2 revealed the CNAs were responsible to document what percentage of the meal a resident ate, for every resident, for every meal. Interview, on 05/01/15 at 1:36 PM, with the UM revealed resident meal intakes should be documented for every meal every day. However, the facility utilized agency staff and she revealed the CNAs did not have access to the Caretracker system (electronic documentation) and should use an Activities of Daily Living (ADL) tracking form.	F 514		

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Continued interview with the DCS, on 05/20/15 at 2:04 PM, revealed Resident #31 had a physician order for weekly weights since 12/18/14; however, the facility did not have weekly weights for the resident. She stated the intake report since January 2015 for Resident #31 revealed intakes were not documented for every meal, every day. She stated the CNAs were responsible to document the resident's intake.

Continued interview, on 05/21/15 at 8:23 AM, with the Interim ED revealed Resident #31's meal intakes were not documented on a daily basis.

The facility took the following actions to remove the Immediate Jeopardy on 05/16/15 as follows:

1. The facility notified Resident #4's physician, of a fall that occurred on 02/25/15 with new orders given to the nurse. The resident transferred to a local hospital on 02/25/15 for a tibia fracture and returned to the facility on 02/28/15 with new orders. The DCS assessed Resident #4 on 04/22/15 and was found in stable condition.

2. On 04/28/15, the facility reported to the SSA that Resident #25 was found to have a black eye on 03/25/15. The incident was investigated and with the assistance of the SSD and DCS the source of the black eye was determined as a result of a resident to resident altercation and abuse was unsubstantiated.

3. On 04/22/15, one hundred twenty-six (126) residents were assessed by the ADCS, Nurse Manager, and Licensed Nurse to determine if any residents had an incident or accident or change in condition that would warrant physician notification

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F 514	Continued From page 660	F 514		

and further intervention. One (1) resident was identified as having an incident, accident, or change of condition and the physician was notified by the nurse on 04/22/15. Additionally, the Nurse notified the RP and documented this in the clinical record. Nurses would additionally report incidents, accidents, or changes in condition to the clinical administrative team.

4. On 04/22/15 the Corporate Administrative Nurses educated twenty-three (23) of thirty-eight (38) Nurses regarding timely notification to the physician related to resident incidents, accidents, or change in condition; care plan policies, evidence of assessments and care planning with immediate falls preventions interventions to meet the resident's needs; and falls procedures, immediate assessment by the Nurse after a resident's fall, notifications to the physician and RP, implementation of an immediate intervention by the Nurse, documentation of the fall in the clinical record by the Nurse, fall root cause investigation report initiated by the Nurse and reviewed by the DCS, and follow up by the IDT in the weekly falls meeting. Nurses were also trained related to reporting an incident, accident, or change in condition, to the resident's RP and documentation in the medical record to include the incident, accident, or change in condition, notifications to the physician, RP, and clinical administrative team, nurse's assessment, and interventions; evidence of assessment would include Situation, Background, Appearance, and Review (SBAR) sheet, Interdisciplinary Progress Note, and Neurological (neuro) checks sheet, and documentation of falls. Staff competencies were completed. Nursing staff not educated by midnight on 04/22/15 would not be allowed to work until they received training. Agency Nurses

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F 514	Continued From page 661	F 514		

would be trained by the Corporate Administrative Nurses, DCS, Assistant DCS, or Nurse Manager prior to working their next shift. The DCS and ED would ensure staff that had not been educated were educated prior to working their next shift. The ED and DCS would monitor the daily schedule and highlight staff already trained. A department manager would stand by the time clock at shift change to direct staff that needed education to the training. The IDT would monitor daily incidents and accidents. Notifications of accidents, incidents, or changes of condition would be reviewed for completion by the DCS, ADCS, or Nurse Manager, who would make notifications if not done.

5. An Ad-Hoc Quality Assurance/ Performance Improvement (QAPI) meeting was conducted on 04/22/15 to discuss facility policy and procedure (P&P) for falls, and notifications of incidents, accidents, or changes of condition; care plans as related to immediate falls interventions and revision status post fall, nursing assessment and documentation for falls; with no changes made. Also discussed the facility protocol related to shift relief and report; and additional avenues to attract new staff and maintaining current staff with a plan for performance improvement.

6. The IDT would review in the daily meeting incidents and accidents reports and the 24 hour report for investigation reports, nursing documentation in the clinical record, an SBAR, notifications to the physician and RP, and care plans with appropriate interventions.

7. On 05/13/15, Corporate Administrative RNs educated facility Administrative Staff on the regulations and P&P for staffing, pest control,

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F 514	Continued From page 662 housekeeping, and maintenance, with competencies completed. The ED would monitor the facility's process for notification, abuse, hiring, dignity, care plan revision, professional standards, assessments, behavior and falls management, incidents and accidents, smoking, call lights, pest control, and staffing. 8. Review of the 24 hour report, incident/ accident reports, in the daily meeting with the IDT; documentation in the clinical record included notification to the physician and new orders, and to the RP. 9. The IDT would meet at least monthly to discuss facility action plan and ensure tasks were completed for the removal of the IJ, and QA monitoring completed according to the AOC during the IJ period, validated by the ED/RVPO/RDCS/Corporate Administrative RNs. 10. Per the Ad-Hoc QAPI meeting, on 05/15/15, QI monitoring would be done utilizing approved audit tool with oversight by the ED, beginning 05/16/15, review of the clinical record for timely notifications to the physician and RP. The State Survey Agency validated the removal of Immediate Jeopardy on 05/22/15 as follows: 1. Review of the facility's SBAR's, incident report, neuro checks, progress notes and physician orders, all dated 02/25/15, revealed Resident #4 had a fall on 02/25/15, the physician was notified on 02/25/15 with new orders received. The resident was transferred to a local hospital on 02/25/15 for a tibia fracture on 02/25/15, and returned to the facility on 02/28/15 with new orders. The DCS assessed Resident #4 on	F 514		

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F 514	Continued From page 663 04/22/15 and found the resident was stable. 2. Review of the facility investigation, dated 04/28/15, for Resident #25's black eye noted on 03/25/15, revealed the SSA was notified on 04/28/15, investigated, and followed up on 05/04/15. The investigation resulted in the cause of the injury from a resident to resident altercation. Interview with the DCS, on 05/20/15 at 2:04 PM, revealed she investigated Resident #25's black eye and the cause was determined to be a resident to resident altercation. Observation, on 05/22/15 at 2:11 PM of Resident #25 revealed the resident was in his/her recliner with the TV on and staff sitting with him/her on a 1:1. 3. Review of one hundred twenty-six (126) resident assessments, completed by Assistant DCS/Nurse Manager/Licensed Nurse, on 04/22/15, revealed residents were assessed for any incident or accident, or change in condition that warranted notification to the physician. One (1) resident was identified as experienced a change in condition, accident, or incident and the physician was notified on 04/22/15. 4. Review of in-service records, revealed twenty-three (23) nurses were educated by Corporate Administrative Registered Nurses regarding: timely notification to the physician related to incidents, accidents, and changes in condition; care plan policies; resident assessments, including SBAR, neuro checks; falls and immediate interventions; notification to the physician and RP; documentation of the fall in the clinical record; fall root cause investigation report. Staff competencies were completed. No staff had worked prior to them receiving the training. Review of staffing schedules revealed	F 514		

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staff who had not yet been trained were not highlighted, which noted they required education. Review of facility records revealed notifications of incidents, accidents, and changes in condition were reviewed for completion by the DCS/ADCS/ Nurse Manager. Interview with the DCS and RDCS, on 05/04/15 at 4:18 PM, revealed twenty-three (23) nurses had been trained. Interview with RN #8, on 05/04/15 at 4:33 PM, with CNA #11, on 05/05/15 at 9:51 AM, with the UM, on 05/05/15 at 9:55 AM, CNA #14, on 05/05/15 at 10:03 AM, CNA #13, on 05/05/15 at 10:10 AM, revealed they had been educated on falls, notifications, Kardex and care plans. Interview, on 05/05/15 at 2:00 PM, with the DCS, ADCS, Nurse Manager, ED, Admissions Coordinator, DSS, MDS Director revealed they had all been trained on care plans, changes in condition, staff look at interventions for residents, the 24 hour report, falls, SBAR, incident reports, Kardex and care plans, notifications to the physician and family.

5. Review of a QAPI sign in sheet, dated 04/22/15, and agenda revealed the committee discussed the P&P for falls management, notifications of incidents, care plans, falls interventions, nursing assessments, shift to shift relief and report, with no changes made. Interview with the DCS, ADCS, Nurse Manager, ED, Admission Coordinator, DSS, MDS Director, on 05/05/15 at 2:00 PM, revealed QA would track and trend falls information to validate interventions and notifications were being completed.

