

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

PRINTED: 04/27/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  R-C 04/13/2012
NAME OF PROVIDER OR SUPPLIER  PROFESSIONAL CARE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
(F 000)	INITIAL COMMENTS  On 04/12-13/12, an onsite revisit to the abbreviated survey was conducted which determined Immediate Jeopardy (IJ) had been removed at F-226, F-250, F-280, F-323, F-490 and F-520 on 03/24/12, as alleged in the Acceptable Allegation of Compliance (AOC), received on 04/20/12. While the IJ was removed at F-226, F-250, F-280, F-323, F-490 and F-520, continued non-compliance remained as follows: F-226, F-250, F-280, F-323, F-490 and F-520 at a S/S of a "D." The facility's Quality and Assurance Committee had not completed the monitoring, analysis of information, nor the development and implementation of a plan to ensure correction of the deficient practice to prevent non-compliance recurrence.  In addition, deficient practice was identified at F221 during the onsite revisit to the abbreviated survey at a S/S of a "D." F 221 SS=D 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS  The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.  This REQUIREMENT is not met as evidenced by: Based on Interview, record review and review of the facility's policy and procedure, it was determined the facility failed to ensure one resident (#6), in the selected sample of 10 residents, had the right to be free from any physical restraint imposed for purposes of	(F 000)	#1 Resident #6 was reassessed on 4-18-12 by the Safety Restraint Committee and the order for the Geri-chair was discontinued. Resident Care Plans were updated.  #2 All residents identified as having any physical restraint was reviewed by the Safety Restraint Committee on 4-18-12. This committee reviewed the Restraint Assessment, verified medical symptoms being treated, evaluated effectiveness of the restraint, discussed the risks and benefits of the restraint and identified individual release plans for each restraint. Committee also identified reduction opportunities. Several reduction efforts were attempted and if possible were made. All care plans were reviewed and updated related to restraint use and release plans.  #3 Education provided on 4-17-12 by Corporate Consultant to Safety Restraint Committee on Facility Restraint Policy and procedure, as well as, the federal regulation related to the use of restraints. All nursing staff were re-educated by 4-24-12 on facility policy and procedure regarding restraints that included restraint must treat medical symptom, restraint assessment process, restraint information for resident/family regarding risks/benefits of use of restraint, use of device decision tree to assess effect of a device on an individual resident, individualized release plans, and need for reduction efforts and the use of the least restrictive device. This education was provided by the DON. All new nursing staff will be educated on restraint use	4-25-12	4-25-12



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

TITLE

(X6) DATE

*Patricia J. Jones* (Signature)

57-12 (Title)

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

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F 221	<p>Continued From page 1</p> <p>discipline or convenience, and not required to treat the resident's medical symptoms. Interviews with facility staff revealed the facility restrained Resident #6 in a gerl-chair with pelvic vest while the staff provided care for other residents. The facility failed to assess that Resident #6 was having aggressive and/or verbal/physical abusive behaviors prior to the use of the restraint per the physician's order dated 04/08/12. The facility could provide no evidence that they attempted less restrictive interventions prior to implementing the restraint for Resident #6. The facility failed to document the Resident #6's behaviors that warranted the use of the restraint and interventions prior to restraining the resident. In addition, the facility staff failed to communicate the use of the restraint for Resident #6.</p> <p>Findings Include:</p> <p>A review of the facility's "Physical Restraint" policy and procedure, dated 01/01/09, revealed it was the intent of the facility that each resident attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrants the use of the restraint.</p> <p>A record review revealed the facility admitted Resident #6 on 07/28/09 with diagnoses to include Alzheimer's Disease, Dementia with Behavior, Anxiety and Impulse Control. A review of the annual Minimum Data Set (MDS) assessment, dated 02/07/12, revealed the facility assessed Resident #6's cognition as moderately</p>	F 221	<p>during orientation. The nursing staff will be re-educated on the use of restraints quarterly for three quarters, then annually. The facility policy and procedure for restraint use was reviewed by Corporate Consultant to ensure all components of the program were in place and the changes were indicated. This occurred on 4-17-12 regarding release of restraints during 1 to 1 visits, programs and during supervised group activities. This was done by Corporate Consultant. Safety Restraint Committee will review all residents with restraints no less than monthly for three months, then quarterly. All reduction attempts will be documented, care plans reviewed and updated as needed.</p> <p>#4 The DON will review all residents with restraints monthly to ensure all components of restraint program are completed properly, that medical symptoms are identified, individualized release plans are in place, that reduction efforts are documented, that risks/benefits are documented and reviewed with resident/family. These reviews will be reported to facility QA Committee no less than quarterly. Nurse responsible for restraint program will observe each resident with a restraint weekly for 4 weeks, then monthly for three months, then quarterly to ensure individual release plans are being followed. These reviews will be reported to the DON to report to facility QA committee.</p>	4-25-12	

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F 221	<p>Continued From page 2</p> <p>impaired and as having physical and verbal behaviors directed at others.</p> <p>A review of a nurse's note, dated 04/08/12 at 11:00 AM, revealed Resident #6 was having safety issues as he/she was attempting to wander in and out of other residents' rooms. When staff attempted to redirect Resident #8 out of other residents' rooms, the resident became verbally and physically abusive, attempting to "slap" at staff. The nurse faxed the physician requesting an order for a reclining geri-chair with a table top tray for the resident's safety during periods of wandering and increased agitation, as needed.</p> <p>A review of the physician's order, dated 04/08/12, revealed an order for a reclining geri-chair with pelvic posey/support during times of wandering and increased agitation for resident safety as needed. Further review of the physician's order revealed an order, also dated 04/08/12, that clarified the original order for the restraint during times of verbal, physical abuse and aggression.</p> <p>A review of a restraint assessment, dated 04/08/12, revealed Resident #6 was assessed for the reclining geri-chair with pelvic/posey support to prevent injury to self and others when wandering, verbally, physically abusive and having aggressive behaviors as needed.</p> <p>A review of the Comprehensive Care Plan for behavior/agitation, dated 08/07/09, and the April 2012 Certified Nurse Aide (CNA) Care Plan revealed to place Resident #6 in a reclining geri-chair with posey/pelvic support during times of wandering with increased agitation for resident safety. The care plan did not indicate the</p>	F226	<p>#1 Resident #2 was discharged from the facility 3-23-12</p> <p>#2 DON reviewed all reports of resident to resident altercations, 24 hour reports, and all incidents for past 30 days to ensure that there were no incidents of abuse, injuries of unknown origin or reports that would require the Abuse Protocol to be followed. This was completed 4-6-12.</p> <p>#3 All available staff were re-educated on the facility policy related to Abuse Prohibition on 3-16 and 3-17-12 by the DON, Administrator, or Charge Nurse. All unavailable staff were re-educated prior to returning to work. All newly hired staff will be educated on the facility policy during orientation by Administrative Staff. Beginning on 4-2-12 and continuing as of 4-6-12 Corporate consultants and administrative staff have been doing one on one interviews with staff members to ensure their understanding of the policy on Abuse Prohibition. On 4-4-12 the facility Ombudsman presented an in-service on resident to resident altercation, reviewed the State and Federal Regulation related to abuse and discussed the responsibility to keep all residents safe. The facility will repeat the in-service on the facility policy on Abuse Prohibition monthly for 3 months then quarterly and will ensure that all staff members attend the in-service no less than 2 more times over the next 12 months. This will be tracked by the DON. Corporate Consultant educated DON and Administrator on 3-17-12 on assessing and</p>	4-14-12	

