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

PRINTED: 08/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185358		C 08/08/2013

NAME OF PROVIDER OR SUPPLIER: SIGNATURE HEALTHCARE OF TRIMBLE COUNTY

STREET ADDRESS, CITY, STATE, ZIP CODE: 50 SHEPHERD LANE, BEDFORD, KY 40006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated survey was initiated and concluded on 08/08/13 to investigate KY20546. The Division of Health Care substantiated the allegation with deficiencies cited.	F 000	F 280 Completion Date: September 13, 2013	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy review, it was determined the facility failed to revise the care plan for two (2) of five (5) sampled residents, Residents #1 and #2, in regards to the presence of staff when Residents #1 and #2 are in a common area at the same time.	F 280	1. On 8/6/13 resident #1 was immediately removed from the dining room, taken to her room and placed on 1:1 with a staff member. At that time resident #1 was asked why she hit resident #2 and he/she stated "he/she said I have a big mouth." A head to toe assessment was completed on resident #2 at the time he/she returned to their room. On 8/7/13 resident #1 was discharged and admitted to a geriatric psychiatric unit. Resident #1 remained on staff 1:1 until she was discharged to the geriatric psychiatric unit. Upon discharge from the geriatric psychiatric unit resident #1 was admitted to another long term care facility. On 8/6/13 resident #2 was removed from the dining room by staff. When he/she returned to their room a head to toe assessment was competed and was started on neurological	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X Elisia [illegible] | TITLE: Administrator | (X6) DATE: X 8-30-13

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

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F 280	Continued From page 1 The findings include: Review of the facility's care plan policy, revised 12/2010, revealed all residents would have care plans. The residents care plan provided guidance to all staff caring for the resident and communicated changes in care to all direct care staff. An interdisciplinary approach to identification of problems and developing solutions and goals provided individualization and coordination of resident care. The interdisciplinary care plan would be reviewed, revised and updated quarterly and more frequently if warranted by a change in the residents condition. Review of Resident #1's record, revealed the facility admitted the resident on 06/08/10 with diagnoses of Dementia, Altered Mental Status, Senile Dementia, Emotional Conduct Disorder, Impulse Control, Personality Disorder, Confusion, Toxic Encephalopathy and Delirium. Review of Resident #2's record, revealed the facility admitted the resident on 05/30/12, with diagnoses of Dementia, Traumatic Subarachnoid Hemmorage, Alzheimer Disease and Psychosis. Review of the Investigation that was completed on 05/30/13, revealed Resident #1 and #2 were in an altercation in which Resident #1 hit Resident #2, (no injury's were noted). The Director of Nursing (DON) completed the investigation and documented a plan for Resident #1 and #2 would be to have staff monitor them when both residents were in common areas at the same time. Interview with the Activity Volunteer, on 08/08/13	F 280	checks by the residents designated LPN. Also at that time the LPN asked if resident #2 was afraid of resident #1? Resident #2 stated "no", he/she was not afraid of anyone. Resident #2 remained in his/her room the rest of the evening. 2. On 8/7/13 all resident in the facility were asked the following question: Are you afraid of any resident/anyone at this facility? All residents answered no they were not afraid of anyone at the facility. All residents that have noted behaviors had their care plans reviewed to ensure their care plans are accurate and up to date to reflect the current needs of the resident. 3. On 8/9/13 the facilities policy regarding care plans was reviewed by the Administrator and DON. On 8/7/13 thru 8/21/13 staff in all departments were in serviced by one of the following individuals: DON, Administrator, Dietary Director, Housekeeping supervisor, and	

