

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

PRINTED: 11/17/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/13/2015
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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014
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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
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{F 000}

INITIAL COMMENTS

{F 000}

An On-Site Revisit Survey was initiated on 11/12/15 and concluded on 11/13/15. Based on the acceptable Plan of Correction received on 10/18/15 it was determined the facility was in compliance on 10/08/15 as alleged.

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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PRINTED: 10/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185038	(X2) MULTIPLE CONSTRUCTION A. BUILDING PP - 4TH FLOOR SKILLED UNIT B. WING _____	(X3) DATE SURVEY COMPLETED R 10/26/2015
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{K 000} INITIAL COMMENTS

{K 000}

Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 10/08/15 as alleged.

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

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION		STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014	

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01 4th Floor</p> <p>Plan Approval: 1992</p> <p>Survey under: 2000 existing</p> <p>Facility type: SNF</p> <p>Type of structure: Five story Type I (Fire Resistive).</p> <p>Smoke Compartment: Four smoke compartments</p> <p>Fire Alarm: Manual initiating devices located at exits. Smoke detectors located in all corridors and resident rooms. Fire Alarm panel updated in 2010.</p> <p>Sprinkler System: Complete automatic (wet) sprinkler system</p> <p>Generator: Type II diesel, installation date unknown by facility.</p> <p>A standard Life Safety Code survey using a 2786S (Short Form) was conducted on 08/18/15. Providence Pavilion was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census the day of the survey was seventy-one (71) and the facility is licensed for eighty-two (82). Deficiencies were cited with the highest deficiency identified at an "D".</p>	K 000	<p>Without admitting or denying the validity of the citations, Providence Pavilion provides the following Plan of Correction. This plan of correction is prepared and executed because it is required by the provisions of the state & federal regulations and not because Providence Pavilion agrees with the allegations and citations listed on this statement of deficiencies. Providence Pavilion maintains that the alleged deficiencies do not, individually or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capability to render adequate care as prescribed by the regulations. This plan of correction shall operate as Providence Pavilion's written credible allegation of compliance, By submitting this plan of correction, Providence Pavilion does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Providence Pavilion reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.</p> <p>Providence Pavilion asserts it will be in substantial compliance with 42 CFR Part 483.70 (a) on October 8, 2015.</p> <p>K039 NFPA 101 Life Safety Code Standard</p> <p>Providence Pavilion does ensure that its Residents, Visitors, & Staff have clear and unobstructed egress from all exits within the facility.</p> <p>1. (a) On October 6, 2015 the facility Administrator was notified by Jerry Brush, Life Safety Inspector, OIG that the Plan of correction initially submitted on September 14, 2015 was not being accepted. At that time Mr. Brush</p>	10/18/15
K 039	NFPA 101 LIFE SAFETY CODE STANDARD	K 039		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director/Administrator	(X6) DATE 10/18/2015
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K 039 SS=D	Continued From page 1 Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit access was maintained, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, two (2) residents, staff and visitors. The findings include: Observation, on 08/18/15 at 4:23 PM with the Maintenance Supervisor, revealed the corridor (Purpose Hall) in one (1) smoke compartment to be 40 inches (40) in width. The corridor was approximately twenty-five (25) feet in distance. This deficiency affected rooms 451 and 452, with one (1) resident in each room. Interview, with the Maintenance Supervisor, at the time of observation revealed the facility thought it was all right to use the rooms in this area if the residents were ambulatory. Interview, on 08/18/15 at 4:30 PM, with the Administrator revealed the facility had been cited for the deficiency in 2013 and it was his understanding since the Plan Of Correction was accepted it was all right to use the rooms. Review, of the Plan Of Correction having a compliance date of 09/07/13, with the Administrator, revealed the facility thought the building met the required codes and if the facility	K 039	indicated the facility needed to submit a Waiver (in order to receive authorization that rooms 451 & 452 could be utilized as Resident Rooms) and Mr. Brush emailed the Administrator the waiver form to the Administrator. (b) On October 7, 2015 the facility Administrator was notified by Jerry Brush, Life Safety Inspector, OIG that CMS was not going to allow a waiver to be submitted for the deficiency cited on the Statement of Deficiencies (Form 2567). Mr. Brush indicated to the facility Administrator that the only way to utilize the rooms in question was to submit a passing FSES score. Mr. Brush also indicated that until the FSES score was submitted the facility would not be in substantial compliance, as long as there are Residents in rooms 451 or 452. (c) On October 7, 2015 The facility administrator inquired to Mr. Brush that if the facility did not place Residents' in rooms 451 or 452 at this time (until a passing FSES score could be obtained) the facility would then be in substantial compliance? Mr. Brush indicated that this solution would place Providence in Substantial Compliance. (d) On October 7, 2015 the Resident in room 452 was moved to room 446-2. Room 451 was unoccupied at this time. 2. No Other Residents have the potential to be affected: as Resident Rooms 451 & 452 are temporarily not being used	

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K 039	<p>Continued From page 2</p> <p>did not the facility was seeking a waiver; however, the facility had no documentation that waiver was approved for occupancy in these two (2) rooms.</p> <p>Reference: NFPA 101 (2000 Edition) 19.2.3.3* Any required aisle, corridor, or ramp shall be not less than 4 ft (1.2 m) in clear width where serving as means of egress from patient sleeping rooms. The aisle, corridor, or ramp shall be arranged to avoid any obstructions to the convenient removal of nonambulatory persons carried on stretchers or on mattresses serving as stretchers.</p> <p>Exception No. 1: Aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall be not less than 44 in. (112 cm) in clear and unobstructed width.</p> <p>Exception No. 2: Exit access within a room or suite of rooms complying with the requirements of 19.2.5.</p>	K 039	<p>as Resident rooms: as noted below in section 3.</p> <p>3. (a) On October 7, 2015 Facility Administrator educated all facility employees (Director of Nursing, Nurse Managers, Assistant Administrator, Admission Nurse, and Social Worker) who have the authority to place Resident into rooms 451 & 452: that these rooms are not to be utilized until the OIG gives Providence Pavillion authorization to utilize rooms 451 & 452. The Facility Maintenance Director was also included in the above education on October 7, 2015.</p> <p>(b) Resident Rooms # 451 & 452 will not be utilized as Resident Rooms until either:</p> <p>1: A passing FSES score is submitted to the OIG and the facility receives authorization from the OIG that rooms 451 & 452 are authorized to be utilized as Resident Rooms;</p> <p>2. The facility makes needed structural improvements to the corridors/rooms that meet NFPA 101 (2000 Edition) requirements as noted in the Statement of Deficiencies. And subsequent approval has been received from the OIG/other appropriate Federal & State authorities that rooms 451 & 452 may be utilized as Resident rooms;</p> <p>3. The facility receives permission to utilize from the OIG/other appropriate Federal & State authorities that other spaces within Providence Pavillion can be used as Resident Rooms in lieu of rooms 451 & 452.</p>

(c) The Facility Administrator is investigating the process to obtain a FSES score. When a passing FSES score is obtained the Administrator will submit the score to the OIG, requesting permission to utilize rooms 451 & 452 as Resident rooms.

4. In order to ensure compliance:
 - (a) The Facility Administrator, Assistant Administrator, Director of Nursing, Managers on Duty, or the Maintenance Director/designee will monitor daily rooms #451 and #452 to ensure the rooms are not being utilized as Resident Rooms;

The monitoring will continue until the facility receives permission from the OIG to utilize Rooms 451 & 452 as Resident Rooms and/or Providence receives permission from the OIG/other appropriate Federal & State authorities that other spaces within Providence Pavilion can be used as Resident Rooms in lieu of rooms 451 & 452.

These audits will be submitted to the Providence Pavilion Quality Assurance (Q/A) committee to ensure that the daily monitors are occurring.

5. Providence Pavilion alleges compliance as of October 8, 2015.

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F 000	INITIAL COMMENTS A Recertification Survey was initiated on 08/18/15 and concluded on 08/21/15, with deficiencies cited at the highest Scope and Severity S/S of a "G".	F 000	F 000 Without admitting or denying the validity of the citations, Providence Pavillion provides the following Plan of Correction. This plan of correction is prepared and executed because it is required by the provisions of the state & federal regulations and not because Providence Pavillion agrees with the allegations and citations listed on this statement of deficiencies. Providence Pavillion maintains that the alleged deficiencies do not, individually or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capability to render adequate care as prescribed by the regulations. This plan of correction shall operate as Providence Pavillion's written credible allegation of compliance. By submitting this plan of correction, Providence Pavillion does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Providence Pavillion reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding. Providence Pavillion asserts it will be in substantial compliance with 42 CFR Part 483 subpart B on October 8, 2015.	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, 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.	F 164	F164 Personal Privacy/Confidentiality of Records Providence Pavillion does ensure that each of its Resident's has the right to personal privacy and confidentiality of his or her personal and clinical records. Providence Pavillion also ensures that clinical records are kept private and confidential. 1. The facility immediately removed the notebook that Resident # 9 was looking through.	10/18/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Robert S. Duple* TITLE: *Executive Director/Administrator* (X6) DATE: *10/18/2015*

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F 164	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, it was determined the facility failed to keep clinical records private and confidential as evidenced by observation of Resident #9 sitting at the nurses station looking at the nurse aide notebook which contained resident information.</p> <p>The findings included:</p> <p>Observation, on 08/18/15 at 3:35 PM, revealed Resident #9 was sitting at the nurse's station looking through a notebook containing resident photographs and other information.</p> <p>Interview, on 08/18/15 at 3:40 PM, with the Speech Therapist (ST) revealed the notebook contained private and confidential information regarding the residents on the unit and the type of care each resident required.</p> <p>Interview, on 08/18/15 at 3:45 PM, with State Registered Nurse Aide (SRNA) #8 revealed the notebook contained private and confidential information regarding residents on the unit and should be placed behind the nurse's desk out of the view of residents and visitors.</p> <p>Interview, on 08/19/15 at 10:00 AM, with Registered Nurse (RN) #2 revealed the nurse aide notebook contained private and confidential information and should not be in view of residents and visitors.</p> <p>Interview, on 08/19/15 at 10:40 AM, with the Director of Nursing (DON) revealed the nurse aide notebook contained private and confidential information and should not be in view of residents</p>	F 164	<p>The Director of Nursing (DON) also immediately re-educated nursing staff of the importance of keeping all notebooks that may contain clinical information out of the view of residents and visitors, to ensure resident privacy and confidentiality.</p> <p>2. No Residents of the facility were found to be affected by the deficient practice;</p> <p>The facility will prevent similar issues occurring by implementation of the following practices, noted in section 3.</p> <p>3. (a) On September 2nd, 3rd, & 4th, 2015 the Administrator, Assistant Administrator & DON re-educated all Providence staff to the expectation that all clinical records be maintained in a fashion that ensures the clinical records are out of the view of Residents and visitors. This education focused on keeping all Resident charts and notebooks out of the reach/view of residents and visitors. On September 17th & 18th 2015 the Director of Nursing educated the Providence Pavilion Staff of the process below in (b). (b) The DON has developed HIPAA clipboards/binders that are designed to protect individual pieces of Resident clinical information from being seen by residents and visitors. The HIPAA clipboards/binders have a coversheet (see attached exhibit (a) that identifies that all clinical information is confidential. These HIPAA clipboards will be hung on the wall behind the Nurses stations, so that confidential Resident information is further protected.</p>	
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F 164	Continued From page 2 and visitors. Further interview revealed the DON expected all staff to keep clinical records out of the view of visitors and residents to ensure resident privacy and confidentiality. Interview, on 08/21/15 at 6:15 PM, with the Administrator revealed he expected all staff to keep clinical records out of the view of visitors and residents to ensure resident privacy and confidentiality.	F 164	(c) The Director of Human resources will educate all new hires during their Orientation period and the Director of Human resources will educate agency staff, prior to being utilized at Providence Pavillion, in regards to the education in the Plan of correction as submitted.	
F 252 SS-E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a clean, comfortable and homelike environment as evidenced by soiled ceiling tiles in resident rooms 431, 435, 444 and 451 and paint chips in need of repair in rooms 425, 427, 429, 436, 439, 442, 446, 434, 435, 430, 419, and 417. The findings include: Observation during the environmental tour of the facility, on 08/18/15 at 2:30 PM, revealed two (2) to three (3) soiled ceiling tiles in resident rooms 431, 435, 444 and 451. Further observation revealed scuff marks, scrapes and chipped paint on the walls in rooms 425, 427, 429, 436, 439,	F 252	4. In order to ensure compliance: The DON/designee will conduct Privacy audits of Providence Pavillion Nurses Stations 3 time weekly for 3 weeks, two times weekly for 3 weeks, one time weekly for 3 weeks, and then one (1) time monthly for 2 months to ensure that Confidential clinical in records are kept out of the view of residents and visitors. Results of the Privacy audits will be submitted to the Providence Pavillion Quality Assurance (Q/A) committee, with the committee determining the need for further monitoring. Providence Pavillion utilizes the PDCA (Plan Do Check Act) approach in solving identified quality issues. Using the PDCA approach all identified quality issues are analyzed and a Plan is then implemented to solve the identified problem (Do phase). If during the routine ongoing check-(the auditing process) Providence Pavillion identifies any problem with the implemented plan; Providence will then re-analyze why the plan is not working and then will adjust the plan accordingly. The PDCA approach is a continuous cycle, therefore the identified quality issue will undergo the Q/A process, until the Q/A committee determines that the issues have been solved. The Administrator & the Assistant Administrator of the facility (in	

