

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

PRINTED: 10/06/2010  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185089	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/22/2010
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NAME OF PROVIDER OR SUPPLIER  ROSEWOOD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101
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F 000	INITIAL COMMENTS  An abbreviated survey (KY#15337) was conducted on 09/16/10 through 09/21/10 to determine the facility's compliance with Federal requirements. Based on findings of the abbreviated survey, Immediate Jeopardy was identified at 483.20 at F280, at 483.25 at F323, and at 483.75 at F490 and F514 at a Scope & Severity of a "K", and Substandard Quality of Care (SQC) was identified at 483.25 at F323. The Immediate Jeopardy was identified on 09/21/10 and found to have existed on 09/01/10 and was on-going. The facility was notified on the determination of Immediate Jeopardy and SQC on 09/21/10. On 09/21/10 and 09/22/10, a partial extended survey was conducted and the facility provided an acceptable Allegation of Compliance, prior to exit. On 09/22/10, the SA investigated and determined the Immediate Jeopardy was removed, effective 09/22/10. The facility remained out of compliance with highest S/S at a "D".	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F 280 SS=K	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	F 280	F280 The care plan for resident #1 was updated to reflect a problem of at risk for Choking - Possible Aspiration and no safety awareness, grabs for other residents' food, with interventions to include, but not limited to: encourage dining room attendance each meal and sit resident with others receiving same texture diet; supervise all po intake and meal times: feed by staff with small spoon; notify nurse of any abnormal behavior; be attentive to resident when reaching.  The care plan for Resident #4 was revised to reflect a problem of Inappropriate behaviors, grabbing at items on dining room tables including food, interventions include, but not	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Kathy Skapp* TITLE *Executive Director* (X6) DATE *10/14/10*

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 280	<p>Continued From page 1</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility failed to revise the care plans for five residents (#1, #4, #5, #6 and #7) in the selected sample of five. Interviews with staff revealed the residents had behaviors of grabbing food from dining room tables and other residents' trays, that was not the right consistency food for these residents. The residents' care plans were not revised to address the residents' behaviors of grabbing food/drinks and the need for adequate monitoring and supervision to prevent choking.</p> <p>On 09/01/10, staff placed bread (regular consistency) at the table accessible to Resident #1. Staff did not provide supervision to ensure Resident #1 did not gain access to the bread despite having knowledge of this resident's history of attempts to obtain food of a different consistency. Staff observed Resident #1 with bread in his/her hand and removed it; however, the resident began to choke. Staff initiated the Heimlich Maneuver; however, this method was not successful. The resident stopped breathing and had no pulse. Emergency Medical Services had to insert a Laryngoscope (instrument inserted into the airway to provide visual access) into the resident's throat to remove the bread with forceps. The resident was sent out to the</p>	F 280	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>limited to: place at table with residents with same diet; table cloth and center piece will be removed; staff to monitor during meals/activities; will not be seated within reach of other residents' food at meals; Psych services as indicated and notify nurse of new abnormal behaviors.</p> <p>The care plan for Resident #5 was revised to reflect a problem of inappropriate behaviors, grabbing objects and food on dining room table. Interventions include: sit at table with others of same diet, provide assistance with needs and have snacks available to offer when hungry; remove objects from table/tablecloth, notify nurse of any new abnormal behaviors.</p> <p>The care plan for Resident #6 was revised to reflect a problem of Repetitive Movements, Oral Fixation, history of taking food from others rooms or trays and over eating. Interventions include: monitor PO intake; if stops feeding self at meals staff to assist; remind resident to slow down if eating too fast; sit out of arms reach of other trays; notify nurse of any new abnormal behaviors;</p> <p>Care plan for resident #7 was revised to show problem of socially inappropriate behaviors; unable to tell the difference between edible and non-edible items at</p>		

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F 280	<p>Continued From page 2 hospital.</p> <p>The facility's failure to revise the care plans related to the residents' behaviors of grabbing food/drinks that was not the right consistency to ensure adequate monitoring/supervision was provided for these residents resulted in a situation that caused and was likely to cause serious injury, harm, impairment or death to a resident, at risk for choking. Immediate Jeopardy was identified on 09/21/10 and found to exist on 09/01/10 and was ongoing. The facility was notified on 09/21/10. Findings include:</p> <p>1. Record review revealed Resident #1 was admitted to the facility with diagnoses to include Dementia, Diabetes Mellitis and Cerebral Vascular Accident.</p> <p>A review of the comprehensive care plan for Alteration in Nutrition/Hydration related to swallowing and chewing problems and risk of aspiration pneumonia, dated 06/15/10, revealed interventions that staff would totally assist with meals, feed per staff 1/2 teaspoon at a time, remind the resident to clear his/her throat in between bites, and follow each bite with honey thick liquids with a spoon.</p> <p>Interviews with the Activity Director on 09/17/10 at 3:50 PM, Registered Nurse (RN) #1 on 09/17/10 at 2:40 PM, RN #2 on 09/16/10 at 2:40 PM, Licensed Practical Nurse (LPN) #1 on 09/16/10 at 5:20 PM, LPN #2 on 09/17/10 at 1:40 PM, LPN #3 on 09/20/10 at 10:55 AM, LPN #4 on 09/17/10 at 3:00 PM, Certified Nurse Aide (CNA) #1 on 09/16/10 at 2:55 PM, CNA #2 on 09/16/10 at 3:20 PM, CNA #3 on 09/16/10 at 3:10 PM, CNA #4 on 09/16/10 at 3:10 PM, CNA #5 on 09/16/10 at</p>	F 280	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>times; history of taking others food from tray. Interventions include: place resident at table with no centerpiece; staff to monitor during meals; do not seat resident within reach of others' food at meals.</p> <p>To identify/validate other residents possibly affected, medical records of all residents receiving mechanically altered diets were reviewed, on 9/19/10 by the Director of Nursing (DNS), Unit Managers (UM), Registered Dietician (RD) and Asst. Dietary Services Manager. In addition, staff interviews were conducted through the in-service offerings, initiated on 9/17/10 by the DNS, UM and Weekend Supervisor (WS), to identify residents with unreported behaviors. Care plans, SRNA assignment sheets have been revised, as indicated, to reflect identified behaviors and interventions. To ensure the safety of all mobile residents on mechanically altered diets with behaviors, all direct care staff, licensed nurses, and SRNAs have been in-serviced to report any and all behaviors, to include wandering or reaching for objects, to include food. Licensed nurses were educated on P&amp;P documentation requirements, via staff in-services. Information related to reporting of behaviors, adequate resident supervision and seating arrangements in dining were also included in staff in-services. In-services</p>

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F 280	<p>Continued From page 3</p> <p>5:05 PM, CNA #6 on 09/16/10 at 5:15 PM, CNA #7 on 09/16/10 at 5:35 PM, CNA #8 on 09/16/10 at 5:50 PM, CNA #9 on 09/16/10 at 2:40 PM and CNA #10 on 09/16/10 at 4:05 PM, revealed Resident #1 had behaviors of grabbing food and/or fluids off of residents' trays and from the dining room table prior to 09/01/10. The staff stated they immediately took the food/fluid away from the resident. The staff revealed they tried to keep an eye on the resident because of the resident's behaviors of grabbing food and drinks from tables and other residents' trays. They stated everyone was aware that Resident #1 had this behavior because the resident did it all the time. However, review of the Comprehensive Care Plan revealed there was no revision to the care plan to address the resident's behavior of grabbing other resident's food off the trays or from the table.</p> <p>Interviews on 09/17/10 at 3:00 PM and on 09/20/10 at 10:50 AM, with the Minimum Data Set (MDS) Supervisor, RN Supervisor and Social Worker #1 (who participated in the resident's care plan meetings), revealed they were not aware Resident #1 had behaviors of grabbing food from the table and other residents' trays. They stated the behavior should have been documented in the record or brought up by staff in the care plan meeting so the behavior could have been addressed in the resident's care plan.</p> <p>A record review to include nurse's notes, behavior assessments and behavior logs revealed there was no documentation Resident #1 had behaviors of grabbing food/drinks from the table or other residents' trays.</p> <p>Interviews with RN #3 on 09/17/10 at 10:40 AM,</p>	F 280	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>were conducted by the DNS, WS &amp; UMs beginning on 9/17/10. Staff will not be allowed to work until attending all appropriate in-services.</p> <p>Investigative in-servicing was completed for administrative staff on 9/18/10 by the District Director of Operation and District Director of Clinical Operations. In-service content included Documentation of Resident Health Status, Needs and Services; Documenting in a Resident's Medical Record; 24-Hour Report and Investigative Protocol. Systemic changes also included implementation of a Dining Room Seating Assignment Chart and meal supervision log. The DNS, UMS and WS initiated in-servicing to all direct care staff, to include licensed nurses and SRNAs on 9/17/10. In-service content included Care plans and Care plan Meeting and Assigned Seating Designations. In addition, all direct care staff, including Activities, were educated on the Dining Room Seating Assignment Chart and on how the chart was designed. All staff were educated that activity seating groups will be designated based on resident attendance and assessments. In-service information will be included in all new hire orientation.</p> <p>Each meal service will be monitored by a licensed nurse for the duration of the meal.</p>	