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F 280	Continued From page 2 at 5:07 PM, revealed she was never instructed not to leave Resident #1 and #2 alone together. She stated she was not given any instructions for the two (2) residents. Interview with CNA#1, on 08/08/13 at 5:49 PM, revealed she was not instructed to monitor both residents when in common areas. Review of the CNA care plan for Resident #1 and #2 revealed no documentation of monitoring by staff when both residents were in common areas at the same time. Interview with Licensed Practical Nursing (LPN) #1, on 08/08/13 at 6:12 PM, revealed she was aware Resident #1 and #2 were to be monitored when left alone by the report that was given by the nursing staff. LPN #1 stated she remembered reporting to the CNA staff to keep an eye on Resident #1 and #2. LPN #1 was not instructed to update the care plans for Residents #1 and #2. She was just instructed to not leave them alone. Interview with the Director of Nursing (DON), on 08/08/13 at 5:30 PM, revealed the Interdisciplinary Team (IDT) decided to come up with the plan to monitor the two residents when in common areas. The DON stated the staff were in-serviced on the new plan and placed the plan on the twenty-four (24) hour sheet. The twenty-four (24) hour sheet stays with the nursing staff for a whole month. The DON stated when the IDT team came up with the plan, the plan should have been placed on the care plan. The DON stated the IDT team was responsible to update Resident #1 and #2 care plans.	F 280	Activity director utilizing the facility abuse policy on the importance of immediately separating residents, and removing one of the residents from the area in an incident of resident on resident abuse. At that time facility nurses were also in-serviced on the importance of updating residents care plans in a timely manner. On 8/8/13 the activity director in-serviced the Activity Volunteer utilizing the facility abuse policy on the importance of immediately separating residents and removing one of the residents from the area in an incident of resident on resident abuse. On 8/9/13 the administrator in serviced the interdisciplinary team (DON, social service director, ADON, activities	
F 323	483.25(h) FREE OF ACCIDENT	F 323		

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director, dietary director, therapy director, and MDS nurse) on the importance of when making a plan of care or a change to a plan of care the residents care plan needs to be updated as does the residents CNA care plan in order for the correct plan of care can to be carried out by all staff.

4. 5 days a week the IDT meets to review recent new physician orders, behaviors and incidents. During the review the IDT adds these items to the residents care plan and CNA care plan. All newly added items on the CNA care plan are written in red to indicate a change. Anything that needs to be removed from the care plan will be highlighted out with a d/c date written next to it. Weekly the administrator will monitor a IDT meeting. During the IDT meeting the administrator will take notes of items that have been added or deleted from the residents care plan. A 20% random audit of noted residents will be conducted by the administrator to ensure care plans were updated appropriately. Care Plans found to be out of compliance will be corrected. The finding of the audit will be given to the QAPI committee. This audit will continue until 100% compliance is achieved for 3 months at that time the QAPI committee will recommend a modification to the frequency of the audit.

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Starting 8/19/13 a CNA notification board was established. This board is placed in an accessible place for CNAs and nurses, but not in a public area for all to view. Daily the DON, ADON 1 or ADON 2, Social Service Director, Activity Director or Dietary Manager can add important resident information that needs to be communicated to the CNAs to ensure continuity of care is delivered. Weekly the administrator will do a random audit of 6 CNAs to see if they can inform the administrator of important resident information that has been communicated through the board. The compliance of the board audit will be given to the QAPI committee monthly. If it is found through the administrators audit that 20% or more of the CNAs are unaware of what is on the board related to their assigned resident the audit will be repeated with repeated education for staff on the use and importance of the communication board. Only when the CNA board utilization audit shows 100% compliance for 3 months will the QAPI committee recommend a modification to the frequency of the audit.

Weekly the social service director will do an audit of 50% of the reported behaviors to ensure care plan updates were added to the resident's plan of care and CNA care plan. Monthly this audit will be given

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to the QAPI committee for review. If it is found that 20% or more behaviors were not care planed the IDT will be re-educated, and the audit will be repeated. Only when the residents care plans are found to have a 100% of compliance related to behavior care plan for 3 months will the QAPI committee recommend a modification to the audit frequency.