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F 252	Continued From page 3 442, 446, 434, 435, 430, 419, and 417. Interview with the Maintenance Director, on 8/20/15 at 11:00 AM, revealed he believed the soiled ceiling tiles could be an indication of moisture and he agreed it did not promote a clean, homelike environment. Regarding the scuff marks, scrapes and chipped paint, the Maintenance Director stated it did not promote a clean, comfortable, and homelike environment and he did not have a system in place to monitor rooms for needed repairs and/or paint. Interview with the Administrator, on 8/21/15 at 6:15 PM, revealed he was unaware of the scuffed walls, scrapes, chipped paint and soiled ceiling tiles. The Administrator stated he expected the Department Managers to have systems in place to assure the facility was kept clean and repairs made as needed.	F 252	collaboration with the Medical Director and Director of Nursing) oversees the facilities Q/A program to ensure that the program is effective and in compliance with Federal & State regulations. 5. Providence Pavillion alleges compliance as of October 8, 2015. F 252 Safe/Clean/Comfortable/Homelike Environment Providence Pavillion does provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the fullest extent possible.	10/8/15
F 280 SS=G	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	F 280	1. The facility Maintenance Director has replaced the affected ceiling tiles in resident rooms: 431, 435, 444, and 451. The facility maintenance director & maintenance assistant have completed the needed re-painting of the paint chips in rooms: 425, 427, 429, 436, 439, 442, 434, 435, 430, 419, and 417. The Assistant Administrator verified that all of the above corrections were completed on/before 9/9/2015. The Administrator immediately (On August 21, 2015) re-educated the maintenance director/department on the need to maintain a safe/clean/comfortable/homelike environment for the Resident of Providence Pavillion 2. On September 17 th , 2015 the maintenance Director and Administrator inspected all Resident Rooms for soiled	

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014
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F 280	<p>Continued From page 4</p> <p>legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's policy and procedures, it was determined the facility failed to review and revise each resident's care plan for one (1) of fifteen (15) sampled residents (Resident #9). Resident #9 sustained falls with injury while attempting to self toilet; however, there was no documented evidence the facility revised the falls interventions to prevent further falls.</p> <p>Resident #9 sustained nine (9) falls from 04/04/15 through 07/28/15. Interview and record review revealed seven (7) of the falls were sustained while the resident was attempting to self toilet. (04/18/15, 04/28/15, 05/05/15, 07/03/15, 07/12/15, 07/27/15, 07/28/15). The resident sustained injury as a result of the falls on 04/18/15, 04/28/15, 07/27/15, and 07/28/15 requiring sutures/staples. However, there was no documented evidence the facility reviewed or revised the resident's Comprehensive Care Plan to implement new interventions to meet the toileting needs of the resident to prevent future falls. Interview and record review revealed even though the facility identified self-ambulation to the toilet as a root cause of some of the falls, there was no documented evidence the facility implemented increased supervision, a toileting program, or a restorative program to prevent</p>	F 280	<p>ceiling tiles and chipped paint on the walls. No further Resident rooms of the facility were found to be affected by the deficient practice.</p> <p>The facility will prevent similar issues occurring by implementation of the following practices, noted in section 3.</p> <p>3. (a) The maintenance director has added monitoring of ceiling tiles & room painting to his weekly building inspection tool. This tool will be provided to the Administrator/designee after weekly completion for Administrative review. (b) Any repairs notes on the weekly building inspection tool will be prioritized and completed by the maintenance department in the prioritized order. (c) The Administrator and maintenance director will establish monthly walking rounds to ensure that repairs are being completed in a timely fashion. (These walking rounds are in addition to the Q/A system noted in section 4 below)</p> <p>4. In order to ensure compliance: The assistant administrator will conduct Environmental audits of Providence Pavillion resident rooms 2 times weekly for 2 months, 1 time weekly for 1 month, and then one (1) time monthly every 2 months to ensure that the rooms are maintained in a safe/clean/comfortable/homelike environment. Results of the Environmental audits will be submitted to the Providence Pavillion Quality Assurance (Q/A) committee, with the committee</p>	
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F 280	<p>Continued From page 5 further falls.</p> <p>The findings include:</p> <p>Review of the facility's Care Plan policy, not dated, revealed the objective was to develop an individualized comprehensive care plan that includes measurable objectives and timetables to meet the residents' medical, nursing, mental and psychological needs. Additionally, paragraph #5 stated, care plans were revised as changes in the resident's condition dictated. Care plans were reviewed as new permanent orders were received, as significant change was assessed, when desired outcomes were not met, and at least quarterly.</p> <p>Review of the facility's "Accident/Injury Reporting and Unusual Occurrence Investigation" Policy, not dated, paragraph #6 revealed, reports would be analyzed for patterns and trends, statistical compilation to identify staff development needs or policy/procedure changes. The interdisciplinary team would review all individual resident falls, unusual skin occurrences, and POC's, causes/motivators, further preventative approaches and interventions, equipment/supply needs, and referrals.</p> <p>Review of Resident #9's medical record revealed the facility admitted the resident on 12/24/14 with diagnoses that included Anxiety, Asthma, Fall's, Muscle Wasting, Malaise/Fatigue, Debility, and Compression Fracture Cervical 2 Vertebra.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment dated 06/12/15 revealed the facility assessed the resident as frequently incontinent requiring extensive assistance with</p>	F 280	<p>determining the need for further monitoring.</p> <p>Providence Pavillion utilizes the PDCA (Plan Do Check Act) approach in solving identified quality issues. Using the PDCA approach all identified quality issues are analyzed and a Plan is then implemented to solve the identified problem (Do phase). If during the routine ongoing check-(the auditing process) Providence Pavillion identifies any problem with the implemented plan; Providence will then re-analyze why the plan is not working and then will adjust the plan accordingly. The PDCA approach is a continuous cycle, therefore the identified quality issue will undergo the Q/A process, until the Q/A committee determines that the issues have been solved. The Administrator & the Assistant Administrator of the facility (in collaboration with the Medical Director and Director of Nursing) oversees the facilities Q/A program to ensure that the program is effective and in compliance with Federal & State regulations.</p> <p>5. Providence Pavillion alleges compliance as of October 8, 2015.</p>	

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F 280	<p>Continued From page 6</p> <p>two (2) person physical assist for transfers, limited assistance with one (1) person physical assist with a walker for ambulation, and extensive assistance with one (1) person physical assist for toileting. The MDS also revealed the resident had a Brief Interview for Mental Status (BIMS) score of five (5) dated 08/12/15 which revealed the resident was severely impaired in cognition.</p> <p>Review of the Comprehensive Care Plan initiated on 01/08/15 revealed the facility identified the resident to be at risk for Falls and Activity of Daily Living (ADL) Self Care Performance and Mobility Deficit related to debility with interventions to include: Bed and Chair alarm in place to alert staff of unassisted transfers - check alarms for functioning daily; Resident needs a safe environment with: even floors free from spills and or clutter; adequate, glare free light; a working and reachable call light, the bed in low position at night; Side rails as ordered, handrails on walls, personal items within reach.</p> <p>Review of the fall incident/investigation follow-up documentation revealed Resident #9 fell on 4/18/15 at 8:14 AM attempting to independently ambulate to the bathroom and was "found on the floor bleeding from the back of the head, behind the left ear". Further documentation revealed all interventions in place and the resident was sent to the hospital emergency room for evaluation and treatment and the resident received staples to close the wound.</p> <p>Review of the resident's care plan revealed no documented evidence the facility reviewed and revised the care plan to meet the resident's toileting needs or to prevent future falls.</p>	F 280	<p>F-280 Right to Participate Planning Care- Revise Care Plan</p> <p>Providence Pavilion does develop a comprehensive care plan that is prepared by an interdisciplinary team, that include 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 Residents family, or the Resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <ol style="list-style-type: none"> On July 27, 2015 the DON reviewed Resident # 9's fall history and implemented the following interventions on 7/28/2015: <ul style="list-style-type: none"> a) a body pillow for positioning, b) a cradle mattress to remind resident to call for assistance, c) a one padded 1/2 side rail on the opposite side of the bed, d) the DON discussed with family POA the risks/benefits of placing a fall mat on the floor-it was decided not to do this at that time, and e) the DON reviewed medications with the residents Psychologist. Since the implementation of these interventions Resident #9 has not fallen. Resident # 9 has also been placed on the "lighthouse program" as described in section #3 below. <p>In addition to the falls interventions above, Resident # 9 has been assessed under the facility new B&B protocol and has been placed upon an individualized toileting program. (See F 315 POC above)</p>	10/8/15

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F 280	<p>Continued From page 7</p> <p>Review of the fall incident/investigation follow-up documentation revealed Resident #9 fell on 04/28/15 at 6:20 PM while attempting to ambulate to the bathroom independently and was "found lying on the floor with moderate amount of blood coming from above the right eyelid". The resident was sent to the hospital emergency room for evaluation and treatment and received sutures to close the wound.</p> <p>Review of the resident's care plan revealed no documented evidence the facility reviewed and revised the care plan to meet the resident's toileting needs or to prevent future falls.</p> <p>Review of the fall incident/investigation follow-up documentation revealed Resident #9 fell on 05/05/15 at 4:22 AM while attempting to ambulate independently to the bathroom and was found on the floor beside the bed. The staff was in-serviced on 05/06/15 to ensure to offer resident assistance to toilet every one to two hours to avoid attempts to self transfer.</p> <p>However, review of the resident's care plan revealed no documented evidence the facility reviewed and revised the care plan to offer resident assistance to toilet every one to two hours to avoid attempts to self transfer per the facility's investigation.</p> <p>Review of the fall incident/investigation follow-up documentation revealed Resident #9 fell on 07/03/15 at 4:33 AM. The resident climbed out of bed unassisted and was "found sitting on the floor while attempting to ambulate independently to the bathroom. The DON documented in the fall incident/investigation report the resident attempts to get out of bed when he/she feels the need to</p>	F 280	<p>All new interventions have been added to the STNA POC and the Residents individualized care plan.</p> <p>2. The facility has implemented a new comprehensive falls program, as discussed in section #3 below. The facility will prevent similar issues occurring by implementation of the comprehensive falls program, noted in section 3.</p> <p>3. (a) The New Providence Pavillion Falls Program provides for each Resident to be individually assessed to their potential of having falls. If the Residents assessment indicates the resident of having a high potential for falls, then individualized interventions are put into place. On September 17th 2015 the IDT (consisting of the Director of Nursing, Nurse Managers, The MDS Coordinator, Social Work, and therapy Manager) reviewed all Residents to assure that the Providence Pavillion Falls Risk assessment was completed. All residents scoring a very high Risk for falling were placed upon the new lighthouse program. In total 8 residents were placed on the lighthouse program.</p> <p>On-Going: Each Resident is assessed regarding their falls potential with every assessment completed on them. Assessments are completed upon admission to the facility and quarterly. If the Resident is identified as being a very high risk for falling (or as determined by the Falls Committee), not only do they receive individualized</p>		