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F 221	<p>Continued From page 3</p> <p>parameters of the physician's order to include using the restraint when the resident was exhibiting verbal, physical abuse and aggression.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 04/12/12 at 3:35 PM, revealed she faxed the physician to obtain the order for the restraint because the resident was wandering into other residents' rooms and was becoming agitated and combative when staff tried to redirect the resident. She stated the resident calmed down and she did not have to use the restraint.</p> <p>An interview with LPN #2, on 04/12/12 at 4:00 PM, revealed when she came to work one day she was making her rounds around 3:00 PM and as she walked by Resident #8's room, she saw Resident #6 in his/her room in a reclining geri-chair with a pelvic posey support. She stated no one had told her in report that Resident #6 had been placed in the restraint. She revealed the Certified Nurse Aide (CNA) assisted her in releasing Resident #8 from the restraint and the resident went to bed.</p> <p>A review of a nurse's note, dated 04/10/12 at 5:00 PM, revealed LPN #2 had completed a resident check at 3:00 PM and released Resident #6 from the restraint. Further review of the nurse's notes, dated 04/10/12, revealed there was no documented evidence that Resident #6 had exhibited any behaviors of wandering, verbal and physical abuse and aggressive behaviors, any interventions attempted for the behavior or any documentation Resident #8 was placed in the restraint.</p> <p>Interviews with Registered Nurse #1 and LPN #3,</p>	F226	<p>identifying possible risks related to behaviors, implementing interventions to manage behaviors, and re-evaluation of interventions for protection of residents, they were also educated on the proper completion of an Incident Report and follow up investigations. DON and Administrator were re-educated on identifying signs of abuse, investigating allegations of abuse, reporting requirements related to abuse, State and Federal Regulations related to abuse reporting, including reporting reasonable suspicion of a crime in a long term care facility on 4-9-12 by the Corporate Clinical Consultant for Elmcroft Senior Living. Staff in-service by Corporate Social Service Consultant on 4-4-12 on behaviors, in-service included determining the impact of behaviors on others, identifying behaviors, investigating behaviors and putting interventions in place to manage behaviors. CareTracker 24 hour group behavior report will be reviewed daily to ensure reported behaviors are investigated and acted on appropriately. This report will be run by licensed staff on first shift. All reports of resident to resident altercations, reports of injuries of unknown origin and reports of suspected abuse will be reviewed by administrative staff in the morning meeting to ensure the Abuse Prohibition Policy has been followed, all appropriate notifications have been made and that the safety of all residents is ensured.</p> <p>#4 DON and Corporate Consultant will review all reports of resident to resident</p>	4-14-12	

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F 221	<p>Continued From page 4</p> <p>on 04/12/12 at 11:30 AM and 1:40 PM, respectively, revealed Resident #6's alarm went off, on 04/10/12, and when they went to check on him/her, the resident was attempting to go in to another resident's room. They stated they redirected the resident by taking him/her back to the room and trying to get the resident to look at a magazine. The resident immediately got up and tried to walk back out to the hall to go into another resident's room. They revealed they placed the resident in the reclining geri-chair and pelvic/posey support. They both stated they did not document anything about the resident's behaviors or interventions tried before placing the resident in the restraint and did not tell the oncoming shift the resident was in the restraint. They also stated the resident was not showing any combative or aggressive behaviors when they tried to redirect the resident.</p> <p>A review of the behavior monitoring for 04/10/12 revealed there were no behaviors of verbal/physical abuse or aggressive behaviors documented.</p> <p>Interview with LPN #4, on 04/12/12 at 3:05 PM, revealed Resident #6 was placed in the reclining geri-chair with a pelvic/posey support two times during the early morning hours on 04/11/12. She stated the resident would not sleep and staff was walking with him/her throughout the night and having him/her sit at the nurse's desk. She revealed she had to place the resident in the restraint once when the CNAs were providing care to other residents and she had to care for a resident with a fever, and once when the CNAs were assisting other residents to get up in the morning and she had to give residents insulin.</p>	F226	<p>altercations, reports of injury of unknown origin and any report of suspected abuse monthly to ensure that the Abuse Prohibition Policy is followed if indicated. Results of these reviews will be presented to the QA Sub Committee. Facility Quality Assurance Committee will meet on 4-9-12 to review the facility POC and to establish a QA subcommittee which will meet weekly for 4 weeks then monthly to monitor the implementation of the POC, including the education component and the ongoing audit component, they are to evaluate the effectiveness of the POC, if necessary provide additional education and request additional audits and report to the facility QA Committee no less than quarterly. This subcommittee will consist of DON, Director of Social Services, MDS Coordinator, one other nurse and one CNA. The Corporate Consultant and Corporate Social Service Consultant will act as resources for this subcommittee and will report on the actions of the subcommittee to the facility QA committee and the Corporate Clinical Consultant for Elmcroft Senior Living.</p>	4-14-12	

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F 221	Continued From page 5 She stated the resident was not exhibiting any aggressive or abusive behaviors and no other interventions were attempted and implemented. She revealed she did not document what behaviors the resident was having prior to the use of the restraint, what interventions were tried prior to implementing the restraint or that the resident was placed in the restraint and removed twice during the night.  A review of the nurse's notes, dated 04/11/12, revealed there was no documented evidence Resident #6 had behaviors of wandering, verbal and physical abuse or aggressive behaviors. In addition, there was no documented evidence the resident was placed in the restraints and removed from the restraints. A review of the behavior monitoring for 04/11/12 revealed there were no documented abusive or aggressive behaviors.  Interview with the Director of Nursing (DON), on 04/12/12 at 3:58 PM, revealed the facility does not place residents in restraints for convenience. She stated staff cannot provide one to one for the resident. She revealed staff should follow the physician's order for the restraint and should document the behaviors prior to the use of the restraints and other interventions used prior to restraint use and when the resident was removed from a restraint. She revealed if a resident was placed in a restraint on one shift, the staff should notify the next shift in report that the resident was in a restraint.	F250	#1 Resident #2 was discharged from the facility 3-23-12  #2 On 3-17-12 a CareTracker Group Behavior Report was run for the past 60 days to identify all residents with reported behaviors. Corporate Consultants reviewed the medical records and care plans for any resident on that report to identify any resident considered to be at risk for aggressive behaviors towards other residents and any such identified behaviors were referred to the facility staff for review and revision of care plans. MDS Coordinator and Social Services Director reviewed the MDS and Care Plans, and nurse aide care plans for all residents listed on the CareTracker Group Behavior Report for the past 60 days on 3-17-12. The last MDS for each identified resident was reviewed as was the Behavior CAA if triggered. If the review indicated the need for a significant change assessment, one was scheduled. Corporate Social Service Consultant has since 3-17-12 been reviewing the behavior reports and reviewing nurses notes and social service notes for appropriate follow up related to behaviors. Social Services has been given direction regarding the follow up on behaviors by the Corporate Social Service Consultant.  #3 Social Service Director was educated on the Care Tracker system including available reports, how to run the 24 Hour Group Behavior Report and how to follow up on any reported behaviors. The	4-14-12	
{F 226} SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit.				

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{F 226}	<p>Continued From page 6 mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and Allegation of Compliance review, it was determined the Immediate Jeopardy (IJ), identified during the abbreviated survey, completed on 03/23/12, had been removed related to development and implementation of the facility's policy and procedure to prevent abuse; however, non-compliance continued to exist at a S/S of a "D," as the facility had not completed the Quality and Assessment and Assurance Committee Initiative related to monitoring, analysis of monitoring, and the implementation of the Plan of Correction (PoC) to ensure the facility's policy and procedure was implemented related to abuse.</p> <p>Findings include:</p> <p>Review of the acceptable AoC, dated 03/24/12, and record review revealed a private sitter was placed outside Resident #2's door twenty four hours a day and if the resident came out of the room, the private sitter supervised the resident at all times until the resident's discharge on 03/23/12. The private sitter also redirected wandering residents from the resident's room. The private sitter was educated by the Administrator, Director of Nursing (DON) or Charge Nurse on the Abuse policy and Effective Coping with Challenging Behaviors. A Licensed nurse verified every two hours and signed a document that included time of visual check, staff</p>	F250	<p>education provided also covered using the RAI process to identify any factors that may lead to behaviors, identifying patterns of behaviors, and the importance of having a careplan with appropriate interventions and evaluation of the interventions. This education was provided by a Corporate Consultant on 3-17-12. On 4-2-12 Corporate Consultant provided education to the IDT team, which included the Director of Social Services, on the Resident Assessment Instrument (RAI)-purpose, 3 basic components: The minimum data set (MDS) the assessment part, Care Area Triggers (CATS), Care Area Assessment (CAA) process and Utilization guidelines. Including that the CAT requires additional investigation, CAA resources, summary to develop individualized care plan, to attain or maintain resident highest practicable physical, mental, and psychosocial well-being. Also covered Assessment, Decision making, Care Plan, Implementation &amp; Evaluation. Following the education the IDT team reviewed all careplans to ensure that they were appropriate, current and individualized for each resident. These reviews were completed by 4-8-12. Beginning 4-8-12 the Corporate Social Service Consultant or Director of Social Services will be reviewing the 24 Hour Behavior Report and providing follow up to the residents to ensure that any identified behavior is assessed, investigated and appropriate</p>	4-14-12	

