

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

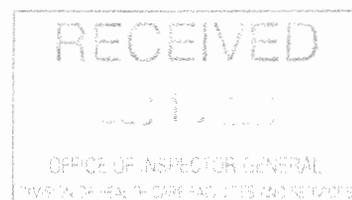
PRINTED: 12/09/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/29/2015
NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 6415 CALM RIVER WAY LOUISVILLE, KY 40299		
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F 323	<p>Continued From page 120</p> <p>Record Staff, Director of Health Services and her assistant, and Social Services were completed on 10/19/15, by the Clinical Director, of the importance of maintaining the integrity of medical record and Advance Directives information being available for Charge Nurses in the event of a resident was transferred to the hospital.</p> <p>9. Scanning guidelines will be followed based on protocols for the Electronic Health Record. Daily audits will be conducted by the DHS, ADHS, MDS, and Medical Records to ensure completion of all admission records and Advance Directive information placed into the Soft Files. These audits will be reviewed during the daily Clinical Care Meeting.</p> <p>10. A Quality Assurance (QA) Meeting was conducted on 09/18/15 to review Falls Trending. Another QA meeting was held on 10/19/15 with the Medical Director in attendance to review the Guidelines and protocol for conducting Quality Assurance Meetings.</p> <p>11. Education was provided by the Clinical Director to the Executive Director, Director of Health Services and her assistant, and other department leaders that included issues of fall management, Advance Directives, and monitoring of care plans. Corrective plans were developed based on trends prevalent in a system not in compliance. Action plans developed with focus on goals and protocols for Clinical Care Meeting and its direct relationship to Quality Assurance activities.</p> <p>12. Audits implemented will be reviewed during the monthly QA meeting and during the Clinical Support Nurse's routine visits that occur once a</p>	F 323			

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F 323	<p>Continued From page 121 week. Audits included Safety Device, Advance Directive, and Soft files, Clinical Care Meetings, Clinical at Risk Meetings, Care Plans, and QA.</p> <p>The State Survey Agency (SSA) validated the implementation of the facility's AOC as follows:</p> <p>1. Record review revealed Residents #5, #8, #10, #13, and #19 care plans were revised. Resident #20 was sampled during the extended survey due to being the only resident with a fall since the alleged Immediate Jeopardy abatement date of 10/23/15. The resident's care plan was reviewed during the Clinical Care Meeting and revised as needed.</p> <p>Interview with the Director of Health Services, on 10/28/15 at 1:50 PM, revealed the interdisciplinary team received training on care plan revision and implementation. She stated she was responsible for overseeing the Clinical Care Meetings and ensured the care plan was revised and all events received follow-up monitoring to ensure the event reports were completed. In addition, she randomly reviewed one-two care plans daily to ensure completion.</p> <p>2. Sampled Resident #20's fall (10/25/15) was discussed in the Clinical Care Meeting and revision of the care plan was completed. Review of the care plan audits revealed revision of the care plans were occurring after an event or change in the resident. Review of the sampled residents for the extended survey revealed the care plan had been revised after a change in the resident's status to include falls.</p> <p>3. Observation of the 400, 500, and Health Care</p>	F 323		



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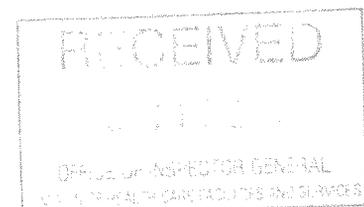
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F 323	Continued From page 122 Units, on 10/27/15 at 11:30 AM and again at 4:00 PM, revealed Profile Binders at each unit that included specific information about each resident including code status. Observation on 10/27/15 at 4:35 PM, revealed staff updating the Profile Binder on the Healthcare Unit. Interview with the Medical Record Director, on 10/28/15 at 2:40 PM, validated the binders are updated after the Clinical Care Meetings with any new care plan interventions. The MDS Nurses were at a training offsite and unavailable for interview during the extended survey.	F 323		
	<p>4. Observation, on 10/28/15 at 10:00 AM, (on the 500 Unit) revealed the nurse was conducting rounds in the residents rooms during the medication pass for safety devices and call light placement.</p> <p>Interviews with LPN #5, on 10/26/15 at 4:00 PM, LPN #12 on 10/27/15 at 11:15 AM, and LPN #6 on 10/28/15 at 9:00 AM, revealed the nurses conducted walking rounds to check for safety devices and call lights at the beginning of the work shift and again when they administered medications. Interview with the Director of Health Services, on 10/28/15 at 1:50 PM, revealed she had randomly observed walking rounds between the nursing aides and nurses giving report.</p> <p>Review of the safety devices/call light audits revealed at least five (5) residents were observed daily for safety device and call light placement and proper functioning of the devices.</p> <p>5. Review of the Fall Circumstance Event Report for Resident #20, revealed the fall was discussed in the Clinical Care Meeting. Audits revealed Resident #20 was included. Interview with LPN</p>			

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F 323	<p>Continued From page 123</p> <p>#5, on 10/26/15 at 4:00 PM, revealed the resident slid from the bed and experienced no injury.</p> <p>Interview with the Director of Health Services, on 10/28/15 at 1:50 PM, Executive Director, on 10/28/15 at 3:00 PM, and Clinical Director, on 10/29/15 at 12:00 PM, revealed all falls and any change in condition were discussed during the Clinical Care Meetings. Review of the audits revealed the meetings were held on October 21, 22, 23, 26, and 27. A meeting was held on 10/28/15 at 10:00 AM and validated by observation of the SSA.</p> <p>Review of the Changes in condition, including fall investigation and root cause analysis will be discussed during the Clinical Care Meetings. The Fall Circumstance Event Reports are reviewed for completion and ensure appropriate safety interventions had been implemented to reduce the risk of future falls.</p> <p>6. The facility reviewed all safety devices and conducted assessments with some safety devices discontinued. There were seven (7) residents with safety devices during the extended survey. Review of the audits revealed five (5) or more residents were audits to ensure safety devices were in place and functioning.</p> <p>7. Review of the Soft files for the 500, 400, and Health Care Units revealed each resident had been offered Advance Directives and each resident had a code status. These forms were scanned into the electronic record and the original signed form was kept in the Soft file at each unit.</p> <p>Interview with the Medical Record Director, on</p>	F 323		



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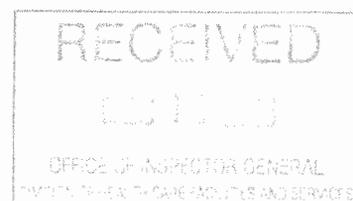
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F 323	<p>Continued From page 124</p> <p>10/28/15 at 2:40 PM, revealed she had received training on the Soft files, scanning forms into the electronic record, and maintaining the medical record. She stated she was responsible for conducting audits of new admission paperwork to ensure the code status and Advance Directive forms are signed and placed into the Soft file on each unit.</p> <p>Observation of the new admission process revealed Advance Directive forms were signed and placed into the Soft file. Resident #21, #22, and #23 were sampled during the extended survey to validate the admission paperwork was completed and Advance Directive forms signed and placed into the Soft file.</p> <p>8. Review of the training record revealed education was provided on 10/19/15 as stated in the AOC. Interview with the Medical Records, on 10/28/15 at 2:40 PM, Director of Health Services, on 10/28/15 at 1:50 PM, and Social Services on 10/28/15 at 2:48 PM, revealed they had received the training.</p> <p>9. Interview with the Medical Record Director, on 10/28/15 at 2:40 PM, revealed she received training on the scanning guidelines. She stated she now had additional staff to help with the scanning of the medical record into the electronic record. She stated audits were conducted daily to ensure scanning guidelines are followed.</p> <p>Review of the Daily Careplan audit forms, Falls Interventions audit forms, Call Light audit forms, Fall Investigation audit forms, the Safety/Assistive Device audit forms, and the Admission audit forms revealed they were all completed.</p>	F 323			

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F 323	<p>Continued From page 125</p> <p>10. Review of the QA signature sheets revealed QA meetings were held on 10/19/15 and 10/29/15. Interview with the Executive Director, on 10/28/15 at 3:00 PM, and the Clinical Director on 10/29/15 at 12:00 PM validated the QA meetings were held on those dates.</p> <p>Interview with the Clinical Director and the Clinical Support Nurse, on 10/29/15 at 12:00 PM, revealed the QA meeting on 10/19/15 was to develop the Plan of Action to correct the Immediate Jeopardy, develop audits, and capture any trends of non-compliance. The Clinical Director stated staffing was reviewed to determine if it contributed to the non-compliance and she was looking at staffing as part of the solution. She stated the facility had been given extra hours for staffing and was in the process of determining where the hours would be best spent. The Clinical Director stated the QA meeting of 10/29/15 was to review audits, and evaluate the plans of actions. She stated the audits revealed no problems and the AOC was implemented and monitored as stated. She stated the facility would continue to meet monthly and she would be at the facility almost daily to assist the new Executive Director and ensure compliance. The Clinical Support Nurse stated she would visit the facility at least twice a week and as needed to ensure the Clinical Care and Clinical at Risk meetings were conducted according to the AOC. The Clinical Director stated she would attend the monthly QA meetings for at least six (6) consecutive months.</p> <p>11. Interview with the Clinical Director, on 10/29/15 at 12:00 PM, revealed she provided the education to the Executive Director and Director of Health Services on 10/19/15. Review of the</p>	F 323			