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F 280	<p>Continued From page 8 toilet and the resident needs to be offered frequent toileting.</p> <p>However, review of the resident's care plan revealed no documented evidence the facility reviewed and revised the care plan to include frequent toileting.</p> <p>Review of the fall incident/investigation follow-up documentation revealed Resident #9 fell on 07/12/15 at 6:30 PM while attempting to ambulate independently to the bathroom and was "found sitting on the floor". Further review revealed the resident needed to be toileted in advance of need and to frequently offer to take the resident to the restroom to help decrease the amount of unassisted transfers.</p> <p>However, further review revealed this intervention was not initiated on the care plan until 07/29/15 and was added. This intervention was added seventeen (17) days after the need for toileting was identified after the fall on 07/12/15.</p> <p>Review of the fall incident/investigation follow-up documentation revealed Resident #9 fell on 07/27/15 at 12:50 AM while the resident attempted to ambulate independently the resident was found "sitting on the floor in the bathroom with blood coming from the side of the head". The resident was sent to the hospital for further evaluation and treatment and received staples to close the wound. The DON further documented the implementation of a body pillow for positioning, a cradle mattress to remind resident to call for assistance instead of climbing out of bed, one padded half side rail on the opposite side of the bed, and discussion with the POA about the implementation of a fall mat could</p>	F 280	<p>Interventions: they are also placed upon the Providence Pavillion lighthouse program. The lighthouse program provides additional safety to the Resident by reminding staff, family, and visitors to frequently monitor the Resident.</p> <p>(b) If a Resident does have a fall at Providence Pavillion, the Resident and any potential causes for the fall are immediately assessed by the Charge Nurse with assistance from the clinical manager.</p> <p>(c) A Follow Up Investigation form has been developed and implemented and is used for documentation of the assessment and interventions following a fall.</p> <p>(d) Falls are analyzed individually by the DON and the Individual Nurse Manager (on a daily basis) to ensure appropriate interventions have been put into place to lower the risk of additional falls occurring. At this time the Residents POC is reviewed and revised as necessary to ensure that appropriate interventions are documented on the Resident individualized POC.</p> <p>(e) Every week, the Providence Pavillion Falls Committee (a newly established interdisciplinary team IDT) meets and discusses falls that have occurred since their last meeting. Suggestions from this committee are added as appropriate to the individualized Resident's care plan & if appropriate to the Providence Pavillion Falls policy.</p>	

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F 280	<p>Continued From page 9</p> <p>Increase fall hazards related to the residents poor safety awareness, and DON documented she would discuss medication alterations with the Psychologist.</p> <p>However, review of the plan of care revealed the new interventions were not added to the care plan until 07/28/15.</p> <p>Review of the fall incident/investigation follow-up documentation revealed Resident #9 fall on 07/28/15 at 6:39 AM while the resident attempted to ambulate independently and was "found on the floor in the bathroom with blood coming from the forehead and a skin tear to the left lateral arm", the resident was sent to the hospital emergency room for evaluation and treatment and received sutures to close the wound. It was further documented that multiple interventions had been added on 07/27/15, but review of the care plan revealed the intervention was not added until 07/28/15.</p> <p>However, there was no documented evidence the facility reviewed and revised the care plan to meet the resident's toileting needs to prevent future falls. Further review revealed no entry regarding the fall, treatment, or follow up interventions at the time of the fall.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator on 08/21/15 at 4:15 PM revealed her role was to review and revise the Comprehensive Care Plan once she received the copy of the physicians order. She also stated the Director of Nursing (DON) and Unit Manager could make changes to the Care Plan as the need arose. She stated the process for updating the care plan following a fall was the nurse on duty completed</p>	F 280	<p>On September 17th 2015 the Administrator of the facility met with members of the care planning team (DON, Nurse Managers, MDS Nurse, SW, and the Assistant Administrator) and presented to the team the expectation of what is expected at Providence Pavilion in regards to updating/revising the Residents fall POC. The expectation is that every Fall intervention is documented on the Residents acute POC and the LTC POC.</p> <p>The Director of Human resources will educate all new hires during their Orientation period and the Director of Human resources will educate agency staff, prior to being utilized at Providence Pavilion, in regards to the education in the Plan of correction as submitted.</p> <p>(f) The facility MDS Nurse is part of the Falls Committee and will ensure that all interventions that are discussed and adapted are added to any affected residents individualized care plan.</p> <p>4. Each Providence Pavilion Nurse Manager Audits each fall that occurs on their floor. This audit monitors the compliance to the Falls Program. The audit is turned into the assistant administrator after completion by the nurse manager.</p> <p>The assistant administrator monitors to ensure that the Falls Program is being consistently implemented. The assistant administrator also monitors to ensure that the weekly fall committee is</p>	

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F 280	<p>Continued From page 10</p> <p>the incident report summarizing the fall and documented it in the progress notes, and the DON completed the follow-up investigation, obtained orders for any new interventions, and then added the new interventions to the care plan.</p> <p>Interview with Unit Manager on 08/21/15 at 4:00 PM revealed the process for revising the care plan following a fall was the nurse on duty completed the incident report summarizing the fall and documented it in the progress notes, and the DON completed the follow-up investigation, orders were obtained for any new interventions and then added to the care plan.</p> <p>Interview with the DON on 08/21/15 at 4:40 PM revealed the facility did not review and revise the care plan with new interventions after falls sustained on (04/18/15, 04/28/15, 05/05/15, 05/28/15, 07/03/15, 07/12/15, 07/28/15). The DON stated the process for revising the care plan following a fall was, the nurse on duty completed the incident report summarizing the fall and documents it in the progress notes, the DON completed the follow-up investigation, orders were obtained for any new interventions and then added to the care plan. She further stated she expected the staff to review and revise the comprehensive care plan as the resident's condition dictated and that licensed staff should follow the facility's care plan policy.</p> <p>Interview on 08/21/15 at 6:15 PM with the Executive Director (ED) revealed he expected the staff to review and revise the comprehensive care plan as the resident's condition dictates and that licensed staff should adhere to the facility's care plan policy.</p>	F 280	<p>meeting, and that the meeting is effective.</p> <p>The assistant administrator will audit all falls occurring within Providence Pavilion for 1 month, then the 50% of all falls for 2 months.</p> <p>Results of the all falls related audits (audits performed by the unit managers & assistant administrator) will be submitted to the Providence Pavillion Quality Assurance (Q/A) committee, with the committee determining the need for further monitoring.</p> <p>The DON, Nurse Manager, & MDS Coordinator will audit All Fall Care Plans weekly on Thursday during the Falls committee weekly meeting for 1 month, then audit 50% of Fall Care Plans weekly on Thursday during the Falls committee weekly meeting for 1 month, then randomly audit 5 Fall Care Plans weekly on Thursday during the Falls committee weekly meeting for 1 month.</p> <p>Results of the all falls related audits (audits performed by the DON, Unit Managers, MDS Coordinator & assistant administrator) will be submitted to the Providence Pavillion Quality Assurance (Q/A) committee, with the committee determining the need for further monitoring.</p> <p>Providence Pavillion utilizes the PDCA (Plan Do Check Act) approach in solving identified quality issues. Using the PDCA approach all identified quality issues are analyzed and a Plan is then implemented to solve the identified problem (Do</p>		

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F 282 SS=D	<p>483.20(k)(3)(II) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility's Care Plan policy, it was determined the facility failed to follow the resident's plan of care for two (2) of fifteen (15) sampled residents (Resident #4 and Resident #5). Resident #4 was care planned for honey thickened liquids and supervision during meals. Resident #4 was observed not to have honey thickened liquids and was not supervised during the lunch meal on 08/19/15. Resident #5 had an order and a care plan intervention for TED (Thrombo-embolic deterrent Hose) each morning and off each night. TED hose are designed to promote circulation in the legs and help prevent blood clot formation. Observation revealed Resident #5 did not have on the TED hose.</p> <p>The findings include: Review of the facility's policy "Care Plans-Comprehensive" not dated, revealed the facility will develop an individualized comprehensive care plan that includes measurable objectives and timetables to meet the residents medical, nursing, mental, and psychological needs. Further review revealed the comprehensive care plan was designed to incorporate identified problem areas and reflect treatment goals and objectives in measurable</p>	F 282	<p>phase). If during the routine ongoing check-(the auditing process) Providence Pavilion identifies any problem with the implemented plan; Providence will then re-analyze why the plan is not working and then will adjust the plan accordingly. The PDCA approach is a continuous cycle, therefore the identified quality issue will undergo the Q/A process, until the Q/A committee determines that the issues have been solved. The Administrator & the Assistant Administrator of the facility (in collaboration with the Medical Director and Director of Nursing) oversees the facilities Q/A program to ensure that the program is effective and in compliance with Federal & State regulations.</p> <p>5. Providence Pavilion alleges compliance as of October 8, 2015.</p>	

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F 282	<p>Continued From page 12</p> <p>outcomes and aid in preventing or reducing declines in the resident's functional status and/or functional level.</p> <p>1. Review of the medical record revealed the facility admitted Resident #4 on 10/01/10 with diagnoses which included Anemia, Heart Failure, Urinary Tract Infection, Diabetes, Anxiety, Depression, Gastrostomy, and Dysphagia. A review of the Quarterly Minimum Data Set (MDS) assessment dated 07/27/15 revealed the resident required extensive assistance with one (1) person physical assist for eating. The MDS also revealed the resident had a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15) indicating the resident was cognitively intact.</p> <p>Review of the Physician's orders, dated August 2015 revealed an order with a start date of 10/14/14 for the resident to receive regular mechanical soft texture diet with honey consistency liquids.</p> <p>Review of the Comprehensive Care Plan dated 08/10/15 revealed the facility identified the resident to be at risk for aspiration. The Care Plan revealed interventions to include provide honey thickened liquids as ordered and up in wheelchair with supervision for all meals.</p> <p>Observation of Resident #4, on 08/19/15 at 12:20 PM, revealed State Registered Nurse Aide (SRNA) #4 delivered Resident #4's lunch tray to the room, set the meal tray up for the resident, and then left the room leaving the resident unsupervised for the meal, sitting up in the wheelchair. Further observation of the meal tray revealed the tea and coffee was not honey thickened.</p>	F 282	<p>F 282 Services by Qualified Persons/Personalized Care Plan</p> <p>Providence Pavillion does provide and/or arrange services that are delivered by a qualified person in accordance with each resident's written plan of care.</p> <ol style="list-style-type: none"> Providence Pavillion's IDT Reviewed and Revised both affected Residents Care plan as follows: Resident's #4 diet was changed to a Regular diet with no required supervision. Resident's #5 TED hose have been discontinued by the attending physician, as they were no longer clinically indicated. No Resident of the facility identified in the statement of deficiencies (2567) were found to be affected by the deficient practice: Resident # 4 was known to facility as not compliant with the order for honey thickened liquids and having supervision during meals. Resident was assessed as having a BIM of 13/15, indicating that the resident was cognitively intact. Because of the facility knowledge of the resident being non-compliant with the diet restrictions: On 9/10/2014 the facility implemented every shift monitoring of the Resident for S/S's of silent aspiration. The monitoring consisted of checking the residents Temperature, Pulse, and Oxygen saturations. The Resident has never experienced an episode of aspiration. As noted above the order for Resident's diet was changes to a regular diet with no required supervision. <p>After the completion of the annual survey the facility determined that Resident # 5</p>	10/18/15	