6. Observation of the morning meeting, on 05/22/15 at 9:05 AM, revealed the IDT reviewed the 24 hour report, care plans, and specific

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F 514	Continued From page 665 resident concerns. 7. Review of in-service records, dated 05/13/15, revealed Administrative staff were trained on staffing, pest control, housekeeping and maintenance, and would be monitored by the ED. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, Assistant DCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS revealed they had been trained on staffing, pest control, housekeeping and maintenance, and any concerns of audits would be taken to the morning meeting. Interview with Resident #3 on 05/22/15 at 1:00 PM, revealed staffing had improved and were answering lights timely and the facility looked cleaner. 8. Observation of the daily morning meeting, on 05/22/15 at 9:05 AM, revealed review of the 24 hour report, notifications made and documented, new physician orders, maintenance concerns and books, pests, rounds and audits, call lights, care plans. Interview with the Maintenance Director, DCS, Assistant DCS, UM, Schedule Coordinator, MDS Coordinator, and DSS, on 05/22/15 at 2:52 PM, revealed they participate in the morning meeting and review the 24 hour report, notifications were made, maintenance books reviewed, physician orders, call lights, care plans, and audits/ round were reviewed in the morning meeting. 9. Review of sign in sheets, dated 04/22/15, 05/13/15, and 05/15/15, revealed QAPI meetings were held on those dates. Interview, with the Maintenance Director, DCS, Assistant DCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, Business Office Manager,	F 514		

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F 514	Continued From page 666 Housekeeping Supervisor, and DSS revealed they attended the QAPI meetings. Interview with the RDCS, on 05/22/15 at 5:05 PM, revealed the next QAPI meeting was scheduled for 06/17/15. Interview with the Medical Director, on 05/22/15 at 8:00 AM, revealed he was informed by the Executive Director of the resident care issues, attended the QA meetings held by the facility and provided direction regarding corrective action plans that were developed to meet the needs of the residents. 10. Review of the QAPI sign in sheet, dated 05/15/15, and agenda revealed audit tools were approved for QA monitoring and discussed: resident interviews; resident/family concerns; morning meeting; new employee files; falls or behaviors reviewed; care plans and Kardexes update; review of the 24 hour report; notifications; maintenance rounds and book; supervised smoking; falls interventions in place; call lights; weekly falls; and, behavior management meetings.	F 514		
F 520 SS=L	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	F 520		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HURSTBOURNE CARE CENTRE AT STONY BROOK	2200 STONY BROOK DR LOUISVILLE, KY 40220

(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	Continued From page 667 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 requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. 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 maintain an effective Quality of Assurance/Performance Improvement Committee (QA) to investigate and develop plans of action in response to identified problems. Observation, interview and record review revealed the facility failed to provide the assessed needs of its residents and failed to maintain a safe enviornment. Interview with Management staff revealed the facility was short staffed and this directly impacted the care the residents received. Interview revealed the QA members were aware of the facility's staffing shortage; however, the developed corrective action plan for the use of agency staff was not implemented due to the lack of the corporations approval process. This failure had the potential to affect all residents of the facility relative to the system for ensuring that residents received the required care and services to maintain their psychosocial well-being. (Refer to F157, F225, F226, F241, F280, F282, F254,	F 520		

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F 520	Continued From page 668 F309, F323, F353, F463, F469, F490, F493, and F514) Immediate Jeopardy was identified on 04/22/15 and determined to exist on 02/25/15. On 02/25/15 at approximately 12:30 AM, Resident #4 was found on the floor by a Certified Nursing Assistant (CNA) while performing rounds. Interview and record review revealed no documented evidence the resident's physician was notified at the time of the fall, there was no documented evidence the resident was assessed and monitored after the fall, and there was no evidence interventions were implemented to prevent recurrence. An x-ray was obtained at 4:30 PM (16 hours after the incident) and the resident was diagnosed with a right tibia fracture. Immediate Jeopardy was identified on 04/21/15 and determined to exist on 04/19/15. Observations revealed ants in the facility. Observation and interview with Resident #24 on 04/21/15 revealed ants in the resident's room. Interview with Resident #24 revealed on 04/19/15 ants were in the bed and crawling all over his/her body. The resident was scared and had to scream out for staff to help him/her. Immediate Jeopardy was identified on 05/12/15 and determined to exist on 03/25/15. Record review and interview revealed on 03/25/15 during the 7:00 AM-3:00 PM shift, Registered Nurse (RN) #6 noted Resident #25's right eye was swollen and bruised on the side with a small cut. The resident had a history of wandering into other resident rooms, both male and female. Interview and record review revealed the resident's eye injury was not assessed or monitored. There was no documented assessment of the injury	F 520		

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F 520	Continued From page 669 until 04/24/15, thirty (30) days after the bruising was identified. The facility could not provide any evidence the physician or responsible party were notified or that the incident was reported or investigated until 04/28/15 (thirty-four [34]days after the incident) after surveyor intervention. Immediate Jeopardy was identified on 05/12/15 and determined to exist on 04/28/15. Observation, interview and record review revealed the facility failed to ensure the resident call system was functional for Residents #5, #7, #12 and Unsampled Residents M, T, Z, AA, CC, GG, HH, II, JJ, KK, and LL in order to notify staff of their needs. The facility failed to provide the residents with an alternate means of notifying staff. Additionally, the call system panel located at the nursing station had buttons missing and others that did not work. The facility's failure to investigate and develop plans of action in response to identified problems has caused or is likely to cause serious injury, harm, impairment or death to a resident. An acceptable Allegation of Compliance (AOC) was received on 05/19/15 alleging the Immediate Jeopardy was removed on 05/16/15. The State Survey Agency validated the Immediate Jeopardy was removed on 05/16/15 as alleged, prior to exit on 05/22/15. The scope and severity was lowered to an F while the facility monitors the implementation of the Plan of Correction and the facility's Quality Assurance monitors the effectiveness of the systemic changes. The findings include:	F 520		

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F 520	Continued From page 670 Review of the facility's policy regarding Quality Assurance/Performance Improvement Committee (QA), dated 11/30/14, revealed the Quality Assurance Committee would meet monthly to review, recommend and act upon activities of the facility, performance action teams and/or departmental activities. The committee would direct all activities including approving proposed monitoring, evaluating, and review of services. The committee would assure activities had written indicators and standard/thresholds for evaluation, that appropriate actions are implemented, and that such correction had been evaluated by subsequent monitoring. Review, on 04/23/15 at 2:30 PM, of the QA signature sheets revealed the facility conducted QA meetings at least monthly with the required members. Interview with the Assistant Director of Clinical Services (ADCS), on 04/24/15 at 10:05 AM, revealed she was the designated Infection Control Nurse; however, since the facility was short staffed, she had been working the floor and had not been able to perform the duties of the infection control nurse. Further interview revealed she was responsible for monitoring and supervising care delivered by staff; however, she was unable to complete those duties because she had been working as a staff nurse. She further stated she was not aware of any action plans that were put in place to ensure resident's needs were met, there was an adequate supply of linens, pests were under control, or falls were prevented. She stated the management staff was supposed to conduct mock survey rounds each day, but due to observation of the facility's environment it was apparent the rounds were not done.	F 520		

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F 520	Continued From page 671	F 520		

Interview with the Medical Director, on 04/24/15 at 10:55 AM, revealed the QA committee did discuss the staffing shortage. He stated the action plan was to ask the corporation for approval to hire agency staff until full time staff could be hired. He stated he was very concerned with the lack of care and services provided by the facility. He stated as far as he could remember no other items were discussed and no other action plans were developed.

Interview with the previous Executive Director (ED), on 04/23/15 at 8:35 AM, and on 05/11/15 at 8:18 AM, revealed she resigned as of 04/17/15. She stated the underlying issue to the facility's inability to meet the needs of the resident was related to the staffing shortage. She stated the staffing shortage was discussed at the 04/01/15 QA Committee meeting and the action plan was to request approval to use agency staff from the Corporation. However, she had yet to obtain the approval prior to leaving the organization. She stated the QA Committee meeting members did not discuss how the staffing shortage effected meeting the resident's needs. She stated the committee did not develop an action plan to ensure the facility would meet the needs of the resident while waiting on the approval to hire agency staff. She stated she did not remember discussing pest control issues, linen shortages, incident reporting, maintenance or housekeeping issues in the QA meeting. She stated she did not conduct or document audits to determine opportunities for improvement or find additional areas of concerns that needed an immediate intervention. She stated she tried to fix issues as they came to her each day. For example, she

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F 520	Continued From page 672 stated the washers and dryers would break down frequently and she would call the repair man to fix them, which would take two days or more for the repairs to occur. However, no interim plan of action was developed to ensure the resident's had an adequate supply of linens and clean clothing until the repairs were made. She further stated she was aware of the pest issue; however, this was not taken to QA and no action plan was developed. She stated the Corporation was slow in paying its bills and this delayed the frequency of the times the pest control company came to the building. Interview with the Interim Executive Director/ Regional Vice President of Operations (ED/RVP) (as of 04/17/15), on 04/28/15 at 9:40 AM, and on 05/21/15 at 8:25 AM, revealed she was not aware of any complaints from residents about not receiving care and services. She stated prior to becoming the Interim ED she visited the building and made rounds with the previous ED to discuss and identify opportunities for improvement. She stated she did not make notes of their findings or discussions for follow up and was unable to provide evidence of any corrections made from the rounds. She stated she would remember her findings and when she made her rounds in the building on her next visit she would make a mental note if they were addressed or not. The ED/RVPO continued to state the Corporate Quality Assurance data/indicators did not address specific resident incidents/accidents or concerns, she stated it was only numbers, so she could not speak to specific resident issues. The ED/RVPO stated she could not say if the quality indicators for the facility had areas of concern or if action plans were developed regarding items discussed.	F 520		