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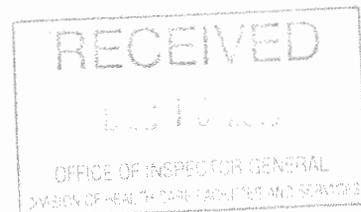
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F 323	Continued From page 126 training records validated the training. Interview with the Executive Director and Director of Health Services on 10/29/15 at 12:15 PM, revealed they received training on Advanced Directives, revision of care plans, documentation, audits, monitoring, scanning guidelines, systems related to falls, and the protocols for Quality Assurance. 12. Review of the audits revealed the facility conducted the audits as stated in the AOC.	F 323			
F 371 SS=E	Interview with the Executive Director, on 10/28/15 at 3:00 PM, and the Clinical Director, on 10/29/15 at 12:00 PM, revealed the audits were conducted and forwarded to them for review of compliance. The audits were brought to the 10/29/15 QA meeting to review and discuss trending. 483.35(i) 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 record	F 371			

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F 371	Continued From page 127 review, it was determined the facility failed to store, prepare, and serve foods under sanitary conditions. The Dietary Department had a build up of grease on the oven doors. There was a brown-sticky substance on the back splash behind the grill, stove top burners, and the grill. There was an open package in the freezer without a date when opened. In addition, Dietary staff was documenting cleaning tasks as completed; however, observations and interviews revealed discrepancies.	F 371	Oven doors were cleaned (build up of grease was removed). Backsplash behind grill was cleaned. Stove top burners, deep fryer and grill were cleaned. The tray under the cook top was cleaned. Open package in freezer	
	The findings include: Review of the facility's policy regarding Storage Procedures for Frozen Storage, revised 2009, revealed all foods in the freezer were to be wrapped in moisture proof wrappings or placed in suitable containers to prevent freezer burn and the item was to be labeled and dated. Review of the facility's Kitchen Cleaning Procedures, not dated, revealed the stove, oven, and grill were to be cleaned weekly with a spray cleaner. Observations, on 10/12/15 at 2:08 PM, during the initial kitchen tour revealed liquid grease on the left stove oven door, a heavy black crusted substance on the stove burners and on the gas grill, a substance, greasy to the touch, was on the front of the deep fryer and front of the gas grill. The back splash below the hood, to the back of the grill, was spattered with grease and there was a brown substance that was sticky and greasy when touched, where the back of the grill met the back splash. The tray under the cook top had uncooked pasta shells, a light brown substance, and black crusted residue present. The tray under		without a date when opened was discarded; bag of pasta that had been opened and resealed with no date (in dry storage) was discarded. Dumpster, and around dumpsters, was cleaned. All residents have the potential to be affected by the alleged deficient practice. Through staff education, inservice and monitoring, we will ensure the campus stores, prepares and distributes and serves food under sanitary conditions and in accordance with guidelines.	



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F 371	<p>Continued From page 128</p> <p>the gas grill was almost full of a black crusted substance. The walk-in freezer had a bag of chicken nuggets that had been opened with no date and the bag was not securely closed. On a wire rack in the kitchen was a bag of pasta that had been opened and resealed with no date.</p> <p>Review of the daily/weekly Cleaning List revealed it was impossible to identify which staff member had been assigned to complete the task. The daily task list stated to clean the cooktop burners daily; however, a crusted build up on the burners disproved daily cleaning had been done. The foil under the cook top was to be replaced daily; however, was heavily soiled and the gas grill was heavily crusted with a residue build-up on and between the grates. The residue collection pan under the gas grill was more than half full with a black crusted substance.</p> <p>Interview with the Director of Food Services, on 10/13/15 at 8:40 AM, revealed he was unaware the kitchen cleaning list did not address the stove ovens and he confirmed the cleaning list documentation by staff using slashes or Xs made it difficult to identify easily which staff member documented they had completed the cleaning task. In addition, he also touched the greasy surfaces.</p> <p>Interview with the Regional Director of Food Services, on 10/13/15 at 11:55 AM, revealed close monitoring would be needed for the cleaning schedule to ensure the assigned cleaning task were completed as assigned. He determined the dietary staff was marking the cleaning schedule as if a cleaning task was complete when it was not.</p>	F 371	<p>All dietary staff were inserviced on 12/4/15, 12/5/15 and 12/7/15 by Dining Services Support on storage procedures for dry food, refrigerated food, leftover food storage, and food labeling.</p> <p>All dietary staff were inserviced on 12/4/15, 12/5/15 and 12/7/15 by Dining Services Support on the proper way to document and complete cleaning procedure in the kitchen.</p> <p>All dietary staff were inserviced on 12/4/15, 12/5/15 and 12/7/15 by Dining Services Support regarding on guidelines for taking trash to the dumpster and their responsibility to pick up trash and/or report heavily soiled areas to the Executive Director.</p> <p>Systemic changes include inservice and re-education for</p>	

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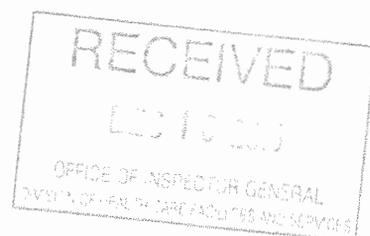
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F 372 F 372 SS=D	Continued From page 129 483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to have a process in place to properly dispose of garbage and refuse. Observations revealed trash on the ground around the dumpsters. The findings include: The facility did not provide a policy to identify which department was responsible for monitoring of the trash/dumpster area to ensure refuse was properly contained. Observations, on 10/12/15 at 2:08 PM and again on 10/13/15 at 8:40 AM, revealed in the dumpster area food residue, a Styrofoam cup, a biscuit, a food item wrapped in plastic, empty condiment packets were on the ground, and food particles that could not be identified. Observations, on 10/12/15 at 3:50 PM, revealed in the dumpster area food residue, a Styrofoam cup, a biscuit, a food item wrapped in plastic, and condiment packets were on the ground. A plastic bag that appeared to have linens hanging on a pole extending from the dumpster. Interview with the Director of Food Services, on 10/13/15 at 8:40 AM, revealed he was unaware of which department was responsible for monitoring	F 372 F 372	dietary staff on proper storage and handling of food items per guidelines. The day and night shift cook will complete a walk through of the kitchen (including cooler, freezer, and dry storage) prior to the end of their shift to assure proper techniques followed for food handling and adherence to cleaning schedules. Additionally, cleaning schedules have been changed to ask staff to initial when cleaning complete vs using a checkmark.		

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F 372	Continued From page 130 the dumpster area. He confirmed his staff had, between 10/12/15 at 4:00 PM and 10/13/15 before 8:00 AM, taken kitchen garbage to the dumpster and had not picked up what appeared to be possible kitchen garbage on the ground. He further stated the kitchen staff should have picked up any kitchen refuse on the ground in the dumpster and placed in the dumpster. Interview with the Director of Environmental Services, on 10/13/15 at 11:20 AM, revealed she felt all staff was responsible to monitor the dumpster area and she knew of no policy identifying a responsible department. Interview with the Executive Director, on 10/13/15 at 11:30 AM, revealed he knew of no policy to identify a department to monitor the dumpster area and no specific person had been designated as responsible. Interview with the Regional Manager, on 10/13/15 at 11:42 AM, revealed to her knowledge there was no corporate policy giving responsibility for monitoring the dumpster area to a specific department. Interview with Campus Support staff, on 10/13/15 at 11:46 AM, revealed he was covering for the Director of Maintenance and stated nursing, environmental services, and the kitchen should all be responsible for the dumpster area. He knew of no official policy for the monitoring of the dumpster area.	F 372	The Executive Director or Administrator will complete unannounced audit of the kitchen for food storage, cleaning schedule and trash disposal 5 times a week for one month then 3 times a week for a month then weekly with results forwarded to the QA committee monthly for 6 months and quarterly thereafter for review and further suggestions/comments. Completion date 12-10-15 F 372 The area identified in the 2567 around the dumpster was cleaned. All residents have the potential to be affected by the alleged deficient practice. Inservice, re-education and monitoring will ensure the campus has a process in place to properly dispose of	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		



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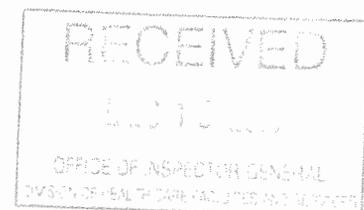
PRINTED: 12/09/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185461	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/29/2015
NAME OF PROVIDER OR SUPPLIER GLEN RIDGE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 6415 CALM RIVER WAY LOUISVILLE, KY 40299	
(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 441	<p>Continued From page 131</p> <p>Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p>garbage and refuse. The inservice for dietary and other staff were conducted on 12/4, 12/5, 12/7, 12/8 and 12/9/15 conducted by Dining Services Support and Director of Clinical Compliance (Interim DHS).</p> <p>All staff have been inserviced on the importance of assuring dumpster area is free of spillage and trash and securely placed in the dumpster. The inservice dates were 12/4, 12/5, 12/7, 12/8 and 12/9/15 conducted by Dining Services Support and Director of Employee Relations.</p> <p>Systemic change is that dietary staff will review the dumpster area when taking out trash daily. Heavily soiled areas will be reported to the Executive Director for additional cleaning.</p>	