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014
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F 282	<p>Continued From page 13</p> <p>Interview, on 08/19/15 at 12:21 PM, with SRNA #4 revealed she was not aware the resident required honey thickened liquids and supervision during meals.</p> <p>Interview, on 08/21/15 at 4:45 PM, with Director of Nursing (DON) revealed she expected all staff to follow the residents care plan and to adhere to the facility's Care Plan Policy. Continued interview with the DON revealed she was aware the Resident #4 was required to have honey thickened liquids, but the resident chose not to have the liquids thickened. The DON further stated she was not aware the resident required supervision during meals.</p> <p>2. Review of Resident #5's medical record revealed diagnosis which included Cognitive Deficits due to Cerebrovascular Disease, Schizoaffective Disorder, Hypertension, Dementia, Unspecified Disorder of Kidney and Ureter, and Pacemaker. Review of the Quarterly Minimum Data Set (MDS) dated 08/15/15, revealed the facility assessed the resident as having a Brief Interview of Mental Status (BIMS) of a nine (9) out of fifteen (15) indicating the resident was interviewable.</p> <p>Review of the Physician's Orders for August 2015 revealed a Physician order for TED hose on every (Q) AM off every evening and night shift.</p> <p>Review of the Comprehensive Plan of Care and the Nurse Aide Care Plan, dated 10/24/13 and revised on 02/11/15 revealed the intervention that Resident #5 was to have TED hose on in the AM and off at night (HS).</p>	F 282	<p>had not worn TED hose for some time because Resident # 5 does not like to wear the TED hose. Resident # 5 has not shown S/S's of any blood clot formation and clinical evaluation revealed that the resident's circulation was satisfactory. Resident # 5 also has had no recent evidence of lower extremity edema. As noted above the TED hose for Resident # 5 were discontinued by the Residents attending physician.</p> <p>All Residents of the facility who may be on a restricted diet/or requiring supervision at meal times & Residents who have orders for TED hose may be affected by the practice identified on the statement of deficiencies.</p> <p>The facility will prevent similar issues occurring by implementation of the following practices, noted in section 3.</p> <p>3. Facility has implemented a new practice to ensure that all care plans are created and/or updated and followed by members of the care team.</p> <p>(a) Under the supervision of the attending MD, the Facility standards of Care (SOC) team, including a Registered Nurse who is responsible for the care of the Resident, the Social Worker, The MDS coordinator, and the Director of Nursing will meet weekly to review all Residents who have new orders. Any Resident who is identified with a new order will have a care plan updated and/or initiated.</p>	
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F 282	Continued From page 14 Observation on 08/18/15 at 12:00 PM, 2:30 PM, 5:30 PM; 08/19/15 at 8:45 AM; 08/20/15 at 8:30 AM, 4:00 PM; and 08/21/15 at 8:45 AM, and 2:00 PM, revealed Resident #5 did not have TED hose on at any of these observations. Interview with SRNA #7, on 08/21/15 at 2:30 PM, revealed she was not aware that Resident #5 was to have TED hose on daily. SRNA #7 reviewed Resident #5's care plan and stated "yes" he/she was care planned to have TED hose on every AM. Interview, on 08/21/15 at 4:45 PM, with the DON revealed she was not aware that Resident #5 did not have TED hose on throughout the survey. She stated she expected the staff to follow the resident's plan of care and adhere to the facility's Care Plan Policy. Interview on 08/21/15 at 6:15 PM with the Administrator revealed he expected all staff to follow the facility's policy regarding Care Plans.	F 282	(b) Five times weekly the Nurse Manager on each Nursing unit reviews all new orders from the previous day (or from the weekend) to ensure that all new orders are completed, accurate, and have an appropriate care plan in place. The order reviews include a review for any new and/or revised treatment modality. If the order review identifies a new order: the nurse manager, DON, and the MDS coordinator will review that resident's care plan to ensure an appropriate care plan is in place. (c) The DON/MDS coordinator and Nurse Managers will ensure that the new order is also posted on the POC (the facilities care plan for STNA's). (d) On September 2 nd , 3 rd , & 4 th , 2015 the Administrator, Assistant Administrator & DON re-educated all Providence Staff on what an Individualized care plan is, why the care plan is to be followed, and the clinical members were re-educated on how to find the care plan. (e) On September 17 th and 18 th the DON educated all nurses & STNA's on the new process being utilized to update the care plan and the importance of following the care plan.		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 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.	F 315			

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F 315	<p>Continued From page 15</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, and clinical record review, it was determined the facility failed to ensure residents received appropriate treatment and services to restore as much normal bladder function as possible for two (2) of fifteen (15) sampled residents (Resident #5 and Resident # 9). Resident #9 and Resident #5 had not had a bladder assessments since admission and had not been placed on a toileting program for documented frequent incontinence after expressing the desire to toilet.</p> <p>The findings include:</p> <p>1. Review of the medical record revealed the facility admitted Resident #9 on 12/24/14 with diagnoses that included Anxiety, Asthma, Falls, Muscle Wasting, Malaise/Fatigue, Debility, and Compression fracture Cervicle 2 vertebra. A review of the Quarterly Minimum Data Set (MDS) Assessment, dated 06/12/15, revealed the resident was frequently incontinent and required extensive assistance with one (1) person physical assist for toileting and was frequently incontinent of bowel and bladder. The MDS also revealed the resident had a Brief Interview for Mental Status (BIMS) score of five (5) out of fifteen (15) dated 06/12/15, indicating the resident was severely cognitively impaired.</p> <p>Review of the Comprehensive Care Plan initiated date 01/08/15 revealed the facility identified the resident to be at risk for Activity of Daily Living (ADL) Self Care Performance and Mobility Deficit related to debility. The Nurse Aide Care Plan initiated 12/24/14 and revised on 07/29/15 revealed interventions to include, assist of one (1)</p>	F 315	<p>(f) The Director of Human resources will educate all new hires during their Orientation period and the Director of Human resources will educate agency staff, prior to being utilized at Providence Pavillion, in regards to the education in the Plan of correction as submitted.</p> <p>4. In order to ensure compliance:</p> <p>(a) The director of nursing, and/or designee, will conduct audits of all residents who have new orders weekly for 4 weeks, two times monthly for 1 month, and then monthly for 1 month to ensure that Residents have appropriate care plans in place.</p> <p>(b) The facility dietician will conduct Bi-weekly audits of all Residents who are receiving alternative diets and/or residents needing supervision with meals for 1 month, then weekly audits of all residents who are receiving alternative diets and/or residents needing supervision with meals for 1 month, then Random audits of 3 Residents who are receiving alternative diets and/or residents needing supervision with meals for 1 month.</p> <p>(c) The Rehab Unit Manager/designee will conduct weekly audits of all Residents who have orders for TED hose for 1 month, then 50% of Residents who have orders for TED hose for 1 month, then 5 Residents who have orders for TED hose for 1 month.</p>	

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F 315	<p>Continued From page 16</p> <p>for toileting, wears pull ups, offer/assist the resident to toilet in advance of need and frequently offer to take resident to the bathroom. The clinical record revealed the resident had not had a bowel and bladder reassessment and had not been on a toileting program. Further review of the clinical record revealed the State Registered Nurse Aide (SRNA) Bowel and Bladder tracking record revealed the resident had been toileted two (2) to three (3) times a day and was continent of bladder thirty two (32) out of fifty four (54) toileting's.</p> <p>Interview, on 08/21/15 at 2:40 PM, with State Registered Nursing Assistant (SRNA) #4 revealed Resident #9 had been offered toileting every two (2) hours. SRNA #4 stated she only documented in the resident record when the resident urinated or had a bowel movement and she did not document every time she offered toileting to the resident.</p> <p>2. Review of Resident #5's medical record revealed diagnosis which included Cognitive Deficits due to Cerebrovascular Disease, Schizoaffective Disorder, Hypertension, Dementia, Unspecified Disorder of Kidney and Ureter, and Pacemaker. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 06/15/15, revealed the facility assessed the resident as having a Brief Interview of Mental Status (BIMS) of a nine (9) out of fifteen (15) indicating the resident was interviewable.</p> <p>Interview with Resident #5, on 08/20/15 at 2:00 PM, revealed that the resident was aware when he/she needed to urinate or have a bowel movement and would call out for assistance to go to the bathroom and sometimes was told by staff that he/she would have to wait, and he/she could</p>	F 315	<p>Results of the New order audits & Resident observation audits (alternative diets/supervision for meal & TED hose audits) will be submitted to the Providence Pavilion Quality Assurance (Q/A) committee, with the committee determining the need for further monitoring.</p> <p>Providence Pavilion utilizes the PDCA (Plan Do Check Act) approach in solving identified quality issues. Using the PDCA approach all identified quality issues are analyzed and a Plan is then implemented to solve the identified problem (Do phase). If during the routine ongoing check-(the auditing process) Providence Pavilion identifies any problem with the implemented plan; Providence will then re-analyze why the plan is not working and then will adjust the plan accordingly. The PDCA approach is a continuous cycle, therefore the identified quality issue will undergo the Q/A process, until the Q/A committee determines that the issues have been solved. The Administrator & the Assistant Administrator of the facility (in collaboration with the Medical Director and Director of Nursing) oversees the facilities Q/A program to ensure that the program is effective and in compliance with Federal & State regulations.</p> <p>5. Providence Pavilion alleges compliance as of October 8, 2015.</p>		

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F 315	<p>Continued From page 17</p> <p>not hold their urine and was incontinent on self. He/She continued that doesn't happen very often, most of the time I make it to the bathroom.</p> <p>A review of Resident #5's comprehensive MDS assessment dated 03/20/15 revealed the facility assessed Resident #5 to have a BIMS score of 13, which indicates no cognitive impairment. The MDS also stated that Resident #5 was frequently incontinent of urine and bowel. Continued review of the medical record revealed that Resident #5 was often continent of bowel and bladder.</p> <p>Further review of the record revealed no "Bowel and Bladder Assessment" had been completed and no Training Program was in place. The plan for management was to toilet the resident in advance of need.</p> <p>A review of the care plan for Resident #5, dated 04/30/13 and updated 02/11/15, revealed Resident #5 was incontinent of bladder and frequently incontinent of bowel. Interventions included assist resident with toileting PRN (as needed), monitor for incontinence episodes every 2 hours and provide incontinence care PRN.</p> <p>Interview with State Registered Nurse Aide (SRNA) #2, on 08/20/15 at 2:30 PM, revealed Resident #5 was usually continent of bowel and bladder. She also stated the resident called for assistance when needing to go to the bathroom.</p> <p>Interview with SRNA #6, on 08/20/15 at 3:00 PM, revealed that Resident #5 did know when he/she needed to use the restroom, and called for assistance when he/she needed help. She further stated we also check on him/her every 2 hours.</p>	F 315	<p>F 315 No Catheter, Prevent UTI, Restore Bladder</p> <p>Providence Pavilion does ensure that resident(s) who enter the facility who are incontinent of bladder receive appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <ol style="list-style-type: none"> Resident's # 5 and #9 each are currently undergoing a Bladder assessment (attachment b) that will be completed on September 18, 2015. Each completed assessment will be reviewed by the interdisciplinary Care Team (IDT) and based upon the clinical upon the assessment outcome each resident will be placed on an appropriate toileting program. The toileting program will be appropriately care planned both on the nurse aides POC & the MDS. The facility is also assessing all residents in the facility to ensure each resident has been individually assessed for their toileting needs. Each incontinent resident B&B assessment will be reviewed by the IDT and each resident will be placed upon an appropriate toileting program. (a) Every new admission will be observed for Bowel & Bladder Incontinence during the first 3 days of admission to the facility. <p>(b) The Initial Bowel & Bladder assessment will be completed by the unit manager within 48-hours of the initial 3-day observation period.</p> <p>(c) The daily Standards of Care Meeting will review Bowel & Bladder assessments weekly ensuring that the assessments</p> 	8/18/15