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F 280	<p>Continued From page 4</p> <p>LPN #5 on 09/17/10 at 10:20 AM, LPN #6 on 09/16/10 at 3:40 PM, CNA #1 on 09/16/10 at 2:55 PM, CNA #2 on 09/16/10 at 3:20 PM, CNA #3 on 09/16/10 at 3:10 PM, CNA #4 on 09/16/10 at 3:10 PM, CNA #9 on 09/16/10 at 2:40 PM and CNA #10 on 09/16/10 at 4:05 PM, revealed Resident #1 was seated at a table on the third row in the dining room with other residents for the noon meal on 09/01/10. The staff had placed sliced fresh baked bread on saucers and passed it out to the residents who were on regular diets. The staff revealed they started passing out trays to the residents at the first row of tables. CNA #9 revealed as she turned around to pass a tray, she observed Resident #1 with a slice of bread in his/her hand. CNA #9 stated Resident #1 had taken the bread from a resident sitting at the table with him/her. CNA #9 stated she walked over to the resident and removed the bread from his/her hand and from the table. She resumed passing out trays. The staff revealed the next thing they knew CNA #4 shouted Resident #1 was turning blue. The staff stated they immediately called a Code, grabbed a crash cart and lowered the resident to the floor. The licensed staff responded to the code and attempted the Heimlich Maneuver with finger sweeps three times with no success. They stated the resident was not breathing and they could not detect a pulse. EMS was called and Cardiopulmonary Resuscitation (CPR) was started. A review of the EMS report, dated 9/01/10, revealed a Laryngoscope was inserted into the resident's throat and the lodged bread was removed with forceps. The resident's pulse and breathing returned. The resident was sent out to the hospital.</p> <p>An interview with the Director of Nursing (DON)</p>	F 280	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>SRNAs are responsible to report any identified behaviors or concerns to the licensed nurse. The licensed nurses are responsible to conduct observations of all residents during the meal service to identify behaviors or concerns, document behaviors and notify DNS and/or Social Service staff. The ED, DNS, RD and WS will audit residents on mechanically altered diets through staff interviews, direct observations of dining services and through record reviews of Behavior and Mood Logs and Resident Progress Notes. The review will also include the Meal Supervision Log and Dietary Communication Book. The ED, DNS, RD and WS will each conduct one audit per week for four weeks. The audit will validate that all behaviors have been appropriately identified and addressed. The DNS and CM will audit four random records (two per unit) per week for any new behaviors exhibited and to validate that all behaviors have been appropriately addressed on the residents' care plan. The DNS and CM will also review the meal Supervision Logs for the previous 7-day period to validate that exhibited behaviors and/or concerns have been identified and addressed. In addition, the DNS and CM participate in the licensed staff dining room observation. The audit will include 4 random staff interviews of licensed nurses and SRNAs (two per unit) per week to</p>

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F 280	<p>Continued From page 5</p> <p>on 09/20/10 at 1:25 PM, revealed she was not aware Resident #1 grabbed other residents' food/fluids prior to this incident. She stated she immediately completed an investigation of the incident. She stated she determined the resident grabbed the bread from a resident at the same table, who was on a regular diet. She stated staff was told that Resident #1 was to be seated at a table with residents with like diets and a licensed nurse would be present in the dining room for all meals.</p> <p>Observation of the noon meal, on 09/16/10 at 12:15 PM, revealed Resident #1 was seated at a table with a resident with the same kind of diet. A licensed staff was in the dining room. Staff began passing fluids to the residents. A CNA sat with Resident #1 when his/her glass of fluid was served and stayed with the resident through the resident's tray being served and then fed the resident his/her meal. The remaining staff began passing out the residents' trays. The staff had their backs to the residents in the dining room while passing the trays and the surveyor observed a resident to take and consume another resident's fluids.</p> <p>A review of the comprehensive care plan, for Resident #1 revealed the resident's care plan was revised for the resident to sit with residents with the same diet consistency on 09/07/10; however, there were no revisions to the care plan to address adequate supervision/monitoring of the resident due to the behavior of grabbing of food/drinks and the increased risk of the resident choking.</p> <p>2. A record review revealed Resident #4 was admitted to the facility with diagnoses to include</p>	F 280	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Identify any new behaviors exhibited and to validate that all behaviors have been appropriately reported and addressed on the comprehensive care plan. The DNS will be responsible to report all audit findings at the weekly PIC meeting. The PIC will meet weekly (Tuesday) for four weeks to review audit findings to determine the need for additional action steps. If no concerns are identified during the weekly (Tuesday) PIC meetings, the audits on a monthly basis for two months, and on an as needed basis thereafter. The DNS will be responsible to report all audit findings at the monthly PIC meeting for the next three months and quarterly thereafter. Findings will be reviewed at the monthly PIC to validate that any identified concerns were immediately corrected. Findings will be tracked and trended at the PIC for additional action steps, as indicated.</p>	Completion date 9/23/10	

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F 280	<p>Continued From page 6 Alzheimer's Disease.</p> <p>A review of the comprehensive care plan for potential for alteration in nutrition/hydration related to mechanically altered diet, end stage Alzheimer's and potential for aspiration, dated 08/04/10, revealed interventions to provide a mechanical soft diet with nectar thick liquids, fed per staff in dining room and encourage to eat slowly. A review of the resident's dietary slip revealed food was to be served in bowls.</p> <p>Interviews with RN #2 on 09/16/10 at 5:40 PM, RN #1 on 09/16/10 at 2:40 PM, LPN #1 on 09/16/10 at 5:20 PM, CNA #5 on 09/16/10 at 5:05 PM, CNA #6 on 09/16/10 at 5:15 PM, CNA #7 on 09/16/10 at 5:35 PM and CNA #8 on 09/16/10 at 5:50 PM, revealed Resident #4 grabbed other residents' food/drinks or pulled the tablecloth to pull items within his/her reach. However, further review of the comprehensive care plan revealed there was no revision to the care plan to address adequate supervision/monitoring related to the resident's behaviors of grabbing food/drinks, pulling the tablecloth to pull items within reach and the risk of the resident choking.</p> <p>Observation of the noon meal on 09/16/10 at 12:15 PM, revealed Resident #4 was seated at a table with a resident with the same kind of diet. A licensed staff was in the dining room. Staff began passing fluids to the residents. Staff began passing out the residents' trays. During this time staff had their backs to the residents and a resident was observed, by the surveyor, to reach out and take and consume another resident's fluids. A CNA sat with Resident #4 when his/her tray was served.</p>	F 280		
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F 280	<p>Continued From page 7</p> <p>A review of Resident #4's clinical record revealed no documentation related to the resident's grabbing at food/drinks and pulling the table cloth to get items within reach.</p> <p>3. A record review revealed Resident #5 was admitted to the facility with diagnoses of Late Effect Cerebral Vascular Accident (CVA) and Vascular Dementia.</p> <p>A review of the comprehensive care plan for alteration in nutrition/hydration related to mechanically altered diet and swallowing problems, dated 03/11/10, revealed an intervention to provide assistance with meals.</p> <p>An interview with CNA #5 on 09/16/10 at 5:05 PM, revealed Resident #5 was blind in one eye and saw objects with the other eye and grabbed for them. She stated the resident had grabbed food/drink belonging to another resident in the dining room. However, further review of the care plan revealed there were no revisions to the care plan to address the resident's behavior of grabbing food/drinks and the increased risk of the resident choking.</p> <p>A review of the clinical record for Resident #5 revealed no documentation of the resident's behavior of grabbing for food/drink in the dining room.</p> <p>4. A record review revealed Resident #6 was admitted to the facility with diagnoses of Alzheimer's Disease.</p> <p>A review of the comprehensive care plan for impaired swallowing related to the resident ate too fast causing him/her to choke revealed</p>	F 280		

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F 280	<p>Continued From page 8</p> <p>interventions to provide a pureed diet with regular liquids and to encourage the resident to slow down and take small bites to decrease the risk of choking.</p> <p>An interview with CNA #7 on 09/16/10 at 5:35 PM, revealed Resident #6 grabbed other residents' food/drink at times when he/she ate in the dining room. However, further review of the care plan revealed there were no revisions to the care plan to address the resident's behavior of grabbing for food/drinks and the increased risk of the resident choking.</p> <p>A review of the clinical record for Resident #6 revealed there was no documentation of the resident's behavior of grabbing food/drinks.</p> <p>5. A record review revealed Resident #7 was admitted to the facility with diagnoses of Mental Disorder.</p> <p>A review of the comprehensive care plan for at risk for altered nutrition/hydration related to Alzheimer's and wandering, dated 03/11/10, revealed an intervention to provide a mechanical soft diet with pureed meat and regular liquids.</p> <p>An interview with LPN #1 on 09/16/10 at 5:20 PM. revealed Resident #7 grabbed other residents' food/drink at times and tried to eat inedible objects. However, further review of the care plan revealed there were no revisions to the care plan to address the resident's behavior of grabbing for food/drinks, trying to eat inedible objects and the increased risk for choking.</p> <p>A review of the clinical record for Resident #7 revealed there was no documentation of the</p>	F 280			