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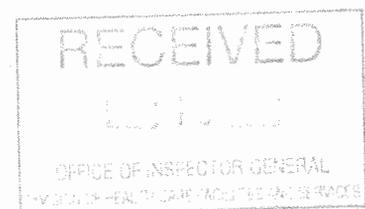
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F 441	Continued From page 132 This STANDARD is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to maintain effective infection control practices for two (2) of twenty-four (24) sampled residents (Resident #7, and #24). Staff failed to utilize the proper Personal Protective Equipment (PPE) and/or practice proper hand hygiene upon entering and exiting rooms for residents who were in contact isolation.	F 441	ED or Administrator will complete a daily audit to assure the dumpsters are free of spillage 5 times a week for one month then 3 times a week for a month then weekly with results forwarded to the QA committee monthly for 6 months and quarterly thereafter for review and further suggestions/comments. Completion date 12/10/15.	
	The findings include: Review of the facility's policy for Infection Control regarding Hand Washing/Hand Hygiene, dated August 2014, revealed hand washing was the single most important factor in preventing transmission of infections. Inadequate hand washing had been responsible for many outbreaks of infectious disease in long-term care facilities. Implementation of proper hand washing practices had interrupted outbreaks in many settings. All health care workers should wash their hands frequently and appropriately. Health care workers should wash their hands at times such as reporting to work; before/after eating; smoking; toileting; blowing nose; coughing and sneezing; before/after meals; before and after direct physical contact with a resident; and, after removing gloves worn per standard precautions for direct contact with the resident or the environment. Review of the facility's policy for Precaution Categories, dated December 2010, revealed the purpose was to ensure appropriate precautions were used for individuals with documented or suspected infections or communicable diseases			



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F 441	Continued From page 133 that could be transmitted to others. Contact precautions should be used for individuals known or suspected to be infected or colonized with microorganisms that could be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the environment. Gloves should be worn when entering the room. The staff was to remove and discard gloves within the room and wash their hands immediately. A gown should be worn when entering the room when anticipating that clothing would have contact with the resident, environmental surfaces, or items in the resident's room. 1. Review of the clinical record for Resident #7, revealed the facility admitted the resident on 09/01/15, with diagnoses of Cancer of the Prostrate, Weakness, Difficulty Walking, Hypertension, Retention, Anemia, Constipation and Chronic Kidney Disease Stage 3. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 09/15/15, revealed the facility assessed Resident #7 with a score of nine (9) of fifteen (15) on the Brief Interview for Mental Status (BIMS) assessment, which meant the resident's cognition was moderately impaired and not interviewable. Resident #7 required limited to extensive assistance with all Activities of Daily Living (ADL) according to the MDS assessment. Review of the Comprehensive Care Plan, dated 10/02/15, for Resident #7, revealed the resident had Methicillin-Resistant Staphylococcus Aureus (MRSA) infection in the urine and was in contact isolation. The staff was to wear PPE for contact isolation while providing care for the resident.	F 441	Resident #7 was discharged from facility on 10/22/15. Resident #24 is still a resident in the facility. Resident is no longer on contact isolation as of 11/19/15. All residents have the potential to be affected by the alleged deficient practice. Inservice, re-education and training for staff will ensure the campus to utilize the proper personal protective equipment (PPE) and/or practice proper hand hygiene upon entering and exiting rooms for residents who are in contact isolation.	



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F 441	<p>Continued From page 134</p> <p>Observations of residents in isolation, on 10/12/15, during the initial tour, revealed several staff members entering and exiting isolation rooms without the proper PPE donned and/or proper hand hygiene performed.</p> <p>Observation of Resident #7, on 10/12/15 at 1:50 PM, during the initial facility tour, revealed a sign on the resident's room door instructing everyone to see the nurse before entering. There was a portable cabinet just inside the doorway of the room with masks, gowns, gloves, and trash bags. There was no signage located for the type of precautions in place. Resident #7 was sitting in the wheelchair next to the bed.</p> <p>Observation of Resident #7, on 10/13/15 at 10:30 AM, revealed the resident was out of the room in the common area in the wheelchair.</p> <p>Observation of Resident #7, on 10/13/15 at 12:47 PM, revealed the resident had two (2) visitors sitting on the couch with gloves on. One of the visitors had exited the room to get a staff member without removing the gloves or washing his hands. The same visitor reentered the room with the same gloves on and had not washed his hands or changed the gloves. The staff member entered the resident's room and donned PPE gown and gloves properly; however when exiting, she had not washed her hands after removing the PPE and exiting the room. The staff member left the unit and walked toward the Environmental Services office.</p> <p>Interview with the Environmental Aide immediately after the above incident, on 10/13/15 at 1:08 PM, revealed she was aware she had not washed her hands when she should have and</p>	F 441	<p>Staff were inserviced on infection control related to PPE needs on 12/8/15 and 12/9/15 by the Director of Clinical Compliance (who is serving as Interim DHS). Inventory of PPE supplies reviewed on 12/8/15 and PAR level was established, DHS and ADHS will monitor PAR levels to assure adequate supplies are available.</p> <p>DHS and/or ADHS will monitor 3 residents for proper infection control measures 5 times a week for one month then 3 times a week for a month then weekly with results forwarded to the QA committee monthly for 6 months and quarterly thereafter for review and further suggestions/comments.</p> <p>Completion date 12-10-15</p>	

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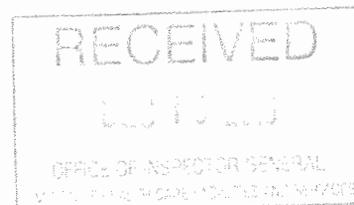
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F 441	Continued From page 135 stated understanding of the spread of infection from poor hand hygiene. The Environmental Aide stated she normally did not work on the floors with nursing staff as she had done that day. Observation of Resident #7, on 10/15/15 at 2:30 PM, revealed Resident #7 had a visitor sitting in the chair beside the bed, leaning over one of the resident's pillows from the bed. The visitor had no PPE donned and had to request PPE due to the portable cart being empty of gowns.	F 441			
	Interview with Licensed Practical Nurse (LPN) #4 during the initial tour, on 10/12/15 at 8:45 AM, revealed Resident #7 was in contact isolation precautions for Methicillin-resistant Staphylococcus Aureus (MRSA) bacterial infection of the urine. Interview with Resident #7's family, on 10/15/15 at 2:30 PM, revealed the family stated when they visited Resident #7, they had to request Personal Protective Equipment (PPE) on more than one occasion because the portable cart was empty. The family stated they were made aware of Resident #7's infection, and what PPE was, by the staff members who took care of Resident #7. However, the family stated the staff had not always worn the proper PPE when they entered the room. The family stated they were never told they had to wear the PPE. Interview with Physical Therapy Assistant (PTA), on 10/15/15 at 10:15 AM, revealed some residents that were in contact isolation would be treated in their rooms depending on if the organism was contained or not. The PTA stated Resident #7 had a urinary catheter, therefore the organism would be considered contained and				

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F 441	<p>Continued From page 136</p> <p>he/she would not have in-room therapy. The PTA stated Resident #7 was wearing gloves because he/she was pulling on the urinary catheter, which increased the risk of spreading the infection.</p> <p>2. Review of the clinical record for Resident #24, revealed the facility admitted the resident on 06/26/15 with diagnoses of Pneumonia, Chronic Respiratory Failure, Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, Chronic Kidney Disease Stage 3, Hypertension and Obstructive Sleep Apnea.</p> <p>Review of the MDS, dated 09/11/15, revealed the facility assessed Resident #24 with a score of eight (8) of fifteen (15) on the BIMS assessment, which meant the resident's cognition was moderately impaired and not interviewable. The facility assessed Resident #24 as requiring extensive to total assistance with most Activities of Daily Living (ADL) and was continent of bowel.</p> <p>Review of the ADL Care Plan, dated 09/21/15, for Resident #24, revealed the resident was in contact isolation for a Clostridium Difficile (C-Diff) bacterial infection.</p> <p>Review of the Comprehensive Care Plan, dated 10/21/15, for Resident #24, revealed the resident was in contact isolation for (C-Diff) and staff was to wear proper PPE while providing care for the resident.</p> <p>Observation of Resident #24, on 10/12/15 at 1:50 PM, during the initial facility tour revealed a sign on the resident's room door instructing everyone to see the nurse before entering. There was a portable cabinet just inside the doorway of the room with masks, gowns, gloves, and trash bags.</p>	F 441		