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F 520	Continued From page 673 The ED/RVPO further stated she knew there were some issues with a few staff not having a high energy level to complete their assigned job duties and they had gotten rid of some of those employees. She stated she was not aware call lights were not working or that staff were unable to answer them timely, or that a resident obtained a wound caused by the brace. She stated she was also not aware the shower bed did not have all the metal pins to maintain the bed rails in the up position, linen par levels were not adequate, or of the environmental repairs that needed to take place. She stated she was only aware of one resident that had an issue with ants and thought that had been resolved. The facility took the following actions to remove the Immediate Jeopardy on 05/16/15 as follows: 1. The facility notified Resident #4's physician, of a fall that occurred on 02/25/15 with new orders given to the nurse. The resident transferred to a local hospital on 02/25/15 for a tibia fracture and returned to the facility on 02/28/15 with new orders. The DCS assessed Resident #4 on 04/22/15 and was found in stable condition. 2. On 04/22/15, one hundred twenty-six (126) residents were assessed by the ADCS, Nurse Manager, and Licensed Nurse to determine if any residents had an incident or accident or change in condition that would warrant physician notification and further intervention. One (1) resident was identified as having an incident, accident, or change of condition and the physician was notified by the nurse on 04/22/15. Additionally, the Nurse notified the RP and documented this in the	F 520		

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F 520	Continued From page 674 clinical record. Nurses would additionally report incidents, accidents, or changes in condition to the clinical administrative team. 3. On 04/22/15 the Corporate Administrative Nurses educated twenty-three (23) of thirty-eight (38) Nurses regarding timely notification to the physician related to resident incidents, accidents, or change in condition; care plan policies, evidence of assessments and care planning with immediate falls preventions interventions to meet the resident's needs; and falls procedures, immediate assessment by the Nurse after a resident's fall, notifications to the physician and RP, implementation of an immediate intervention by the Nurse, documentation of the fall in the clinical record by the Nurse, fall root cause investigation report initiated by the Nurse and reviewed by the DCS, and follow up by the IDT in the weekly falls meeting. Nurses were also trained related to reporting an incident, accident, or change in condition, to the resident ' s RP and documentation in the medical record to include the incident, accident, or change in condition, notifications to the physician, RP, and clinical administrative team, nurse's assessment, and interventions; evidence of assessment would include Situation, Background, Appearance, and Review (SBAR) sheet, Interdisciplinary Progress Note, and Neurological (neuro) checks sheet, and documentation of falls. Staff competencies were completed. Nursing staff not educated by midnight on 04/22/15 would not be allowed to work until they received training. Agency Nurses would be trained by the Corporate Administrative Nurses, DCS, Assistant DCS, or Nurse Manager prior to working their next shift. The DCS and ED would ensure staff that had not been educated	F 520		

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were educated prior to working their next shift. The ED and DCS would monitor the daily schedule and highlight staff already trained. A department manager would stand by the time clock at shift change to direct staff that needed education to the training. The IDT would monitor daily incidents and accidents. Notifications of accidents, incidents, or changes of condition would be reviewed for completion by the DCS, ADCS, or Nurse Manager, who would make notifications if not done.

4. An Ad-Hoc Quality Assurance/ Performance Improvement (QAPI) meeting was conducted on 04/22/15 to discuss facility policy and procedure (P&P) for falls, and notifications of incidents, accidents, or changes of condition; care plans as related to immediate falls interventions and revision status post fall, nursing assessment and documentation for falls; with no changes made. Also discussed the facility protocol related to shift relief and report; and additional avenues to attract new staff and maintaining current staff with a plan for performance improvement.

5. On 04/22/15, 126 residents were reviewed for fall risk with a fall risk assessment completed by the DCS and MDS Nurses who had previously been educated on 04/22/15, and care plans and Kardexes were also reviewed, with seventy-four (74) residents whose fall care plans were updated on 04/22/15.

6. On 04/22/15 the Corporate Administrative Nurses educated the DCS, ADCS, and Nurse Manager regarding evidence of assessment and care planning, with immediate falls prevention interventions to meet the resident's needs. On 04/22/15, thirty (30) of fifty-eight (58) CNAs and

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two (2) Agency CNAs were educated to review the Kardex for specific fall risk information.

7. Certified Medication Technician's (CMT) would be supervised by the Nurse they work with on the unit. The current resident census was reviewed by the ED and DCS to determine which residents required total care, assistance, or were independent with care.

8. On 04/22/15, 126 residents were assessed by Nurses using a visual and/or verbal nursing assessment that included vital signs to ensure there were no current physical or emotional distress or needs that were not met as related to inadequate staffing. One (1) resident was identified in physical distress and the Nurse timely notified the physician.

9. On 04/22/15, The Corporate Administrative Nurses educated twenty-three (23) of thirty-eight (38) Nurses, thirty (30) of fifty-eight (58) CNAs, and two (2) Agency CNAs related to staffing, to notify the ED, DCS, or ADCS for any staff call outs. The ED, DCS, ADCS, or Scheduler would attempt to replace the staff member who called out by calling on facility staff to stay over or come into work. If staffing needs could not be met the ED, DCS, ADCS could mandate staff currently working. Staff were educated on waiting for their relief to arrive prior to leaving the facility, and to give shift report to oncoming staff, that would include resident status, falls that occurred, and any new interventions. Staff competencies were completed.

10. On 04/28/15, the facility reported to the SSA that Resident #25 was found to have a black eye on 03/25/15. The incident was investigated and

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F 520	Continued From page 677 with the assistance of the SSD and DCS the source of the black eye was determined as a result of a resident to resident altercation and abuse was unsubstantiated. 11. One hundred twenty-one (121) residents were assessed by a nurse for suspicious injuries on 05/12/15 and 05/13/15. No suspicious injuries were found. 12. Current residents with BIMS Scores of twelve (12) or higher were interviewed by the ED, on 05/12/15 and 05/13/15, about their safety. 13. Staff in Nursing, Dietary, Housekeeping and Laundry, and Therapy were interviewed by the ED/Assistant ED on 05/12/15, 05/13/15, and 05/14/15. Two (2) new allegations of abuse/neglect that required reporting to the SSA were reported on 05/14/15. 14. The Corporate Administrative RNs educated 107 of 149 staff and fourteen (14) agency staff on abuse and neglect and injuries of unknown origin from 05/09/15 through 05/14/15 with competency. Forty-two (42) staff not educated as of 05/14/15 will not be allowed to work without having been educated prior to the start of their shift. Agency staff will be educated prior to working their next shift. Staff, through the use of a Performance Improvement tool, staff were aware of the types of abuse, injuries of unknown origin, and when and whom to report to. Forty- two (42) staff not educated as of 05/14/15 15. One hundred twelve (112) of 112 employee personnel files were reviewed by the Regional Director of HR (RDHR), facility HR, and BOM to ensure files were complete with criminal	F 520		

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F 520	Continued From page 678 background checks, nurse aide abuse registry checks, and abuse training. The RDHR corrected discrepancies on 05/13/15. Ongoing reviews of five (5) new employee files would occur twice weekly. 16. The ED or DCS would review all allegations of abuse, complete the 24 hour report, investigation, and five (5) day report. 17. The QAPI Committee met on 05/13/15 and reviewed the Policy and Procedures (P&P) for abuse with no changes made. 18. The Regional Director of Clinical Services (RDCS) reviewed potential reportable events were completed on 04/21/15 through 04/24/15, 04/26/15 through 04/29/15, 05/01/15, 05/04/15, 05/06/15, 05/09/15, and on 05/11/15 with no issues identified. On 05/14/15 the RDCS reviewed abuse allegations and investigations for the last ninety (90) days for timely reporting, investigation, and resolution. 19. An Ad-Hoc QAPI Committee meeting on 05/15/15 discussed ongoing quality improvement monitoring for abuse and neglect reporting beginning 05/16/15 using an approved audit tool and included: a. Five (5) resident interviews on 05/12/15 and ongoing five (5) times weekly. b. Skins sweeps on 05/08/15, 05/12/15, 05/13/15 completed by a nurse and reviewed by RDCS, Corporate Administrative RNs, DCS, ADCS, or Nurse Manager for any suspicious injuries, of five (5) residents, five (5) times a week.	F 520		

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F 520	Continued From page 679 c. Beginning 04/21/15 and ongoing the RDCS, RVPO, RDHR will review new allegations of abuse and neglect for timely reporting, investigation, and resolution once a week. d. On 05/15/15 and ongoing new resident and family concerns would be reviewed by the ED, RDCS, RCPO, RDHR, or Corporate Administrative RNs for resolution five (5) times a week. e. On 05/12/15 an ongoing Daily Department Head Meeting led by the ED and DCS would be attended by Corporate Administrative RN, RDCS, RVPO, or RDHR to ensure new resident injuries or concerns were discussed five (5) times weekly. 20. Current residents were reviewed for behaviors, on 05/12/15 and 05/13/15, by Corporate Administrative RNS and two (2) members of the IDT. Care plans were reviewed for sixty-six (66) residents with behaviors, with twenty (20) care plans updated, with one (1) resident placed on 1:1 supervision. 21. 101 of 149 staff and 10 agency staff were educated regarding resident behaviors and documentation, care planning and following the care plan, reporting maintenance issues, safe smoking policy, on 05/13/15 and 05/14/15 by the Corporate Administrative RNs. IDT will meet to ensure behaviors were documented and care planned, notification to the physician, and document on the 24 hour report. Residents with behaviors would be reviewed during the weekly IDT meeting beginning 05/12/15. The 24 hour report would be reviewed in the morning meeting. Forty-eight (48) staff not educated will not be allowed to work until they have been trained. No	F 520		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HURSTBOURNE CARE CENTRE AT STONY BROOK	2200 STONY BROOK DR LOUISVILLE, KY 40220