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F 280	<p>Continued From page 9</p> <p>resident's behavior of grabbing food/drinks or trying to eat inedible objects.</p> <p>An interview with the DON on 09/20/10 at 1:25 PM, revealed during the investigation of Resident #1's incident, she did not identify that there were four other residents (#4, #5, #6 and #7), who also had behaviors of grabbing for other residents' food/drink, with no care plan in place to address the needed supervision/monitoring of the residents to prevent choking. The DON stated she had not asked staff if there were any other residents in the facility who grabbed food/drinks. The facility's investigation failed to identify individual residents' risks including supervision, resulting in the failure to implement interventions for supervision.</p> <p>An acceptable credible allegation of correction for the removal of the Immediate Jeopardy was received on 09/22/10. The Immediate Jeopardy was verified removed on 09/22/10, prior to exit. The alleged date of removal was 09/22/10. Based on observations, interviews and record reviews, verification was made the Immediate Jeopardy was removed on 09/22/10.</p> <p>The AOC revealed:</p> <p>Affected residents:</p> <p>On 09/02/10, the ARNP communicated to all direct care staff, licensed nurses State Registered Nurse Aides, that Resident #1 would be seated in the dining room at a table with other residents who received the same type of mechanically altered diet.</p> <p>On 09/07/10, the care plan was updated to reflect</p>	F 280		
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F 280	<p>Continued From page 10</p> <p>dining room seating arrangement for Resident #1. On 09/16/10, the care plan was updated to reflect a problem of At risk for Choking Possible Aspiration related to Dementia with Impulsive Behavior , Past Behavior of Grabbing food and/or liquids, with interventions to include, but not limited to: provide LCS pureed diet with honey thick liquids by small spoon per staff; encourage po intake and po fluids, fed per staff; encourage dining room attendance each meal and sit with resident with same texture diet; supervise all po intake and meal times. On 09/21/10, the care plan was updated, with a problem of no safety awareness as resident grabs out for people and items, with interventions to include, but not limited to: keep resident in supervised area when out of bed; notify nurse of any abnormal behavior; be attentive to resident when reaching; and encourage resident to attend activities.</p> <p>In addition, the Executive Director (ED), Director of Nursing Services (DNS), the District Director of Operations (DO), and the District Director of Clinical Operations, (DDCO), conducted further investigation for Resident #1 on 09/19/10. This investigation consisted of staff interviews and medical record review, to include but not limited to: the comprehensive Minimum Data Set (MDS) Assessment, Resident Assessment Protocols (RAPs), Comprehensive Care Plan, Behavior and Mood Logs and Resident Progress Notes. The 24-hour report, the Dining Room Communication Book and the Dining Room Seating Arrangement Diagram were also reviewed. The SRNA Assignment Sheet and the Dining Room Seating Arrangement Diagram were updated for Resident #1.</p> <p>The care plan for Resident #4 was revised on</p>	F 280			

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F 280	<p>Continued From page 11</p> <p>09/17/10 with a problem of Inappropriate Behaviors of grabbing at items on dining room tables, including food, with interventions to include, but not limited to: place at table with residents with same diet; table cloth will be removed; center piece removed; staff will monitor during meals/activities; will not be seated within reach of other residents' food at meals; psych services as indicated for management of behaviors. On 09/21/10, the care plan was updated with an intervention to notify nurse of any new abnormal behaviors.</p> <p>The care plan for Resident #5 was revised on 09/17/10 with a problem of Inappropriate Behaviors of grabbing objects, food on dining table, and at persons, with interventions to include, but not limited to: sitting at table with others who have same diet; have snacks available when hungry, needs assistance; reassure resident; remove objects from table/tablecloth. On 09/21/10, the care plan was updated with an intervention to notify nurse of any new abnormal behaviors.</p> <p>The care plan for Resident #6 was revised on 09/20/10 with a problem of Repetitive Movements, Oral Fixation, does not currently, but in past, has taken food from others rooms or trays and over eating, with interventions to include, but not limited to: monitor all po intake; set up and episodic chewing during meals; feed assist if stops feeding self at meals; have resident slow down if eating fast; notify nurse of any new onset of abnormal behaviors and document.</p> <p>The care plan for Resident #7 was revised on 09/16/10 with a problem of Socially Inappropriate Behaviors, at time unable to tell the difference</p>	F 280			

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F 280	<p>Continued From page 12</p> <p>from edible and non-edible item, history of taking food off others' trays, with interventions to include, but not limited to: place at table without centerpieces; staff to monitor during meals; will not be seated within reach of other residents' food at meals.</p> <p>Homemade bread would continue to be served during meal service as appropriate and in accordance with MD order for diet consistency. For residents with mechanically altered diets, bread would be altered accordingly and served with the meal service.</p> <p>Effective 09/17/10, residents who have known behaviors of reaching for and obtaining items that are not on their meal tray or that are inedible, have been arranged to be seated at tables with same MD ordered mechanically altered diet. This is reflected on the Dining Room Seating Assignment Chart, effective 09/17/10.</p> <p>Effective 09/02/10, each meal service will be monitored by a licensed nurse for the duration of the meal service. SRNAs are responsible to report any identified behaviors or concerns to the licensed nurse. The licensed nurse are responsible to conduct observations of all residents during the meal service to identify behaviors or concerns. The licensed nurse are responsible to document any behaviors or identified concerns on the Meal Supervision Log, the 24-hour report and will report the behaviors or identified concerns to the Director of Nursing Services and/or the Social Worker. The DNS and CM will also review the Meal Supervision Logs for the previous 7-day period to validate that exhibited behaviors and/or concerns are identified and addressed on the care plan and that</p>	F 280		

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F 280	<p>Continued From page 13</p> <p>supervision is appropriate. In addition, the DNS and CM participate in the licensed staff dining room observation to validate appropriate supervision.</p> <p>Effective 09/17/10, each activity with meal service is monitored by the Activities Staff for the duration of the meal service. Activities Staff are responsible to report any identified behaviors or concerns to the licensed nurse. The licensed nurse is responsible to document any behaviors or identified concerns on the 24-hour Report and to report the behaviors or identified concerns to the DNS and/or Social Worker(SW).</p> <p>Effective 09/17/10, Administrative Licensed Nurses (DNS, Assistant Director of Nursing Services (ADNS), Unit Manager (UM), Minimum Data Set Coordinator (MDSC), Case Manager (CM), Weekend Supervisor (WS) and Staff Development Coordinator (SDC) participate in the licensed staff dining room observation. Administrative nurses through direct observation will validate that all behaviors and/or concerns have been identified, documented on the 24-Hour Report and report to the DNS and SW.</p> <p>Meal Supervision, behaviors and/or concerns will be documented at each meal on the Meal Supervision Log. The Meal Supervision Log will be reviewed daily in the Stand-Up meeting and on weekends by the WS to identify any concerns and to validate that appropriate corrective action has been taken. Any concerns identified will be documented on the Meal Supervision Log at the time of the review.</p> <p>All direct care staff, licensed nurses, and SRNAs have been in-serviced to report any and all</p>	F 280			

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F 280	<p>Continued From page 15</p> <p>were educated to document on the Behavior Log and report to the licensed nurse. The DNS and CM will conduct 4 random staff interviews of licensed nurses and SRNAs (two per unit) per week to identify any new behaviors exhibited and to validate that all behaviors have been appropriately reported and addressed on the comprehensive care plan.</p> <p>The DNS, UM, Minimum Data Set Coordinator (MDSC), Case Manager (CM), and Advanced Register Nurse Practitioner (ARNP) reviewed the medical records of all facility residents on 09/21/10. Record reviews included but were not limited to: the MDS Assessment, Comprehensive Care Plan, Behavior and Mood Logs and Resident Progress Notes for the previous 30-day period. Record review was conducted to validate that all care plans were revised as appropriate and indicated based on documentation. In addition, staff interviews were conducted through the in-service offerings to identify residents with unreported behaviors. The comprehensive care plan, SRNA Assignment Sheet and Dining Room Seating Arrangement Diagram were updated, as indicated, based on record review and staff interviews.</p> <p>In addition, on 09/21/10, all SRNA Assignment Sheets were updated to reflect the intervention for staff to report any and all new behaviors to the licensed nurse.</p> <p>Systemic Changes to Prevent Reoccurrence of Deficient Practice:</p> <p>The DNS, UMS and Weekend Supervisor initiated in-servicing to all direct care staff, to include licensed nurses and SRNAs on 09/17/10.</p>	F 280			

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F 280	<p>Continued From page 14</p> <p>behaviors, to include wandering or reaching for objects, to include food, and to document on the 24-Hour Report and to address in care plan.</p> <p>Other Facility Residents with the Potential to be Affected:</p> <p>The DNS, UM, Registered Dietician (RD) and Assistant Dietary Services Manager (ADSM) reviewed the medical records of all other facility residents on mechanically altered diets on 09/19/10. Record reviews included, but not limited to, the comprehensive MDS Assessment, Comprehensive Care Plan, Behavior and Mood Logs, and Resident Progress Notes. The 24-Hour Report, The Dining Room Communication Book and the Dining Room Seating Arrangement Diagram were also reviewed. Record review was conducted to validate that all care plans were revised as appropriate and indicated based on documentation. In addition, staff interviews were conducted through the in-service offerings to identify residents with unreported behaviors. The Comprehensive Care Plan, the State Registered Nurse Aide Assignment Sheet and the Dining Room Seating Arrangement Diagram were updated as indicated, based on record review and staff interviews.</p> <p>To ensure the safety of all mobile residents on mechanically altered diets with behaviors, all direct care staff, licensed nurses, and SRNAs have been in-serviced to report any and all behaviors, to include wandering or reaching for objects, to include food. Licensed nurses were educated to document on the 24-Hour Report, the Resident Progress Notes and on the Behavior Log and to address on the care plan. The SRNAs</p>	F 280			