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(F 226)	Continued From page 7 member/private sitter present and nurse's signature that the private sitter assigned outside of the room or with Resident #2. All available licensed nurses were in-serviced by the DON or Administrator on 03/16/12 or 03/17/12 on the verification process. Unavailable staff was in-serviced prior to returning to work. All available staff was in-serviced on 03/16/12 or 03/17/12 on Facility Abuse Policy and Effective Coping with Challenging Behaviors by the DON or Administrator. Licensed Nurses were instructed by the DON to run Group Behavior reports from the Care Tracker system daily to ensure that any behavior noted was reported and if any follow up was needed that the follow up occurred. The Social Service Director was educated on the Care Tracker system including the available reports, how to run the 24 hour group report and how to follow up on behaviors noted on the report, and her responsibility to follow up on any reported behaviors. On 03/17/12, a CareTracker Group Behavior Report was run for the past sixty days to identify all residents with reported behaviors. On that day, Corporate Consultants reviewed the medical records and care plans for any resident on that report to identify any resident considered to be at risk for aggressive behavior toward other residents, and any identified behaviors were referred to facility staff and any identified potential behaviors were referred to the facility staff for review and revision of care plans. On 03/17/12, the DON reviewed all resident that wander for appropriate interventions on care plan to ensure safety needs were identified. Revisions were made as indicated. On 03/17/12, the Minimum Data Set (MDS) Coordinator and Social Services Director reviewed the MDS and Care Plans for all residents listed on the Caretracker Behavior	F250	care plan interventions are initiated as needed.  #4 Corporate Consultant or Corporate Social Services Consultant will review no less than 25% of all Behavior CAA's, and behavior care plans each month for 4 months to ensure appropriate completion of the CAA, and appropriate care planning. Results of the audit will be used for re-education of the Director of Social Services on the CAA. Facility Quality Assurance Committee will meet on 4-9-12 to review the facility POC and to establish a QA subcommittee which will meet weekly for 4 weeks then monthly to monitor the implementation of the POC, including the education component and the ongoing audit component, they are to evaluate the effectiveness of the POC, if necessary provide additional education and request additional audits and report to the facility QA Committee no less than quarterly. This subcommittee will consist of DON, Director of Social Services, MDS Coordinator, a staff nurse and a CNA. The Corporate Consultant and Corporate Social Service Consultant will act as resources for this subcommittee and will report on the actions of the subcommittee to the facility QA committee and the VP of Operations for Elmcroft Senior Living.	4-14-12	

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{F 226}	Continued From page 8 Report who had behaviors in the last 60 days. If the behavior identified met the criteria for a significant change, a significant change assessment was completed. Care plans and interventions were reviewed and revisions were made as indicated. All care plans and nurse aide care plans were updated if indicated. All reported behaviors were reviewed in the morning meetings. The care plan and interventions were reviewed to ensure the effectiveness of the interventions to determine if additional interventions were required. Corporate Nursing Consultant educated the DON and Administrator, on 03/17/12, on assessing and identifying possible risks, implementing interventions to manage behaviors and re-evaluation of interventions for protection of the residents. They were also educated on the proper completion of Incident Report and follow up investigation as indicated.  Interview with the Administrator, on 04/12/12 at 2:45 PM, revealed in the future the facility was having staff from a psychiatric service to come in and inservice the staff on behaviors and interventions to address behaviors. She stated the Quality Assessment Committee is going to meet once a month to discuss aggressive behaviors, abuse and resident to resident altercations and follow up. She revealed the Medical Director will be assisting the facility with outside resources to assist the facility in coming up with new intervention.	F280	#1 Resident #2 was discharged from the facility 3-23-12  #2 On 3-17-12 a CareTracker Group Behavior Report was run for the past 60 days to identify all residents with reported behaviors. Corporate Consultants reviewed the medical records and care plans for any resident on that report to identify any resident considered to be at risk for aggressive behaviors towards other residents and any such identified behaviors were referred to the facility staff for review and revision of care plans. MDS Coordinator and Social Services Director reviewed the MDS and Care Plans, and nurse aide care plans for all residents listed on the CareTracker Group Behavior Report for the past 60 days on 3-17-12. The last MDS for each identified resident was reviewed as was the Behavior CAA if triggered. If the review indicated the need for a significant change assessment, one was scheduled.  #3 On 4-2-12 Corporate Consultant provided education to the IDT team, which included the Director of Social Services, on the Resident Assessment Instrument (RAI)-purpose, 3 basic components: The minimum data set (MDS) the assessment part, Care Area Triggers (CAT'S), Care Area Assessment (CAA) process and Utilization guidelines. Including that the CAT requires additional investigation, CAA resources, summary to develop individualized care plan, to attain or	4-14-12
{F 250} SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE  The facility must provide medically-related social services to attain or maintain the highest			

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(F 250)	<p>Continued From page 9 practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and Allegation of Compliance review, it was determined the immediate Jeopardy (IJ), identified during the abbreviated survey completed on 03/23/12, had been removed related to the provision of medically related Social Services; however, non-compliance continued to exist at a S/S of a "D," as the facility had not completed the Quality Assessment and Assurance Committee initiative related to monitoring, analysis of monitoring, and the Implementation of the Plan of Correction (PoC) to ensure medically-related Social Services was provided.</p> <p>Findings include: Review of the acceptable AoC, dated 03/24/12, and record review revealed Licensed Nurses were instructed by the DON to run Group Behavior reports from the Care Tracker system daily to ensure that any behavior noted was reported and if any follow up was needed that the follow up occurred. The Social Service Director was educated on the Care Tracker system including the available reports, how to run the 24 hour group report and how to follow up on behaviors noted on the report, and her responsibility to follow up on any reported behaviors. On 03/17/12, a CareTracker Group Behavior Report was run for the past sixty days to identify all residents with reported behaviors. On</p>	F280	<p>maintain resident highest practicable physical, mental, and psychosocial well-being. Also covered Assessment, Decision making, Care Plan, Implementation &amp; Evaluation. Following the education the IDT team reviewed all careplans to ensure that they were appropriate, current and individualized for each resident. These reviews were completed by 4-8-12. On 4-4-12 Corporate Consultant and DON presented education to the Licensed staff on their role and responsibility for updating and revising care plans.</p> <p>#4 Corporate Consultant or Corporate Social Services Consultant will review no less than 25% of all Behavior CAA's, and behavior care plans each month for 4 months to ensure appropriate completion of the CAA, and appropriate care planning. Results of the audit will be used for re-education of the Director of Social Services on the CAA. Facility Quality Assurance Committee will meet on 4-9-12 to review the facility POC and to establish a QA subcommittee which will meet weekly for 4 weeks then monthly to monitor the implementation of the POC, including the education component and the ongoing audit component, they are to evaluate the effectiveness of the POC, if necessary provide additional education and request additional audits and report to the facility QA Committee no less than quarterly. This subcommittee will consist</p>	4-14-12	

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(F 250)	<p>Continued From page 10</p> <p>that day, Corporate Consultants reviewed the medical records and care plans for any resident on that report to identify any resident considered to be at risk for aggressive behavior toward other residents, and any identified behaviors were referred to facility staff and any identified potential behaviors were referred to the facility staff for review and revision of care plans. On 03/17/12, the DON reviewed all resident that wander for appropriate interventions on care plan to ensure safety needs were identified. Revisions were made as indicated. On 03/17/12, the Minimum Data Set (MDS) Coordinator and Social Services Director reviewed the MDS and Care Plans for all residents listed on the Caretracker Behavior Report who had behaviors in the last 60 days. If the behavior identified met the criteria for a significant change, a significant change assessment was completed. Care plans and interventions were reviewed and revisions were made as indicated. All care plans and nurse aide care plans were updated if indicated. All reported behaviors were reviewed in the morning meetings. The care plan and interventions were reviewed to ensure the effectiveness of the interventions to determine if additional interventions were required.</p> <p>Interview with the Administrator, on 04/12/12 at 2:45 PM, revealed, in the future, the facility was having staff from a psychiatric service to come in and inservice the staff on behaviors and interventions to address behaviors. She stated the Quality Assessment Committee was going to meet once a month to discuss aggressive behaviors, abuse and resident to resident altercations and follow up. She revealed the Medical Director will be assisting the facility with</p>	F280	<p>of DON, Director of Social Services, MDS Coordinator, a staff nurse and a CNA. The Corporate Consultant and Corporate Social Service Consultant will act as resources for this subcommittee and will report on the actions of the subcommittee to the facility QA committee and the VP of Operations for Elmcroft Senior Living.</p>	4-14-12	