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F 520	Continued From page 680 staff will be allowed to work after 05/14/15 until they have been educated prior to the start of their shift. The ED or DCS would monitor the schedule and appoint a department manager to stand at the time clock to direct employees still needing education to the in-service. 22. QAPI meeting was held on 05/13/15 to review the P&P for care plans and behavior management, resident weights, skin assessments, ADLs, smoking, assistive devices related to lifts and shower bed, facility maintenance, pest control, housekeeping/ laundry, and staffing, falls, incidents/accidents, grievances, with no changes made. The facility's action plan for removal of the IJ was reviewed and tasks assigned, with department managers assigned to provide daily oversight along with the RDCS/ RVPO/ RDHC/ RCMC/Corporate Administrative RNs. 23. Beginning 05/15/15, residents with new falls and behaviors were reviewed by the Daily IDT team for completion of SBAR, assessment, notification, immediate interventions, and investigation with root cause analysis. Care plans and Kardexes were reviewed/updated with appropriate interventions. No issues were identified, and would be validated five (5) times weekly. 24. Beginning 05/12/15 weekly falls management meeting and weekly behavior management meeting occurred with IDT, with no issues identified. The IDT in the daily meeting reviewed the 24 hour report with no issues identified, and validated one (1) time weekly. 25. An Ad-Hoc QAPI meeting held on 05/15/15	F 520		

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F 520	Continued From page 681 for ongoing QI monitoring of the facility process for abuse and neglect reporting is done, and call lights, beginning 05/16/15 using an approved audit tool. Any issues identified in audits were addressed and ongoing plans developed. 26. A weekly behavior meeting was held on 05/12/15 and 05/13/15 and discussed six (6) residents with resident to resident behaviors or sexual/ physical behaviors to ensure behaviors were documented, care planned, and interventions in place. 27. On 05/13/15 and 05/14/15 twenty-two (22) nurses were educated by the Corporate Administrative RNS to complete skin sweeps weekly and PRN, and complete residents' weights per physician order. 28. The IDT would review in the daily meeting incidents and accidents reports and the 24 hour report for investigation reports, nursing documentation in the clinical record, an SBAR, notifications to the physician and RP, and care plans with appropriate interventions. 29. On 04/30/15, one hundred twenty-four (124) residents were reviewed for appropriate transfer/lift method and updated the care plans and Kardexes, including Residents #4 and #34. The shower bed was removed from the facility and discarded. A new shower bed was ordered on 05/07/15. A shower bed located in the shed was inspected and discarded by Maintenance on 05/13/15. 30. The SSD completed safe smoking evaluations on fifteen (15) residents who smoke, on 05/13/15, with three (3) identified to require a	F 520		

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F 520	Continued From page 682 smoking apron and two (2) referred to therapy for adaptive smoking equipment. Residents who smoke were given a copy of the facility's safe smoking rules on 05/13/15 and 05/14/15. 31. Room rounds were conducted by the ED, on 05/13/15, for incendiary smoking items, with any items found removed and maintained in a locked box at the nurse's station for supervised smoking times by facility staff. A list of residents who smoke and who require supervision or aprons would be kept in the locked box with the Kardexes. 32. On 05/12/15 Corporate Administrative Nurses made walking rounds to identify any maintenance/resident safety concerns. Identified concerns were given to the ED and Maintenance Director for prioritization and repair. On 05/13/15 The ED and Maintenance Director made facility rounds and reviewed the maintenance books at the nurse's stations to identify safety concerns. Safety concerns were addressed by the Maintenance Director on 05/13/15 and 05/14/15. The Maintenance Director was educated on 05/13/15 to check the maintenance books at each nurse's station five (5) times weekly and prioritize based on safety concerns. 33. Fifty-one (51) nursing staff and 10 agency staff were educated on 05/13/15 and 05/14/15 to observe shower beds for safety prior to use. If a shower bed was unsafe or non-functional, staff would immediately remove the equipment and notify maintenance. 34. QAPI monitoring, beginning 05/15/15 of the facility process for falls, smoking, assistive devices, lifts, shower beds, and facility	F 520		

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F 520	Continued From page 683 maintenance. 35. Beginning 05/12/15 the IDT would round to observe for environment safety concerns in five (5) resident care areas and immediately addressed by maintenance, and validated five (5) times weekly. Maintenance books would be brought to the daily meeting to discuss concerns five (5) times weekly. 36. Beginning 05/13/15 training and return demonstration of five (5) nursing staff will be completed five (5) times weekly. Observations of five (5) residents during supervised smoking by a member of the IDT five (5) times weekly. Rounds of five (5) resident rooms for incendiary items by a member of the IDT would be completed five (5) times weekly. Any issues would be brought to the daily meeting. 37. Five (5) residents would be observed, beginning 05/12/15, to ensure fall interventions were in place per the care plan would be completed by IDT five (5) times weekly. 38. Resident call lights were checked for function on 05/12/15 for Resident #7, #5, #12, Unsampled Residents Z, and AA. Unsampled Resident M no longer resided in the facility. Resident #12's call light was found not to light at the desk or the door. 39. On 05/12/15, one hundred twenty-four (124) residents call lights were checked for function and twenty-two (22) rooms were found to not light at the desk, one (1) room did not light at the desk or door, and two (2) rooms did not light at the desk or door, or sound. The ED was notified of the three (3) resident rooms, on 05/13/15, that	F 520		

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F 520	Continued From page 684	F 520		

had call lights that did not work. All six (6) residents of the three (3) rooms were put on fifteen (15) minute safety checks. On 05/13/15 an outside contractor initiated maintenance to ensure functionality and made repairs on 05/13/15 with an additional room repaired on 05/14/15 of a call light that would not turn off. The annunciator system at the nurse's station on the 200 unit was repaired, on 05/14/15.

40. Twelve (12) nursing staff working 11:00 PM to 7:00 AM on 05/12/15 were educated on the call light P&P on 005/09/15 through 05/12/15 with competencies. The 11:00 PM to 7:00 AM staff working on 05/12/15 were re-educated on the facility's P&P for an inoperable call light system, on 05/13/15, and the six (6) residents were placed on fifteen (15) minute safety checks until the call lights were functional. Hand bells were also given to the six (6) residents on 05/13/15.

41. One hundred and one (101) of 149 staff were educated on 05/09/15 through 05/14/15 on the facility's call light P&P and what to do if there was an inoperable call light, and use the pest sightings book at the nurse's station. Forty-eight (48) staff not educated by 05/14/15 would not be allowed to work until they had been educated prior to the start of their shift.

42. On 05/11/15, pest control service evaluated the facility and rendered services on 05/13/15, with another visit on 05/14/15. Pest control would visit monthly and as needed. As of 05/15/15 live pests in the facility had been eliminated.

43. Walking rounds were conducted by Corporate Administrative Nurses, on 05/12/15, to look for pests, with none seen. One hundred twenty-one

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F 520	Continued From page 685 (121) residents were assessed by skin sweeps, with no pest bites evident. No pests were observed in resident beds or rooms. 44. Beginning 05/14/15 rounds were completed by IDT Monday through Friday with no pest issues identified. 45. An Ad-Hoc QAPI meeting, held on 05/14/15, related to QI monitoring of the facility's process for pest control would be completed by the ED/RVPO one (1) time monthly that pest control visits occurred monthly. Beginning 05/15/15 resident care areas would be checked to ensure there were no live pests five (5) times weekly. 46. On 05/12/15 and 05/13/15, housekeeping rounds were completed by the ED and Housekeeping Supervisor for facility cleanliness and odors, with areas needing cleaning were cleaned on 05/12/15 through 05/15/15. 47. On 05/13/15, Corporate Administrative RNs educated facility Administrative Staff on the regulations and P&P for staffing, pest control, housekeeping, and maintenance, with competencies completed. The ED would monitor the facility's process for notification, abuse, hiring, dignity, care plan revision, professional standards, assessments, behavior and falls management, incidents and accidents, smoking, call lights, pest control, and staffing. 48. New employee files would be reviewed by the ED or Corporate Administrative Nurses for completeness two (2) times weekly. 49. Review of the 24 hour report, incident/ accident reports, in the daily meeting with the	F 520		