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F 280	<p>Continued From page 16</p> <p>In-service content included Care plans and Care plan Meeting and Assigned Seating Designations. In addition, all direct care staff, including Activities, were educated on the Dining Room Seating Assignment Chart and on how the chart was designed. All staff were educated that activity seating groups will be the same as the Dining Room Seating Assignment Chart.</p> <p>The DO and DDCO initiated Investigative Training in-servicing on 09/18/10 with the ED and DNS. The DDCO completed in-servicing to all Administrative Staff (ED, DNS, CM, MDSC, Social Worker, UM, RD, Activity Director, Housekeeping Supervisor, Rehab Manager, Program Director, Nutrition Services Manager, ARNP and Respiratory Therapist) on 09/20/10. In-service content included Documentation of Resident Health Status, Needs and Services; Documenting in a Resident's Medical Record; 24-Hour Report and Investigative Protocol.</p> <p>The DNS and UM initiated additional in-servicing on 09/21/10 with all direct care staff to include licensed nurses, SRNAs, and Activities staff related to meal supervision.</p> <p>In-servicing was initiated on 09/17/10 and 09/20/10 and will continue until all appropriate staff have attended the appropriate in-service. Staff will not be allowed to work until having attended the appropriate in-service. The in-service will be included in New Employee Orientation for all new hires. The facility does not utilize Agency Staff. If the facility should employ Agency Staff, they will receive the in-service prior to working.</p> <p>The ED and DNS will be responsible to validate</p>	F 280			

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F 280	<p>Continued From page 17</p> <p>that staff do not work prior to receiving the in-service. A sign is posted at the time clock to notify staff they are not to work or provide care to any resident prior to reporting to a charge nurse to receive the in-service. If the staff in need of in-service is a charge nurse, they are to report to a charge nurse on a different unit.</p> <p>Facility Monitoring:</p> <p>An ad hoc Performance Improvement Committee was held on 09/17/10. Members in attendance included the ED, DNS, UM and RD.</p> <p>The Medical Director was notified of the Facility Action Plan on 09/20/10.</p> <p>The ED, DNS, RD and WS will audit residents on mechanically altered diets through staff interviews, direct observations of dining services and through record reviews of Behavior and Mood Logs and Resident Progress Notes. The review will also include the Meal Supervision Log and Dietary Communication Book. The ED, DNS, RD and WS will each conduct one audit per week for four weeks. The audit will validate that all behaviors have been appropriately identified and addressed.</p> <p>The DNS and CM will audit four random records (two per unit) per week for any new behaviors exhibited and to validate that all behaviors have been appropriately addressed on the comprehensive care plan. The audit will include but will not be limited to: the MDS Assessment, Comprehensive Care Plan, Behavior and Mood Logs and Resident Progress Notes for the previous 7-day period. The DNS and CM will also review the meal Supervision Logs for the previous</p>	F 280			

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F 280	<p>Continued From page 18</p> <p>7-day period to validate that exhibited behaviors and/or concerns have been identified and addressed. In addition, the DNS and CM participate in the licensed staff dining room observation.</p> <p>In addition, the audit will include 4 random staff interviews of licensed nurses and SRNAs (two per unit) per week to identify any new behaviors exhibited and to validate that all behaviors have been appropriately reported and addressed on the comprehensive care plan.</p> <p>The DNS will be responsible to report all audit (residents on mechanically altered diets, behaviors, and the Meal Supervision Logs) findings at the weekly PIC meeting. The PIC will meet weekly (Tuesday) for four weeks to review audit findings to determine the need for additional action steps.</p> <p>If no concerns are identified during the weekly (Tuesday) PIC meetings, the audits on a monthly basis for two months, and on an as needed basis thereafter.</p> <p>The DNS will be responsible to report all audit findings at the monthly PIC meeting. All monthly findings will be reviewed at the monthly PIC to validate that any identified concerns were immediately corrected. Findings will be tracked and trended at the PIC for additional action steps, if indicated.</p> <p>The Interdisciplinary Team, to include but not limited to: ED, DNS, UM, RD, Social Worker, DM, Activities Director, will review all resident events during morning Stand-Ups by reviewing Event Reports, 24-Hour Reports, Hospitalizations,</p>	F 280			

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F 280	<p>Continued From page 19</p> <p>Dietary Communications Book to ensure that all events are investigated to ensure the health, safety and overall well-being is met and maintained for the affected resident, other facility residents with the potential to be affected, to identify the need for systemic changes and to validate that the PI process is effective.</p> <p>The ED is responsible for overall compliance through attendance at the Stand -Up Meeting and by reviewing audits to ensure conducted. The ED will assume overall responsibility for the Performance Improvement Program at the Facility.</p> <p>The ED will utilize weekly (Wednesday) IDT recommendations to validate one medical record (from resident identified in the IDT Meeting) to ensure implementation of the Credible Allegation of Compliance. The ED/Administrator will then return to routine monitoring, of the facility systems each month as specified in the Facility Performance Improvement policy and procedure, when substantial compliance is achieved.</p> <p>In addition, the DDCO will conduct weekly calls with the facility to review events from the previous week to validate that all events are thoroughly investigated, to include care plan revision.</p> <p>Interviews conducted on 09/22/10, during the extended survey, with the DON and direct care staff (SW #2, RN #1, RN #3, LPN #2, LPN #6, LPN #7, LPN #8, CNA #3, CNA #5, CNA #6, CNA #11, CNA #13, CNA #14 and CNA #15 ), revealed there was now a seating chart for the dining room. Residents were seated with residents on the same diet consistency. Licensed staff were present in the dining room for all meals</p>	F 280		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185089</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/22/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>ROSEWOOD HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>550 HIGH ST.</b> <b>BOWLING GREEN, KY 42101</b>		
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F 280	<p>Continued From page 20</p> <p>and Administrative staff participated in the dining room service. They revealed if any behaviors were noted, the staff reported the behavior to the licensed staff in the dining room. The licensed staff then documented it on the behavior log in the dining room and reported it to the Charge nurse and documented on the 24 hour report and in the resident's record.</p> <p>Observation of the noon meal on 09/22/10 revealed Resident #1 was seated at a table by him/herself. No food was placed on the table until Resident #1's tray was served. The CNA immediately sat down next to the resident when the tray was served. Residents #4, #5, #6 and #7 were seated with residents with like diets and were seated according to the dining room seating chart. A licensed staff was present during the entire meal. Staff were reporting observations of behaviors to the licensed staff during the meal. A review of the Dining Room behavior observation sheets for 09/22/10, revealed each resident's name was documented with the behaviors that were observed. Observations of Resident #,1 on 09/22/10 at 2:20 PM, revealed the resident was in a wheelchair seated in the area across from the nurse's station in view of staff.</p> <p>A review of Resident #1's comprehensive care plan revisions, dated 09/07/10, 09/16/10, 09/19/10 and 09/21/10, revealed the care plan had been revised to include interventions to seat the resident at a table with same texture diets, supervise all po intake and meal times, keep the resident in a supervised area when out of bed, notify the nurse of any abnormal behavior and be attentive to the resident when reaching.</p> <p>A review of Residents' #1, #4, #5, #6 and #7</p>	F 280			

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F 280	Continued From page 21 comprehensive care plans, revealed the care plans were updated to include individual interventions to provide supervision for the residents related to their behaviors of grabbing for food/drinks.  A review of the in-service trainings provided to all direct care staff, dated 09/17/10, 09/18/10, 09/19/10 and 09/21/10, revealed all staff received training on care plans and care plan meetings, assigned seating charts, dining/meal service supervision, activity seating groups, to report any and all behaviors (to include wandering or reaching for objects to include food/drink) and documentation. In addition, Administrative Staff were in-serviced on 09/20/10, on Documentation, Documenting Residents' Health Status, Needs and Services, and Documenting in a Resident's Medical Record and on the 24- Hour Report. The Executive Director and Director of Nursing received in-servicing on 09/18/10 related to conducting investigations.  Although it was determined the Immediate Jeopardy was removed on 09/22/10, noncompliance continued with the scope and severity of a "D", based on the facility's need to monitor for the ongoing effectiveness of the corrective actions taken and to ensure evaluation through the facility's Quality Assurance process.	F 280	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F 323 SS=K	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.	F 323	F 323 The care plan for resident #1 was updated to reflect a problem of at risk for Choking - Possible Aspiration and no safety awareness, grabs for other residents' food, with interventions to include, but not limited to: encourage dining room attendance each meal and sit resident with others receiving same texture diet; supervise all po intake and meal times: feed by staff with small spoon; notify nurse of any abnormal behavior; be	

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F 323	<p>Continued From page 22</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility failed to provide adequate supervision to prevent accidents for five residents (#1, #4, #5, #6 and #7), in the selected sample of five. The facility failed to supervise and monitor residents who required supervision due to choking risk while eating. Facility staff was aware of Residents #1, #4, #5, #6 and #7 history of attempts to obtain food of a different consistency than their diets, but failed to develop and implement interventions to prevent the residents from obtaining the food/fluids.</p> <p>On 09/01/10, staff placed bread (regular consistency) at the table accessible to Resident #1. Staff did not provide supervision to ensure Resident #1 did not gain access to the bread despite having knowledge of this resident's history of attempts to obtain food of a different consistency. Staff observed Resident #1 with bread in his/her hand and removed it; however, the resident began to choke. Staff initiated the Heimlich Maneuver; however, this method was not successful. The resident stopped breathing and had no pulse. Emergency Medical Services had to insert a Laryngoscope (instrument inserted into the airway to provide visual access) into the resident's throat to remove the bread with forceps. The resident was sent out to the hospital.</p> <p>Additionally, the facility failed to follow its' accidents and supervision to prevent accidents</p>	F 323	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>attentive to resident when reaching. Staff will sit with resident immediately when the meal tray is served.</p> <p>The care plan for Resident #4 was revised to reflect a problem of inappropriate behaviors, grabbing at items on dining room tables including food, interventions include, but not limited to: place at table with residents with same diet; table cloth and center piece will be removed; staff to monitor during meals/activities; will not be seated within reach of other residents' food at meals; psych services as indicated and notify nurse of new abnormal behaviors.</p> <p>The care plan for Resident #5 was revised to reflect a problem of inappropriate behaviors, grabbing objects and food on dining room table. Interventions include: sit at table with others of same diet and out of reach of others' food, provide assistance with needs and have snacks available to offer when hungry; remove objects from table/tablecloth, notify nurse of any new abnormal behaviors;</p> <p>The care plan for Resident #6 was revised to reflect a problem of Repetitive Movements, Oral Fixation, history of taking food from others rooms or trays and over eating. Interventions include: monitor PO intake; if stops feeding self at meals staff to assist; remind resident to slow down if eating too</p>