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F 315	Continued From page 18 Interview, on 08/21/15 at 4:45 PM, with the DON revealed the facility did not have a bowel and bladder assessment program, a toileting program or a restorative program in place to restore as much bladder function as possible to incontinent residents. The DON also stated a bowel and bladder assessment and toileting program would provide improved quality of life for the facility's incontinent residents. Interview on 08/21/15 at 6:15 PM with the Administrator revealed he expected staff to follow the care plan for toileting needs of incontinent resident. He state he was not aware the facility did not have a bowel and bladder assessment program, a toileting program, or a restorative program in place to restore as much bowel and bladder function as possible to incontinent residents. The Administrator further stated these programs could improve residents quality of life.	F 315	have been accurately completed & the SOC committees will review weekly to discuss any care planning revisions and changes. (d) In Addition all Residents will receive a Bowel & Bladder assessment quarterly and annually. (e) The resident's incontinence status will be appropriately care planned as dictated by the Bowel & Bladder assessment. On September 17 th & 18 th the Director of Nursing In-serviced all nursing staff regarding the new Bowel & Bladder protocol to ensure that all residents receive the Bowel & Bladder assessment upon admission and quarterly. The Director of Human resources will educate all new hires during their Orientation period and the Director of Human resources will educate agency staff, prior to being utilized at Providence Pavilion, in regards to the education in the Plan of correction as submitted.	
F 323 SS=G	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 and procedures, it was determined the facility failed to ensure the resident's environment remained as free from accidents and hazards as possible and failed to	F 323	4. The Director of Nursing and/or Designee will audit the chart of all new admissions after 1 week of being admitted to the facility to ensure that the Bowel & Bladder assessment has been completed. All new admission audits will continue for 1 month, then 50% of all new admits will be audited for 1, month, then 5 random new admission audits will occur for 1 month. The Director of Nursing and/or designee will also conduct audits of Quarterly & annual assessments to ensure that the Bowel & Bladder assessment has been completed. These audits will be	

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F 323	<p>Continued From page 19</p> <p>ensure the resident received adequate supervision to prevent accidents for one (1) of fifteen (15) sampled residents, (Resident #9).</p> <p>Resident #9 sustained nine (9) falls from 04/04/15 through 7/28/15. Interview and record review revealed seven (7) of the falls were sustained while the resident was attempting to self toilet (04/18/15, 04/28/15, 05/05/15, 07/03/15, 07/12/15, 07/27/15, 07/28/15). The resident sustained injury as a result of the falls on 04/18/15, 04/28/15, 07/27/15, and 07/28/15 requiring sutures/staples. However, there was no documented evidence the facility conducted a thorough investigation to determine the root cause of the falls and/or revised the falls interventions to prevent further falls. Interview and record review revealed even though the facility identified self-ambulation to toilet as the root cause of some of the falls, there was no documented evidence the facility implement increased supervision, a toileting program, or a restorative program to prevent further falls.</p> <p>In addition, observation revealed resident room doors and bathroom doors had rough edges and there were toilet bolt caps missing.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON) on 08/21/15 at 4:40 PM revealed bladder assessments were conducted on admission, but the facility did not have a formal bladder assessment policy for incontinent residents. Continued interview revealed the facility did not have a toileting program or a restorative program in place to help reduce the risk for fall, and the facility did not have a "Fall Risk" policy.</p>	F 323	<p>conducted on all Quarterly & Annual assessments for 1 month, then on 50% of all Quarterly & Annual assessments for 1 month, then 5 random Quarterly & Annual assessments for 1 month.</p> <p>Reports of both of the above audits will be provided to the Q/A committee: after the 3 month cycle The Q/A committee may determine if the audits are further needed.</p> <p>Providence Pavillion utilizes the PDCA (Plan Do Check Act) approach in solving identified quality issues. Using the PDCA approach all identified quality issues are analyzed and a Plan is then implemented to solve the identified problem (Do phase). If during the routine ongoing check-(the auditing process) Providence Pavillion identifies any problem with the implemented plan; Providence will then re-analyze why the plan is not working and then will adjust the plan accordingly. The PDCA approach is a continuous cycle, therefore the identified quality issue will undergo the Q/A process, until the Q/A committee determines that the issues have been solved. The Administrator & the Assistant Administrator of the facility (in collaboration with the Medical Director and Director of Nursing) oversees the facilities Q/A program to ensure that the program is effective and in compliance with Federal & State regulations.</p> <p>5. Providence Pavillion alleges compliance as of October 8, 2015.</p>	

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F 323	Continued From page 20 Interview on 08/21/15 at 6:15 PM with the Executive Director revealed, the facility did not have a "Fall Risk" policy, a bladder reassessment process after the original admission assessment, a toileting program, or a restorative program in place to help reduce the risk for fall. Review of the facility's "Accident/Injury Reporting and Unusual Occurrence Investigation" Policy, not dated, revealed the objective was "to provide a safe healthful environment and therefore, all accidents/incidents or unusual occurrences occurring on the premises must be reported to the Nurse Manager or Director of Nursing/Designee and would undergo a follow up investigation". Paragraph # six (6) stated, "reports will be analyzed for patterns and trends, statistical compilation to identify staff development needs or policy /procedure changes, etc., and reported to the Quality Assurance (QA) Committee. A weekly (and as needed) interdisciplinary team meeting will be held to review all individual resident falls, unusual skin occurrences, and Plan of Care, cause/motivators, further preventative approaches and interventions, equipment/supply needs and referrals". Further review revealed the facility did not have a "Falls Risk" Policy, a bladder reassessment process, a toileting program, or a restorative program for incontinent residents. Interview with Unit Manager on 08/21/15 at 4:00 PM revealed the process for investigating a fall was the nurse on duty completed the incident report summarizing the fall and documented it in the progress notes. The DON completed the follow-up investigation, obtained orders for any new interventions, and then added the	F 323	F-323 Free of Accidents Hazards/Supervision/Devices Providence Pavilion does ensure that the resident environment remains free of accident hazards as is possible; and each resident does receive adequate supervision and assistance devices to prevent accidents. 1. On July 27, 2015 the DON reviewed Resident # 9's fall history and implemented the following interventions on 7/28/2015: a) a body pillow for positioning, b) a cradle mattress to remind resident to call for assistance, c) a one padded 1/2 side rail on the opposite side of the bed, d) the DON discussed with family POA the risks/benefits of placing a fall mat on the floor-It was decided not to do this at that time, and e) the DON reviewed medications with the residents Psychologist. Since the implementation of these interventions Resident #9 has not fallen. Resident # 9 has also been placed on the "lighthouse program" as described in section #3 below. In addition to the falls interventions above, Resident # 9 has been assessed under the facility new B&B protocol and has been placed upon an individualized toileting program. (See F 315 POC above) All new interventions have been added to the STNA POC and the Residents individualized care plan. The facility Maintenance Director sanded Resident the rough edges on resident	10/8/15

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F 323	<p>Continued From page 21</p> <p>interventions to the care plan. The Unit Manager further stated the root cause analysis for falls was determined during the Quality Assurance (QA) meeting. Further interview revealed the staff was trained on falls during orientation and when the need arose.</p> <p>1. Observation on 08/18/15 at 12:10 PM revealed, Resident #9 sitting in wheelchair in the dining room; the resident was neat, clean and appropriately dressed. The resident was wearing gripper socks and a Wander guard alarm was in place. Continued observation revealed a self releasing seat-belt was in place. Further observation revealed the resident had what appeared to be a green bruise to the right side of face, temple and forehead area.</p> <p>Review of Resident #9's medical record revealed the facility admitted the resident on 12/24/14 with diagnoses which included Anxiety, Asthma, Falls, Muscle Wasting, Malaise/Fatigue, Debility, and Compression Fracture Cervical 2 Vertebra. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 06/12/15 revealed the facility assessed the resident as frequently incontinent, requiring extensive assistance with two (2) person physical assist for transfers, limited assistance with one (1) person physical assist with a walker for ambulation, and extensive assistance with one (1) person physical assist for toileting. The MDS also revealed the resident had a Brief Interview for Mental Status (BIMS) score of five (5) dated 06/12/15 which revealed the resident was severely impaired in cognition.</p> <p>Review of the Comprehensive Care Plan Initiated on 01/08/15 revealed the facility identified the resident to be at risk for Falls and Activity of Daily</p>	F 323	<p>room doors and bathroom doors in rooms: 425, 427, 429, 431, 435, 444, 436, 439, 442, 446, 434, 435, 430, 419, and 417.</p> <p>The facility Maintenance Director placed plastic toilet bolt protectors on the exposed toilet bolts in rooms: 425, 427, 431, 435, 444, 434, 435, 430, 419, and 417.</p> <p>2. The facility has implemented a new comprehensive falls program, as discussed in section #3 below.</p> <p>The facility Maintenance Director also has examined all resident doors and bathroom doors to ensure there are no rough edges.</p> <p>The facility Maintenance Director also has examined all Resident toilets to ensure that there are no exposed toilet bolts.</p> <p>The facility will prevent similar issues occurring by implementation of the comprehensive falls program, noted in section 3.</p> <p>3. (a) The New Providence Pavilion Falls Program provides for each Resident to be individually assessed to their potential of having falls. If the Residents assessment indicates the resident of having a high potential for falls, then Individualized interventions are put into place. On September 17th 2015 the IDT (consisting of the Director of Nursing, Nurse Managers, The MDS Coordinator, Social Work, and therapy Manager) reviewed all Residents to assure that the Providence Pavilion Falls Risk assessment was</p>	