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{F 250}	Continued From page 11	F323	#1 Resident #2 was discharged from the facility 3-23-12  #2 DON reviewed all reports of resident to resident altercations, 24 hour reports, and all incidents for past 30 days to ensure that there were no incidents of abuse, injuries of unknown origin or reports that would require the Abuse Protocol to be followed. This was completed by 4-6-12.  #3 All available staff were re-educated on the facility policy related to Abuse Prohibition on 3-16 and 3-17-12 by the DON, Administrator or Charge Nurse. All unavailable staff were re-educated prior to returning to work. All newly hired staff will be educated on the facility policy during orientation by Administrative Staff. Beginning on 4-2-12 and continuing as of 4-6-12 Corporate consultants and administrative staff have been doing one on one interviews with staff members to ensure their understanding of the policy on Abuse Prohibition. On 4-4-12 the facility Ombudsman presented an in-service on resident to resident Altercation, reviewed the State and Federal Regulation related to Abuse and discussed the responsibility to keep all residents safe. The facility will repeat the in-service on the facility policy on Abuse Prohibition monthly for 3 months then quarterly and will ensure that all staff members attend the in-service no less than 2 more times over the next 12 months. This will be tracked by the DON, Corporate Consultant educated DON and Administrator on 3-17-12 on assessing and identifying possible risks related to behaviors, implementing interventions to manage behaviors, and re-evaluation of interventions for protection of residents, they were also educated on the proper completion of an	4-14-12	
{F 290} SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Based on Interview, record review and Allegation of Compliance review, it was determined the Immediate Jeopardy (IJ), identified during the abbreviated survey completed on 03/23/12, had been removed related to revision of the care plan related to aggressive behaviors; however, non-compliance continued to exist at a S/S of a "D," as the facility had not completed the Quality and Assessment and Assurance Committee				

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(F 280)	<p>Continuad From page 12</p> <p>Initiative related to monitoring, analysis of monitoring, and the implementation of the Plan of Correction (PoC) to ensure care plans were revised.</p> <p>Findings include:</p> <p>Review of the acceptable AoC, dated 03/24/12, and record review revealed Licensed Nurses were instructed by the DON to run Group Behavior reports from the Care Tracker system daily to ensure that any behavior noted was reported and if any follow up was needed that the follow up occurred. The Social Service Director was educated on the Care Tracker system including the available reports, how to run the 24 hour group report and how to follow up on behaviors noted on the report, and her responsibility to follow up on any reported behaviors. On 03/17/12, a CareTracker Group Behavior Report was run for the past sixty days to identify all residents with reported behaviors. On that day Corporate Consultants reviewed the medical records and care plans for any resident on that report to identify any resident considered to be at risk for aggressive behavior toward other residents, and any identified behaviors were referred to facility staff and any identified potential behaviors were referred to the facility staff for review and revision of care plans. On 03/17/12, the DON reviewed all resident that wander for appropriate interventions on care plan to ensure safety needs were identified. Revisions were made as indicated. On 03/17/12, the Minimum Data Set (MDS) Coordinator and Social Services Director reviewed the MDS and Care Plans for all residents listed on the CareTracker Behavior Report who had behaviors in the last 60 days. If</p>	F323	<p>Incident Report and follow up Investigations. DON and Administrator were re-educated on identifying signs of abuse, investigating allegations of abuse, reporting requirements related to abuse, State and Federal Regulations related to Abuse reporting, including reporting reasonable suspicion of a crime in a long term care facility on 4-9-12 by the Corporate Clinical Consultant for Elmcraft Senior Living. Staff in-serviced by Corporate Social Service Consultant on 4-4-12 on Behaviors, in-service included determining the impact of behaviors on others, identifying behaviors, investigating behaviors and putting interventions in place to manage behaviors. CareTracker 24 hour group behavior report will be reviewed daily to ensure reported behaviors are investigated and acted on appropriately. This report will be run by licensed staff on first shift. All reports of resident to resident altercations, reports of injuries of unknown origin and reports of suspected abuse will be reviewed by administrative staff in the morning meeting to ensure the Abuse Prohibition Policy has been followed, all appropriate notifications have been made and that the safety of all residents is ensured. On 4-4-12 DON, Corporate Consultant, Administrator and VP of Operations for Elmcraft Senior Living re-educated licensed staff on managing aggressive behavior by residents. Included in this education was resident to resident behavior, resident to staff behavior, identifying aggressive behavior, implementation of a procedure to follow when there are aggressive behaviors and instructions on the completion of the Post Altercation Investigation (new tool to be used to investigate altercations and document actions for Quality Assurance) Beginning 4-8-12 the following actions will occur when a resident exhibits aggressive</p>	4-14-12

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{F 280}	Continued From page 13 the behavior identified met the criteria for a significant change, a significant change assessment was completed. Care plans and interventions were reviewed and revisions were made as indicated. All care plans and nurse aide care plans were updated if indicated. All reported behaviors were reviewed in the morning meetings. The care plan and interventions were reviewed to ensure the effectiveness of the interventions to determine if additional interventions were required.  Interview with the Administrator, on 04/12/12 at 2:45 PM, revealed in the future the facility was having staff from a psychiatric service to come in and inservice the staff on behaviors and interventions to address behaviors. She stated the Quality Assessment Committee was going to meet once a month to discuss aggressive behaviors, abuse and resident to resident altercations and follow up. She revealed the Medical Director will be assisting the facility with outside resources to assist the facility in coming up with new intervention.	F323	behavior towards another resident or staff. The resident will be removed from the situation with safety of residents and staff to be maintained, the nurse in charge is to notify the DON and/or Administrator of the behavior, the MD is to be notified and the family is to be notified. We will review the care plan and determine if there are measures to put in place that will allow the resident to remain in the facility until the resident behavior can be reviewed by DON, Administrator, Social Services or MD. Interventions may include increased supervision, a move to a private room, medication if ordered by MD, a private sitter or family at bedside. The DON, Administrator, Social Services or the residents MD will review the resident and the resident's behavior within 24 hours and determine if the resident presents an acute threat to self, or others. If the determination is that the resident is an acute threat to self or others, the resident will be transferred out of the facility and not re-admitted until it is determined that the resident is no longer an acute threat to self or others. If the determination is that the resident is not an acute threat to self or others, a care plan meeting will be held to review interventions that may be put in place to allow the resident to remain in the facility, these may include but are not limited to increased supervision, referral to psychiatric services, medication adjustments, behavioral modification interventions. The care plan will be reviewed along with the residents behavior daily for 5 days, then no less than weekly for 4 weeks to ensure the interventions in place are effective and the behavior is managed. After 4 weeks the care plan and resident behavior will be monitored monthly for 3 months by Social Services. A resident with ongoing aggressive behaviors that are not manageable in the facility will be given a Notice	4-14-12
{F 323} SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced			

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{F 323}	Continued From page 14 by: Based on interview, record review and Allegation of Compliance review, it was determined the Immediate Jeopardy (IJ), identified during the abbreviated survey completed on 03/23/12, had been removed related to supervision to prevent accidents; however, non-compliance continued to exist at a S/S of a "D," as the facility had not completed the Quality and Assessment and Assurance Committee initiative related to monitoring, analysis of monitoring, and the implementation of the Plan of Correction (PoC) to ensure resident supervision is provided to prevent accidents.  Findings Include:  Review of the acceptable AoC, dated 03/24/12, and record review revealed a private sitter was placed outside Resident #'s door twenty four hours a day and if the resident came out of the room, the private sitter supervised the resident at all times up till the resident's discharge on 03/23/12. The private sitter also redirected wandering residents from the resident's room. The private sitter was educated by the Administrator, Director of Nurse (DON) or Charge Nurse on the Abuse policy and Effective Coping with Challenging Behaviors. A Licensed nurse verified every two hours and signed a document that included time of visual check, staff member/private sitter present and nurse's signature that the private sitter assigned outside of the room or with Resident #2. All available licensed nurses were in-serviced by the DON or Administrator on 03/16/12 or 03/17/12 on the verification process. Unavailable staff was in-service prior to returning to work. All available	F323	of Discharge. All aggressive behaviors towards another resident or staff will require the facility to complete a Post Altercation Investigation.  #4 Monthly the QA Sub Committee will review behavior reports, reports of resident to resident altercations, and Post Altercation Investigations for physically aggressive behaviors and ensure that the above noted procedure is followed for each incident. Facility Quality Assurance Committee will meet on 4-9-12 to review the facility POC and to establish a QA subcommittee which will meet weekly for 4 weeks then monthly to monitor the implementation of the POC, including the education component and the ongoing audit component, they are to evaluate the effectiveness of the POC, if necessary provide additional education and request additional audits and report to the facility QA Committee no less than quarterly. This subcommittee will consist of DON, Director of Social Services, MDS Coordinator, a staff nurse and a CNA. The Corporate Consultant and Corporate Social Service Consultant will act as resources for this subcommittee and will report on the actions of the subcommittee to the facility QA committee and the VP of Operations for Elmcroft Senior Living.	4-14-12	