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F 323	<p>Continued From page 23</p> <p>policy and procedure as it related to implementing interventions after staff had identified the residents' risk. The facility's investigation failed to identify individual residents' risks including supervision, resulting in the failure to implement interventions for supervision.</p> <p>The facility's failure to provide adequate supervision for residents' at risk for choking, represented a situation that had caused and was likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 09/21/10 and found to exist on 09/01/10 and was ongoing. Substandard Quality of Care was identified at 483.25 Quality of Care. The facility was notified on 09/21/10.</p> <p>Findings include:</p> <p>A review of the facility's Accidents and Supervision to Prevent Accidents policy and procedure, dated 08/06/07, revealed the center provided supervision to each resident to prevent avoidable accidents. This included systems to identify and evaluate hazards and risks, implement interventions to reduce hazards and risks and to monitor the effectiveness and modify approaches when necessary. The center identified hazards and the risks of the resident having an unavoidable accident through Quality Assurance activities, medical history, physical exam and individual observation. Staff were involved in observing and identifying potential hazards. The Center investigates accidents and develops a plan of action to prevent the accident from reoccurring. A review of the Accidents and Supervision to Prevent Accidents Definitions revealed an avoidable accident was when the facility failed to identify: 1. environmental hazards</p>	F 323	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>fast; sit out of arms reach of other trays; notify nurse of any new abnormal behaviors.</p> <p>Care plan for resident #7 was revised to show problem of socially inappropriate behaviors; unable to tell the difference between edible and non-edible items at times; history of taking others food from tray. Interventions include: place resident at table with no centerpiece; staff to monitor during meals; do not seat resident within reach of others' food at meals.</p> <p>To identify/validate other residents possibly affected, medical records of all residents receiving mechanically altered diets were reviewed, on 9/19/10 by the Director of Nursing (DNS), Unit Managers (UM), Registered Dietician (RD) and Asst. Dietary Services Manager. In addition, staff interviews were conducted through the in-service offerings, initiated on 9/17/10 by the DNS, UM and Weekend Supervisor (WS), to identify residents with unreported behaviors. Care plans, SRNA assignment sheets have been revised, as indicated, to reflect identified behaviors and interventions.</p> <p>To ensure the safety of all mobile residents on mechanically altered diets with behaviors, all direct care staff, licensed nurses, and SRNAs have been in-serviced to report any and all behaviors, to include wandering or</p>

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F 323	<p>Continued From page 24</p> <p>and individual resident risks of an accident, including supervision, 2. evaluate the hazards and risks and 3. implement interventions, including adequate supervision, consistent with the resident's needs, resident's goals, resident's plan of care, and current standards of practice in order to reduce the risks of an accident. Lack of Supervision was the lack of adequate supervision to prevent accidents occurred when the center failed to accurately assess a resident to determine whether supervision to avoid an accident or injury was necessary.</p> <p>1. Resident #1 was admitted to the facility with diagnoses of Diabetes Mellitis, Cerebral Vascular Accident and Dementia.</p> <p>Reviews of the Dysphagia Discharge Summary, dated 06/22/09, a Speech Therapy Recommendation, dated 01/22/10, and an interview with the Speech Therapist, on 09/20/10 at 9:55 AM, revealed Resident #1 was admitted to the facility on 12/16/08, status post CVA. She stated Resident #1 choked on his/her regular diet during a meal in July 2009 and was sent out to the hospital. She stated the resident returned on a pureed diet with thin liquids. Strategies were put in place to take the resident's spoon away after each bite and provide hand over hand feeding with a small spoon to include the resident's liquids. She stated the resident was very impulsive and grabbed the food or fluids off the tray and ate and drank them very fast. An intervention was put in place for staff to sit with the resident immediately when the resident's tray was served. In March/April 2010, a modified swallow was completed and the resident's diet was changed to a pureed diet with honey thick liquids, however, the same strategies were kept in</p>	F 323	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>reaching for objects, to include food. Licensed nurses were educated on P&amp;P for documentation requirements, via staff in-services. Information related to reporting of behaviors, adequate supervision and seating arrangements in dining were also included in staff in-services. In-services were conducted by the DNS, WS &amp; UMs beginning on 9/17/10. Staff will not be allowed to work until attending all appropriate in-services.</p> <p>Each meal service will be monitored by a licensed nurse for the duration of the meal. Effective 09/17/10, Administrative Licensed Nurses (DNS), Assistant Director of Nursing Services (ADNS), Unit Manager (UM), Minimum Data Set Coordinator (MDSC), Case Manager (CM), Weekend Supervisor (WS) and Staff Development Coordinator (SDC) participate in the licensed staff dining room observation. Administrative nurses through direct observation will validate that all behaviors and/or concerns have been identified, documented on the 24-Hour Report and report to the DNS and SW. SRNAs are responsible to report any identified behaviors or concerns to the licensed nurse. The licensed nurses are responsible to conduct observations of all residents during the meal service to identify and document on behaviors or concerns, and notify DNS and/or Social Service staff.</p>

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F 323	<p>Continued From page 25</p> <p>place. She stated she knew of another time the resident had grabbed macaroni off either another resident's tray or from a table. She revealed staff was very aware of the resident's behavior of trying to grab food and fluids, so they tried to keep a close eye on the resident.</p> <p>A review of the comprehensive care plan for Alteration in Nutrition/Hydration related to swallowing and chewing problems and risk of aspiration pneumonia, dated 06/15/10, revealed interventions to totally assist with meals, feed per staff 1/2 teaspoon at a time, remind resident to clear throat in between bites, follow each bite with honey thick liquids with spoon. A review of the comprehensive care plan, dated 06/15/10, revealed there were no changes to the care plan despite staff's knowledge of the resident's behavior of grabbing food, according to speech therapy.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment, dated 08/23/10, revealed the facility assessed Resident #1 as severely impaired cognitively and the resident never or rarely made decisions. Resident #1 was also assessed as having chewing and swallowing problems.</p> <p>Interviews with Registered Nurse (RN) #3 on 09/17/10 at 10:40 AM, Licensed Practical Nurse (LPN) #5 on 09/17/10 at 10:20 AM, LPN #6 on 09/16/10 at 3:40 PM, Certified Nurse Aide (CNA) #1 on 09/16/10 at 2:55 PM, CNA #2 on 09/16/10 at 3:20 PM, CNA #3 on 09/16/10 at 3:10 PM, CNA #4 on 09/16/10 at 3:10 PM, CNA #9 on 09/16/10 at 2:40 PM and CNA #10 on 09/16/10 at 4:05 PM, revealed Resident #1 was seated at a table on the third row in the dining room with other</p>	F 323	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>The ED, DNS, RD and WS will audit residents on mechanically altered diets through staff interviews, direct observations of dining services and through record reviews of Behavior and Mood Logs and Resident Progress Notes. The review will also include the Meal Supervision Log and Dietary Communication Book. The ED, DNS, RD and WS will each conduct one audit per week for four weeks. The audit will validate that all behaviors have been appropriately identified and addressed. The DNS and CM will audit four random records (two per unit) per week for any new behaviors exhibited and to validate that all behaviors have been appropriately addressed on the residents' care plan. The DNS and CM will also review the meal Supervision Logs for the previous 7-day period to validate that exhibited behaviors and/or concerns have been identified and addressed. In addition, the DNS and CM participate in the licensed staff dining room observation. In addition, the audit will include 4 random staff interviews of licensed nurses and SRNAs (two per unit) per week to identify any new behaviors exhibited and to validate that all behaviors have been appropriately reported and addressed on the comprehensive care plan.</p> <p>The DNS will be responsible to report all audit findings at the weekly PIC meeting. The PIC will meet weekly (Tuesday) for four</p>