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F 323 SS=D	Continued From page 3 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 policy review, it was determined the facility failed to ensure supervision was provided to two (2) of five (5) residents. Resident #1 and #2. The findings include: Review of the Incident Reporting Policy, dated 12/2010, revealed the intent of the facility was to provide a safe and healthful work environment. The facility should ensure that the residents environment would remain free of accident hazards as possible and that each resident should receive adequate supervision and assistive devices that should reduce accidents. The charge nurse or designee would add interventions on to the care plan as needed. Review of the Behavior Management Program Policy, effective 12/2010, revealed the facility would identify and assess complex behaviors in residents in order to develop effective behavior management plans. The facility shall also identify, assess, monitor and manage manifested behaviors in residents to ensure the safety of all residents.	F 323	F 323 Completion Date: September 13, 2013 1. On 8/6/13 resident #1 was immediately removed from the dining room, taken to her room and placed on 1:1 with a staff member. At that time resident #1 was asked why she hit resident #2 and he/she stated "he/she said I have a big mouth." A head to toe assessment was completed on resident #2 at the time he/she returned to their room. On 8/7/13 resident #1 was discharged and admitted to a geriatric psychiatric unit. Resident #1 remained on staff 1:1 until she was discharged to the geriatric psychiatric unit. Upon discharge from the geriatric psychiatric unit resident #1 was admitted to another long term care facility.	

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F 323	Continued From page 4 Review of Resident #1's record revealed the facility admitted the resident on 06/08/10 with diagnoses of Dementia, Altered Mental Status, Senile Dementia, Emotional Conduct Disorder, Impulse Control, Personality Disorder, Confusion, Toxic Encephalopathy and Delirium. Observations made of Resident #2, on 08/08/13 at 11:06 AM, 11:33 AM, 11:40 AM, 11:56 AM and 2:00 PM, revealed no behaviors were observed by Resident #2. Review of Resident #2's record, revealed the facility admitted the resident on 05/30/12, with diagnoses of Dementia, Traumatic Subarachnoid Hemmorage, Alzheimer Disease and Psychosis. Interview with the Activity Volunteer, on 08/08/13 at 1:21 PM, revealed on 08/08/13 at 7:45 PM, while working in the activity room she heard Resident #2 hollering in the dining room. As the Activity Volunteer walked up to Resident #2, she saw Resident #1 hit Resident #2 in his/her left ear. The Activity Volunteer stated she asked Resident #1 to follow her. Resident #1 then attempted to wheel self behind the Activity Volunteer. When the Activity Volunteer met with Certified Nursing Assistant (CNA) #1 in the hall, she turned and saw that Resident #1 was not behind her and both her and the CNA #1 went into the dining room and saw Resident #1 hit Resident #2 again. Resident #1 was then wheeled by the CNA#1 back to Resident #1's room for assessmemnt. Interview with CNA#1, on 08/08/13 at 5:49 PM, revealed she was up in the front of the building when the activity volunteer motioned for her to	F 323	On 8/6/13 resident #2 was removed from the dining room by staff. When he/she returned to their room a head to toe assessment was competed and was started on neurological checks by the residents designated LPN. Also at that time the LPN asked if resident #2 was afraid of resident #1? Resident #2 stated "no", he/she was not afraid of anyone. Resident #2 remained in his/her room the rest of the evening. 2. On 8/7/13 all resident in the facility were asked the following question: Are you afraid of any resident/anyone at this facility? All residents answered no they were not afraid of anyone at the facility. 3. On 8/9/13 the facilities policy regarding care plans was reviewed by the Administrator and DON. On 8/7/13 thru 8/21/13 staff in all departments were in serviced by one of the following individuals: DON, Administrator, Dietary Director,	