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F 323	<p>Continued From page 22</p> <p>Living (ADL) Self Care Performance and Mobility Deficit related to debility with interventions to include Bed and Chair alarm in place to alert staff of unassisted transfers - check alarms for functioning daily. Per the care plan, the resident needs a safe environment with: even floors free from spills and or clutter; adequate, glare free light; a working and reachable call light, the bed in low position at night; Side rails as ordered, handrails on walls, personal items within reach, and encourage resident to use call light.</p> <p>Review of the fall incident/investigation follow-up documentation revealed Resident #9 fell on 04/04/15 at 2:44 PM while attempting to independently transfer from one wheelchair to another. Further documentation revealed the resident frequently self transferred and multiple interventions had been attempted and were noted to be ineffective. The family was notified and a consent for self releasing seat belt was obtained. Further review of the nurses progress note on 04/04/15 revealed alarm sounding, on entering the room the resident stood up from bed and began ambulating.</p> <p>Review of the resident's care plan revealed the care plan was revised on 04/07/15 to add a self releasing seat belt. Further review of the resident's care plan revealed the care plan was not revised to include interventions related to toileting.</p> <p>Review of the fall incident/investigation follow-up documentation revealed Resident #9 fell on 04/18/15 at 8:14 AM the resident attempted to independently ambulate to the bathroom, was "found on the floor bleeding from the back of the head, behind the left ear", the resident was sent</p>	F 323	<p>completed. All residents scoring a very high Risk for falling was placed upon the new lighthouse program. In total 8 residents were placed on the lighthouse program.</p> <p>On-going: Each Resident is assessed regarding their falls potential with every assessment completed on them. Assessments are completed upon admission to the facility and quarterly. If the Resident is identified as being a very high risk for falling (or as determined by the Falls Committee), not only do they receive individualized interventions: they are also placed upon the Providence Pavilion lighthouse program. The lighthouse program provides additional safety to the Resident by reminding staff, to frequently monitor the Resident: All staff were In-serviced by the Director of nursing on September 17th & 18th, 2015 that all residents who have a lighthouse on their door, walker and/or wheel chair should be observed every time they pass that resident to ensure the Residents is ambulating safely and/or that they are safe.</p> <p>(b) If a Resident does have a fall at Providence Pavilion, the Resident and any potential causes for the fall are immediately assessed by the Charge Nurse with assistance from the clinical manager. On September 17th & 18th the Director of Nursing educated all nurses that every after every Resident fall, there needs to be an immediate assessment of why the Resident fell: the DON explained that this will assist better interventions to be put into place, thus reducing the possibility of a future fall.</p>	
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F 323	<p>Continued From page 23</p> <p>to the hospital emergency room. Review of the hospital emergency room report revealed the resident received six (6) staples to close the wound. However, there was no documented evidence the facility revised the care plan to meet the resident's toileting needs and to prevent future falls. Further review of the nurses progress note revealed no entry regarding the fall, treatment, or follow-up interventions related to the fall.</p> <p>Review of the fall incident/investigation follow-up documentation revealed Resident #9 fall on 04/28/15 at 6:20 PM while attempting to ambulate to the bathroom independently and was "found lying on the floor with moderate amount of blood coming from above the right eyelid". Further documentation revealed the area to the right eyelid was cleansed, pressure dressing was applied and the resident was sent to the hospital emergency room for evaluation and treatment. Review of the hospital emergency room report revealed the resident received sutures to close the wound. The Psychologist was notified and an order was received to increase Risperdal to 0.25 milligrams three times a day related to increased behaviors. However, there was no documented evidence the facility revised the care plan to meet the resident's toileting needs and to prevent future falls. Further review of the nurses progress note revealed no entry regarding the fall, treatment or follow-up interventions related to the fall.</p> <p>Review of the fall incident/investigation follow-up documentation revealed Resident #9 fall on 05/05/15 at 4:22 AM while attempting to ambulate independently to the bathroom and was found on the floor beside the bed. Further documentation</p>	F 323	<p>The Director of Human resources will educate all new hires during their Orientation period and the Director of Human resources will educate agency staff, prior to being utilized at Providence Pavilion, in regards to the education in the Plan of correction as submitted.</p> <p>(c) A Follow Up Investigation form has been developed and implemented and is used for documentation of the assessment and interventions following a fall. The Director of Nursing & and nurse managers are responsible for completing the form and performing any needed investigation into the root cause of the fall. On September 17th, 2015 the Administrator & Director of Nursing educated the Nurse Managers and Assistant Administrator of the rationale and process of completing the follow up investigation form. The Director of Nursing & Assistant administrator reviews the follow up investigation form after it has been completed: reviewing the form for completion and ensuring that the process is being followed.</p> <p>(d) Falls are analyzed individually by the DON and the Individual Nurse Manager (on a daily basis) to ensure appropriate interventions have been put into place to lower the risk of additional falls occurring. The DON and Managers are informed of falls as they occur by the involved nursing staff. If a fall occurs after business hours; the clinical manager on duty</p>	
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F 323	<p>Continued From page 24</p> <p>revealed the resident was assessed for injury, assisted to the bathroom then back to bed with the bed alarm in place, the bed in low position and staff was educated to offer resident assistance to toilet every one to two hours. The staff was in-serviced on 05/06/15 to ensure to offer resident assistance to toilet every one to two hours to avoid attempts to self transfer. However, there was no documented evidence the facility revised the care plan to meet the resident's toileting needs and to prevent future falls. Further review of the nurses progress note revealed no entry regarding the fall, treatment or follow-up interventions related to the fall.</p> <p>Review of the fall incident/investigation follow-up documentation revealed Resident #9 fell on 05/28/15 at 4:25 PM while attempting to self transfer and was "found sitting on the floor". Further documentation revealed the Director of Nursing (DON) called the Power of Attorney (POA) and discussed the potential of a trial to use a lap buddy if the physician agrees. The POA stated she was willing to try the lap buddy but did not want the resident to become anxious. The DON further documented all interventions were in place for this resident. On 06/01/15 the DON discussed with the Psychologist to try routine Ativan before trying the lap buddy. The Psychologist assessed the resident on 06/01/15 and wrote an order to increase Buspar for anxiety. However, there was no documented evidence the facility revised the care plan to meet the resident's toileting needs and to prevent future falls. Further review of the nurses progress note revealed no entry regarding the fall or follow-up interventions related to the fall.</p> <p>Review of the fall incident/investigation follow-up</p>	F 323	<p>falls are reported to the Director of Nursing and the appropriate Manager the next business morning.</p> <p>(e) Every week, the Providence Pavilion Falls Committee (a newly established interdisciplinary team IDT) meets and discusses falls that have occurred since their last meeting. The IDT reviews falls as presented by the Director of Nursing, Unit Managers, or the MDS coordinator. Suggestions from this committee are added as appropriate to the individualized Resident's care plan & if appropriate to the Providence Pavilion Falls policy.</p> <p>(f) The facility MDS Nurse is part of the Falls Committee and will ensure that all interventions that are discussed and adapted are added to any affected residents Individualized care plan.</p> <p>The maintenance director has added monitoring of door edges & toilet bolt covers to his weekly building inspection tool.</p> <p>This tool will be provided to the Administrator/designee after weekly completion for Administrative review.</p> <p>(b) Any repairs notes on the weekly building inspection tool will be prioritized and completed by the maintenance department in the prioritized order.</p> <p>(c) The Administrator and maintenance director will establish monthly walking rounds to ensure that repairs are being completed in a timely fashion. (These</p>		

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F 323	<p>Continued From page 25</p> <p>documentation revealed Resident #9 fell on 07/03/15 at 4:33 AM. The resident climbed out of bed unassisted and was "found sitting on the floor while attempting to ambulate independently to the bathroom. Further documentation revealed the resident's coccyx was red. The DON documented in the fall incident/investigation report the resident attempts to get out of bed when he/she feels the need to toilet. The resident needs to be offered frequent toileting. However, there was no documented evidence the facility revised the care plan to meet the resident's toileting needs and to prevent future falls. Further review of the nurses progress note revealed no entry regarding the fall or follow-up interventions related to the fall.</p> <p>Review of the fall incident/investigation follow-up documentation revealed Resident #9 fell on 07/12/15 at 6:30 PM while attempting to ambulate independently to the bathroom and was "found sitting on the floor". Further review revealed the resident needed to be tolleted in advance of need. Frequently offer to take the resident to the restroom to help decrease the amount of unassisted transfers. Staff education provided on 07/15/15 to offer resident frequent toileting even through the night to help decrease her rising from the bed unassisted. However, there was no documented evidence the facility revised the care plan to meet the resident's toileting needs and to prevent future falls. Further review of the nurses progress note revealed no entry regarding the fall or follow-up interventions related to this fall.</p> <p>Review of the fall incident/investigation follow-up documentation revealed, Resident #9 fell on 07/27/15 at 12:50 AM attempting to ambulate independently the resident was found "sitting on the floor in the bathroom with blood coming from</p>	F 323	<p>walking rounds are in addition to the Q/A system noted in section 4 below)</p> <p>4. Each Providence Pavilion Nurse Manager Audits each fall that occurs on their floor. This audit monitors the compliance to the Falls Program. The audit is turned into the assistant administrator after completion by the nurse manager.</p> <p>The assistant administrator also monitors to ensure that the Falls Program is being consistently implemented. The assistant administrator also monitors to ensure that the weekly fall committee is meeting, and that the meeting is effective.</p> <p>The assistant administrator will audit all falls occurring within Providence Pavilion for 1 month, then the 50% of all falls for 2 months. Results of the all falls related audits (audits performed by the unit managers & assistant administrator) will be submitted to the Providence Pavilion Quality Assurance (Q/A) committee, with the committee determining the need for further monitoring.</p> <p>Also: the assistant administrator will conduct Environmental audits of Providence Pavilion resident rooms 2 times weekly for 2 months, 1 time weekly for 1 month, and then one (1) time monthly every 2 months to ensure that the rooms are maintained in a safe/clean/comfortable/homelike</p>		

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F 323	<p>Continued From page 26</p> <p>the side of the head". The resident was sent to the hospital emergency room for further evaluation and treatment. Review of the hospital emergency room report revealed the resident received staples to close the wound. The DON further documented the implementation of a body pillow for positioning, a cradle mattress to remind resident to call for assistance instead of climbing out of bed, one padded half side rail on the opposite side of the bed, and discussion with POA about the implementation of a fall mat could increase fall hazards related to the resident's poor safety awareness, and DON documented she would discuss medication alterations with the Psychologist. However, review of the care plan revealed the new interventions were not added to the care plan until 07/28/15. Further review of the nurses progress note revealed no entry regarding the fall or follow-up interventions.</p> <p>Review of the fall incident/investigation follow-up documentation revealed Resident #9 fell on 07/28/15 at 6:39 AM while the resident attempted to ambulate independently and was "found on the floor in the bathroom with blood coming from the forehead and a skin tear to the left lateral arm", the resident was sent to the hospital emergency room for evaluation and treatment. Review of the hospital emergency room report revealed the resident received six (6) sutures to close the wound. It was further documented that multiple interventions had been added on 07/27/15, but review of the care plan revealed the intervention were not added until 07/28/15. However, there was no documented evidence the facility revised the care plan to meet the resident's toileting needs and to prevent future falls. Further review of the nurses progress note revealed no entry regarding the fall, treatment, or follow-up</p>	F 323	<p>environment. Results of the Environmental audits will be submitted to the Providence Pavilion Quality Assurance (Q/A) committee, with the committee determining the need for further monitoring.</p> <p>Providence Pavilion utilizes the PDCA (Plan Do Check Act) approach in solving identified quality issues. Using the PDCA approach all identified quality issues are analyzed and a Plan is then implemented to solve the identified problem (Do phase). If during the routine ongoing check-(the auditing process) Providence Pavilion identifies any problem with the implemented plan; Providence will then re-analyze why the plan is not working and then will adjust the plan accordingly. The PDCA approach is a continuous cycle, therefore the identified quality issue will undergo the Q/A process, until the Q/A committee determines that the issues have been solved. The Administrator & the Assistant Administrator of the facility (In collaboration with the Medical Director and Director of Nursing) oversees the facilities Q/A program to ensure that the program is effective and in compliance with Federal & State regulations.</p> <p>5. Providence Pavilion alleges compliance as of October 8, 2015.</p>		

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F 323	<p>Continued From page 27 interventions at the time of the fall.</p> <p>Further review of the resident's care plan revealed on 07/29/15 an intervention was added to offer/assist resident to toilet in advance of need, frequently offer to take resident to the restroom. This intervention was added seventeen (17) days after the need for toileting was identified after the fall on 07/12/15.</p> <p>Interview with State Registered Nurse Aide (SRNA) #4 on 08/21/15 at 2:40 PM revealed, she offered toileting to Resident #9 every two (2) hours, ensured the bed and chair alarms were in place and functioning daily, ensured the resident's safety belt was on, ensured the cradle mattress was in place, and the half side rail was padded, and the body pillow was in place for positioning when the resident was in bed to help decrease falls. Further interview revealed toileting was offered every two (2) hours to Resident #9 but the SRNA#4 stated she did not document when toileting was offered, she only documented when the resident had been incontinent.</p> <p>Interview with SRNA #6 on 08/21/15 at 2:45 PM revealed, she offered toileting to Resident #9 every two (2) hours, ensured the bed and chair alarms were in place and functioning daily, ensured the resident's safety belt was on, ensured the cradle mattress was in place, and the half side rail was padded, and the body pillow was in place for positioning when the resident was in bed to help decrease falls. Further interview revealed toileting was offered every two (2) hours to Resident #9 but the SRNA#4 stated she did not document when toileting was offered, she only documented when the resident had been</p>	F 323			

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F 323	<p>Continued From page 28 incontinent.</p> <p>Review of Resident #9's bowel and bladder tracking record revealed the resident had been offered toileting two (2) to three (3) times a day and was continent of urine thirty one (31) out of fifty four (54) toilettings.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator on 08/21/15 at 4:15 PM revealed the process for investigating a fall was the nurse on duty completed the incident report summarizing the fall and documented it in the progress notes. The DON completed the follow-up investigation, orders were obtained for any new interventions and then added to the care plan. She further stated the root cause analysis for falls was determined during the Quality Assurance (QA) meeting; however, she did not attend the QA meeting on falls. Further interview revealed the staff was trained on falls during orientation and as the need arose.</p> <p>Interview with the DON, on 08/21/15 at 4:40 PM, revealed the process for investigating a fall was, the nurse on duty completed the incident report summarizing the fall and documents it in the progress notes, the DON completed the follow-up investigation, orders were obtained for any new interventions and then added to the care plan. She further stated the root cause analysis for falls was determined during the Quality Assurance (QA) meeting and that interventions were determined at that time. She further stated she felt the investigations conducted at the time of the falls were adequate; however, looking back the fall investigation and documentation process was lacking and could use improvement. The DON further revealed she was aware the facility did not</p>	F 323			

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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	<p>Continued From page 29</p> <p>have a bladder reassessment process after the initial admission assessment, a toileting program, or a restorative program in place and agreed that if Resident # 9 had a reassessment of bladder function and had been placed on a training program it might have helped to reduce the risk for future falls.</p> <p>Interview on 08/21/15 at 6:15 PM with the Administrator revealed, he felt the facility's investigation and documentation of falls was adequate, and he was not aware the facility did not have a bladder reassessment process, a toileting program, or a restorative program in place. He agreed that if Resident #9 had a reassessment of bladder function and had been placed on a training program it might have helped to reduce the risk for fall. He further stated the falls were discussed in the QA meeting. However, the facility failed to identify and address toileting needs, as a cause for the resident's falls, through a bladder reassessment and a toileting program.</p> <p>2. Observation during the environmental tour of the facility on 08/20/15 at 10:00 AM revealed sharp edges on resident room doors and bathroom doors in the following rooms: 425,427,429, 431, 435, 444, 438, 439, 442, 446, 434, 435, 430, 419, and 417. Bolts at the base of the toilets was also observed to be uncovered in the following resident rooms: 425,427, 431, 435, 444, 434, 435, 430, 419, and 417. The sharp edges and exposed bolts presented a safety hazard to the residents in the facility.</p> <p>Interview with the Maintenance Director on 8/20/15 at 11:00 AM revealed it was a safety hazard for the residents of the facility to have</p>	F 323			

