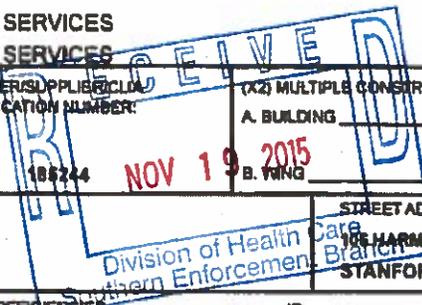


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186244	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/21/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-STANFORD		STREET ADDRESS, CITY, STATE, ZIP CODE 125 HARMON HEIGHTS STANFORD, KY 40484	
(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)



F 000 INITIAL COMMENTS

An abbreviated survey (KY23934) was initiated on 10/20/15 and concluded on 10/21/15. The complaint was substantiated with deficient practice identified at "D" level.

F 282 SS=D 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, record review, and review of the facility's policy and procedures it was determined the facility failed to ensure services were provided in accordance with each resident's plan of care for one (1) of four (4) sampled residents (Resident #1). Resident #1 had a history of falls, was assessed to be at risk for falls, and had a care plan intervention for an alarm on the bathroom door to prevent falls. Observations on 10/20/15 revealed the alarm on the bathroom door was not in place.

The findings include:

Interview with the Director of Nursing (DON) on 10/20/15 at 6:50 PM, revealed the facility did not have a specific policy on care plans; however, the DON stated the facility followed the Resident Assessment Instrument (RAI) guidelines regarding care plans.

Review of the facility's policy and procedure titled

F 000 This Plan of Correction is the provider's credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

F 282

F282 D and F323 D

1) 1. What actions did the provider take to correct the alleged deficient practice for the resident(s) found to have been affected?

Resident # 1 Bathroom door alarm placed back onto door facing where the alarm had fallen off. Fall interventions will be monitored every 2 hours for 2 weeks then every 4 hours. This monitoring will be documented on the medication administration record ongoing.

Care plan was reviewed which did indicate current interventions to prevent further falls to include the alarm to bathroom door facing.

CNA care sheet reviewed and reflected all interventions related to resident's falls to include Bathroom door alarm.

2. How will the provider identify other

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

Kurt M. Orr

TITLE

Administrator

(X5) DATE

11/19/15

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

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F 282	Continued From page 1 "Falls Management Guideline," last reviewed 08/26/15, revealed the facility would evaluate and care plan residents assessed to be at risk for falls with individualized interventions to prevent falls Record review revealed the facility readmitted Resident #1 on 08/19/14 with diagnoses that included Dementia, Anxiety, Depression, and Hypertension. Review of an annual Minimum Data Set (MDS) assessment dated 05/22/15, revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of 3, indicating the resident was not interviewable. Review of Event Reports dated 09/19/15 and 09/29/15 revealed Resident #1 sustained non-injury falls on 09/19/15 and 09/29/15. Review of the Comprehensive Care Plan, updated 09/29/15, revealed Resident #1 was assessed to be at risk for falls with an intervention for a squealer alarm to be placed on his/her bathroom door. Observations of Resident #1's room on 10/20/15 at 10:00 AM, 12:45 PM, and 5:55 PM, revealed there was no squealer alarm observed on the bathroom door. Interview with Certified Nurse Assistant (CNA) #1 and CNA #2 on 10/20/15 at 6:00 PM and 6:05 PM, revealed they were not aware the resident was supposed to have a squealer alarm on his/her bathroom door. Interview with Licensed Practical Nurse (LPN) #2	F 282	<u>resident(s) who have the potential to be affected by the alleged deficient practice and what actions will be taken</u> <i>All residents have potential to be affected by deficient practice.</i> <i>Audit completed for current residents to ensure care plans reflect current status to include fall interventions according to individual care needs such as: Alarms, fall mats, etc.</i> <i>Interdisciplinary Care Plan Team (RNAC, Social Services, and Dietary Manager) reviewed/ revised Care Plans for residents with interventions to prevent further falls to include alarms, etc.</i> <i>The IDT reviewed CNA care sheets to ensure care provided as per care plans. CNA care sheets/Care Plans were reviewed/ revised to ensure they reflect resident's current needs.</i>		

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F 282 Continued From page 2
and LPN #3 on 10/20/15 at 8:10 PM and 8:15 PM revealed the squealer alarm should have been on the door per the care plan.