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F 323	<p>Continued From page 26</p> <p>residents for the noon meal, on 09/01/10. The staff had placed sliced fresh baked bread on saucers and passed it out to the residents who were on regular diets. The staff revealed they started passing out trays to the residents at the first row of tables. CNA #9 revealed as she turned around to pass a tray, she observed Resident #1 with a slice of bread in his/her hand. CNA #9 stated Resident #1 had taken the bread from a resident sitting at the table with him/her. CNA #9 stated she walked over to the resident and removed the bread from Resident #1's hand and from the table. She resumed passing out trays. The staff revealed the next thing they knew CNA #4 shouted Resident #1 is turning blue. The staff stated they immediately called a Code, grabbed a crash cart and lowered the resident to the floor. The licensed staff responded to the code and attempted the Heimlich Maneuver with finger sweeps three times with no success. They stated the resident was not breathing and they could not detect a pulse. EMS was called and Cardiopulmonary Resuscitation (CPR) was started. A review of the EMS report, dated 09/01/10, revealed a Laryngoscope was inserted into the resident's throat and the lodged bread was removed with forceps. The resident's pulse and breathing returned. The resident was sent out to the hospital.</p> <p>Interviews with the Activity Director on 09/17/10 at 3:50 PM, RN #1 on 09/17/10 at 2:40 PM, RN #2 on 09/16/10 at 2:40 PM, LPN #1 on 09/16/10 at 5:20 PM, LPN #2 on 09/17/10 at 1:40 PM, LPN #3 on 09/20/10 at 10:55 AM, LPN #4 on 09/17/10 at 3:00 PM, CNA #1 on 09/16/10 at 2:55 PM, CNA #2 on 09/16/10 at 3:20 PM, CNA #3 on 09/16/10 at 3:10 PM, CNA #4 on 09/16/10 at 3:10 PM, CNA #5 on 09/16/10 at 5:05 PM, CNA</p>	F 323	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>weeks to review audit findings to determine the need for additional action steps. If no concerns are identified during the weekly (Tuesday) PIC meetings, the audits on a monthly basis for two months, and on an as needed basis thereafter. The DNS will be responsible to report all audit findings at the monthly PIC meeting for the next three months and quarterly thereafter. Findings will be reviewed at the monthly PIC to validate that any identified concerns were immediately corrected. Findings will be tracked and trended at the PIC for additional action steps, as indicated.</p>

Completion date 9/23/10

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F 323	<p>Continued From page 27</p> <p>#6 on 09/16/10 at 5:15 PM, CNA #7 on 09/16/10 at 5:35 PM, CNA #8 on 09/16/10 at 5:50 PM, CNA #9 on 09/16/10 at 2:40 PM and CNA #10 on 09/16/10 at 4:05 PM, revealed Resident #1 had behaviors of grabbing food and/or fluids off other residents' trays and from the dining room table prior to the resident's choking on 09/01/10. The staff stated they immediately took the food/fluid away from the resident. The staff revealed they tried to keep an eye on the resident because of the resident's behaviors of grabbing food and drinks of other residents. They stated everyone was aware that Resident #1 had this behavior because the resident did it all the time. Although the interviews revealed the staff were aware of the resident's behavior of grabbing for food/drinks prior to 09/01/10, there was no evidence the facility implemented any interventions after identifying this risk to avoid an accident.</p> <p>An interview with the Director of Nursing (DON) on 09/20/10 at 1:25 PM, revealed she immediately completed an investigation of the incident. She stated she determined the resident had grabbed the bread from a resident seated at the same table, who was on a regular diet. Based on the investigation, she stated staff was told that Resident #1 was to be seated at a table with residents with like diets and licensed nurses would be present in the dining room for all meals. The DON revealed during her investigation, she did not identify that Resident #1 had displayed behaviors of grabbing for other residents' food and/or drinks numerous times prior to this incident. She did not identify the need for increased supervision for Resident #1 due to this behavior. She stated she had not asked staff if Resident #1 had tried to grab food/drinks before. She revealed she had not identified that there</p>	F 323			

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F 323	<p>Continued From page 28</p> <p>was no documentation in Resident #1's record related to this behavior. The DON failed to follow the facility's policy and procedure related to developing a plan or action to prevent the accident from reoccurring and failed to identify individual resident's risks so interventions could be implemented, including adequate supervision, in order to reduce the risk of an accident.</p> <p>Observation of the noon meal on 09/16/10 at 12:15 PM, revealed Resident #1 was seated at a table with a resident with the same kind of diet. A licensed staff was in the dining room. Staff began passing fluids to the residents. A CNA sat with Resident #1 when his/her glass of fluid was served and remained with the resident through the resident's tray being served and then fed the resident. The remaining staff began passing out the residents' trays. During this time staff had their backs to the residents in the dining room and a resident was observed, by the surveyor, to reach out and take and consume another resident's fluids.</p> <p>Further review of Resident #1's care plan, dated 09/07/10, revealed the resident's care plan was updated for the resident to sit with residents with the same diet consistency; however, there were no interventions to address supervision or monitoring of the resident related to grabbing of food/drinks.</p> <p>2. A record review revealed Resident #4 was admitted to the facility with diagnoses to include Alzheimer's Disease.</p> <p>A review of Speech Therapy's recommendations, dated 02/04/10, revealed the resident was on a Dysphasia II diet with nectar thick liquids and</p>	F 323		

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F 323	<p>Continued From page 29</p> <p>required 1:1 feeding, small bites and sips and cue to double swallow with each bite.</p> <p>A review of the quarterly MDS assessment, dated 07/27/10, revealed the facility assessed Resident #4 as severely impaired cognitively and never/rarely made decisions.</p> <p>Interviews with RN #2 on 09/16/10 at 5:40 PM, RN #1 on 09/16/10 at 2:40 PM, LPN #1 on 09/16/10 at 5:20 PM, CNA #5 on 09/16/10 at 5:05 PM, CNA #6 on 09/16/10 at 5:15 PM, CNA #7 on 09/16/10 at 5:35 PM and CNA #8 on 09/16/10 at 5:50 PM, revealed Resident #4 grabbed other residents' food/drinks or pulled the tablecloth to pull items within his/her reach prior to 09/01/10. Further review of Resident #4's clinical record revealed no documentation related to the resident's grabbing at food/drinks and pulling the table cloth to get items within reach.</p> <p>A review of the comprehensive care plan for potential for alteration in nutrition/hydration related to mechanically altered diet, end stage Alzheimer's and potential for aspiration, dated 08/04/10, revealed interventions to provide a mechanical soft diet with nectar thick liquids, to feed per staff in dining room and to encourage to eat slowly. A review of the resident's dietary slip revealed food was to be served in bowls. However, further review of the comprehensive care plan revealed there were no interventions to provide supervision/monitoring of the resident related to the behaviors of grabbing food/drinks and of pulling the tablecloth to pull items within reach.</p> <p>Observation of the noon meal on 09/16/10 at 12:15 PM, revealed Resident #4 was seated at a</p>	F 323		
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F 323	<p>Continued From page 30</p> <p>table with a resident with the same kind of diet. A licensed staff was in the dining room. Staff began passing fluids to the residents. Staff began passing out the residents' trays. During this time staff had their backs to the residents and a resident was observed, by the surveyor, to reach out and take and consume another resident's fluids. A CNA sat with Resident #4 when his/her tray was served.</p> <p>3. A record review revealed Resident #5 was admitted to the facility with diagnoses of Late Effect CVA and Vascular Dementia.</p> <p>A review of the comprehensive care plan for alteration in nutrition/hydration related to mechanically altered diet and swallowing problems, dated 03/11/10, revealed an intervention to provide assistance with meals.</p> <p>A review of the quarterly MDS assessment, dated 08/12/10, revealed the facility assessed Resident #5 as severely impaired cognitively and never or rarely made decisions. Resident #5 was also assessed as having swallowing problems.</p> <p>An interview with CNA #5 on 09/16/10 at 5:05 PM, revealed Resident #5 was blind in one eye; however, could see objects with the other eye and grabbed for food/drink. She stated the resident had a history of grabbing food/drink belonging to another resident in the dining room.</p> <p>However, a reviews of the clinical record and the care plan for Resident #5, revealed no documentation of the resident's behavior of grabbing for food/drink in the dining room and no interventions to address supervision/monitoring of the resident related to the resident's behavior of</p>	F 323			

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F 323	<p>Continued From page 31 grabbing food/drinks.</p> <p>4. A record review revealed Resident #6 was admitted to the facility with diagnoses of Alzheimer's Disease.</p> <p>A review of the annual MDS assessment, dated 08/19/10, revealed the facility assessed Resident #6 as severely impaired cognitively and rarely/never made decisions. Resident #6 was also assessed as having chewing and swallowing problems.</p> <p>A review of the comprehensive care plan, dated 08/04/10, for impaired swallowing related to ate too fast, which caused the resident to choke, revealed interventions to provide a pureed diet with regular liquids and to encourage the resident to slow down and take small bites to decrease the risk of choking.</p> <p>An interview with CNA #7, on 09/16/10 at 5:35 PM, revealed Resident #6 grabbed other residents' food/drink at times when he/she ate in the dining room.</p> <p>However, reviews of the clinical record and care plan for Resident #6, revealed there was no documentation of the resident's behavior of grabbing food/drinks or interventions to address supervision/monitoring of the resident related to the resident's behavior of grabbing for food/drinks.</p> <p>5. A record review revealed Resident #7 was admitted to the facility with diagnoses of Mental Disorder.</p> <p>A review of the quarterly MDS assessment, dated</p>	F 323			

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F 323	<p>Continued From page 32</p> <p>08/03/10, revealed the facility assessed Resident #7 as severely impaired cognitively and the resident rarely/never made decisions. Resident #7 was assessed as having chewing problems.</p> <p>An interview with LPN #1 on 09/16/10 at 5:20 PM, revealed Resident #7 grabbed other residents' food/drink at times and tried to eat inedible objects.</p> <p>A review of the clinical record for Resident #7, revealed there was no documentation of the resident's behavior of grabbing food/drinks or trying to eat inedible objects.</p> <p>A review of the comprehensive care plan for at risk for altered nutrition/hydration related to Alzheimer's and wandering, dated 08/18/10, revealed an intervention to provide a mechanical soft diet with pureed meat and regular liquids. However, further review revealed there were no interventions to address supervision/monitoring of the resident related to the resident's behaviors of grabbing for food/drinks and trying to eat inedible objects.</p> <p>An interview with the DON, on 09/20/10 at 1:25 PM, revealed during the investigation of Resident #1's incident she did not identify that there were four other residents (#4, #5, #6 and #7), who also had behaviors of grabbing for other residents' food/drink, with no care plans in place to address the needed supervision/monitoring of the residents to prevent choking. The DON stated she had not asked staff if there were any other residents in the facility, who grabbed foods/drinks. The facility's investigation failed to identify individual residents' risks including supervision, resulting in the failure to implement interventions</p>	F 323			