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F 520	Continued From page 686 IDT; documentation in the clinical record included notification to the physician and new orders, and to the RP; the IDT made rounds in five (5) resident care areas to observe for maintenance and safety concerns; observations of five (5) residents during supervised smoking by the IDT; room rounds for five (5) residents to search for incendiary items by a member of the IDT, maintenance concerns were written in the maintenance books and taken to the daily meeting and prioritized for repair; observations of five (5) residents to ensure falls interventions were in place per the care plan by the IDT; call lights checked in resident rooms and bathrooms to ensure lights and sound; five (5) staff educated what to do if call light inoperable; resident care areas checked for no live pests; were validated five (5) times weekly. 50. Daily oversight since 04/22/15 on all shifts to ensure residents were safe and the plan of care was followed to meet resident needs, by the ED/ DCS/ RVPO/RDCS/Corporate Administrative Nurses. 51. The IDT would meet at least monthly to discuss facility action plan and ensure tasks were completed for the removal of the IJ, and QA monitoring completed according to the AOC during the IJ period, validated by the ED/RVPO/RDCS/Corporate Administrative RNs. 52. Per the Ad-Hoc QAPI meeting, on 05/15/15, QI monitoring would be done utilizing approved audit tool with oversight by the ED, beginning 05/16/15, five (5) resident interview; new resident/ family concerns; daily department head meeting to ensure new resident injuries or concerns were discussed; five (5) new employee files reviewed	F 520		

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F 520	Continued From page 687 two (2) times weekly; residents with new falls or behaviors were reviewed in the daily meeting with IDT and care plans/ Kardexes reviewed and updated; review of the 24 hour report and the incident and accident reports in the daily meeting with IDT; review of the clinical record for timely notifications to the physician and RP; the IDT rounds in five (5) resident care areas to observe the environment for safety and maintenance concerns; observations of five (5) residents during supervised smoking; room rounds of five (5) residents for incendiary items; maintenance concerns listed in the maintenance book and taken to the daily meeting to discuss and prioritize repairs; observations of five (5) residents to ensure falls interventions were in place per the care plan by the IDT; five (5) resident rooms call lights checked to ensure they light at the door, nurse's station, and sound; five (5) staff education what to do if a call light was inoperable; five (5) times weekly; weekly falls and behavior management meetings occur with IDT one (1) time weekly. 53. Linen rounds were completed, on 05/13/15, by the ED/ Housekeeping Supervisor/Department Managers to ensure PAR levels and available resident laundry, with areas of concern addressed by the Housekeeping Supervisor at that time. 54. The RVPO/RDCS/Corporate Administrative RNs would provide daily oversight of the ED and DCS in areas of falls, incidents, accidents, change in condition, sufficient staffing to meet resident needs, housekeeping and laundry, and pest control during the IJ period until removal. 55. Grievances were reviewed, on 05/13/15, by	F 520		

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F 520	Continued From page 688 the ED/SSD/DCS back to 05/1/15 for any areas requiring additional follow up, which was handled by 05/15/15. 56. Resident #39's hair was washed and combed, shaved and care provided, sheets changed, privacy curtain provided. 57. On 05/12/15 rounds were completed by the DCS/ADCS/ Nurse Managers, and Corporate Administrative Nurses to identify residents who needed additional grooming or incontinent care; bed linens checked to ensure they were clean and pest free; call lights checked to ensure they were within resident reach and answered timely; resident's skin observed to ensure free from pests; and privacy curtains in place. Additional grooming was provided to residents requiring it, and one (1) resident room was identified to need a privacy curtain on 05/13/15. 58. On 05/13/15 and 05/14/15, nursing staff and ten (10) agency staff were educated on incontinent care, bathing, shaving, washing resident's hair, with those not trained would not allowed to work until trained prior to the start of their shift. 59. On 05/13/15 and 05/14/15, 101 of 149 staff and ten (10) agency staff were educated to notify housekeeping when privacy curtains were needed; report pest sightings in the pest sightings book; any pests noticed on residents should be reported immediately to the nurse supervisor/DCS/ADCS for completion of a skin assessment; resident privacy. Forty-eight (48) staff not educated will be trained prior to working their next scheduled shift.	F 520		

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F 520	Continued From page 689 60. A QAPI meeting was held, on 05/13/15, to discuss the facility's P&P for incontinent care, resident privacy, shaving, AM care, with no changes made. 61. Daily rounds were conducted by department managers and corporate administration Monday through Friday to identify any issues with resident incontinent care, privacy, shaving and AM care, with any issues identified discussed in the daily IDT meeting and resolved with further Ad-Hoc education. 62. An Ad-Hoc QAPI meeting, on 05/15/15, discussed QI monitoring would be completed beginning 05/16/15 for: beginning 05/12/15 observations of five (5) residents to ensure they were shaven, hair combed, provided incontinent care, privacy curtains were clean, bed linens were clean, rooms/bed/residents were free from pests, privacy provided for care, call lights in reach and answered timely, would be conducted five (5) times weekly. The State Survey Agency validated the removal of Immediate Jeopardy on 05/22/15 as follows: 1. Review of the facility's SBAR's, incident report, neuro checks, progress notes and physician orders, all dated 02/25/15, revealed Resident #4 had a fall on 02/25/15, the physician was notified on 02/25/15 with new orders received. The resident was transferred to a local hospital on 02/25/15 for a tibia fracture on 02/25/15, and returned to the facility on 02/28/15 with new orders. The DCS assessed Resident #4 on 04/22/15 and found the resident was stable. 2. Review of one hundred twenty-six (126)	F 520		

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F 520	Continued From page 690 resident assessments, completed by ADCS/Nurse Manager/Licensed Nurse, on 04/22/15, revealed residents were assessed for any incident or accident, or change in condition that warranted notification to the physician. One (1) resident was identified as experienced a change in condition, accident, or incident and the physician was notified on 04/22/15. 3. Review of in-service records, revealed twenty-three (23) nurses were educated by Corporate Administrative Registered Nurses regarding: timely notification to the physician related to incidents, accidents, and changes in condition; care plan policies; resident assessments, including SBAR, neuro checks; falls and immediate interventions; notification to the physician and RP; documentation of the fall in the clinical record; fall root cause investigation report. Staff competencies were completed. No staff had worked prior to them receiving the training. Review of staffing schedules revealed staff who had not yet been trained were not highlighted, which noted they required education. Review of facility records revealed notifications of incidents, accidents, and changes in condition were reviewed for completion by the DCS/ADCS/ Nurse Manager. Interview with the DCS and RDCS, on 05/04/15 at 4:18 PM, revealed twenty-three (23) nurses had been trained. Interview with RN #8, on 05/04/15 at 4:33 PM, with CNA #11, on 05/05/15 at 9:51 AM, with the UM, on 05/05/15 at 9:55 AM, CNA #14, on 05/05/15 at 10:03 AM, CNA #13, on 05/05/15 at 10:10 AM, revealed they had been educated on falls, notifications, Kardex and care plans. Interview, on 05/05/15 at 2:00 PM, with the DCS, ADCS, Nurse Manager, ED, Admissions Coordinator, DSS, MDS Director revealed they	F 520		

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had all been trained on care plans, changes in condition, staff look at interventions for residents, the 24 hour report, falls, SBAR, incident reports, Kardex and care plans, notifications to the physician and family.

4. Review of a QAPI sign in sheet, dated 04/22/15, and agenda revealed the committee discussed the P&P for falls management, notifications of incidents, care plans, falls interventions, nursing assessments, shift to shift relief and report, with no changes made. Interview with the DCS, ADCS, Nurse Manager, ED, Admission Coordinator, DSS, MDS Director, on 05/05/15 at 2:00 PM, revealed QA would track and trend falls information to validate interventions and notifications were being completed.

5. Review of resident assessments for risk for falls, dated 04/22/15, for one hundred twenty-six (126) residents revealed seventy-four (74) residents were assessed by the ADCS as at risk for falls. Review of the Kardexes and Care Plans for the seventy-four (74) residents assessed at risk for falls revealed the Kardexes and care plans had been updated, on 04/22/15. Observation of room 107-A, on 05/05/15 at 1:26 PM, revealed the resident had falls interventions in place. Observation, on 05/05/15 at 1:30 PM, of room 112-A, revealed the resident's falls interventions were in place. Observation, on 05/05/15 at 1:30 PM, of Unsampled Resident Y revealed the resident had falls interventions in place. Observation of Unsampled Resident O, on 05/05/15 at 2:52 PM, revealed the resident's falls interventions were in place.