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(F 323)	Continued From page 15 staff was inserviced on 03/16/12 or 03/17/12 on Facility Abuse Policy and Effective Coping with Challenging Behaviors by the DON or Administrator. Licensed Nurses were instructed by the DON to run Group Behavior reports from the Care Tracker system daily to ensure that any behavior noted was reported and if any follow up was needed that the follow up occurred. The Social Service Director was educated on the Care Tracker system including the available reports, how to run the 24 hour group report and how to follow up on behaviors noted on the report, and her responsibility to follow up on any reported behaviors. On 03/17/12, a CareTracker Group Behavior Report was run for the past sixty days to identify all residents with reported behaviors. On that day Corporate Consultants reviewed the medical records and care plans for any resident on that report to identify any resident considered to be at risk for aggressive behavior toward other residents, and any identified behaviors were referred to facility staff and any identified potential behaviors were referred to the facility staff for review and revision of care plans. On 03/17/12, the DON reviewed all resident that wander for appropriate interventions on care plan to ensure safety needs were identified. Revisions were made as indicated. On 03/17/12, the Minimum Data Set (MDS) Coordinator and Social Services Director reviewed the MDS and Care Plans for all residents listed on the Caretracker Behavior Report who had behaviors in the last 60 days. If the behavior identified met the criteria for a significant change, a significant change assessment was completed. Care plans and interventions were reviewed and revisions were made as indicated. All care plans and nurse aide care plans were updated if indicated. All reported	F490	#1 Resident #2 has been discharged from the facility on 3-23-12.  #2 DON reviewed all reports of resident to resident altercations, 24 hour reports, and all incidents for past 30 days to ensure that there were no incidents of abuse, injuries of unknown origin or reports that would require the Abuse Protocol to be followed. This was completed by 4-8-12  On 3-17-12 a CareTracker Group Behavior Report was run for the past 60 days to identify all residents with reported behaviors. Corporate Consultants reviewed the medical records and care plans for any resident on that report to identify any resident considered to be at risk for aggressive behaviors towards other residents and any such identified behaviors were referred to the facility staff for review and revision of care plans. MDS Coordinator and Social Services Director reviewed the MDS and Care Plans, and nurse aide care plans for all residents listed on the CareTracker Group Behavior Report for the past 60 days on 3-17-12. The last MDS for each identified resident was reviewed as was the Behavior CAA if triggered. If the review indicated the need for a significant change assessment, one was scheduled. Corporate Social Service Consultant has since 3-17-12 been reviewing the behavior reports and reviewing nurses notes and social service notes for appropriate follow up related to behaviors. Social Services has been given direction regarding the follow up on behaviors by the Corporate Social Service Consultant.  On 3-17-12 a CareTracker Group Behavior Report was run for the past 60 days to identify all residents with reported behaviors. Corporate	4-14-12

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{F 323}	Continued From page 16 behaviors were reviewed in the morning meetings. The care plan and interventions were reviewed to ensure the effectiveness of the interventions to determine if additional interventions were required. Corporate Nursing Consultant educated the DON and Administrator on 03/17/12 on assessing and identifying possible risks, implementing interventions to manage behaviors and re-evaluation of interventions for protection of the residents. They were also educated on the proper completion of Incident Report and follow up investigation as indicated.  Interview with the Administrator, on 04/12/12 at 2:45 PM, revealed in the future the facility was having staff from a psychiatric service to come in and inservice the staff on behaviors and interventions to address behaviors. She stated the Quality Assessment Committee was going to meet once a month to discuss aggressive behaviors, abuse and resident to resident altercations and follow up. She revealed the Medical Director will be assisting the facility with outside resources to assist the facility in coming up with new interventions.	F490	Consultants reviewed the medical records and care plans for any resident on that report to identify any resident considered to be at risk for aggressive behaviors towards other residents and any such identified behaviors were referred to the facility staff for review and revision of care plans. MDS Coordinator and Social Services Director reviewed the MDS and Care Plans, and nurse aide care plans for all residents listed on the CareTracker Group Behavior Report for the past 60 days on 3-17-12. The last MDS for each identified resident was reviewed as was the Behavior CAA if triggered. If the review indicated the need for a significant change assessment, one was scheduled.  #3 All available staff were re-educated on the facility policy related to Abuse Prohibition on 3-18 and 3-17-12 by the DON, Administrator and Charge Nurse. All unavailable staff were re-educated prior to returning to work. All newly hired staff will be educated on the facility policy during orientation by Administrative Staff. Beginning on 4-2-12 and continuing as of 4-6-12 Corporate consultants and administrative staff have been doing one on one interviews with staff members to ensure their understanding of the policy on Abuse Prohibition. On 4-4-12 the facility Ombudsman presented an in-service on Resident to resident Altercation, reviewed the State and Federal Regulation related to Abuse and discussed the responsibility to keep all residents safe. The facility will repeat the in-service on the facility policy on Abuse Prohibition monthly for 3 months then quarterly and will ensure that all staff members attend the in-service no less than 2 more times over the next 12 months. This will be tracked by the DON. Corporate Consultant educated DON and Administrator	4-14-12	
(F 490) SS-D	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING  A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by:				

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NAME OF PROVIDER OR SUPPLIER  PROFESSIONAL CARE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347	
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(F 490)	<p>Continued From page 17</p> <p>Based on interview, record review and Allegation of Compliance review, it was determined the Immediate Jeopardy (IJ), identified during the abbreviated survey completed on 03/23/12, had been removed related to administering the facility in a manner that it enabled it to use its resources effectively; however, non-compliance continued to exist at a S/S of a "D," as the facility had not completed the Quality and Assessment and Assurance Committee Initiative related to monitoring, analysis of monitoring, and the implementation of the Plan of Correction (PoC) to ensure the facility was administered in a manner that it enabled it to use its resources effectively.</p> <p>Findings include:</p> <p>Review of the acceptable AoC, dated 03/24/12, and record review revealed a private sitter was placed outside Resident #2's door twenty four hours a day and if the resident came out of the room, the private sitter supervised the resident at all times until the resident's discharge on 03/23/12. The private sitter also redirected wandering residents from the resident's room. The private sitter was educated by the Administrator, Director of Nurse (DON) or Charge Nurse on the Abuse policy and Effective Coping with Challenging Behaviors. A Licensed nurse verified every two hours and signed a document that included time of visual check, staff member/private sitter present and nurse's signature that the private sitter assigned outside of the room or with Resident #2. All available licensed nurses were in-service by the DON or Administrator on 03/16/12 or 03/17/12 on the verification process. Unavailable staff was in-service prior to returning to work. All available</p>	F490	<p>on 3-17-12 on assessing and identifying possible risks related to behaviors, implementing interventions to manage behaviors, and re-evaluation of interventions for protection of residents, they were also educated on the proper completion of an Incident Report and follow up investigations. DON and Administrator were re-educated on identifying signs of abuse, investigating allegations of abuse, reporting requirements related to abuse, State and Federal Regulations related to Abuse reporting, including reporting reasonable suspicion of a crime in a long term care facility on 4-9-12 by a Corporate Consultant. Staff in-service by Corporate Social Service Consultant on 4-4-12 on Behaviors, in-service included determining the impact of behaviors on other, identifying behaviors, investigating behaviors and putting interventions in place to manage behaviors. CareTracker 24 hour group behavior report will be reviewed daily to ensure reported behaviors are investigated and acted on appropriately. This report will be run by licensed staff on first shift. All reports of Resident to Resident altercations, reports of injuries of unknown origin and reports of suspected abuse will be reviewed by administrative staff in the morning meeting to ensure the Abuse Prohibition Policy has been followed, all appropriate notifications have been made and that the safety of all residents is ensured. Social Service Director was educated on the Care Tracker system including available reports, how to run the 24 Hour Group Behavior Report and how to follow up on any reported behaviors. The education provided also covered using the RAI process to identify any factors that may lead to behaviors, identifying patterns of behaviors, and the importance of having a careplan with appropriate interventions and evaluation of the</p>	4-14-12