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F 323	Continued From page 30 sharp edges on the doors as this could cause skin tears. He stated toilet bolts not covered were also a hazard because residents that were unsteady could fall in the bathroom. He continued that he did not have a system in place to monitor rooms for needed repairs. Interview with the Administrator on 8/21/15 at 8:15 PM, revealed he was unaware of the sharp edges on resident room doors and toilet bolts uncovered. The Administrator stated he expected the Department Managers to have systems in place to assure the facility was kept clean and repairs made as needed.	F 323		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of facility policy and review of practice standards, it was determined the facility failed to ensure the medication administration error rate was less than five percent. Observations of facility staff administering medications to residents with gastric tubes on 08/19/15 and 08/20/15 revealed staff failed to administer each medication separately and flush the tube between each medication for one (1) of fifteen sampled residents, (Resident #3), and one (1) unsampled resident, (Resident A) in accordance with accepted standards of practice. As a result of the failure, the facility's medication error rate was 7.6	F 332	F 332 Free of Medication Error Rates of 5% or More. Providence Pavillion does ensure that it is free of medication error rates of five percent or greater. 1. (a)The DON immediately assessed Resident # 3 & Resident A to ensure that neither Resident was suffering from any possible medication related adverse reaction. Neither resident was adversely affected. (b) On August 21 st , 2015 the DON immediately (after being questioned by the State surveyor) re-educated both LPN #4 and LPN #3 on the correct way to administer medications to the resident with a gastric tube: the gastric tube should be flushed with 60 cc of liquid prior to the delivery of medication and that every medication should be individually delivered with a 10cc flush of liquid between each medication. 2. While all residents of the facility who have a gastric tube have the potential to be effected by practice observed by the surveyors, no Residents of the facility	10/8/15

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F 332	Continued From page 31 percent. The findings include: Review of the facility policy for Medication Administration via G-tube, Document # M-116, revealed facility staff was to flush the gastrostomy tube (a device surgically implanted into the stomach to provide nutrition, liquids and medications) with sixty (60) cubic centimeters (cc) of water prior to administration of medication. Additionally, if more than one medication was to be given, the tube should be flushed with ten (10)cc of water between medications. Review of Survey and Certification Letter 13-02 NH, dated 11/02/12 and review of "ASPEN enteral nutrition practice recommendations, http://www.guidelines.gov/content.aspx?id=14718 03/15/10" revealed for each resident with a gastric tube, each medication should be administered separately and the tube flushed between each medication. Observation of medication administration for Resident #3 on 08/19/15 at 9:40 AM revealed Licensed Practical Nurse (LPN) #4 placed Allopurinol 100 milligrams (mg), Aspirin (ASA) 81 mg chew tab, Colchicine 0.6 mg, Potassium Chloride 20 lileviable (meq), Lasix 20 mg, Metoprolol 12.5 mg, Senna Plus and a Multi-vitamin in a pill crusher, crushed the pills and dissolved the pills in one hundred twenty (120) cc of water and let the medication gravity flow through a 60 cc syringe into the G-tube. LPN #4 was observed to not flush the tube with 60 cc of water before or after medication administration, and did not flush with 10 cc of water between each medication.	F 332	were found to be affected by the deficient practice. On September 17 th & 18 th , 2015 the DON educated all licensed nurses who administer medication via a gastric tube of the procedure as follows: the gastric tube should be flushed with 60 cc of liquid prior to the delivery of medication and that every medication should be individually delivered with a 10cc flush of liquid between each medication. The facility will prevent similar issues occurring by implementation of the following practices, noted in section 3. 3. (a) Providence Pavillion reviewed the Medication Administration via G-tube policy and found it in compliance with current State & Federal guidelines. (b) On September 17 th and 18 th , 2015 the DON re-educated all RN's and LPN's on the appropriate way to deliver medication via a gastric tube: the gastric tube should be flushed with 60 cc of liquid prior to the delivery of medication and that every medication should be individually delivered with a 10cc flush of liquid between each medication. The Director of Human resources will educate all new hires during their Orientation period and the Director of Human resources will educate agency staff, prior to being utilized at Providence Pavillion, in regards to the education in the Plan of correction as submitted. 4. (a)The DON/Pharmacy Consultant and Nurse Manager/designee will audit medication administration for residents	

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F 332	Continued From page 32 Observation of medication administration conducted for Resident A on 08/20/15 at 9:15 AM revealed LPN #3 crushed and dissolved the following medications together in the same cup: Metoprolol 50 mg, Prevacid 15 mg, Desmopressin 0.1 mg. LPN #3 was observed to flush Resident A's G-tube with 30 cc of water, let the dissolved medication gravity flow through the G-tube. She flushed the tube with 30 cc of water. LPN #3 then administered 5 milliliters (ml) of Valproic Acid 250 mg through the tube and flushed with 120 cc of free water. LPN #3 did not flush the tube with 10 cc of water between each medication. Interview with LPN #3 and LPN #4 on 08/20/15 at 10:10 AM and 10:25 AM, respectively, revealed it was facility policy was to crush medications together, mix in 30 cc of water, administer the medications and flush with 30 cc water when complete. Continued interview revealed liquid medication was to be given separately. LPN #3 stated she was taught in nursing school to crush and administer medications separately. Interview with LPN #1, a Nurse Manager, on 08/21/15 at 11:45 AM, revealed it was facility policy was to crush and administer medications separately. She was unaware staff was crushing and administering medications together. Interview with the Director of Nursing (DON) on 08/21/15 at 11:50 AM revealed licensed staff go through an orientation process upon hire and medication administration was included in that process. She further stated licensed staff worked with a preceptor during orientation on the floor. She stated she was not aware staff were not	F 332	who have a gastric tube 3 times weekly for 1 month, 2 times weekly for 1 month, and 1 time weekly for 1 month. Results of the Medication Administration will be submitted to the Providence Pavilion Quality Assurance (Q/A) committee, with the committee determining the need for further monitoring. Providence Pavilion utilizes the PDCA (Plan Do Check Act) approach in solving identified quality issues. Using the PDCA approach all identified quality issues are analyzed and a Plan is then implemented to solve the identified problem (Do phase). If during the routine ongoing check-(the auditing process) Providence Pavilion identifies any problem with the implemented plan; Providence will then re-analyze why the plan is not working and then will adjust the plan accordingly. The PDCA approach is a continuous cycle, therefore the identified quality issue will undergo the Q/A process, until the Q/A committee determines that the issues have been solved. The Administrator & the Assistant Administrator of the facility (in collaboration with the Medical Director and Director of Nursing) oversees the facilities Q/A program to ensure that the program is effective and in compliance with Federal & State regulations. 5. Providence Pavilion alleges compliance as of October 8, 2015.		

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F 332	Continued From page 33 crushing and administering medication separately. Further interview revealed her expectation was that licensed staff followed the facility's policy and accepted practice standards by crushing and administering each medication separately.	F 332		
F 371 SS=E	The Administrator was on vacation and therefore not available for an interview. 483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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 observations, interviews, and review of the facility's policy, it was determined the facility failed to store, prepare, and serve food under sanitary conditions. During the initial tour of the kitchen area on 08/18/15, Observation revealed several dented cans, and one wet pan was observed in the clean storage area. During a tour of the refrigerator and freezers in the patient care area dining rooms, several beverages and food items were observed to be unlabeled, uncovered, with no expiration date observed.	F 371	F-371 Food Procedure, Store/Prepare/Serve-Sanitary Providence Pavillon does ensure that: (1) Food is procured from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Food is stored, prepared, distributed and served under sanitary conditions. 1. The Dietary manager/designee immediately corrected all items listed on the 2567 to ensure that Providence Pavillon was in immediate compliance with any/all food safety/sanitary issues. Specifically the dietary director/designee removed all dented cans from service, immediately ensured that all pots and pans were dry, and discarded any beverage that was not covered, removed any individually packed food item that was not labeled and/or dated appropriately. 2. All residents have the potential to be affected by a failure to (a) inspect deliveries with dented cans, (b) completely dry pots, pans and other items that have been recently washed, (c) bag and label single served items with the expiration date on the bag and (d) properly label and cover food and	10/8/15

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F 371	<p>Continued From page 34</p> <p>Findings include:</p> <p>Review of the facility's "Dietary Services Policy" #402 re: Receiving and Storage revealed all foods will be properly wrapped, dated and labeled and/or stored in sealed containers. Food will be discarded within appropriate shelf life.</p> <p>Review of the Cabinet for Health and Family Service (CHFS), Department for Public Health, Food Establishment Inspection Report, for a regularly scheduled inspection dated 05/26/15, by Inspector G1186 revealed Violation (1) - an open package of pre-sliced ham and turkey in walk in cooler lacking date, mark, and labels which was voluntarily discarded. Violation (20) - food storage pans were observed to be stacked wet in dry good storage area, - shall air dry prior to stacking.</p> <p>Observations made during the initial tour of the kitchen on 08/18/15 at 10:00 AM, revealed one wet pan in the clean storage area and 12 dented cans of food: four (4) large cans of pineapple tidbits, two (2) cans of diced tomatoes, one (1) can of tomato sauce, one (1) large can of cream of mushroom soup, one (1) can of sliced peaches, and three (3) cans of tropical fruit that were all dented. The Dietary Manager was observed to voluntarily take all the dented cans of the food off the shelf for use and placed in the dented can area, not to be used.</p> <p>Observation of the lunch meal, on 08/19/15 at 12:00 PM, revealed two (2) uncovered cups of black coffee on the serving cart. All of the other beverages were observed to be covered on the tray.</p>	F 371	<p>beverages for storage and transportation of items. However, No Residents of the facility were found to be affected by the deficient practice.</p> <p>The facility will prevent similar issues occurring by implementation of the following practices, noted in section 3.</p> <p>3. (a) On August 20th and 21st 2015 All Dietary staff were re-educated by the facility Dietician & Dietary Manager to the following: the inspection of dented cans, drying pots, pans and other items that have been recently washed, placing single served items in a bag with the expiration date on it and properly labeling, dating and covering food and beverages for storage and transportation of items. In addition On September 2nd, 3rd, and 4th the Administrator/Assistant Administrator re-educated all staff of the need to inspect all food items for expiration dates and the need to monitor food items to ensure they are being correctly stored.</p> <p>The Director of Human resources/Dietary Manager will assure that all new hires will receive the education during their orientation period in accordance with the POC, as submitted. (The Dietary department does utilize agency employees)</p> <p>(b) The dietary staff will inspect all deliveries for dented cans. If a dented can is delivered it will be placed on a cart for further investigation. (c) There is a new drying rack that will be used prior to being stored to allow sufficient drying of pots,</p>		