6. Review of training records, dated 04/22/15,

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F 520	Continued From page 692 revealed thirty (30) CNAs and two (2) agency staff were educated on the Kardex and falls risk. The Corporate Administrative RNs educated the DCS/ADCS/Nurse Manager, on 04/22/15, regarding assessments, care plans, documentation of falls, and immediate falls interventions. Interview with CNA #6, on 05/05/15 at 10:12 AM, revealed he received training on the Kardex, falls, and notify the nurse if a resident had a change in condition. 7. Review of staff schedules revealed CMTs were scheduled to work with another nurse present on the unit. Review of a resident census revealed, on 04/22/15, the ED and DCS reviewed which residents required total care, assistance, or were independent with care. Observation, on 05/05/15 at 10:15 AM, revealed CMT/ CNA #11 on the 200 unit was supervised by LPN #1. 8. Review of assessments for one hundred twenty-six (126) residents, dated 04/22/15, revealed residents were assessed by the DCS, with vital signs taken. One (1) resident was identified in distress and the physician was notified at that time. 9. Review of in-service records, dated 04/22/15, revealed twenty-three (23) nurses, thirty (30) CNAs, and two (2) agency staff were educated who to call when they call out and how the shift may be covered to ensure adequate staffing, shift report. Staff competencies were completed. Interview, on 05/04/15 at 4:00 PM, with the RDCS and Interim ED, revealed twenty-three (23) nurses were educated on staffing. Interview with LPN #1, on 05/05/15 at 9:45 AM, revealed he had been trained on what to do and who to call if calling in, and call in to the ED, DCS, or ADCS;	F 520		

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F 520	Continued From page 693 stated he had to go through training before he was allowed to work. Interview, on 05/05/15 at 9:51 AM, with CNA #11 revealed she had been educated on staffing, to call the ED, DCS, or ADCS, and had to be trained prior to working. Interview with the UM, on 05/05/15 at 9:55 AM, revealed she was educated on staffing and the ED, DCS, or ADCS should be called if staff were to call in. Interview with CNA #6, on 05/05/15 at 10:12 AM, revealed he could only call the ED, DCS, or ADCS if he could not come in to work and he was to wait for the next shift before leaving. 10. Review of the facility investigation, dated 04/28/15, for Resident #25's black eye noted on 03/25/15, revealed the SSA was notified on 04/28/15, investigated, and followed up on 05/04/15. The investigation resulted in the cause of the injury from a resident to resident altercation. Interview with the DCS, on 05/20/15 at 2:04 PM, revealed she investigated Resident #25's black eye and the cause was determined to be a resident to resident altercation. Observation, on 05/22/15 at 2:11 PM of Resident #25 revealed the resident was in his/her recliner with the TV on and staff sitting with him/her on a 1:1. 11. Review of skin sweeps, dated 05/12/15 and 05/13/15, for one hundred twenty-one (121) residents revealed no suspicious injuries were identified. Interview with the RDCS, on 05/22/15 at 8:59 AM, revealed all residents skin were assessed for any injuries that did not have reasonable cause. Observation of Resident #25, on 05/05/15 at 2:11 PM, Unsampled Resident KK, on 05/05/15 at 2:11 PM, Resident #8, on 05/22/15 at 4:20 PM, Resident #6, on 05/05/15 at 2:26 PM, revealed no concerns with new or unknown	F 520		

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F 520	Continued From page 694 injuries. 12. Review of resident interview questionnaire, dated 05/12/15 and 05/13/15, revealed residents with a BIMS Score of twelve (12) or more were interviewed by the Executive Director about their safety, no concerns identified. Interview with the DCS, on 05/22/15 at 2:52 PM, revealed residents were interviewed about their safety with no concerns identified. Interview with Resident #8, on 05/22/15 at 4:20 PM, revealed the resident felt safe in the facility. 13. Review of staff questionnaires, dated 05/12/15 and 05/13/15, revealed staff were interviewed by the ED to determine if any staff member had witnessed abuse or neglect. Review of two (2) facility reports to the SSA revealed the reports were made on 05/14/15. Interview with the DCS, on 05/22/15 at 2:52 PM, revealed staff were interviewed about abuse. She stated two (2) new additional reports were made and investigations were begun. 14. Review of in-service records, dated 05/09/15 through 05/14/15, revealed one hundred one (107) staff and fourteen (14) agency staff were educated on abuse and neglect and injury of unknown origin, with staff competencies completed. Interview with CNA #7, on 05/22/15 at 8:05 AM, RN #6, on 05/22/15 at 8:13 AM, with Housekeeper, on 05/22/15 at 8:20 AM, with LPN #1, on 05/22/15 at 8:25 AM, CNA #8, on 05/22/15 at 8:37 AM, had been trained on abuse and neglect, could name the types of abuse, and who and when to report. Interview, on 05/22/15 at 2:52 PM, with the DCS, Maintenance Director, ADCS, UM, Staffing Coordinator, Medical Records, MDS Coordinator, Housekeeping Supervisor, revealed	F 520		

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F 520	Continued From page 695 they had been trained on abuse. 15. Review of one hundred twelve (112) employee file audits, dated 05/13/15, revealed employee files were audited by the Regional Director of Human Resources by the Regional Director of Clinical Services for criminal background checks, nurse aide abuse registry, OIG checks, and telephone reference checks with no discrepancies corrected. Review of the QAPI meeting, held on 05/15/15, five (5) new employee files would be reviewed for completeness, twice a week. Review of five (5) new employee files, dated 05/15/15 and 05/20/15, revealed they were complete with criminal checks, nurse aide abuse registry, OIG checks, and reference checks. 16. Review of the facility abuse allegation investigations, revealed complete investigations and five day follow up. Interview with the RDCS, on 05/22/15 at 12:07 PM, revealed allegations were reviewed for investigation and follow up. 17. Review of a QAPI sign in sheet, dated 05/13/15, revealed review of the P&P for abuse with no changes made. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, ADCS, UM, Staffing Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS had all been trained on abuse, and staff trained on abuse. 18. Review of facility investigations , dated 04/21/15 through 04/24/15, 04/26/15 through 04/29/15, 05/01/15, 05/04/15, 05/06/15, 05/09/15, 05/11/15, revealed incidents were reviewed by the RDCS for regulatory compliance and timeliness with no issues identified. Review of the	F 520		

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F 520	Continued From page 696 investigations audit for the last thirty (30) days, dated 05/14/15, revealed the investigations were reviewed for timely reporting, investigation, and resolution. Interview with the RDCS, on 05/22/15 at 12:07 PM, revealed she completed the review of investigations with no concerns. 19. Review of the sign in sheet and agenda for QAPI meeting, dated 05/15/15, revealed monitoring of abuse and neglect reporting: resident interviews, dated 05/12/15, 05/13/15, 05/15/15, 05/16/15, 05/18/15, 05/19/15, would be completed for five (5) residents five (5) times weekly; skin sweeps, dated 05/08/15, 05/12/15, 05/13/15, and would be conducted for five (5) residents five (5) times a week; beginning 05/15/15 resident and family concerns would be reviewed five (5) times weekly; beginning 05/12/15 and on 05/15/15, 05/18/15, 05/19/15, 05/20/15, daily meeting would discuss new resident injuries or concerns five (5) times weekly; and use of an abuse audit tool for abuse reporting beginning on 05/15/15. Observation of the daily meeting, on 05/22/15 at 9:05 AM, revealed specific residents were discussed in regard to specific resident concerns. Interview with the DCS, on 05/22/15 at 2:52 PM, revealed residents were discussed in the morning meeting for specific concerns and plan. 20. Review of current residents were assessed for behaviors by the Corporate Administrative Registered Nurses/Interdisciplinary Team, on 05/12/15 and 05/13/15, revealed sixty-four (64) residents with behaviors had their care plans reviewed, with nineteen (19) care plans updated. One (1) resident was placed on 1:1 supervision, on 05/13/15. Interview with the RDCS, on 05/22/15, revealed sixty-four (64) residents were	F 520		

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F 520	Continued From page 697 reviewed, and nineteen (19) actually had care plan interventions updated. 21. Record review of in-services conducted 05/13/15 and 05/14/15 revealed one hundred one (101) staff were educated by Corporate Administrative Registered Nurses on bathing, AM care, shaving, hair care, change in condition, notifications to physician and RP, assessments, linens and laundry, falls, behaviors, abuse, resident smoking and use of aprons. Observation on the IDT in daily morning meeting, on 05/22/15 at 9:05 AM, revealed specific residents and behaviors, the 24 hour report, with department heads noted an new orders or changes to the care plans. 22. Review of a QAPI sign in sheet, dated 05/13/15, and agenda revealed the P&P for care plans and behavior management were discussed with no changes made. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Staff Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS attended the QA meetings. 23. Review of audit tools revealed residents with new falls and behaviors were reviewed by the Interdisciplinary Team in the daily meeting for completion of the documentation, notifications, care plans and Kardexes. Observation, on 05/22/15 at 9:05 AM, of the IDT morning meeting revealed specific resident concerns were reviewed, 24 hour report and behaviors were discussed, and care plans reviewed. Interview, on 05/22/15 at 2:52 PM, with the DCS revealed facility audits were reviewed in the daily meeting and any concerns discussed.	F 520		

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F 520	Continued From page 698 24. Review of the weekly falls meeting and behavior management meeting with the IDT, beginning 05/12/15, revealed meetings were conducted. Observation of the daily IDT meeting, on 05/22/15 at 9:05 AM, revealed the 24 hour report was discussed. Interview with the DCS, on 05/22/15 at 2:52 PM, revealed resident behaviors were reviewed in the behavior management meeting. 25. Review of the sign in sheet for an Ad-Hoc QAPI meeting, dated 05/15/15, and audit tools revealed abuse and neglect reporting was monitored by the QA. 26. Review of weekly behavior meeting notes, dated 05/12/15 and 05/13/15, revealed six (6) residents with resident to resident behaviors or sexual/physical behaviors were reviewed for documentation, care plan interventions. Interview with the DCS, on 05/22/15 at 2:52 PM, revealed the behavior meeting reviewed and monitored residents with behaviors, notifications, interventions were in place, and possibility for more frequent monitoring. 27. Record review of in-services conducted on 05/13/15 and 05/14/15 revealed education provided for skin assessments, resident weights. Interview with CNA #7, on 05/22/15 at 8:05 AM, with RN #1, on 05/22/15 at 8:13 AM, with LPN #1, on 05/22/15 at 8:25 AM, with CNA #8, on 05/22/15 at 8:37 AM, revealed they had been trained on resident weights and skin assessments. Observation, on 05/22/15 at 3:30 PM, revealed Resident #34 skin assessment was performed by Registered Nurse #11 and no new skin issues were identified and the documentation was completed as required.	F 520		