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{F 490}	Continued From page 18 staff was inserviced on 03/16/12 or 03/17/12 on Facility Abuse Policy and Effective Coping with Challenging Behaviors by the DON or Administrator. Licensed Nurses were instructed by the DON to run Group Behavior reports from the Care Tracker system daily to ensure that any behavior noted was reported and if any follow up was needed that the follow up occurred. On 03/17/12, the Social Service Director was educated on the Care Tracker system including the available reports, how to run the 24 hour group report and how to follow up on behaviors noted on the report, and her responsibility to follow up on any reported behaviors. On 03/17/12, a CareTracker Group Behavior Report was run for the past sixty days to identify all residents with reported behaviors. On that day Corporate Consultants reviewed the medical records and care plans for any resident on that report to identify any resident considered to be at risk for aggressive behavior toward other residents, and any identified behaviors were referred to facility staff and any identified potential behaviors were referred to the facility staff for review and revision of care plans. On 03/17/12, the DON reviewed all resident that wander for appropriate interventions on care plan to ensure safety needs were identified. Revisions were made as indicated. On 03/17/12, the Minimum Data Set (MDS) Coordinator and Social Services Director reviewed the MDS and Care Plans for all residents listed on the Caretracker Behavior Report who had behaviors in the last 60 days. If the behavior identified met the criteria for a significant change, a significant change assessment was completed. Care plans and interventions were reviewed and revisions were made as indicated. All care plans and nurse aide	{F 490}	interventions. This education was provided by a Corporate Consultant on 3-17-12. On 4-2-12 Corporate Consultant provided education to the IDT team, which included the Director of Social Services, on the Resident Assessment Instrument (RAI)-purpose, 3 basic components: The minimum data data set (MDS) the assessment part, Care Area Triggers (CATS), Care Area Assessment (CAA) process and Utilization guidelines. Including that the CAT requires additional investigation, CAA resources, summary to develop individualized care plan, to attain or maintain resident highest practicable physical, mental, and psychosocial well-being. Also covered Assessment, Decision making, Care Plan, Implementation & Evaluation. Following the education the IDT team reviewed all care plans to ensure that they were appropriate, current and individualized for each resident. These reviews were completed by 4-6-12. Beginning 4-6-12 the Corporate Social Service Consultant or Director of Social Services will be reviewing the 24 Hour Behavior Report and provide follow up to the residents whose behavior was not alterable to ensure that any identified behavior is assessed, investigated, and appropriate care plans are initiated.  On 4-2-12 Corporate Clinical Consultant provided education to the IDT team, which included the Director of Social Services, on the Resident Assessment Instrument (RAI)-purpose, 3 basic components: The minimum data data set (MDS) the assessment part, Care Area Triggers (CATS), Care Area Assessment (CAA) process and Utilization guidelines. Including that the CAT requires additional investigation, CAA resources, summary to develop individualized care plan, to attain or maintain resident highest practicable	4-14-12	

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(F 490)	Continued From page 19 care plans were updated if indicated. All reported behaviors were reviewed in the morning meetings. The care plan and interventions were reviewed to ensure the effectiveness of the interventions to determine if additional interventions were required. Corporate Nursing Consultant educated the DON and Administrator on 03/17/12 on assessing and identifying possible risks, implementing interventions to manage behaviors and re-evaluation of interventions for protection of the residents. They were also educated on the proper completion of Incident Report and follow up investigation as indicated.  Interview with the Administrator, on 04/12/12 at 2:45 PM, revealed in the future the facility was having staff from a psychiatric service to come in and inservice the staff on behaviors and interventions to address behaviors. She stated the Quality Assessment Committee was going to meet once a month to discuss aggressive behaviors, abuse and resident to resident altercations and follow up. She revealed the Medical Director will be assisting the facility with outside resources to assist the facility in coming up with new intervention.	(F 490)	physical, mental, and psychosocial well-being. Also covered Assessment, Decision making, Care Plan, Implementation & Evaluation. Following the education the IDT team reviewed all careplans to ensure that they were appropriate, current and individualized for each resident. These reviews were completed by 4-6-12. On 4-4-12 Corporate Consultant and DON presented education to the Licensed staff on their role and responsibility for updating and revising care plans.  All available staff were re-educated on the facility policy related to Abuse Prohibition on 3-16 and 3-17-12 by the DON, Administrator and Charge Nurse. All unavailable staff were re-educated prior to returning to work. All newly hired staff will be educated on the facility policy during orientation by Administrative Staff. Beginning on 4-2-12 and continuing as of 4-8-12 Corporate consultants and administrative staff have been doing one on one interviews with staff members to ensure their understanding of the policy on Abuse Prohibition. On 4-4-12 the facility Ombudsman presented an in-service on Resident to resident Altercation, reviewed the State and Federal Regulation related to Abuse and discussed the responsibility to keep all residents safe. The facility will repeat the in-service on the facility policy on Abuse Prohibition monthly for 3 months then quarterly and will ensure that all staff members attend the in-service no less than 2 more times over the next 12 months. This will be tracked by the DON. Corporate Consultant educated DON and Administrator on 3-17-12 on assessing and identifying possible risks related to behaviors, implementing interventions to manage behaviors, and re-evaluation of interventions for protection of residents, they were also	4-14-12
(F 520) SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.  The quality assessment and assurance			

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{F 520}	<p>Continued From page 20</p> <p>committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and Allegation of Compliance review, it was determined the Immediate Jeopardy (IJ), identified during the abbreviated survey completed on 03/23/12, had been removed related to not having an effective quality assessment and assurance committee; however, non-compliance continued to exist at a S/S of a "D," as the facility had not completed the Quality Assessment and Assurance Committee initiative related to monitoring, analysis of monitoring, and the implementation of the Plan of Correction (PoC) to ensure the facility's Quality Assessment and Assurance Committee was effective.</p> <p>Findings include:</p> <p>Review of the acceptable AoC, dated 03/24/12, and record review revealed a private sitter was</p>	F490	<p>educated on the proper completion of an Incident Report and follow up investigations. DON and Administrator were re-educated on identifying signs of abuse, investigating allegations of abuse, reporting requirements related to abuse, State and Federal Regulations related to Abuse reporting, including reporting reasonable suspicion of a crime in a long term care facility on 4-9-12 by the Corporate Clinical Consultant for Elmcroft Senior Living. Staff in-service by Corporate Social Service Consultant on 4-4-12 on Behaviors, in-service included determining the impact of behaviors on other, identifying behaviors, investigating behaviors and putting interventions in place to manage behaviors. CareTracker 24 hour group behavior report will be reviewed daily to ensure reported behaviors are investigated and acted on appropriately. This report will be run by licensed staff on first shift. All reports of Resident to Resident altercations, reports of injuries of unknown origin and reports of suspected abuse will be reviewed by administrative staff in the morning meeting to ensure the Abuse Prohibition Policy has been followed, all appropriate notifications have been made and that the safety of all residents is ensured. On 4-4-12 DON and Corporate Consultant, Administrator and VP of Operations for Elmcroft Senior Living re-educated licensed staff on managing aggressive behavior by residents. Included in this education was resident to resident behavior, resident to staff behavior, identifying aggressive behavior, implementation of a procedure to follow when there are aggressive behaviors and instructions on the completion of the Post Altercation Investigation ( new tool to be used to investigate altercations and document actions for Quality Assurance) Beginning 4-6-12 the following actions will</p>	4-14-12