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F 323	Continued From page 5 come to the dining room. CNA #1 then saw Resident #1 hit Resident #2 in the head. CNA #1 stated she saw Licensed Practical Nurse (LPN) #1 come up behind her and held onto Resident #2 and CNA #1 held Resident #1, then both escorted the residents to their rooms. CNA #1 stated she knew Resident #2 liked sitting by the window in the dining room and Resident #1 liked to wipe down the tables after dinner. CNA #1 stated it was not unusual for the two (2) residents to be sitting in the dining room. Interview with Licensed Practical Nurse (LPN) #1, on 08/08/13 at 2:17 PM, revealed as she was passing pills, she heard her name being yelled by one of the aids. LPN #1 stated she saw Resident #1 standing by Resident #2 and witnessed Resident #1 hit Resident #2 on the left side of his/her face. CNA #1 then placed her arms around Resident #1 took him/her to his/her room. LPN #1 then stated she placed Resident #1 with a 1:1 staff member. LPN #1 asked Resident #1 why he/she hit Resident #2 and Resident #1 stated that Resident #2 had a big mouth. LPN #1 stated Resident #1 could be easily agitated. LPN #1 stated Resident #1 should have been brought back to the nurses station the first time it was observed. LPN #1 stated she had never actually seen Resident #1 or #2 ever be aggressive. Review of the Investigation that was completed on 05/30/13, revealed Resident #1 and #2 were in an altercation in which Resident #1 hit Resident #2, (no injury's were noted). The Director of Nursing (DON) completed the investigation and documented a plan that Resident #1 and #2 would have staff monitor them when both residents were in common areas.	F 323	Housekeeping supervisor, and Activity director utilizing the facility abuse policy on the importance of immediately separating residents, and removing one of the residents from the area in an incident of resident on resident abuse. At that time facility nurses were also in-serviced on the importance of updating residents care plans in a timely manner. On 9/6/2013 the Behavior Management Program policy was reviewed by the administrator and social service director. The section of the policy that addresses "abuse risk" was revised and updated. The staffs in all departments were educated by the MDS nurse, Social Service Director or Administrator by 9/10/2013 on the revised policy and procedure related to the Behavior Management Program policy and procedure. The policy specifies questions that will be answered on admission, if an incident occurs, a significant change, quarterly, and annually. The questions include: Does the behavior place this resident at	

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F 323	Continued From page 6 Interview with the Activity Volunteer, on 08/08/13 at 5:07 PM, revealed she was not aware Resident #1 and #2 were not suppose to be left alone. She was normally informed by nursing what the plan was for each resident. Interview with CNA #1, on 08/08/13 at 5:49 PM, revealed she was not instructed to monitor both residents when in common areas. Interview with Licensed Practical Nursing (LPN) #1, on 08/08/13 at 6:12 PM, revealed she was aware Resident #1 and #2 were to be monitored when left alone by the report that was given by the nursing staff. LPN #1 stated she remembered reporting to the CNA staff to keep an eye on Resident #1 and #2. Review of Resident #1's record revealed the facility transferred the resident to a Psyciatric Hospital for evaluation and treatment on 08/07/13. Further record review revealed Resident #1 did not have any other conflicts with any other residents. Interview with Resident #2, on 8/08/13 at 2:00 PM, revealed Resident #2 did not know why Resident #1 hit him/her. Resident #2 stated he/she did not hit Resident #1. Resident #2 stated he/she felt safe in the facility and did not fear his/her life. Interview with the Director of Nursing (DON), on 08/08/13 at 5:30 PM, revealed the Interdisciplinary Team (ID) decided the plan to monitor the residents when in common areas. The DON stated the staff were in-serviced on the new plan and placed the plan on the twenty-four (24) hour sheet. The twenty-four (24) hour sheet	F 323	risk for abuse or abusing others? Does this resident exhibit behaviors that trigger negative responses from other residents or staff that result in this resident becoming an object of abuse? Does this resident's behavior result in abuse toward another resident? Does this resident indicate the need for supervision? A yes answer to any of these questions would result in the resident having a Behavior Management Care Plan established to further explain the resident's specific need. A Behavior Management Care Plan Form will be initiated and a Behavior Management Program Sheet for all staff to review and sign and will be placed in the Behavior Management Plan binder. Nurses are to document each behavior each time it occurs, the intervention used, the precipitation factor(s), and the outcome of the intervention on the monitoring sheet. Any resident that displays behaviors that could cause an issue of accident or incident will be placed on the 24 hour nursing	