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F 520	Continued From page 699 28. Observation of the morning meeting, on 05/22/15 at 9:05 AM, revealed the IDT reviewed the 24 hour report, care plans, and specific resident concerns. 29. Review of facility assessments, dated 04/30/15, revealed one hundred twenty-four (124) residents were assessed for transfer/lift with Kardexes and care plans updated. Observation, on 05/22/15 at 2:20 PM, revealed no concerns with a broken shower bed in the 100 Unit shower room and lifts were functional. 30. Review of resident Safe Smoking Evaluations for fifteen (15) residents and completed by the SSD, on 05/13/15, revealed three (3) residents were identified to need a smoking apron. Review of the therapy screening tool revealed, and two (2) residents were referred to therapy. Observation, on 05/22/15 at 4:53 PM, revealed one (1) resident was smoking, used an apron, and staff assisted the resident to smoke. Interview with the DSS, on 05/22/15 at 2:52 PM, revealed she completed the resident smoking assessments and if the resident needed an apron. 31. Observation of the resident smoking area, on 05/22/15 at 4:53 PM, revealed eight (8) aprons hanging near the door, one (1) resident smoking with staff assistance, and wearing an apron. Observation of the smoking box on the 200 Unit, on 05/22/15 at 4:57 PM, revealed boxes of cigarettes for all residents of the facility; a list of residents who smoked and who required an apron. Interview with CNA #2, on 05/22/15 at 4:57 PM, revealed Central Supply and a staff from the 200 Unit cover the smoking times during the day;	F 520		

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resident cigarettes and lighters should be kept in the smoking box which was kept locked in the medication room.

32. Review of rounding sheets, dated 05/12/15, revealed maintenance and environmental concerns were audited by Executive Director and Maintenance Director. Review of rounds completed by the ED and Maintenance Director, on 05/13/15, revealed maintenance books on each unit were reviewed for any maintenance issues, with concerns addressed on 05/13/15 and 05/14/15. Interview with the Maintenance Director, on 05/22/15 at 2:52 PM, revealed any maintenance issues should be listed in the maintenance book at each nurse's station, which he will take to the morning meeting, and discuss what had been addressed on the maintenance concerns.

33. Review of in-service records, dated 05/13/15 and 05/14/15, revealed staff were educated on showers and beds. Interview, on 05/22/15 at 3:20 PM, with CNA #5 revealed she was educated not to use broken equipment or shower beds and to report to supervisor and maintenance if equipment/shower bed was broken.

34. Review of a QAPI sign in sheet, dated 05/15/15, audit tools, and agenda revealed monitoring of falls, smoking, assistive devices, lifts, shower beds, and maintenance occurred. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, Housekeeping Supervisor, and DSS revealed they attended the QA meetings.

35. Review of facility rounding sheets, dated

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F 520	Continued From page 701 05/12/15, revealed the environment was observed, by Corporate Administrative Registered Nurses for maintenance needs. Observation of the morning meeting, on 05/22/15 at 9:05 AM, revealed the maintenance books were taken to the IDT meeting and reviewed. Interview with the Maintenance Director, on 05/22/15 at 2:52 PM, revealed he would take the maintenance books to the morning meetings. 36. Review of staff training records, beginning 05/13/15, revealed five (5) staff were trained with return demonstration for transfers. Review of the smoking list revealed residents who smoked were listed, with resident who required an apron and/or supervised smoking were identified. Review of rounding sheets, beginning 05/13/15, revealed resident rooms were searched for incendiary smoking items by the Executive Director. Observation of the facility's smoking box on the 200 unit, on 05/22/15 at 4:57 PM, revealed cigarettes were stored for the entire facility, and contained a list of residents who smoked, with those who required an apron identified. Interview with CNA #2, on 05/22/15 at 4:57 PM, revealed the box should be locked in the med room and the box had the cigarettes and lighters for all residents who smoked in the facility. 37. Review of the facility's audit tool revealed, beginning 05/12/15, residents were observed to ensure fall interventions were in place per the care plan. Interview with the DCS, ADCS, UM, Medical Records, BOM, and DSS, on 05/22/15 at 2:52 PM, revealed audits were conducted every morning and looked for falls interventions compared to the care plan and discussed in morning meeting.	F 520		

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F 520	Continued From page 702 38. Record review of resident call light audit, dated 05/12/15, revealed Residents #7, #5, #12, Unsampled Resident Z and AA call lights were checked for function, with Resident #12's call light was found to not light at the desk or the door. 39. Record review of call light audits, completed on 05/12/15, found one hundred twenty-four (124) resident call lights were checked for functionality, with twenty-two (22) rooms found that call lights did not light at the desk, one (1) room did not light at the desk or the door, and two (2) rooms did not light at the desk, the door, or sound. Six (6) residents in the three (3) rooms that call lights did not work, were placed on fifteen (15) minute checks and given a hand bell. Record review of the call light work order, dated 05/13/15, revealed the call lights for the six (6) residents were repaired by an outside contractor on 05/13/15 and another call light was repaired on 05/14/15 that would not turn off; the annunciator on the 200 Unit was repaired at the nurse's desk on 05/15/15. Observation, on 05/22/15 at 2:03 PM, of room 18 revealed the call light functional at the door, desk and sounding. Observation, on 05/22/15 at 2:15 PM, on the 200 Unit of two (2) nurse's stations revealed each desk had a new call light system installed on the wall behind the desk. Interview with the RDCS, on 05/22/15 at 12:07 PM and 05/22/15 at 3:42 PM, revealed call lights were repaired on 05/13/15 and 05/14/15, and the 200 Unit annunciators were repaired, and then moved to the wall behind each nurse's station. The six (6) residents were given hand bells on 05/13/15 and placed on fifteen (15) minute safety checks. Review of fifteen (15) minute check sheets revealed residents were checked on every fifteen minutes until call light was repaired. Interview with DCS on 05/22/15 at	F 520		

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F 520	Continued From page 703 5:30 PM, revealed she had call bells purchased and given to residents. 40. Review of in-service training records, dated 05/09/15 through 05/12/15, revealed twelve (12) nursing staff working the 11:00 PM through 7:00 AM shift on 05/12/15 were re-educated on 05/13/15 on what to do if the call lights were inoperable and the six (6) residents identified with inoperable call lights were placed on fifteen (15) minute checks. Interview, on 05/22/15 at 3:42 PM, with the RDCS revealed staff working on 05/12/15 and 05/13/15 were educated on the call lights not working for the six (6) residents and conduct fifteen (15) minute safety checks and were provided hand bells. Observation on 05/21/15 at 11:10 AM, revealed a hand bell was rung and the Medical Records Coordinator answered the hand bell immediately upon hearing it ring. 41. Record review of in-services conducted 05/13/15 and 05/14/15 revealed 101 of 149 staff were educated on providing call lights and what to do if not working, and answering call lights timely. Interview, on 05/22/15 at 8:05 AM, with CNA #7, on 05/22/15 at 8:13 AM with RN #1, on 05/22/15 at 8:25 AM with LPN #1, revealed they had been trained on call lights and knew what to do if a resident's call light did not work. Interview, on 05/22/15 at 2:52 PM, with the DCS, ADCS, UM, Medical Records, and Staffing Coordinator revealed staff were trained on call lights, answering call lights, and what to do if call lights were not functioning. Observation, on 05/22/15 at 1:58 PM, of room 106 revealed the call light was functional at the door, at the desk, and sounded. 42. Review of the pest control company invoice,	F 520		

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NAME OF PROVIDER OR SUPPLIER
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STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520	Continued From page 704 dated 05/13/15 and 05/14/15 revealed services were provided to the interior and exterior of the facility. Review of the pest control contract revealed services would be provided to the facility monthly and as needed. Interview with the Maintenance Director, on 05/22/15 at 2:52 PM, revealed the new pest control company had begun services inside and outside of the facility. Observation of the Sub acute 1 nurse's station, on 05/22/15 at 2:03 PM, revealed the maintenance book also contained the pest sightings book. Observation of Sub acute 2 nurse's station, on 05/22/15 at 2:07 PM, revealed the maintenance book also included the pest sightings log. Observation of room 215, on 05/22/15 at 2:09 PM, revealed no pests were seen. Observation of the 100 Unit nutrition room, on 05/22/15 2:20 PM, revealed no pests were seen. Observation, on 05/22/15 at 5:20 PM, of the kitchen revealed no pests were seen. Interview with the Dietary Director, on 05/22/15 at 2:52 PM, revealed the kitchen did not currently have pests. 43. Review of facility rounding sheets, dated 05/12/15, revealed no pests were observed. One hundred twenty-one (121) residents were assessed via skin sweeps on 05/12/15 and 05/13/15 with no pest bites evident, and no pests documented in resident beds or rooms. Interview with the DCS, ADCS, UM, MDS Director, on 05/22/15 at 2:52 PM, revealed residents were assessed via skin sweeps, and no concerns. Interview with Resident #24 on 05/22/15 at 4:30 PM, revealed no pests were in his/her room. 44. Review of rounding records, dated 05/14/15 through 05/21/15, revealed no concerns identified with pests. Interview, on 05/22/15 at 2:52 PM,	F 520		

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F 520	Continued From page 705	F 520		

with the Maintenance Director, DCS, ADCS, Central Supply, and DSS revealed daily rounds occurred with no concerns of pests. Interview with Resident #8 on 05/22/15 at 2:00 PM, revealed no pests were in his/her room.