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F 441	<p>Continued From page 137</p> <p>Resident #24 was not in the room.</p> <p>Observation of Resident #24, on 10/13/15 at 10:30 AM, revealed the resident was not in the room; however, was in the common area of the unit.</p> <p>Observation of Resident #24, on 10/14/15 at 10:00 AM, revealed a closed room door.</p> <p>Observation of Resident #24, on 10/26/15 at 11:30 AM, revealed the resident was in the room with the MDS Nurse. The MDS Nurse had gown and gloves on, with the isolation gown not secured around the back of her body at either the waist or neck ties, leaving the gown open and unsecured. Additionally, the front of the gown was sagging to the waist and left the upper portion of her body from the neck to the waist unprotected. The MDS Nurse exited the room after removing the PPE and did not wash her hands until she was down the hallway, through the resident's common area and past the nurse's station.</p> <p>Interview with the MDS Nurse immediately exiting Resident #24's room, revealed she was aware she did not wash her hands in the resident's room as she was supposed to, she wanted to wash them in the sink down the hallway and stated at least she had her PPE on.</p> <p>Interview with Assistant Director of Environmental Services (ADES), on 10/15/15 at 10:00 AM, revealed she was educated on infection control cleaning and PPE. The ADES stated she wore a gown and gloves for cleaning contact isolation rooms.</p>	F 441			

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F 441	Continued From page 138 Interview with Licensed Practical Nurse (LPN) #14, on 10/15/15 at 10:10 AM, revealed contact isolation to her meant she had to wear a gown and gloves when she entered the room, but stated not all staff members would agree. Interview with the Director of Health Services (DHS), on 10/15/15 at 11:30 AM and 10/16/15 at 10:28 AM, revealed contact isolation to her meant the staff should wear a gown and gloves when caring for any resident in their environment who may be suspected of having or actively has a contagious infection. She stated the Corporate Office provided infection control training during orientation that educated the staff to practice the philosophy if there was no direct resident contact then gloves only were acceptable PPE. The DHS stated she was aware of the confusion among the staff regarding isolation and the proper PPE and it had been an ongoing staff education and re-education. She stated not properly monitoring infection control and accurately tracking and trending infections could increase the facilities infection rate and cause residents and staff to become ill.	F 441		
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.	F 456		

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F 456	Continued From page 139 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the manufacture's recommendations for the TRUEbalance Glucometers, it was determined the facility failed to ensure glucometers were kept in safe operating order based on the manufacture's recommendations for four (4) of four (4) glucometers on five (5) of five (5) nursing units. The findings include: Review of the Quality Control Manual for TRUEbalance Glucometers, not dated, revealed the control test checks that the system is working properly. It is important to use more than one (1) level of control solution to ensure that the system is working properly. Use the daily quality control log to record the control test. Review of the Glucometer Log for the 100 Unit, dated for August 2015, revealed the glucometer had only been tested eight (8) times out of thirty-one (31) days. The facility could not locate the log for September 2015. For the month of October 2015 the glucometers had been tested nine (9) out of fourteen (14) days. Review of the Glucometer log for the 200 and 300 Units, revealed for the month of September 2015 the glucometer was checked one (1) day out of thirty (30) days. The facility could not find any logs for the month of October or August, 2015. Review of the Glucometer Logs for the 400 Unit, revealed for the month of October 2015, the	F 456	All glucometers were checked and corrected by the DHS at the time of the identification. All residents receiving clinical services related to glucometer use have the potential to be affected by the alleged deficient practice. Inservice, re-education, and monitoring will ensure glucometers are maintained in safe operating order based on the manufacturer's recommendation.		

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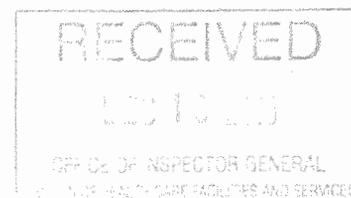
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F 456	Continued From page 140 glucometer had only been tested three (3) out of fourteen (14) days. The facility could not find any logs for September or August, 2015. Review of the Glucometer Logs for the 500 Unit, revealed for the month of August 2015, the glucometer had only been checked fifteen (15) of thirty-one (31) days. For the month of October 2015, the glucometer had only been checked four (4) out of fourteen (14) Days.	F 456	Education on manufacturer's guidelines for glucometer machines was completed for all nurses on 12/8/15 and 12/9/15 by the Director of Clinical Compliance (who is serving as Interim DHS). Glucometer machines will be Quality Control checked when a new vial of strips is opened, when results are unusually high or low, or if a meter is dropped. QC Glucometer log will be placed in the 24 hour binder at the nurses stations. Systemic change is the log will be maintained per manufacturer's guidelines and checked as part of the QA process with results submitted at least monthly.	
	Interview with Licensed Practical Nurse (LPN) #5, on 10/14/15 at 3:22 PM, revealed the glucometer machines should be test every day with the control solutions to ensure the machine was functioning properly. She stated there was a possibility the machine could malfunction and could give a false reading. She stated she thought the Director of Health Services (DHS) or Assistant Director of Health Services (ADHS) was conducting audits on the Glucometer machines. Interview with the DHS, on 10/15/15 at 11:30 AM, revealed the glucometers should be tested daily on the night shift. She stated the ADHS was monitoring the glucometer logs, but they had a new ADHS and he was still in training, so medical records staff was given the task. She stated the ball was dropped in the system to ensure glucometers were tested daily. She stated the potential was the machine may not record accurately or give a false reading. Interview with LPN #9, who worked in medical records, on 10/15/15 at 11:40 AM, revealed the purpose of checking the glucometers was to ensure the glucometer was functioning accurately. She did not get the glucometer logs last month and no one sent them to her. She			

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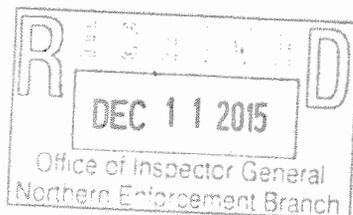
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F 456 F 490 SS=K	Continued From page 141 further stated the potential was the glucometers would not be functioning properly. 483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 456 F 490	DHS and/or ADHS will monitor glucometer Quality Check (QC) completion to assure we are meeting the expectations 3 times a week for a month then weekly with results forwarded to the QA committee monthly for 6 months and quarterly thereafter for review and further suggestions/comments. Completion date 12-10-15		
	This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the Administration failed to ensure the facility was administered in a manner which enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychological well-being of each resident. The facility's Interim Administration failed to have oversight in the overall safe environment in order to evaluate the facility's Falls Policy to ensure the policy was effective for prevention of avoidable accidents, as well as the Interdisciplinary Team Care Plan Guidelines; the Clinical Documentation System and Forms; the Electronic Medical Records; and Quality Assurance. On 09/07/15, Resident #1 sustained an unwitnessed fall that resulted in injury and transfer to the hospital. Review of the Emergency Room record, dated 09/07/15, revealed the resident sustained a 2.5 centimeter laceration to the cheek/eye area, two (2) rib fractures and a Flailed Chest injury (a life threatening medical				



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F 490	<p>Continued From page 142</p> <p>condition that occurs when a segment of the rib cage breaks under extreme stress and becomes detached from the rest of the chest wall, so a part of the chest wall moves independently). Review of the Death Summary, dated 09/07/15, revealed the resident passed, thirteen (13) hours after the fall, on 09/07/15, due to the injuries sustained from the fall which led to respiratory failure.</p> <p>On 09/30/15, Resident #10 sustained an unwitnessed fall. The staff found the resident on the floor complaining of back pain. The resident told the staff he/she had attempted to get to his/her walker; however, the walker tipped over and the resident fell. Emergency Medical Services was called and transferred the resident to the hospital. Hospital x-ray results revealed a thoracic compression fracture at T9. The resident continued to have severe pain and muscle spasms and a back brace was ordered.</p> <p>On 09/09/15, Resident #9 sustained an unwitnessed fall. The resident was found on the floor by the resident's son. The resident's right foot was bleeding and the resident continued to be extremely confused. The resident's bed alarm was noted on the floor and non-functioning with a tear in the wiring. The family transported the resident to the hospital for evaluation and the resident required ten (10) sutures to the right foot, underneath and between the fourth and fifth toes. The hospital x-ray results revealed a closed non-displaced transverse fracture of the right fifth metatarsal.</p> <p>In addition, the facility failed to ensure staff provided assistance to residents for toileting to prevent falls for Residents #11 and #13; and, failed to monitor and follow the manufacture's</p>	F 490	<p>The facility Administration was evaluated and a decision was made to make changes within the organizational chart/structure to ensure it is using its resources effectively and efficiently. These changes included a change in the Executive Director to a more experienced Executive Director, additional training for campus leadership/Administration staff which is detailed below.</p> <p>Residents identified during the survey were reviewed with the following corrective action found to be affected by the deficient practice:</p> <p>Resident #1 was discharged to hospital on 9/7/15.</p>