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F 323	<p>Continued From page 33 for supervision.</p> <p>A credible allegation of correction for removal of the Immediate Jeopardy was received on 09/22/10. The Immediate Jeopardy was verified removed on 09/22/10, prior to exit. The alleged date of removal was 09/22/10. Based on observations, interviews and record reviews, verification was made the Immediate Jeopardy was removed on 09/22/10.</p> <p>The AOC revealed:</p> <p>On 09/02/10, the ARNP communicated to all direct care staff, licensed nurses State Registered Nurse Aides, that Resident #1 would be seated in the dining room at a table with other residents who received the same type of mechanically altered diet.</p> <p>On 09/07/10, the care plan was updated to reflect the dining room seating arrangement for Resident #1. On 09/16/10, the care plan was updated to reflect a problem of At risk for Choking Possible Aspiration related to Dementia with Impulsive Behavior, Past Behavior of Grabbing food and/or liquids, with interventions to include but not limited to: provide LCS pureed diet with honey thick liquids by small spoon per staff; encourage po intake and po fluids, fed per staff; encourage dining room attendance each meal and sit with resident with same texture diet; supervise all po intake and meal times. On 09/21/10, the care plan was updated, with a problem of no safety awareness as resident grabs out for people and items, with interventions to include but not limited to: keep resident in supervised area when out of bed; notify nurse of any abnormal behaviors; be attentive to resident when reaching; and</p>	F 323			

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F 323	<p>Continued From page 34 encourage resident to attend activities.</p> <p>In addition, the Executive Director (ED), Director of Nursing Services (DNS), the District Director of Operations (DO), and the District Director of Clinical Operations, (DDCO), conducted further investigation for Resident #1 on 09/19/10. This investigation consisted of staff interviews and medical record reviews, to include but not limited to, the comprehensive MDS Assessment, Resident Assessment Protocols (RAPs), Comprehensive Care Plans, , Behavior and Mood Logs and Resident Progress Notes. The 24-hour report, the Dining Room Communication Book and the Dining Room Seating Arrangement Diagram were also reviewed. The SRNA Assignment Sheet and the Dining Room Seating Arrangement Diagram were updated for Resident #1.</p> <p>The care plan for Resident #4 was revised on 09/17/10 with a problem of Inappropriate Behaviors of grabbing at items on dining room tables, including food, with interventions to include but not limited to: place at table with residents with same diet; table cloth will be removed; center piece removed; staff will monitor during meals/activities; will not be seated within reach of other residents' food at meals; psych services as indicated for management of behaviors. On 09/21/10, the care plan was updated with an intervention to notify the nurse of any new abnormal behaviors.</p> <p>The care plan for Resident #5 was revised on 09/17/10 with a problem of Inappropriate Behaviors of grabbing objects, food on dining table, and at persons, with interventions to include but not limited to: sitting at table with others who</p>	F 323		

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F 323	<p>Continued From page 35</p> <p>have same diet; have snacks available when hungry, needs assistance; reassure resident; remove objects from table/tablecloth. On 09/21/10, the care plan was updated with an intervention to notify the nurse of any new abnormal behaviors.</p> <p>The care plan for Resident #6 was revised on 09/20/10 with a problem of Repetitive Movements, Oral Fixation, does not currently, but in past, had taken food from others' rooms or trays and over eating, with interventions to include but not limited to: monitor all po intake; set up and episodic chewing during meals; feed assist if stops feeding self at meals; have resident slow down if eating fast; notify nurse of any new onset of abnormal behaviors and document.</p> <p>The care plan for Resident #7 was revised on 09/16/10 with a problem of Socially Inappropriate Behaviors, at time unable to tell the difference from edible and non-edible item, history of taking food off others' trays, with interventions to include, but not limited to: place at table without centerpieces; staff to monitor during meals; will not be seated within reach of other residents' food at meals.</p> <p>Homemade bread will continue to be served during meal service as appropriate and in accordance with MD order for diet consistency. For residents with mechanically altered diets, bread will be altered accordingly and served with the meal service.</p> <p>Effective 09/17/10, residents who have known behaviors of reaching for and obtaining items that are not on their meal tray or that are inedible, have been arranged to be seated at tables with</p>	F 323		

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F 323	<p>Continued From page 36</p> <p>same MD ordered mechanically altered diet. This is reflected on the Dining Room Seating Assignment Chart, effective 09/17/10.</p> <p>Effective 09/02/10, each meal service is monitored by a licensed nurse for the duration of the meal service. SRNAs are responsible to report any identified behaviors or concerns to the licensed nurse. The licensed nurse is responsible to conduct observations of all residents during the meal service to identify behaviors or concerns. The licensed nurse is responsible to document any behaviors or identified concerns on the Meal Supervision Log, the 24-hour report and to report the behaviors or identified concerns to the Director of Nursing Services and/or the Social Worker. The DNS and CM will also review the Meal Supervision Logs for the previous 7-day period to validate that exhibited behaviors and/or concerns have been identified and addressed on the care plan and that supervision is appropriate. On addition, the DNS and CM participate in the licensed staff dining room observation to validate appropriate supervision.</p> <p>Effective 09/17/10, each activity with meal service is monitored by the Activities Staff for the duration of the meal service. Activities Staff are responsible to report any identified behaviors or concerns to the licensed nurse. The licensed nurse is responsible to document any behaviors or identified concerns on the 24-hour Report and to report the behaviors or identified concerns to the DNS and/or Social Worker(SW).</p> <p>Effective 09/17/10, Administrative Licensed Nurses (DNS), Assistant Director of Nursing Services (ADNS), Unit Manager (UM), Minimum</p>	F 323		

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F 323	<p>Continued From page 37</p> <p>Data Set Coordinator (MDSC), Case Manager (CM), Weekend Supervisor (WS) and Staff Development Coordinator (SDC) participate in the licensed staff dining room observation. Administrative nurses through direct observation will validate that all behaviors and/or concerns have been identified, documented on the 24-Hour Report and report to the DNS and SW.</p> <p>Meal Supervision, behaviors and/or concerns will be documented at each meal on the Meal Supervision Log. The Meal Supervision Log will be reviewed daily in the Stand-Up meeting and on weekends by the WS to identify any concerns and to validate that appropriate corrective actions had been taken. Any concerns identified will be documented on the Meal Supervision Log at the time of the review.</p> <p>All direct care staff, licensed nurses, and SRNAs have been inserviced to report any and all behaviors, to include wandering or reaching for objects, to include food, and to document on the 24-Hour Report and to address in care plan.</p> <p>Other Facility Residents with the Potential to be Affected:</p> <p>The DNS, UM, Registered Dietician (RD) and Assistant Dietary Services Manager (ADSM) reviewed the medical records of all other facility residents on mechanically altered diets on 09/19/10. Record reviews included but were not limited to: the comprehensive MDS Assessment, Comprehensive Care Plan, Behavior and Mood Logs, and Resident Progress Notes. The 24-Hour Report, The Dining Room Communication Book and the Dining Room Seating Arrangement Diagram were also</p>	F 323			

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F 323	<p>Continued From page 38</p> <p>reviewed. Record reviews were conducted to validate that all care plans were revised as appropriate and indicated based on documentation. In addition, staff interviews were conducted through the in-service offerings to identify residents with unreported behaviors. The Comprehensive Care Plan, the State Registered Nurse Aide Assignment Sheets and the Dining Room Seating Arrangement Diagram were updated as indicated, based on record reviews and staff interviews.</p> <p>To ensure the safety of all mobile residents on mechanically altered diets with behaviors, all direct care staff, licensed nurses, and SRNAs have been in-serviced to report any and all behaviors, to include wandering or reaching for objects, to include food. Licensed nurses were educated to document on the 24-Hour Report, the Resident Progress Notes and on the Behavior Logs and to address on the care plans. The SRNAs were educated to document on the Behavior Logs and report to the licensed nurse. The DNS and CM will conduct 4 random staff interviews of licensed nurses and SRNAs (two per unit) per week to identify any new behaviors exhibited and to validate that all behaviors have been appropriately reported and addressed on the comprehensive care plans.</p> <p>The DNS, UM, MDS Coordinator (MDSC), Case Manager (CM), and Advanced Register Nurse Practitioner (ARNP) reviewed the medical records of all facility residents on 09/21/10. Record reviews included but were not limited to: the MDS Assessments, Comprehensive Care Plans, Behavior and Mood Logs and Resident Progress Notes for the previous 30-day period. Record reviews were conducted to validate that all care</p>	F 323			

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F 323	<p>Continued From page 39</p> <p>plans were revised as appropriate and indicated based on documentation. In addition, staff interviews were conducted through the in-service offerings to identify residents with unreported behaviors. The comprehensive care plans, SRNA Assignment Sheets and Dining Room Seating Arrangement Diagram were updated, as indicated, based on record reviews and staff interviews.</p> <p>In addition, on 09/21/10, all SRNA Assignment Sheets were updated to reflect the interventions for staff to report any and all new behaviors to the licensed nurse.</p> <p>Systemic Changes to Prevent Reoccurrence of Deficient Practice:</p> <p>The DNS, UMS and Weekend Supervisor initiated in-servicing to all direct care staff, to include licensed nurses and SRNAs on 09/17/10. In-service content included care plans and care plan meetings and Assigned Seating Designations. In addition, all direct care staff, including Activities, were educated on the Dining Room Seating Assignment Chart and on how the chart was designed. All staff were educated that activity seating groups will be the same as the Dining Room Seating Assignment Chart.</p> <p>The DO and DDCO initiated Investigative Training in-servicing on 09/18/10 with the ED and DNS. The DDCO completed in-servicing to all Administrative Staff (ED, DNS, CM, MDSC, Social Worker, UM, RD, Activity Director, Housekeeping Supervisor, Rehab Manager, Program Director, Nutrition Services Manager, ARNP and Respiratory Therapist) on 09/20/10. In-service content included Documentation of</p>	F 323			