Interview with the DON on 10/20/15 at 6:50 PM, revealed the squealer alarm should have been on the bathroom door per the care plan. The DON stated she rounded daily to ensure fall interventions were in place and was not sure how the squealer alarm was missed.

F 323 483.25(h) FREE OF ACCIDENT
SS=D 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 each resident received adequate assistive devices to prevent accidents for one (1) of four (4) sampled residents (Resident #1) who had a history of falls and was assessed to be at risk for falls. Observations on 10/20/15 revealed Resident #1's alarm on the bathroom door that was a care plan intervention to prevent falls was not in place.

The findings include:

F 282

The revised Care Sheets were then utilized to conduct daily rounds on current residents to ensure resident care needs were in place according to care sheets. Daily rounds will be ongoing and conducted daily by the Charge Nurse, Unit Manager, and DNS/ADNS/Designee utilizing the C.N.A care sheets to ensure resident needs is being provided as relates to physician orders and care plans.

F 323

3. What action did the provider take to assure that the alleged deficient practice does not recur?

In-service conducted on 10/29/15 by DNS/ADNS/Designee to nursing staff as relates to following plan of care/care sheet for each resident. IDT will revise Care Plans daily to ensure residents care reflects current status to include risk factors, risk for injury. IDT will be responsible for updating CNA

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F 323 Continued From page 3

F 323

Review of the facility's policy and procedure titled "Falls Management Guideline," last reviewed 08/26/15, revealed the facility would evaluate and care plan residents assessed to be at risk with individualized interventions to prevent falls.

Record review revealed the facility readmitted Resident #1 on 08/19/14 with diagnoses that included Dementia, Anxiety, Depression, and Hypertension.

Review of an annual Minimum Data Set (MDS) assessment dated 05/22/15, revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of 3, indicating the resident was not interviewable.

Review of facility Event Reports dated 09/19/15 and 09/29/15 revealed Resident #1 sustained non-injury falls on 09/19/15 and 09/29/15 while in the bathroom.

Review of the Comprehensive Care Plan, updated 09/29/15, revealed Resident #1 was assessed to be at risk for further falls and an intervention for a squealer alarm was put into place on his/her bathroom door after the 09/29/15 fall.

Observations of Resident #1's room on 10/20/15 at 10:00 AM, 12:45 PM, and 5:55 PM, revealed there was no squealer alarm observed on the bathroom door.

Interview with Certified Nurse Assistant (CNA) #1 and CNA #2 on 10/20/15 at 6:00 PM and 6:05 PM, revealed they were not aware the resident was supposed to have a squealer alarm on

care sheets daily to reflect changes / current status for resident care. Charge nurse will provide CNA's with current updated care sheets each shift to reflect care needs daily. CNA's will provide care according to resident care sheets every shift daily.

4. What quality assurance measures have been implemented to monitor and assure that the deficient practice does not recur on an ongoing basis?

Department heads will complete daily rounds Monday through Friday using the C.N.A. care sheets to ensure resident care needs are being provided as relates to the physician orders and care plans. Charge Nurses will complete daily rounds on Saturday and Sunday using the C.N.A. care sheets to ensure resident care needs are being provided as relates to the physician orders and care plans.

Any concerns noted will be corrected

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F 323 Continued From page 4
his/her bathroom door.

Interview with Licensed Practical Nurse (LPN) #2 and LPN #3 on 10/20/15 at 8:10 PM and 8:15 PM revealed the squealer alarm should have been on the door per the care plan.

Interview with the Director of Nursing (DON) on 10/20/15 at 8:50 PM, revealed the squealer alarm should have been on the bathroom door per the care plan. The DON stated she rounded daily to ensure fall interventions were in place and was not sure how the squealer alarm was missed.

F 323 _____
promptly.

The audits of the daily monitoring of Care Sheets will be reviewed in the daily morning meeting Monday through Friday. The results of the audits by use of the care sheet will be taken to the monthly QAA meeting for discussion/review.

QAA committee (Administrator, Director of Nursing, Medical Director, and Assistant Director of Nursing, Social Services, Activities, and Dietary Service Manager, others as indicated) will meet monthly and discuss concerns noted with following care plans/ care sheets and AP developed as indicated.

*Expected date of completion:
11/30/2015*

11/30/15