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F 323	Continued From page 7 stays with the nursing staff for a whole month. The DON stated she had not known Resident #1 to be aggressive toward anyone else. The DON stated if the Residents were monitored appropriately, the staff could intervened quicker with the residents. Interview with the Administrator, on 08/08/13 at 6:01 PM, stated she remembered the DON conducting the investigation for the first altercation between Resident #1 and #2. The Administrator stated the plan to keep the residents separate should have been initiated. The Administrator stated normally after lunch and dinner there was a staff member in the room. The Administrator stated even if the residents were monitored she was not sure if the staff member could have stopped the incident from occurring.	F 323	report and reviewed in the daily IDT meeting. On 9/9/2013 and 9/10/2013 nurses were educated by one of the two ADONs on the importance of reporting all resident behavior onto the 24 hour report. On 8/8/13 the activity director in-serviced the Activity Volunteer utilizing the facility abuse policy on the importance of immediately separating residents and removing one of the residents from the area in an incident of resident on resident abuse. On 8/9/13 the administrator in serviced the interdisciplinary team (DON, social service director, ADON, activities director, dietary director, therapy director, and MDS nurse) on the importance of when making a plan of care or a change to a plan of care the residents care plan needs to be updated as does the residents CNA care plan in order for the correct plan of care can to be carried out by all staff.	

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4. 5 days a week the IDT meets to review recent new physician orders, behaviors and incidents. During the review the IDT adds these items to the residents care plan and CNA care plan. All newly added items on the CNA care plan are written in red to indicate a change. Anything that needs to be removed from the care plan will be highlighted out with a d/c date written next to it. Weekly the administrator will monitor a IDT meeting. During the IDT meeting the administrator will take notes of items that have been added or deleted from the residents care plan. A 20% random audit of noted residents will be conducted by the administrator to ensure care plans were updated appropriately. Care Plans found to be out of compliance will be corrected.

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The finding of the audit will be given to the QAPI committee. This audit will continue until 100% compliance is achieved for 3 months at that time the QAPI committee will recommend a modification to the frequency of the audit.

Starting 8/19/13 a CNA notification board was established. This board is placed in an accessible place for CNAs and nurses, but not in a public area for all to view. Daily the DON, ADON 1 or ADON 2, Social Service Director, Activity Director or Dietary Manager can add important resident information that needs to be communicated to the CNAs to ensure continuity of care is delivered. Weekly the administrator will do a random audit of 6 CNAs to see if they can inform the administrator of important resident information that has been communicated through the board. The compliance of the board audit will be given to the QAPI committee monthly. If it is found through the administrators audit that 20% or more of the CNAs are unaware of what is on the board related to their assigned resident the audit will be repeated with repeated education for staff on the use and importance of the communication board. Only when the CNA board utilization audit shows 100% compliance for 3 months will the QAPI committee recommend a

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modification to the frequency of the audit.

Weekly the social service director will do an audit of 50% of the reported behaviors to ensure care plan updates were added to the resident's plan of care and CNA care plan. Monthly this audit will be given to the QAPI committee for review. If it is found that 20% or more behaviors were not care planed the IDT will be re-educated, and the audit will be repeated. Only when the residents care plans are found to have a 100% of compliance related to behavior care plan for 3 months will the QAPI committee recommend a modification to the audit frequency.

Residents that have a Behavior Management Plan will have a Behavior Management Plan Sheet initiated indicating to staff that they need to review and sign the new or updated Behavior Management Plan of a resident. This allows staff to be aware and alerted to residents that have the potential to have behaviors that could lead to accidents or incidents. Anytime staff witness or are made aware of a behavior a residents displays that could lead to an accident or incident they are to document the incident in the residents chart and on the 24 hour report. 5 days a week the IDT will review the 24 hour report for any documentation related to resident displaying

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behaviors that could lead to an accident or incident. The social service director will update the Behavioral Assessment/Management Plan. The update in behavior will also be added to CNA care plan. Monthly the social service director will report to the QAPI team of any new or updated resident Behavior Management Plans. After updating the plan, the Social Service Director shall make a notation of the new plan on the Behavior Management Program Signature Sheet for the nursing team to re-sign the acknowledgement. If after 90 days the identified behavior is no longer occurring, the Behavioral Management Plan will be discontinued.

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