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{F 520}	Continued From page 21 placed outside Resident #'s door twenty four hours a day and if the resident came out of the room, the private sitter supervised the resident at all times up till the resident's discharge on 03/23/12. The private sitter also redirected wandering residents from the resident's room. The private sitter was educated by the Administrator, Director of Nurse (DON) or Charge Nurse on the Abuse policy and Effective Coping with Challenging Behaviors. A Licensed nurse verified every two hours and signed a document that included time of visual check, staff member/private sitter present and nurse's signature that the private sitter assigned outside of the room or with Resident #2. All available licensed nurses were in-serviced by the DON or Administrator on 03/16/12 or 03/17/12 on the verification process. Unavailable staff was in-service prior to returning to work. All available staff was in-serviced on 03/16/12 or 03/17/12 on Facility Abuse Policy and Effective Coping with Challenging Behaviors by the DON or Administrator. Licensed Nurses were instructed by the DON to run Group Behavior reports from the Care Tracker system daily to ensure that any behavior noted was reported and if any follow up was needed that the follow up occurred. The Social Service Director was educated on the Care Tracker system including the available reports, how to run the 24 hour group report and how to follow up on behaviors noted on the report, and her responsibility to follow up on any reported behaviors. On 03/17/12, a CareTracker Group Behavior Report was run for the past sixty days to identify all residents with reported behaviors. On that day Corporate Consultants reviewed the medical records and care plans for any resident on that report to identify any resident considered	F490	occur when a resident exhibits aggressive behavior towards another resident or staff. The resident will be removed from the situation with safety of residents and staff to be maintained, the nurse in charge is to notify the DON and Administrator of the behavior, the MD is to be notified and the family is to be notified. We will review the care plan and determine if there are measures to put in place that will allow the resident to remain in the facility until the resident behavior can be reviewed by DON, Administrator, Social Services or MD. Interventions may include increased supervision, a move to a private room, medication if ordered by MD, a private sitter or family at bedside. The DON, Administrator, Social Services or the residents MD will review the resident and the resident's behavior within 24 hours and determine if the resident presents an acute threat to self, or others. If the determination is that the resident is an acute threat to self or others, the resident will be transferred out of the facility and not re-admitted until it is determined that the resident is no longer an acute threat to self or others. If the determination is that the resident is not an acute threat to self or others, a care plan meeting will be held to review interventions that may be put in place to allow the resident to remain in the facility, these may include but are not limited to increased supervision, referral to psychiatric services, medication adjustments, behavioral modification interventions. The care plan will be reviewed along with the residents behavior daily for 5 days, then no less than weekly for 4 weeks to ensure the interventions in place are effective and the behavior is managed. After 4 weeks the care plan and resident behavior will be monitored monthly for 3 months by Social Services. A resident with ongoing aggressive behaviors that are not	4-14-12	

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(F 520)	<p>Continued From page 22</p> <p>to be at risk for aggressive behavior toward other residents, and any identified behaviors were referred to facility staff and any identified potential behaviors were referred to the facility staff for review and revision of care plans. On 03/17/12, the DON reviewed all resident that wander for appropriate interventions on care plan to ensure safety needs were identified. Revisions were made as indicated. On 03/17/12, the Minimum Data Set (MDS) Coordinator and Social Services Director reviewed the MDS and Care Plans for all residents listed on the Caretracker Behavior Report who had behaviors in the last 60 days. If the behavior identified met the criteria for a significant change, a significant change assessment was completed. Care plans and interventions were reviewed and revisions were made as indicated. All care plans and nurse aide care plans were updated if indicated. All reported behaviors were reviewed in the morning meetings. The care plan and interventions were reviewed to ensure the effectiveness of the interventions to determine if additional interventions were required. Corporate Nursing Consultant educated the DON and Administrator on 03/17/12 on assessing and identifying possible risks, implementing interventions to manage behaviors and re-evaluation of interventions for protection of the residents. They were also educated on the proper completion of Incident Report and follow up investigation as indicated.</p> <p>Interview with the Administrator, on 04/12/12 at 2:45 PM, revealed in the future the facility was having staff from a psychiatric service to come in and inservice the staff on behaviors and interventions to address behaviors. She stated the Quality Assessment Committee was going to</p>	F490	<p>manageable in the facility will be given a Notice of Discharge. All aggressive behaviors towards another resident or staff will require the facility to complete a Post Altercation Investigation.</p> <p>#4. Facility Quality Assurance Committee will meet on 4-9-12 to review the facility POC and to establish a QA subcommittee which will meet weekly for 4 weeks then monthly to monitor the implementation of the POC. Including the education component and the ongoing audit component, they are to evaluate the effectiveness of the POC, if necessary provide additional education and request additional audits and report to the facility QA Committee no less than quarterly. This subcommittee will consist of DON, Director of Social Services, MDS Coordinator, a staff nurse and a CNA. The Corporate Consultant and Corporate Social Services Consultant will act as resources for this subcommittee and will report on the actions of the subcommittee to the facility QA committee and the VP of Operations for Elmcroft Senior Living. DON and Corporate Consultant will review all reports of Resident to Resident Altercations, reports of Injury of unknown origin and any report of suspected Abuse monthly to ensure that the Abuse Prohibition Policy is followed if indicated. Results of these reviews will be presented to the QA Sub Committee. Corporate Consultant or Corporate Social Services Consultant will review no less than 25% of all Behavior CAA's, and behavior care plans each month for 4 months to ensure appropriate completion of the CAA, and appropriate care planning. Results of the audit will be used for re-education of the Director of Social Services on the CAA. Monthly, the QA Sub Committee will review behavior reports, reports of resident to resident altercations, and Post Altercation Investigations</p>	4-14-12	

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(F 520)	Continued From page 23 meet once a month to discuss aggressive behaviors, abuse and resident to resident altercations and follow up. She revealed the Medical Director will be assisting the facility with outside resources to assist the facility in coming up with new intervention.	F490	for physically aggressive behaviors and ensure that the above noted procedure is followed for each incident.	4-14-12	

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{F 520}		F520	<p>#1 Resident #2 has been discharged from the facility on 3-23-12.</p> <p>#2 DON reviewed all reports of resident to resident altercations, 24 hour reports, and all incidents for past 30 days to ensure that there were no incidents of abuse, injuries of unknown origin or reports that would require the Abuse Protocol to be followed. This was completed by 4-6-12.</p> <p>On 3-17-12 a CareTracker Group Behavior Report was run for the past 60 days to identify all residents with reported behaviors. Corporate Consultants reviewed the medical records and care plans for any resident on that report to identify any resident considered to be at risk for aggressive behaviors towards other residents and any such identified behaviors were referred to the facility staff for review and revision of care plans. MDS Coordinator and Social Services Director reviewed the MDS and Care Plans, and nurse aide care plans for all residents listed on the CareTracker Group Behavior Report for the past 60 days on 3-17-12. The last MDS for each identified resident was reviewed as was the Behavior CAA if triggered. If the review indicated the need for a significant change assessment, one was scheduled. Corporate Social Service Consultant has since 3-17-12 been reviewing the behavior reports and reviewing nurses notes and social service notes for appropriate follow up related to behaviors. Social Services has been given direction regarding the follow up on behaviors by the Corporate Social Service Consultant.</p> <p>On 3-17-12 a CareTracker Group Behavior Report was run for the past 60 days to identify all residents with reported behaviors. Corporate</p>	4-14-12	

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{ F 520 }		F520	<p>Consultants reviewed the medical records and care plans for any resident on that report to identify any resident considered to be at risk for aggressive behaviors towards other residents and any such identified behaviors were referred to the facility staff for review and revision of care plans. MDS Coordinator and Social Services Director reviewed the MDS and Care Plans, and nurse aide care plans for all residents listed on the CareTracker Group Behavior Report for the past 60 days on 3-17-12. The last MDS for each identified resident was reviewed as was the Behavior CAA if triggered. If the review indicated the need for a significant change assessment, one was scheduled.</p> <p>#3 All available staff were re-educated on the facility policy related to Abuse Prohibition on 3-16 and 3-17-12 by the DON, Administrator and Charge Nurse. All unavailable staff were re-educated prior to returning to work. All newly hired staff will be educated on the facility policy during orientation by Administrative Staff. Beginning on 4-2-12 and continuing as of 4-6-12 Corporate consultants and administrative staff have been doing one on one interviews with staff members to ensure their understanding of the policy on Abuse Prohibition. On 4-4-12 the facility Ombudsman presented an in-service on Resident to resident Altercation, reviewed the State and Federal Regulation related to Abuse and discussed the responsibility to keep all residents safe. The facility will repeat the in-service on the facility policy on Abuse Prohibition monthly for 3 months then quarterly and will ensure that all staff members attend the in-service no less than 2 more times over the next 12 months. This will be tracked by the DON. Corporate Consultant educated DON and Administrator</p>	4-14-12	