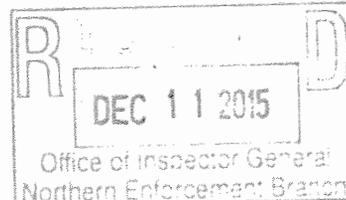


*Corrected pages
F490
pages 143-151*

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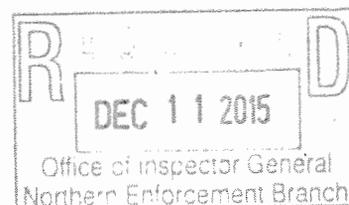
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F 490	Continued From page 143 recommendations for use of sensor pads for Residents #2, #5, and #6. Refer to F323. The facility's failure to have an effective Administration, with oversight to ensure an overall safe environment, in order to evaluate the facility's "Falls Policy" to ensure the policy was effective in the prevention of avoidable accidents placed Resident #1 and other residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 10/16/15 and determined to exist on 09/07/15 at 42 CFR 483.20 Resident Assessment (F280 and F282) at a Scope and Severity of a "K"; 42 CFR 483.25 Quality of Care (F323) at a Scope and Severity of a "K"; and, 42 CFR 483.75 Administration (514 and 520) at a Scope and Severity of a "K". Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care. The facility was notified of the Immediate Jeopardy on 10/16/15. An acceptable Allegation of Compliance (AOC) was received on 10/22/15 which alleged removal of the Immediate Jeopardy on 10/23/15. The State Survey Agency verified Immediate Jeopardy was removed on 10/23/15 as alleged prior to exit on 10/29/15. The Scope and Severity was lowered to an "E" at F280, F282, F323, F514, and F520, while the facility implements and monitors the Plan of Correction for the effectiveness of systemic changes and quality assurance. After supervisory and CMS review, F490 was cited at a Scope and Severity of a K. The facility provided an acceptable AOC on 12/03/15 alleging removal of Immediate Jeopardy on 10/23/15.	F 490	Resident #10 experienced a fall on 9/30/15 while attempting to get walker and it tipped resulting in her fall. Resident was transferred to hospital. Upon return to facility, prevention care plan in place which included proper footwear, resident was re-educated on use of walker. Care plan and profile updated at the time and reviewed again on October 17 and 18, 2015 by MDS nurses. No additional interventions indicated based on reassessment. Resident was on therapy caseload at the time and therapists were made aware of the fall. IDT review of all indicated to insure supervision to prevent accidents, residents will need proper footwear, walker in reach, encourage use of call light and offer rest periods during the day.		



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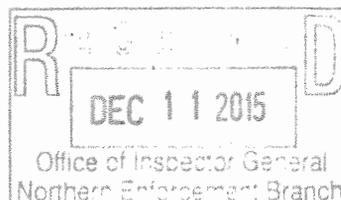
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F 490	Continued From page 144 Refer to F280, F282, F323, F514, and F520. The findings include: Review of the facility's policy regarding Interdisciplinary Team Care Plan Guidelines, dated June 2015, revealed the purpose was to ensure appropriateness of services and communication that would meet the residents' needs, severity/stability of conditions, impairments, disability, or disease in accordance with state and federal guidelines. The care plan interventions would be reflective of the impact the risk area(s), disease process(es) have on the individual resident. Goals would be measurable and attainable. Interventions would be reflective of the individuals' needs and risk influence as well as the resident's strengths. Review of the facility's policy regarding Clinical Documentation Systems, Circumstance, and Reassessment Forms, not dated, revealed the purpose was to provide a tool to document an investigation as to the root cause of an episodic event. Reassessment of the resident's risk factors that may have contributed to the event and evaluate the current care of plan interventions for effectiveness and select additional interventions if required. The care plan would be reviewed for the effectiveness of the current interventions in place to minimize or eliminate the risk factors. New interventions would be implemented as appropriate. Review of the facility's policy for Falls Management, dated February 2015, revealed the facility would maintain a hazard free environment, mitigate fall risk factors and implement preventative measures. Should the resident	F 490	Resident #9 experienced falls on 9/9/15 and 10/2/15. Resident discharged from facility on 10/4/15. Resident #11 discharged from facility on 8/27/15. Resident #13 experienced a fall on 7/7/15. New intervention implemented after the fall included placing bed in lowest position and toileting every 2 hours. Falls risk reassessment was completed by DHS and clinical support nurse. Resident #2 had Point of Care Profile and care plan interventions related to accidents reviewed by MDS nurses on October 12 and 13, 2015 to insure being followed by staff based on care observation. Treatment records were also reviewed on 10/20/15 by LPN Mentor to insure interventions were being followed as outlined on care plan.	



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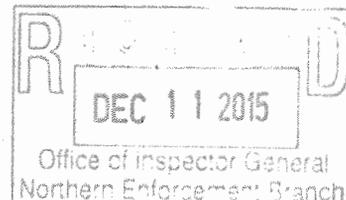
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F 490	<p>Continued From page 145</p> <p>experience a fall the attending nurse would complete the Fall Circumstance and Reassessment Form. The form included an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possible contributing factors, interventions to reduce risk of a repeat and a review by the Interdisciplinary Team to evaluate thoroughness of the investigation and appropriateness of the interventions. The resident care plan/profile would be updated to reflect any new or change in interventions.</p> <p>Review of the facility's policy for Scanning of Paper Medical Records into the Matrix Care system, not dated, revealed the purpose was to provide a successful transition from paper-based charts to Electronic Medical Records (EMR). The policy stated the medical records and/or other designated staff would assemble the documents to be scanned into the EMR. After scanning, the document would be reviewed to ensure the document was legible and all pages were present. Once the review had been completed and the document verified to be present the document would be returned to the paper chart. Documents originated after the date of electronic conversion may be disposed of in the confidential bin. All paper documents shall be maintained per the State and/or Federal regulations.</p> <p>Review of the facility's policy related to Guidelines for the Quality Assessment and Assurance Process, not dated, revealed the purpose was to provide continuous evaluation of campus systems to distinguish between isolated, pattern or system concerns, ensure systems were functioning appropriately, to prevent problems from rising to the extent possible, recognize incremental</p>	F 490	<p>Resident #5 experienced falls on 7/1/15, 8/11/15, 8/19/15, and 8/20/15. New interventions were implemented after each fall. For the fall occurring on 7/1/15, a bed/chair alarm was implemented. For the fall on 8/11/15, intervention was to increase observation after the fall by asking the resident to transfer to a room closer to the nurses station. On 8/19/15, interventions were to review medications to determine if contributing factor and to obtain UA/C&S. For 8/20/15, the intervention initiated was not documented. Falls reassessment completed by DHS and Clinical Support Nurses on completed October 12, 13 and 17, 2015. Care plan was revised by MDS nurses and interventions updated based on reassessment on 10/17/15. MDS nurses updated to include personal safety alarm</p>	



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F 490	<p>Continued From page 146</p> <p>change that may be early signs of potential/future problems, and correct identified issues. The primary purposes of the Quality Assessment and Assurance Plan would be to establish and provide a system whereby a specific process, and the documentation relative to it, would be maintained to support evidence of an ongoing Quality Assessment and Assurance Program, encompassing all aspects of resident care including safety, infection control, and quality of life applicable to campus residents. To develop a plan of correction and evaluate corrective actions taken to obtain the desired results. To provide a centralized, coordinated approach to quality assessment and assurance activities so as to bring about a comprehensive program of quality assessment and assurance to meet the needs of the facility.</p> <p>Interview with the Director of Health Services (DHS), on 10/05/15 at 2:00 PM and on 10/09/15 at 12:20 PM, revealed the facility had not provided training to the staff for quite sometime. She stated she began her role in February of 2015 and she had not provided training and had not instructed anyone else to train staff on the bed/chair alarms. She stated she had not read the manufacturer's recommendations and was not aware there were three (3) different brands in use. She stated malfunctions could occur if staff did not know how to test the alarms appropriately and resident harm could occur.</p> <p>Interview with the Interim Executive Director, on 10/05/15 at 2:40 PM, revealed interviews and statements obtained from staff were not taken into account. She stated the facility determined the root cause of the fall was Resident #1</p>	F 490	<p>(already in place) and wanderguard. No further updates indicated based on reassessment.</p> <p>Resident #6 was discharged on 11/6/15. Care plan interventions were reviewed on 10/18/15. Resident experienced no falls during this time. Resident discharged 11/6/15.</p> <p>All residents have the potential to be affected by the deficient practices.</p> <p>Measures and systemic changes made to ensure the deficient practice will not recur include:</p>	



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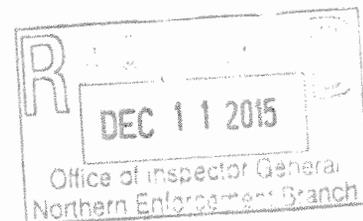
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F 490	<p>Continued From page 147</p> <p>frequently did not use the call light to ask for assistance prior to transferring. She stated the facility did not determine the staff failed to follow care plan interventions related to ensuring bed alarms were functional, call light was kept in reach or checking on the resident frequently; even though interviews and written statements obtained stated the bed alarm did not sound, the bed rail was in the down position with the call light attached and not within reach of the resident. Interviews and written statements also indicated the nurse was off the unit and the two (2) CNAs were busy providing care to another resident at the time of the fall.</p> <p>Interview with the Executive Director, on 10/05/15 at 3:20 PM, revealed he briefly reviewed Resident #1's incident/event file after he began his employment on 09/21/15. He stated after reviewing the event he did not provide any further direction to staff to determine if there were system issues in relation to meeting the care needs of the resident. He stated if he had conducted the investigation and determined the bed alarm had not sounded; he would have directed staff to conduct an audit of the alarms to determine if they were functional at all times. He stated if he had determined the call light had not been in reach of the resident he would have conducted audits of call light accessibility. Continued interview revealed if he had determined staff was not available to meet the needs of the resident he would have looked into that also, as it was the facility's responsibility to ensure resident safety.</p> <p>Interview with the Interim Executive Director, on 10/07/15 at 11:00 AM, revealed her position was to provide ongoing monitoring, as well as clinical</p>	F 490	<p>On November 17, 2015, an experienced Executive Director began mentoring the Glen Ridge Executive director full time. Some of the duties included with the mentor program included reviewing policies, reviewing procedures, continued education for regulations and campus systems, assisting with development of plan of correction. In addition, Clinical Support has been in the facility daily during the month of October and Monday through Friday during November. October 30, 2015, the Medical Records person was reassigned to a Charge Nurse position and a more experienced person has been hired. The new medical records clerk started full time at Glen Ridge on 12/7/15. During October we also had additional support with records</p>	