45. Review of the Ad-Hoc sign in sheet, dated 05/15/15, and agenda, and audit tools revealed monitoring of the facility's pest control would be completed by the QA. Review of rounding records, dated 05/14/15 through 05/21/15, revealed no live pests were seen. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, Central Supply, and DSS revealed daily rounds occurred with no concerns of pests.

46. Review of rounding sheets, dated 05/12/15 and 05/13/15, revealed the ED and Housekeeping Supervisor observed the facility for cleanliness. Interview with the Housekeeping Supervisor, on 05/22/15 at 2:52 PM, revealed he conducted rounds for cleanliness of the facility, including linens, resident rooms, shower rooms, trash, webs and pests, and privacy curtains. Interview with Resident #10 on 05/22/15 at 12:30 PM, revealed no concerns with linens.

47. Review of in-service records, dated 05/13/15, revealed Administrative staff were trained on staffing, pest control, housekeeping and maintenance, and would be monitored by the ED. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS revealed they had been trained on staffing, pest control, housekeeping and maintenance, and any concerns of audits would

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F 520	Continued From page 706 be taken to the morning meeting. Interview with Resident #3 on 05/22/15 at 1:00 PM, revealed staffing had improved and were answering lights timely and the facility looked cleaner. 48. Review of audits for employee files revealed they were audited twice per week by the Executive Director/RDHR/RVPO/RDCS or Corporate Administrative Nurse. 49. Observation of the daily morning meeting, on 05/22/15 at 9:05 AM, revealed review of the 24 hour report, notifications made and documented, new physician orders, maintenance concerns and books, pests, rounds and audits, call lights, care plans. Interview with the Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, MDS Coordinator, and DSS, on 05/22/15 at 2:52 PM, revealed they participate in the morning meeting and review the 24 hour report, notifications were made, maintenance books reviewed, physician orders, call lights, care plans, and audits/ round were reviewed in the morning meeting. 50. Interview, on 05/22/15 at 2:52 PM, with the DCS revealed facility concerns were reviewed in the morning meeting, including audits and rounding results, for department heads to address. She stated she (the DCS) or the ED would initial when concerns were resolved. Observation, on 05/22/15 at 9:05 AM, of the morning meeting revealed the DCS provided direction and asked clarifying questions related to information discussed with follow up items determined. 51. Review of sign in sheets, dated 04/22/15, 05/13/15, and 05/15/15, revealed QAPI meetings were held on those dates. Interview, with the	F 520		

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F 520	Continued From page 707 Maintenance Director, DCS, ADCS, UM, Schedule Coordinator, Medical Records, MDS Coordinator, BOM, Housekeeping Supervisor, and DSS revealed they attended the QAPI meetings. Interview with the RDCS, on 05/22/15 at 5:05 PM, revealed the next QAPI meeting was scheduled for 06/17/15. Interview with the Medical Director, on 05/22/15 at 8:00 AM, revealed he was informed by the Executive Director of the resident care issues, attended the QA meetings held by the facility and provided direction regarding corrective action plans that were developed to meet the needs of the residents. 52. Review of the QAPI sign in sheet, dated 05/15/15, and agenda revealed audit tools were approved for QA monitoring and discussed: resident interviews; resident/family concerns; morning meeting; new employee files; falls or behaviors reviewed; care plans and Kardexes update; review of the 24 hour report; notifications; maintenance rounds and book; supervised smoking; falls interventions in place; call lights; weekly falls; and, behavior management meetings. 53. Review of facility linen rounds, dated 05/13/15, revealed resident laundry available for use and linen PAR levels were observed. Observation, on 05/22/15 at 2:05 PM, of the linen closet on Journey Home 1 revealed adequate numbers of linens, wash cloths and towels, pillows, and gowns. Observation of the linen closet on the 200 Unit, on 05/22/15 at 2:15 PM, revealed adequate linens, gowns, towels, washcloths, pillows, blankets and clothing protectors. Interview with the Housekeeping Supervisor, on 05/22/15 at 2:52 PM, revealed he	F 520		

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F 520	Continued From page 708 completed rounds three (3) times a day and checked the linen closets for adequate supplies. Observation, on 05/22/15 at 2:00 PM, revealed Resident #4's linens on the bed were clean, neat and were not torn, tattered or frayed. 54. Review of the sign in sheet for QAPI, dated 05/13/15, revealed the ED and DCS presented and reviewed falls, changes in condition, staffing, housekeeping, and laundry, and pest control, and would provide daily oversight. 55. Review of grievance audit, dated 05/13/15, revealed grievances were reviewed since 05/01/15 and resolved by 05/15/15. Interviews on 05/22/15 with Resident #3 at 2:10 PM, Resident #8 at 2:00 PM, and Resident #10 at 12:30 PM, revealed the issues and concerns they had regarding linens, pests, environment repairsand answering call lights were resolved. 56. Review of rounds , dated 05/12/15, revealed Resident #39 was groomed and had clean linens. 57. Review of the facility rounds, dated 05/12/15, revealed residents were observed to identify residents grooming, incontinent care, bed linens, pests, call lights in reach, and privacy curtains in place. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, UM, Staffing Coordinator, BOM, Central Supply, Housekeeping Supervisor, and DSS revealed daily rounds were completed to identify resident grooming needs and care, linens, pests, call lights in reach, and privacy curtains in place. Interviews with Resident #3, #8 and #10 on 05/22/15, revealed the issues and concerns they had regarding linens, pests, environment repairs and answering call lights had improved.	F 520		

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58. Review of in-service records, dated 05/13/15 and 05/14/15, revealed nursing staff and ten (10) agency staff were educated on incontinent care, bathing, shaving, and hair care. Interview, on 05/22/15 at 2:52 PM, with the DCS, ADCS, UM, and Staffing Coordinator revealed staff were trained on grooming, incontinent care, shaving, and bathing. Interview with CNA #31, on 05/22/15 at 8:10 AM, revealed she received training on incontinent care, bathing, shaving, hair care, reporting pest, broken equipment, fall prevention, lifts, reporting change in condition, and answering call lights, abuse, resident laundry and linens.

59. Review of in-service records, dated 05/13/15 and 05/14/15, revealed one hundred one (101) staff and ten (10) agency staff were educated on privacy curtains; using the pest sightings book; resident privacy. Interview, on 05/22/15 at 2:52 PM, with the Maintenance Director, DCS, ADCS, Staffing Coordinator, Central Supply and Housekeeping Supervisor revealed they were trained on privacy curtains, resident privacy, and pests. Interview with Housekeeper #1, on 05/22/15 at 8:20 AM, revealed she received training on cleaning resident rooms, privacy curtains, reporting pests and broken equipment. Interview with Registered Nurse #11, on 05/22/15 at 8:10 AM, revealed she was educated on abuse, falls, physician orders, dignity, grievances, infection control, call lights, and reporting pests and maintenance issues.

60. Review of QAPI sign in sheet, dated 05/13/15, revealed incontinent care, resident privacy, shaving and AM care P&P were reviewed. Interview, on 05/22/15 at 2:52 PM, with the

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F 520	Continued From page 710 Maintenance Director, DCS, ADCS, UM, Staffing Coordinator, MDS Director, Housekeeping Supervisor, and DSS attended the QA meetings. 61. Review of rounding sheets revealed residents were observed by staff to identify any issues with grooming, incontinent care, privacy, shaving and AM care. Interview, on 05/22/15 at 2:52 PM with the DCS, ADCS, UM, Staffing Coordinator, Medical Records, BOM, MDS Director, Central Supply, Housekeeping Supervisor, and DSS revealed they conducted rounds to assess residents grooming, privacy, shaved, and care. 62. Review of a QAPI sign in sheet, dated 05/15/15, revealed residents would be observed to ensure they were shaved, hair combed, incontinent care, privacy curtains and bed linens in place and clean, residents and environment free from pests, resident privacy, and call lights. On 05/22/15 at 2:52 PM, interview with the Maintenance Director, DCS, ADCS, UM, Staffing Coordinator, MDS Director, Housekeeping Supervisor, and DSS attended the QA meetings. Interview with Resident #8, on 05/22/15 at 4:20 PM, Resident #6, on 05/05/15 at 2:26 PM, Resident #24, on 05/22/15 at 8:07 AM, revealed the issues they had with not getting shaved, hair washed and combed, incontinent care provided, bed linens without tears, an environment free from pests, and call lights answered timely had improved. Observation of Resident #43, on 05/22/15 at 8:00 AM, revealed two staff were using a lift to transfer the resident into a wheelchair and then proceeded to shave the resident.	F 520		