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F 371	<p>Continued From page 35</p> <p>An interview with Dietary Aide #1, on 08/19/15 at 12:05 PM, revealed all of the beverages should be covered to maintain the proper temperature and prevent contamination of the food. Dietary Aide #1 did not know why the two (2) cups of black coffee were not covered and was observed to voluntarily take the two (2) uncovered cups of black coffee to the sink and discarded the coffee down the sink drain.</p> <p>An observation of the refrigerator in the main dining room, on 08/20/15 at 9:00 AM, revealed: twelve (12) containers of sour cream which had been labeled, no dates were observed; fifty-on (51) containers of whipped spread with no expiration date; three (3) containers of Dole Tropical Fruits which had expired on 07/28/15; four (4) strawberry smart gels which had expired on 08/06/15; and four(4) Skippy peanut butter containers with no expiration date.</p> <p>An observation of the refrigerator and freezer in the small dining room, on 08/20/15 at 9:30 AM, revealed one (1) container of ice cream which had expired on 07/15, twelve (12) containers of vanilla ice cream which had no expiration date, two (2) Blue Ribbon ice cream bars with no expiration date, twenty-four (24) Dean country fresh pops and sixty (60) buttery spread containers with no expiration date, and four(4) strawberry gels with no expiration date.</p> <p>An observation of the refrigerator and freezer in the rehabilitation dining room, on 08/20/15 at 9:55 AM, revealed one (1) large pitcher of clear yellow liquid, possibly lemonade, not covered, not labeled, and not dated, forty (40) packages of whipped butter spread with no expiration date, three (3) strawberry gels which had expired on</p>	F 371	<p>pans and other items that have been recently washed. (d) The dietary staff will inspect all deliveries and document expiration dates in a binder. They will place single serve items in a clear bag, put the expiration date on the bag and then stock the bags in the pantry. (e) The dietary staff will ensure that proper labeling, dating and covering of food and beverages for storage and transportation of items.</p> <p>4. In order to ensure compliance The Dietary Manager will perform Bi-weekly food safety audits (FSA's) for 2 months and then weekly for 1 month. These audits will be turned into the Administrator, to ensure audit compliance.</p> <p>The FSA's will be designed to verify that the dietary staff is: inspecting for dented cans, drying pots & pans, inspecting and labeling food products for appropriate labeling.</p> <p>Results of all the FSA's will be submitted to the Providence Pavilion Quality Assurance (Q/A) committee, with the committee determining the need for further monitoring.</p> <p>Providence Pavilion utilizes the PDCA (Plan Do Check Act) approach in solving identified quality issues. Using the PDCA approach all identified quality issues are analyzed and a Plan is then implemented to solve the identified problem (Do phase). If during the routine ongoing check-(the auditing process) Providence Pavilion identifies any problem with the implemented plan; Providence will then</p>	
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F 371	Continued From page 38 08/08/15, one (1) bottle of Sierra Mist not labeled or dated, three (3) containers of organic rice milk, opened, not dated, and two (2) cans of Glucose Control Boost which had expired on 01/29/15. An interview with Dietary Aide #4, on 08/20/15 at 9:15 AM, revealed the dietary aides put a label and date on the food when it came up from the main kitchen area. The dietary aide was not aware of the above food products not having expiration dates, or expired dates on their labels. An interview with the Dietary Manager, on 08/20/15 at 9:20 AM revealed he/she was not aware of unlabeled, no expiration date, or expired food being present in the refrigerator and freezers on the main dining room, small dining room and rehabilitation dining room. The Dietary Manager and Dietary Aide #4 voluntarily removed the unlabeled, no expiration date, and expired beverage and food containers from the refrigerators and freezers and discarded the food. The Dietary Manager revealed it was his expectation that all of the food and beverages should be properly stored, labeled, date, and checked for an expiration date. An interview with the Administrator, on 08/21/15 at 6:15 PM, revealed it was his expectation that all of the food and dishware which was prepared and stored for the residents should be conducted in a sanitary manner, following the state and federal requirements for dietary management. The Administrator related he would speak with the Dietary Manager and correct the situation.	F 371	re-analyze why the plan is not working and then will adjust the plan accordingly. The PDCA approach is a continuous cycle, therefore the identified quality issue will undergo the Q/A process, until the Q/A committee determines that the issues have been solved. The Administrator & the Assistant Administrator of the facility (In collaboration with the Medical Director and Director of Nursing) oversees the facilities Q/A program to ensure that the program is effective and in compliance with Federal & State regulations. 5. Providence Pavilion alleges compliance as of October 8, 2015.		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441			

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F 441	Continued From page 37 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 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.	F 441	F-441 Infection Control, Prevent Spread, Linens Providence Pavillion has an established Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. 1. (a) On August 21 st 2015 STNA #5 was immediately re-educated by the DON on the proper procedure for delivering perineal care to an incontinent resident, including the washing of hands and the donning of gloves prior to delivering perineal care. This education included re-education on when to wash hand/change gloves prior to care, during care, and prior to exiting the room. On September 11, 2015 the DON presented On August 21 st STNA #4 was also re-educated by the DON on the appropriate care for the resident in contact isolation. All STNA's caring for resident #4 were immediately re-educated on appropriate perineal care and the care of the resident in contact isolation prior to their next shifts. This re-education specifically focused on Hand washing and the when to change gloves during care. This education was provided by the DON & Nurse Managers. (b) The DON/Nurse Managers immediately inspected every resident room to ensure that bedpans, bath basins, and all resident care items were individually labeled and not on the floor. 2. All Residents of the facility have the potential to be affected by the deficient	10/8/15

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F 441	Continued From page 38 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's Infection Control Policy, Hand Washing Policy, and Perineal Care Policy, it was determined the facility failed to ensure and maintain an Infection Control Program to provide a safe, sanitary and comfortable homelike environment and help minimize the development and transmission of infection for one (1) of fifteen (15) sampled residents (Resident #4). Observation of perineal care revealed staff failed to remove gloves and wash hands before providing other care to the resident. In addition, bedpans, bath pans, and suction equipment was observed on the floor not bagged or labeled, and nebulizer equipment was observed not bagged or labeled during the initial facility tour. The findings include: Review of the facility's Infection Control Policy, dated September 2009, revealed the facility would maintain an Infection Control Program designed to provide a safe, sanitary and comfortable homelike environment and help minimize the development and transmission of infection. Review of the facility's Handwashing Procedure Policy, not dated, revealed staff was to wash their hands with soap and water to remove transient micro-organisms from hands. Review of the facility's Perineal Care Policy, not dated, revealed the staff would perform hand hygiene after care was provided, remove gloves and wash hands (do not touch anything with	F 441	practice, as noted in the Statement of deficiencies. The facility will prevent similar issues occurring by implementation of the following practices, noted in section 3. 3. (a) On September 2 nd , 3 rd , and 4 th the Administrator/Assistant Administrator re-educated all staff on the correct way: when to wash hand/change gloves prior to care, during care, and prior to exiting the room. This education also reeducated the staff on what the procedures are to be followed on Residents who are in Isolation (who have Isolation signs on their door). On September 17 th and 18 th 2015 The DON & Nurse Managers re-educated all nursing staff on the correct procedures, to follow when delivering perineal care, delivering care to residents in contact Isolation: including the appropriate hand washing method & the appropriate Donning & Doffing of PPE. The Director of Human resources will assure that all new hires and agency staff will receive the education in accordance with the POC, as submitted. (b) The Assistant Administrator and DON have developed a new procedure for the storage of resident's personal items. The facility will obtain Individually labeled drawers so that Resident items are stored in accordance with appropriate infection control guidelines.		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/21/2015
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION			STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014	
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F 441	<p>Continued From page 39</p> <p>soiled gloves after procedure (i.e., curtain, side rails, clean linen, call bell, etc.) and perform hand washing after removing gloves.</p> <p>1. Review of the medical record revealed the facility admitted Resident #4 on 10/01/10 with diagnoses that included Anemia, Heart Failure, Urinary Tract Infection, Diabetes, Anxiety, Depression, Gastrostomy, and Dysphagia. A review of the Minimum Data Set (MDS) assessment dated 07/27/15 revealed the resident required extensive assist with one (1) person physical assistance, for hygiene and bathing and was always incontinent of bowel and bladder and required total assistance of one (1) person physical assist for toileting.</p> <p>Review of the Comprehensive Care Plan dated 09/12/11 and revised on 02/11/15 revealed the facility identified the resident had stress bladder incontinence and required perineal care as needed after incontinent episodes.</p> <p>Observation, on 08/20/15 at 9:10 AM, revealed States Registered Nurse Aide (SRNA) #5 donned gown and gloves outside the resident's room without washing her hands. The SRNA began to perform perineal care, dressed the resident, undonned gown and gloves, and left the room without washing her hands. SRNA #5 returned to the room with the Hoyer lift, donned gown and gloves without washing her hands and assisted the resident from the bed to the wheelchair using the Hoyer lift. Further observation revealed SRNA #5 brushed the residents hair, removed the soiled linens from the bed, placed clean linen on the bed, cleaned the over bed table and pulled the privacy curtain back while wearing soiled gown and gloves. SRNA then removed the soiled gown</p>	F 441	<p>On September 2nd, 3rd, and 4th 2015 the Administrator/Assistant Administrator educated all staff on the new policy of acquiring the individually labeled drawers and what items belonged in each drawer.</p> <p>On September 17th and 18th 2015 the DON educated all nurses and STNA's regarding the proper storage of bedpans, bath basins, suction equipment, and nebulizer equipment. The DON reviewed the information contained in the Resident Personal Item Storage Policy.</p> <p>The Director of Human resources will educate all new hires during their Orientation period and the Director of Human resources will educate agency staff, prior to being utilized at Providence Pavillion, in regards to the education in the Plan of correction as submitted.</p> <p>4. In order to ensure compliance: (a) The DON/Nurse Manager, and/or designee will monitor/audit: 1. the delivery of perineal care three times a week for 4 weeks, two times weekly for 2 weeks, and then one (1) time monthly for 2 months. These monitors/audits will observe staff delivering care to ensure the staff knows the correct procedure/s when to wash hands, change gloves, and provide care to residents in contact isolation.</p>	

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F 441	<p>Continued From page 40</p> <p>and gloves and left the room carrying the bagged dirty linens without washing her hands.</p> <p>Interview, on 08/20/15 at 9:45 AM, with SRNA #5 revealed she was aware the facility had an infection control policy but was not aware what the policy stated. SRNA #5 stated the process for contact precautions was "to gown and glove outside the resident's room and wash your hands after care was provided to a resident". SRNA #5 also stated she was last trained on infection control in June of 2015. The SRNA further stated she should have washed her hands.</p> <p>2. Observation of the facility, on 08/18/15 at 10:10 AM, revealed seven (7) out of sixteen (16) resident rooms had bedpans, bath pans and suction equipment on the floor not bagged or labeled.</p> <p>Interview, on 08/21/15 at 2:00 PM, with the Director of Nursing (DON) revealed all bedpans, bath pans and other equipment should be bagged and labeled and should not be on the floor.</p> <p>Interview, on 08/21/15 at 2:00 PM, with the Director of Nursing (DON) revealed the staff was trained on the facilities Infection Control Policy, Hand Washing Policy, and Perineal Care Policies during orientation, annually and whenever it was necessary. The DON further stated she expected all staff to follow the facility policy in regards to hand washing, infection control, and perineal care to help minimize the development and transmission of infection. The DON also stated that all bedpans, bath pans and other equipment should be bagged and labeled and should not be</p>	F 441	<p>(b) The Assistant Administrator will audit individual Resident rooms (to ensure compliance with the new storage policy) three times a week for 4 weeks, two times weekly for 2 weeks, and then one (1) time monthly for 2 months. This audit will be monitoring to ensure the facilities newly implemented storage drawers are being correctly utilized for proper storage of bedpans, bath pans, suction equipment, and nebulzer equipment.</p> <p>Results of these audits will be submitted to the Providence Pavilion Quality Assurance (Q/A) committee, with the committee determining the need for further monitoring.</p> <p>Providence Pavilion utilizes the PDCA (Plan Do Check Act) approach in solving identified quality issues. Using the PDCA approach all identified quality issues are analyzed and a Plan is then implemented to solve the identified problem (Do phase). If during the routine ongoing check-(the auditing process) Providence Pavilion identifies any problem with the implemented plan; Providence will then re-analyze why the plan is not working and then will adjust the plan accordingly. The PDCA approach is a continuous cycle, therefore the identified quality issue will undergo the Q/A process, until the Q/A committee determines that the issues have been solved. The Administrator & the Assistant Administrator of the facility (in collaboration with the Medical Director and Director of Nursing) oversees the</p>	
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F 441	Continued From page 41 on the floor. Interview on 08/21/15 at 6:15 PM with the Administrator revealed he expects all staff to follow the facilities policies in regards to Infection Control, Hand Washing, and Perineal Care. The ED also stated he expects all equipment, bedpans, and bath pans to be bagged and labeled and stored appropriately.	F 441	facilities Q/A program to ensure that the program is effective and in compliance with Federal & State regulations. 5. Providence Pavilion alleges compliance as of October 8, 2015.		