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F 490	Continued From page 148 direction. In addition, her position was to review system changes and concerns and communicate them as appropriate. However, she had not received any concerns from the facility. She stated she was not in the building prior to the State's investigation and came to the facility as support for the facility only. The Interim Executive Director further stated the computer system should be fully implemented at this campus. However, interview with the Director of Health Services (DHS), on 10/15/15 at 11:30 AM, revealed the computer system was confusing and since they went to computers, things were getting missed with documentation. The DHS further stated she was not aware what closing out an event form meant and learned she should have been reviewing them. She stated she had not received training on this process as it related to the DHS' responsibility and was still learning where to go first online. Interview with the Executive Director (ED), on 10/16/15 at 3:35 PM, revealed he was aware of open staffing positions that were posted; however, most of them were for part time. The ED was unable to voice the number of staff hired. He further stated he felt the units were adequately staffed for the care provided. The staff can call each other and he stated they did random checks on staff to ensure they were providing care to the residents. During his last check nothing stood out. Interview with the Director of Clinical Support and the Executive Director, on 10/16/15 at 10:45 AM, revealed the QA Committee met monthly to discuss QA issues. They stated no action plan was developed related to falls; however, a plan should have been developed to ensure resident	F 490	management which included our Chief Compliance Officer on 10/19/15 with additional unannounced visits through December 8, 2015. On November 30, 2015 the Director of Clinical Compliance assumed the Director of Health Services position in the campus. The Director of Health Services continues to monitor programs and systems along with the Executive Director, with feedback to the QA committee when any concerns are identified. On December 7, 2015, we changed our Executive Director and the more experienced Executive Director began full time at Glen Ridge. Orientation for the new Executive Director included review of all deficiencies related to this survey, review of the QA program and processes. The new ED has been instrumental in re-education of		



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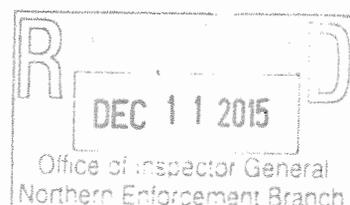
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F 490	<p>Continued From page 149</p> <p>safety. They stated the Interdisciplinary Team (IDT) should have been monitoring the electronic medical record documentation to determine if staff had not completed Event Reports and resident reassessments, in addition to determining the root cause of the events. They stated it was also the role of the DHS to monitor and address any identified concerns. They stated prior to the survey process beginning they had not identified any issues with the QA system process conducted by the IDT or the DHS. They stated prior to the survey process neither had provided direction or guidance to the facility staff in regards to improving the quality processes, related to falls, care planning, or documentation.</p> <p>The facility took the following steps to remove the Immediate Jeopardy:</p> <ol style="list-style-type: none"> 1. On 10/16/15, immediate education was provided to the Executive Director and other Department Leaders related to causation, systems noncompliance and plan for removal. This was also discussed on 10/17/15. 2. On 10/12/15 through 10/17/15, the External Audit Nurse and the Assessment Support Nurse provided education to the Executive Director and staff related to timely and accurate revisions of care plans based on resident condition and following care plan interventions. In addition, these nurses conducted audits of care plans to ensure accuracy starting on 10/19/15. 3. On 10/18/15-10/22/15, the Divisional Vice President (DVP) educated the Executive Director and reviewed the day to day review of the AOC binder to ensure all audits were being completed; the development of a new binder for the 	F 490	<p>campus leaders/Administration team about how to be effective and provide oversight to ensure an overall safe environment for residents. This re-education training by the New ED occurred on 12/7/15.</p> <p>The facility will continue audits outlined in the Plan of Correction for this survey, as well as conduct QA meetings. Frequency of the QA meetings will be at least monthly and will include members of key Administration, as well as our Medical Director and pharmacy consultants. More frequent QA meetings may occur as needed, but a minimum of monthly will be held.</p> <p>The facility will monitor the effectiveness of the QA process through participation/oversight by our Chief Compliance Officer and/or Director of Clinical Services monthly x 6 months. After 6 months, we will review in QA to determine frequency of ongoing oversight.</p>	

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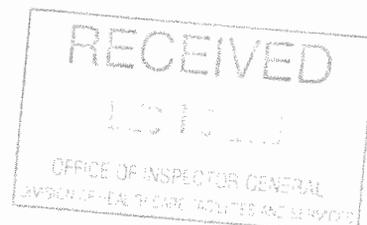
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F 490	Continued From page 150 SOD/POC and the DHS' responsibility to maintain; assignment of all Department Leaders to a specific part of the facility for daily monitoring; effectiveness of staff training and communication with new hires; and, reviewed specific tags and how to monitor, and the QA process. 4. On 10/19/15, each campus leader was reeducated by the DVP on the tags related to immediate jeopardy, causation, steps for removal, and steps needed to monitor. Campus leaders included the ED, DHS, MDS, Director of Plant Operations, Therapy Director, Activities, Medical Director, ADHS, Director of Social Services, DFS, Environmental Director, Pharmacy Consultant, and the Director of Clinical Support. 5. QA meetings were held on 09/19/15, 10/09/15, 10/19/15, and 11/24/15. The meetings included education on the Falls Management Program and systems implementation, fall trends, investigation and follow up. In addition, guidelines and protocols for conducting QA meetings, and the development of measurable corrective action plans were discussed. 6. On 10/19/15, the Clinical Director provided education to Campus Leaders and the ED regarding ongoing audits of assigned residents, safety devices, water accessible, and call lights in reach. 7. On 11/24/15, the QA meeting focused on the deficiencies cited regarding care plans, notification of Medical Director and families, supervision to prevent accidents, infection control related to Personal Protective Equipment and	F 490	Completion date 12/10/15		



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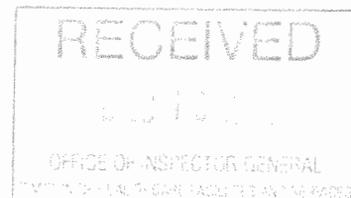
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F 490	<p>Continued From page 151 handwashing, dietary tags, and medical record audits.</p> <p>The State Survey Agency validated the removal of Immediate Jeopardy on 12/04/15 as follows:</p> <p>1. Review of Attachment Forms #1-a and #1-b, dated 10/16/15, revealed on 10/16/15 and 10/17/15, immediate education was provided by the Division Vice President to the ED and other Department Leaders related to causation, systems noncompliance and plan for removal.</p> <p>Interview with the Division Vice President on 12/14/15 at 2:30 PM, revealed she provided training to the ED and other department leaders related to causation, systems noncompliance and plan for removal on 10/16/15 and 10/17/15. She stated she mentored the ED regarding the QA process. She stated she specifically went over the audit tools with the ED and mentored him on the process for developing action plans related to issues found and how to monitor for effectiveness and reevaluating to determine if processes were being maintained.</p> <p>2. Review of Attachment Form #2, undated, revealed on 10/12/15 through 10/17/15, the External Audit Nurse and the Assessment Support Nurse provided education to the ED and staff related to timely and accurate revisions of care plans based on resident condition and following care plan interventions. In addition, these nurses conducted audits of care plans to ensure accuracy starting on 10/19/15.</p> <p>Interview with the Division Vice President (DVP) on 12/14/15 at 2:30 PM, stated she conducted</p>	F 490		



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F 490	<p>Continued From page 152</p> <p>some of the care plan audits herself. She stated she reviewed the audit results and mentored the ED in the QA process. She stated she provided education to the ED related to the care planning process and how to evaluate it for effectiveness.</p> <p>Interview with Director of Clinical Support on 12/04/15 at 2:09 PM, revealed she mentored the ED and reviewed the facility's audits with him. She stated a Safety Device Monitoring Tool was used daily by leaders in the facility to document their audits of safety interventions and devices in use by their residents. She stated she reviewed the results with the ED and did not determine any trends just isolated issues and they were immediately corrected.</p> <p>3. Review of Attachment Form #3, undated, revealed on 10/18/15-10/22/15 the DVP educated the ED and reviewed the day to day review of the AOC binder to ensure all audits were being completed; the development of a new binder for the SOD/POC and the DHS's responsibility to maintain; assignment of all Department Leaders to a specific part of the facility for daily monitoring; effectiveness of staff training and communication with new hires; and, reviewed specific tags and how to monitor, and the QA process.</p> <p>Interview with DVP on 12/14/15 at 2:30 PM, revealed she trained the ED on the organization's process for on-boarding new employees from 10/18/15-10/22/15. She stated leaders were assigned different areas of the facility to audit for AOC compliance, using the Safety Device Audit Tool. She stated she reviewed the day to day review of the AOC binder to ensure all audits were being completed with the ED. She stated</p>	F 490			