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{F 520}		F520	<p>on 3-17-12 on assessing and identifying possible risks related to behaviors, implementing interventions to manage behaviors, and re-evaluation of interventions for protection of residents, they were also educated on the proper completion of an Incident Report and follow up investigations. DON and Administrator were re-educated on identifying signs of abuse, investigating allegations of abuse, reporting requirements related to abuse, State and Federal Regulations related to Abuse reporting, including reporting reasonable suspicion of a crime in a long term care facility on 4-9-12 by a Corporate Consultant. Staff in-service by Corporate Social Service Consultant on 4-4-12 on Behaviors, in-service included determining the impact of behaviors on other, identifying behaviors, investigating behaviors and putting interventions in place to manage behaviors. CareTracker 24 hour group behavior report will be reviewed daily to ensure reported behaviors are investigated and acted on appropriately. This report will be run by licensed staff on first shift. All reports of Resident to Resident altercations, reports of Injuries of unknown origin and reports of suspected abuse will be reviewed by administrative staff in the morning meeting to ensure the Abuse Prohibition Policy has been followed, all appropriate notifications have been made and that the safety of all residents is ensured. Social Service Director was educated on the Care Tracker system including available reports, how to run the 24 Hour Group Behavior Report and how to follow up on any reported behaviors. The education provided also covered using the RAI process to identify any factors that may lead to behaviors, identifying patterns of behaviors, and the importance of having a careplan with appropriate interventions and evaluation of the</p>	4-14-12	

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{F 520}		F520	<p>Interventions. This education was provided by a Corporate Consultant on 3-17-12. On 4-2-12 Corporate Consultant provided education to the IDT team, which included the Director of Social Services, on the Resident Assessment Instrument (RAI)-purpose, 3 basic components: The minimum data data set (MDS) the assessment part, Care Area Triggers (CAT'S), Care Area Assessment (CAA) process and Utilization guidelines. Including that the CAT requires additional investigation, CAA resources, summary to develop individualized care plan, to attain or maintain resident highest practicable physical, mental, and psychosocial well-being. Also covered Assessment, Decision making, Care Plan, Implementation &amp; Evaluation. Following the education the IDT team reviewed all care plans to ensure that they were appropriate, current and individualized for each resident. These reviews were completed by 4-6-12. Beginning 4-6-12 the Corporate Social Service Consultant or Director of Social Services will be reviewing the 24 Hour Behavior Report and provide follow up to the residents whose behavior was not alterable to ensure that any identified behavior is assessed, investigated, and appropriate care plans are initiated.</p> <p>On 4-2-12 Corporate Consultant provided education to the IDT team, which included the Director of Social Services, on the Resident Assessment Instrument (RAI)-purpose, 3 basic components: The minimum data data set (MDS) the assessment part, Care Area Triggers (CAT'S), Care Area Assessment (CAA) process and Utilization guidelines. Including that the CAT requires additional investigation, CAA resources, summary to develop individualized care plan, to attain or maintain resident highest practicable physical,</p>	4-14-12

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(F 520)		F520	<p>mental, and psychosocial well-being. Also covered Assessment, Decision making, Care Plan, Implementation &amp; Evaluation. Following the education the IDT team reviewed all careplans to ensure that they were appropriate, current and individualized for each resident. These reviews were completed by 4-8-12. On 4-4-12 Corporate Consultant and DON presented education to the Licensed staff on their role and responsibility for updating and revising care plans.</p> <p>All available staff were re-educated on the facility policy related to Abuse Prohibition on 3-16 and 3-17-12 by the DON, Administrator and Charge Nurse. All unavailable staff were re-educated prior to returning to work. All newly hired staff will be educated on the facility policy during orientation by Administrative Staff. Beginning on 4-2-12 and continuing as of 4-8-12 Corporate consultants and administrative staff have been doing one on one interviews with staff members to ensure their understanding of the policy on Abuse Prohibition. On 4-4-12 the facility Ombudsman presented an in-service on Resident to resident Altercation, reviewed the State and Federal Regulation related to Abuse and discussed the responsibility to keep all residents safe. The facility will repeat the in-service on the facility policy on Abuse Prohibition monthly for 3 months then quarterly and will ensure that all staff members attend the in-service no less than 2 more times over the next 12 months. This will be tracked by the DON. Corporate Consultant educated DON and Administrator on 3-17-12 on assessing and identifying possible risks related to behaviors, implementing interventions to manage behaviors, and re-evaluation of interventions for protection of residents, they were also</p>	4-14-12	

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[F 520]		F520	<p>educated on the proper completion of an Incident Report and follow up investigations. DON and Administrator were re-educated on identifying signs of abuse, investigating allegations of abuse, reporting requirements related to abuse, State and Federal Regulations related to Abuse reporting, including reporting reasonable suspicion of a crime in a long term care facility on 4-9-12 by the Corporate Clinical Consultant for Elmcroft Senior Living. Staff in-service by Corporate Social Service Consultant on 4-4-12 on Behaviors, in-service included determining the impact of behaviors on other, identifying behaviors, investigating behaviors and putting interventions in place to manage behaviors. CareTracker 24 hour group behavior report will be reviewed daily to ensure reported behaviors are investigated and acted on appropriately. This report will be run by licensed staff on first shift. All reports of Resident to Resident altercations, reports of injuries of unknown origin and reports of suspected abuse will be reviewed by administrative staff in the morning meeting to ensure the Abuse Prohibition Policy has been followed, all appropriate notifications have been made and that the safety of all residents is ensured. On 4-4-12 DON and Corporate Consultant, Administrator and VP of Operations for Elmcroft Senior Living re-educated licensed staff on managing aggressive behavior by residents. Included in this education was resident to resident behavior, resident to staff behavior, identifying aggressive behavior, implementation of a procedure to follow when there are aggressive behaviors and instructions on the completion of the Post Altercation Investigation ( new tool to be used to investigate altercations and document actions for Quality Assurance) Beginning 4-8-12 the following actions will</p>	4-14-12	

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(F 520)		F520	<p>occur when a resident exhibits aggressive behavior towards another resident or staff. The resident will be removed from the situation with safety of residents and staff to be maintained, the nurse in charge is to notify the DON and Administrator of the behavior, the MD is to be notified and the family is to be notified. We will review the care plan and determine if there are measures to put in place that will allow the resident to remain in the facility until the resident behavior can be reviewed by DON, Administrator, Social Services or MD. Interventions may include increased supervision, a move to a private room, medication if ordered by MD, a private sitter or family art bedside. The DON, Administrator, Social Services or the residents MD will review the resident and the resident's behavior within 24 hours and determine if the resident presents an acute threat to self, or others. If the determination is that the resident is an acute threat to self or others, the resident will be transferred out of the facility and not re-admitted until it is determined that the resident is no longer an acute threat to self or others. If the determination is that the resident is not an acute threat to self or others, a care plan meeting will be held to review interventions that may be put in place to allow the resident to remain in the facility, these may include but are not limited to increased supervision, referral to psychiatric services, medication adjustments, behavioral modification interventions. The care plan will be reviewed along with the residents behavior daily for 5 days, then no less than weekly for 4 weeks to ensure the interventions in place are effective and the behavior is managed. After 4 weeks the care plan and resident behavior will be monitored monthly for 3 months by Social Services. A resident with ongoing aggressive behaviors that are not</p>	4-14-12	

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{F 520}		F520	<p>manageable in the facility will be given a Notice of Discharge. All aggressive behaviors towards another resident or staff will require the facility to complete a Post Altercation Investigation.</p> <p>#4 . Facility Quality Assurance Committee will meet on 4-9-12 to review the facility POC and to establish a QA subcommittee which will meet weekly for 4 weeks then monthly to monitor the implementation of the POC, including the education component and the ongoing audit component, they are to evaluate the effectiveness of the POC, if necessary provide additional education and request additional audits and report to the facility QA Committee no less than quarterly. This subcommittee will consist of DON, Director of Social Services, MDS Coordinator, a staff nurse and a CNA. The Corporate Consultant and Corporate Social Service Consultant will act as resources for this subcommittee and will report on the actions of the subcommittee to the facility QA committee and the VP of Operations for Elmcrest Senior Living. DON and Corporate Consultant will review all reports of Resident to Resident Altercations, reports of injury of unknown origin and any report of suspected Abuse monthly to ensure that the Abuse Prohibition Policy is followed if indicated. Results of these reviews will be presented to the QA Sub Committee. Corporate Consultant or Corporate Social Services Consultant will review no less than 25% of all Behavior CAA's, and behavior care plans each month for 4 months to ensure appropriate completion of the CAA, and appropriate care planning. Results of the audit will be used for re-education of the Director of Social Services on the CAA. Monthly the QA Sub Committee will review behavior reports, reports of resident to resident altercations, and Post Altercation Investigations</p>	4-14-12

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{F 520}		F520	for physically aggressive behaviors and ensure that the above noted procedure is followed for each incident.	4-14-12