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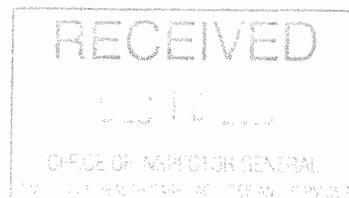
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F 490	<p>Continued From page 153</p> <p>she did not identify any issues during her reviews. She stated she also reviewed the specific tags cited during the survey process; and provided education on how to monitor for continued compliance, along with the how to conduct the QA process with the ED and other QA committee members.</p> <p>4. Review of Attachment Form #4, undated, revealed on 10/19/15 each campus leader was reeducated by the DVP on the tags related to immediate jeopardy, causation, steps for removal, and steps needed to monitor. Campus leaders were ED, DHS, MDS, Director of Plant Operations, Therapy Director, Activities, Medical Director, ADHS, Director of Social Services, DFS, Environmental Director, Pharmacy Consultant, and the Director of Clinical Support.</p> <p>Interview with Director of Clinical Support on 12/04/15 at 2:09 PM, revealed she attended the training provided by the DVP on 10/19/15, and received education on the tags cited related to immediate jeopardy, causation, steps for removal, and steps needed to monitor.</p> <p>Interview with DVP on, 12/14/15 at 2:30 PM, revealed she held a training on 10/19/15, with campus leaders and discussed tags related to immediate jeopardy, causation, steps for removal, and steps needed to monitor.</p> <p>5. Review of QA meeting sign in sheets, dated 09/19/15, 10/09/15, 10/19/15, and 11/24/15, revealed QA meetings were held and included education on the Falls Management Program and systems implementation, fall trends, investigation and follow up. In addition, guidelines and</p>	F 490			

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F 490	Continued From page 154 protocols for conducting QA meetings, and the development of measurable corrective action plans were discussed. Interview with Director of Clinical Support on 12/04/15 at 2:09 PM, revealed she attended the QA committee meetings and assisted with providing education related to falls, medication errors, infection control, care planning processes and the QA process.	F 490		
	Interview with the Division Vice President on 12/14/15 at 2:30 PM, revealed she attended the facility's QA committee meetings and she provided education regarding the Falls Management Program and systems implementation, fall trends, investigation and follow up expectations. In addition, she educated the members on the guidelines and protocols for conducting QA meetings, and the development of measurable corrective action plans. 6. Review of Attachment Form #4, dated 10/19/15, revealed a meeting with Campus Leaders and the ED was held. Interview on 12/04/15 at 2:09 PM with the Director of Clinical Support revealed she provided education, on 10/19/15, to Campus leaders and the ED regarding ongoing audits of assigned residents, safety devices, water accessible, and call lights in reach. 7. Review of QA Committee meeting sign in sheet, dated 11/24/15, revealed a QA Committee meeting was held with the ED, DVP, Director of Clinical Support, DHS, Pharmacy, Dietary and Social Services among others.			



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F 490	Continued From page 155 Interview on 12/04/15 at 2:09 PM with the Director of Clinical Support and the Division Vice President on 12/14/15 at 2:30 PM, revealed the QA meeting held on 11/24/15 focused on the deficiencies cited regarding care plans, notification of MDs and families, supervision to prevent accidents, infection control related to Personal Protective Equipment and handwashing, dietary tags, and medical record audits.	F 490	Residents #8, #9, #10 and #12 advanced directives have been reviewed to ensure copy scanned into the EMR and copy is in soft file chart. Resident #1 discharged to the hospital 9/8/15.	
F 514 SS=K	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system in place to ensure resident medical records were completed and accurate related to	F 514	Resident #9 had fall on 9/9/15 and 10/2/15. Resident discharged from the facility on 10/4/15. Resident #10 experienced falls on 9/30/15 and 10/9/15. Falls risk reassessment completed on October 17, 2015. Care plan was revised and updated by MDS nurses on October 13, 2015 based on reassessment. Resident discharged from facility 11/25/15. Resident #12 was discharged from facility on August 6, 2015. All residents have the potential to be affected by the alleged	



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F 514	<p>Continued From page 156</p> <p>the availability of Do Not Resuscitate documents and completed Circumstance Event Form documentation, along with the required reassessments in order for the residents medical records to reflect the residents actual condition and the services provided. This failure affected five (5) of twenty-five (25) sampled residents (Resident's #1, #8, #9, #10 and #12).</p> <p>Review of Resident #1's Emergency Room documents and the Death Summary, both dated 09/07/15, revealed the resident sustained a fall from the bed and a 2.5 centimeter laceration to the left eye/cheek area. The resident was transferred to the hospital and diagnosed with rib fractures to the second and third ribs on the left side with a Flailed Chest. Upon transfer, the resident's Advance Directive was not sent with the resident to the hospital. The resident experienced respiratory failure requiring the placement of a breathing tube. However, the resident was a Do Not Resuscitate (DNR). Per the hospital record, the resident's prognosis was discussed with the resident's sons and the resident was extubated and passed away at 4:50 PM on 10/07/15.</p> <p>Review of Resident #8's Fall Circumstance Event Form (FCEF), dated 09/26/15, revealed Resident #8 sustained an unwitnessed fall with injury. The resident sustained bruising and a skin tear to the right elbow, abrasion to mid-lower spinal bony prominence, and complained of right lower rib pain. However, there was no documented evidence a review of the fall was conducted by the Interdisciplinary Team or of the seventy-two hours of nursing assessment documentation regarding the resident's response to treatments or the effectiveness of the interventions as per</p>	F 514	<p>deficient practice. Through inservice, re-education and monitoring will ensure the campus maintains a clinical record on each resident in accordance with accepted professional standards and practices. The clinical record will contain sufficient information to identify the resident, a record of the resident-assessments, the plan of care and services provided, and progress notes.</p> <p>An audit has been completed to ensure all residents have the proper information related to Advanced Directives in their soft files at the nurse's station. This was completed on 12/3/15 by the Clinical Support nurses.</p>		

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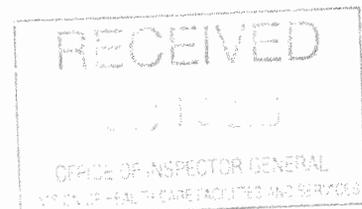
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F 514	<p>Continued From page 157 the facility's policy.</p> <p>Review of Resident #9's FCEF, dated 09/09/15, revealed Resident #9 sustained an unwitnessed fall and sustained a laceration to the right foot. The form did not have seventy-two hours of reassessment documentation of the resident's response to treatments or the effectiveness of the interventions per the facility's policy. Continued review of the form revealed the Interdisciplinary Team did not document a review regarding the evaluation, thoroughness or effectiveness of the actions taken. The resident sustained another fall, on 10/02/15, without injury. Continued review of the FCEF, revealed the form did not have reassessment documentation of the resident's response to treatments or the effectiveness of the interventions and the Interdisciplinary Team did not document a review regarding the evaluation, thoroughness or effectiveness of the actions taken.</p> <p>Review of the Nursing Notes, dated 09/30/15 at 1:52 PM, revealed Resident #10 sustained an unwitnessed fall and sustained a thoracic compression fracture at T9 (9th vertebra). Review of Resident #10's medical record revealed no evidence a FCEF was completed for the fall event on 09/30/15.</p> <p>Review of Resident #12's FCEF, dated 08/04/15 at 11:37 PM, revealed the resident sustained an unwitnessed fall and sustained swelling and an abrasion with bleeding to the nose. The form did not have seventy-two hours of reassessment documentation of the resident's response to treatments or the effectiveness of the interventions per the facility's policy and the Interdisciplinary Team did not document a review</p>	F 514	<p>Inservice of campus leaders and floor nurses completed on 12/8/15 and 12/9/15 by the Director of Clinical Compliance (who is serving as Interim DHS) regarding obtaining Advanced Directives upon admission and maintaining a copy in each resident's soft file at the nurses station, and with nurses concerning completing 72 hour follow up documentation when applicable.</p> <p>Systemic change includes maintaining a copy of the advanced directive in the soft file of each resident at the nurse's station. Systemic change also includes the nurses will review the facility activity report/open</p>

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F 514	Continued From page 158 regarding the established root cause, evaluation, thoroughness or effectiveness of the actions taken. The facility's failure to have an effective system in place, to ensure the facility maintained a complete and accurate clinical record, has caused or is likely to cause serious injury, harm, impairment or death. Immediate Jeopardy was determined to exist on 09/07/15.	F 514	events to ensure communication on events that need follow up documentation. DHS and/or ADHS will complete an audit of 3 resident advance directive and event forms for 72 hour documentation 5 times a week for one month then 3 times a week for a month then weekly with results forwarded to the QA committee monthly for 6 months and quarterly thereafter for review and further suggestions/comments. Completion date 12/10/15		
	The facility provided an acceptable Allegation of Compliance (AOC) on 10/22/15, which alleged removal of the Immediate Jeopardy on 10/23/15. The State Survey Agency verified Immediate Jeopardy was removed on 10/23/15 as alleged prior to exit on 10/29/15. The scope and severity was lowered to a "E" at F514, while the facility implements and monitors the Plan of Correction for the effectiveness of systemic changes and quality assurance. The findings include: Review of the facility's policy for Scanning of Paper Medical Records into the Matrix Care system, not dated, revealed the purpose was to provide a successful transition from paper-based charts to Electronic Medical Records (EMR). The policy stated the medical records and/or other designated staff would assemble the documents to be scanned into the EMR. After scanning, the document would be reviewed to ensure the document was legible and all pages were present. Once the review had been completed and the document verified to be present the document would be returned to the paper chart. Documents originated after the date of electronic conversion may be disposed of in the confidential				



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F 514	<p>Continued From page 159</p> <p>bin. All paper documents shall be maintained per the State and/or Federal regulations.</p> <p>Review of the facility's policy regarding Clinical Documentation Systems, Circumstance, and Reassessment Forms, not dated, revealed the purpose was to provide a tool to document an investigation as to the root cause of an episodic event. Reassessment of the resident's risk factors that may have contributed to the event and evaluate the current care plan interventions for effectiveness and select additional interventions if required. The care plan would be reviewed for effectiveness of the current interventions in place to minimize or eliminate the risk factors. New interventions would be implemented as appropriate.</p> <p>Review of the facilities policy regarding Clinical Documentation Systems, not dated, revealed the facility would document assessment and provision of services through a variety of forms and systems. The expectations of clinical documentation was to meet the individual needs of the residents and promote independence and prevent decline in physical and mental functioning. The staff would be expected to document their service delivery and assessment of mental and physical functioning.</p> <p>1. Review of the closed clinical record revealed the facility admitted Resident #1 on 06/08/13, with the diagnoses of Senile Psychosis, Atrial Fibrillation, and Orthostatic Hypotension. Continued review of the medical record revealed a physician's order that stated the resident made a healthcare decision to not be resuscitated.</p> <p>Interview with Licensed Practical Nurse (LPN) #1</p>	F 514			

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F 514	<p>Continued From page 160</p> <p>on, 10/02/15 at 9:30 AM, revealed she was off the unit when the resident fall on 09/07/15. She stated Emergency Medical Services was called to transport the resident to the hospital. She stated Resident #1's medical record stated the resident had made a health care decision not to be resuscitated. However, she was unable to locate the "Kentucky Emergency Medical Services Do Not Resuscitate" document in the resident's medical record. She stated as required by law, this document had to be provided to the Emergency Medical personnel prior to transferring the resident to the hospital for the resident's wishes to be honored during transport and at another medical facility. However, this was not done.</p> <p>Review of Resident #1's Emergency Room documents and the Death Summary, both dated 09/07/15, revealed the resident the resident experienced respiratory failure requiring a breathing tube to be placed. In addition, the Death Summary noted "At the time, it was not known about the patient's code status. The family was called and they informed them the patient was indeed a DNR and would not have wanted to be supported on a breathing machine for an extended amount of time. The patient's sons arrived and discussion of the patient's prognosis including likelihood of death if the patient was extubated. The patient's sons agreed that extubation was what the patient would have wanted and the patient was extubated and passed away at 4:50 PM on 10/07/15."</p> <p>Interview with the Medical Records staff member on, 10/05/15 at 3:00 PM, revealed it was determined Resident #1's Do Not Resuscitate (DNR) form did not get scanned into the</p>	F 514			

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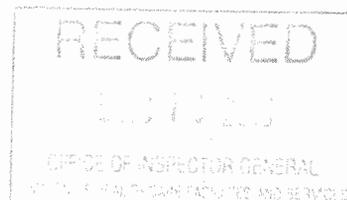
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	<p>Continued From page 161</p> <p>electronic medical record and was found locked up in the Minimum Data Set (MDS) nurses' office. She stated the facility could not determine how the form came to be located there.</p> <p>Interview with the Director of Health Services (DHS), on 10/05/15 at 2:00 PM, revealed staff informed her the next morning that Resident #1's DNR paperwork could not be located prior to sending the resident to the hospital. She stated the facility recently implemented an all electronic medical record and if residents had paper documents, such as DNR papers, the medical records staff would scan them into the electronic medical record. She stated they also kept a few paper documents in a box at the nurses station. She stated the staff searched for Resident #1's documents in the box and reviewed the electronic medical record again; however, they still were unable to locate the DNR papers. She stated the medical records staff conducted a search of the building and eventually located the documents. She stated if the DNR papers were not in a residents' chart, then the chart was considered incomplete, and care givers would not know or be able to carry out the resident's wishes.</p> <p>2. Review of the clinical record for Resident #8 revealed the facility admitted Resident #8 on 08/04/15 with diagnoses of Colon Cancer, Respiratory Failure and Atrial Fibrillation. The resident had a hospital admission on 09/15/15 and was re-admitted to the facility on 09/24/15.</p> <p>Review of Resident #8's FCEF, dated 09/26/15, revealed Resident #8 sustained an unwitnessed fall and sustained bruising and a skin tear to the right elbow, abrasion to mid-lower spinal bony prominence, and complained of right lower rib</p>	F 514		

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

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F 514	<p>Continued From page 162</p> <p>pain. The resident was diagnosed with a right non-displaced lateral 8th rib fracture.</p> <p>Review of Resident #8's EMR revealed sections for X-ray, Laboratory and Other reports; however, review of these sections revealed no evidence of the x-ray report for the resident's recent right rib fracture.</p> <p>Interview, on 10/07/15 at 9:45 AM, with LPN #14, revealed she was unable to locate Resident #8's x-ray report in the EMR or in the black box at the nurses station. She stated medical records staff may have the document and had not scanned it into the system yet.</p> <p>Interview with the Medical Records employee, on 10/07/15 at 10:00 AM, revealed she did not know the location of Resident #8's x-ray report. She stated she would have to look for it. She stated she looked in the EMR and in the black box on the unit and did not find it there. She stated after some searching she located the report in her mail box and did not know how long it had been there. She stated the staff was not filing reports correctly and due to this the medical records were not organized and scanning into the EMR was not always timely.</p> <p>Further review of the FCEF, dated 09/26/15, revealed no documented evidence a review of the fall was conducted by the Interdisciplinary Team or the seventy-two hours of nursing assessment per the facility's policy.</p> <p>3. Review of the closed clinical record revealed the facility admitted Resident #9 on 09/09/15 with the diagnoses Gastro-intestinal Hemorrhage, Urinary Retention, Weakness and Difficulty</p>	F 514			



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F 514	<p>Continued From page 163</p> <p>Walking.</p> <p>Review of Resident #9's FCEF, dated 09/09/15, revealed Resident #9 sustained an unwitnessed fall with injury requiring ten (10) sutures to the right foot, underneath and between the fourth and fifth toes and a closed non-displaced transverse fracture of the right fifth metatarsal. The form did not have seventy-two hours of reassessment documentation of the resident's response to treatments or the effectiveness of the interventions per the facility's policy or the documentation by the Interdisciplinary Team regarding the evaluation, thoroughness or effectiveness of the actions taken.</p> <p>Review of the FCEF, dated 10/02/15, revealed Resident #9 had an unwitnessed fall from the wheelchair, without injury. The FCEF, revealed nursing did not document additional interventions to prevent another fall. In addition, the form did not have reassessment documentation of the resident's response to treatments or the effectiveness of the interventions. Continued review of the form revealed the Interdisciplinary Team did not document a review regarding the evaluation, thoroughness or effectiveness of the actions taken.</p> <p>Interview with LPN #9, on 10/15/15 at 11:40 AM, revealed it was a facility policy to perform neurological checks on all residents that sustained an unwitnessed fall. She stated she forgot to do this for Resident #9. She stated she also forgot to completely fill out the FCEF. She stated if nursing did not complete their documentation then management would inform them by giving them a note. However, she had not received a note from management that stated</p>	F 514			

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F 514	<p>Continued From page 164</p> <p>she had incomplete documentation in Resident #9's medical record. She stated a complete medical record ensured staff had the necessary information to meet the needs of the resident.</p> <p>Interview, on 10/16/15 at 3:00 PM, with the DHS revealed she had not identified that all the areas on FCEF were not completed. She stated if the team determined a form had not been completed or had areas left blank they would inform the nurse that she needed to complete the form. However, she had no memory of informing LPN #9 of the need to complete the form, and the team did not keep a record of such notification. She stated if the forms were not complete it would be difficult for the team to analyze the information or for staff to provide the necessary care and services.</p> <p>4. Review of the clinical record for Resident #10 revealed the facility admitted the resident on 09/23/15 with a history of falls with hip fractures and kidney transplant. The resident had diagnoses of Spinal Stenosis, Colon Cancer, and Deep Vein Thrombosis.</p> <p>Review of the Nursing Notes, dated 09/30/15 at 1:52 PM, revealed Resident #10 had an unwitnessed fall and sustained a thoracic compression fracture at T9. The resident continued to have severe pain and muscle spasms and a back brace was ordered. However, record review revealed a FCEF was not completed regarding the fall.</p> <p>Interview with LPN #4, on 10/09/15 at 12:55 PM, revealed did not complete a FCEF. She stated she did not receive any notification from nursing management that she failed to complete a fall</p>	F 514		