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F 323	<p>Continued From page 40</p> <p>Resident Health Status, Needs and Services; Documenting in a Resident's Medical Record; 24-Hour Report and Investigative Protocol.</p> <p>The DNS and UM initiated additional in-servicing on 09/21/10 with all direct care staff to include licensed nurses, SRNAs, and Activities staff related to meal supervision.</p> <p>In-servicing was initiated on 09/17/10 and 09/20/10 and will continue until all appropriate staff have attended the appropriate in-service. Staff will not be allowed to work until having attended the appropriate in-service. The in-service will be included in New Employee Orientation for all new hires. The facility does not utilize Agency Staff. If the facility should employ Agency Staff, they will receive the in-service prior to working.</p> <p>The ED and DNS will be responsible to validate that staff do not work prior to receiving the in-service. A sign is posted at the time clock to notify staff they are not to work or provide care to any resident prior to reporting to a charge nurse to receive the in-service. If the staff in need of in-service is a charge nurse, they are to report to a charge nurse on a different unit.</p> <p>Facility Monitoring:</p> <p>An ad hoc Performance Improvement Committee was held on 09/17/10. Members in attendance included the ED, DNS, UM and RD.</p> <p>The Medical Director was notified of the Facility Action Plan on 09/20/10.</p> <p>The ED, DNS, RD and WS will audit residents on</p>	F 323			

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F 323	<p>Continued From page 41</p> <p>mechanically altered diets through staff interviews, direct observation of dining service and through reviews of Behavior and Mood Logs and Resident Progress Notes. The review will also include the Meal Supervision Logs and Dietary Communication Book. The ED, DNS, RD and WS will each conduct one audit per week for four weeks. The audit will validate that all behaviors have been appropriately identified and addressed.</p> <p>The DNS and CM will audit four random records (two per unit) per week for any new behaviors exhibited and to validate that all behavior have been appropriately addressed on the comprehensive care plans. The audit will include but will not be limited to: the MDS Assessments, Comprehensive Care Plans, Behavior and Mood Logs and Resident Progress Notes for the previous 7-day period. The DNS and CM will also review the meal Supervision Logs for the previous 7-day period to validate that exhibited behaviors and/or concerns have been identified and addressed. In addition, the DNS and CM participate in the licensed staff dining room observations.</p> <p>In addition, the audit will include 4 random staff interviews of licensed nurses and SRNAs (two per unit) per week to identify any new behaviors exhibited and to validate that all behaviors have been appropriately reported and addressed on the comprehensive care plans.</p> <p>The DNS will be responsible to report all audit (residents on mechanically altered diets, behaviors, and the Meal Supervision Logs) findings at the weekly PIC meeting. The PIC will meet weekly (Tuesday) for four weeks to review</p>	F 323			

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F 323	<p>Continued From page 42</p> <p>audit findings to determine the need for additional action steps.</p> <p>If no concerns are identified during the weekly (Tuesday) PIC meetings, the audits will take place on a monthly basis for two months, and on an as needed basis thereafter.</p> <p>The DNS will be responsible to report all audit findings at the monthly PIC meeting. All monthly findings will be reviewed at the monthly PIC to validate that any identified concerns were immediately corrected. Findings will be tracked and trended at the PIC for additional action steps, if indicated.</p> <p>The Interdisciplinary Team to include, but not limited to: ED, DNS, UM, RD, Social Worker, DM, Activities Director, will review all resident events during morning Stand-Up by reviewing Event Reports, 24-Hour Reports, Hospitalizations, Dietary Communications Book to ensure that all events are investigated to ensure the health, safety and overall well-being is met and maintained for the affected resident, other facility residents with the potential to be affected, to identify the need for systemic changes and to validate that the PI process is effective.</p> <p>The ED is responsible for overall compliance through attendance at the Stand-Up Meetings and by reviewing audits to ensure they were conducted. The ED will assume overall responsibility for the Performance Improvement Program at the Facility.</p> <p>The ED will utilize weekly (Wednesday) IDT recommendations to validate one medical record (from resident identified in the IDT Meeting) to</p>	F 323		

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F 323	<p>Continued From page 43</p> <p>ensure implementation of the Credible Allegation of Compliance. The ED/Administrator will then return to routine monitoring, of the facility systems each month as specified in the Facility Performance Improvement policy and procedure, when substantial compliance is achieved.</p> <p>In addition, the DDCO will conduct weekly calls with the facility to review events from the previous week to validate that all events are thoroughly investigated, to include care plan revisions.</p> <p>Interviews conducted on 09/22/10, during the extended survey, with the DON and direct care staff (Social Worker #2, RN #1, RN #3, LPN #2, LPN #6, LPN #7, LPN #8, CNA #3, CNA #5, CNA #6, CNA #11, CNA #13, CNA #14 and CNA #15 ), revealed there was now a seating chart for the dining room. Residents were seated with residents receiving the same diet consistency. Licensed staff were present in the dining room for all meals and Administrative staff participated in the dining room services. They revealed if any behaviors were noted, the staff reported the behaviors to the licensed staff in the dining room. The licensed staff then documented it on the behavior logs in the dining room, reported it to the charge nurse and documented on the 24 hour reports and in the residents' records.</p> <p>Observation of the noon meal on 09/22/10, revealed Resident #1 was seated at a table by him/herself. No food was placed on the table until Resident #1's tray was served. The CNA immediately sat down next to the resident when the tray was served. Residents #4, #5, #6 and #7 were seated with residents with like diets and were seated according to the dining room seating chart. A licensed staff was present during the</p>	F 323		

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F 323	<p>Continued From page 44</p> <p>entire meal. Staff were reporting observations of behaviors to the licensed staff during the meal. A review of the Dining Room behavior observation sheets for 09/22/10, revealed each resident's name was documented with the behaviors that was observed. Observations of Resident #1 on 09/22/10 at 2:20 PM, revealed the resident was in a wheelchair sitting in the area across from the nurse's station, in view of staff.</p> <p>Reviews of Resident #1's comprehensive care plan revisions, dated 09/07/10, 09/16/10, 09/19/10 and 09/21/10, revealed the care plans had been revised to include interventions to seat the resident at a table with residents receiving same texture diets, supervise all po intake and meal times, keep the resident in a supervised area when out of the bed, notify the nurse of any abnormal behaviors and be attentive to the resident when reaching.</p> <p>A review of Residents #1, #4, #5, #6 and #7 comprehensive care plans, revealed the care plans were updated to include individual interventions to provide supervision for the residents related to their behaviors of grabbing for food/drinks.</p> <p>Reviews of the in-service training provided to all direct care staff on 09/17/10, 09/18/10, 09/19/10 and 09/21/10, revealed all staff received training on care plans and care plan meetings, assigned seating charts, dining/meal service supervision, activity seating groups, to report any and all behaviors (to include wandering or reaching for objects to include food/drink) and documentation. In addition, Administrative Staff were in-serviced on Documentation, Documenting the Residents' Health Status, Needs and Services, Documenting</p>	F 323		

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F 323	Continued From page 45 in a Resident's Medical Record and on the 24-Hour Report on 09/20/10. The Executive Director and Director of Nursing received in-servicing on 09/18/10 related to conducting investigations.  Although it was determined the Immediate Jeopardy was removed on 09/22/10, non-compliance continued with the scope and severity of a "D", based on the facility's need to monitor for the on-going effectiveness of the corrective action taken and to ensure evaluation through the facility's Quality Assurance process.	F 323	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F 490 SS=K	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: Based on observations, interviews and record review, it was determined the Administration failed to ensure the facility was administered in a manner that enabled it to use its' resources effectively to attain or maintain the highest practicable physical, mental and psychosocial well-being of five residents (#1, #4, #5, #6 and #7) in the selected sample of five. The Administration failed to ensure staff followed the facility's Accident and Supervision to Prevent Accidents policy and procedure related to identifying resident risks, implementing interventions to prevent accidents and the staff's failure to conduct a thorough investigation to identify residents' risks, ensuring care plan	F 490	F 490 Care plans for residents #1, #4, #5, #6 and #7 were revised to identify possible resident risks during meal service, including choking risks and inappropriate behaviors. Interventions were implemented to be consistent with the individual resident's needs. Interventions include but not limited to: siting residents at dining tables with other residents receiving the same MD ordered diets; notify nurse of inappropriate behaviors; provide assistance or feed resident and monitor po intake. (Refer to F323)  To identify/validate other residents possibly affected, medical records of all residents receiving mechanically altered diets were reviewed, on 9/19/10 by the Director of Nursing (DNS), Unit Managers (UM), Registered Dietician (RD) and Asst. Dietary Services Manager. In addition, staff interviews were conducted through the in-service offerings, initiated on 9/17/10 by the DNS, UM and Weekend Supervisor (WS), to identify residents with unreported behaviors. Care plans, SRNA assignment sheets have been revised, as indicated, to reflect individual resident's identified behaviors and interventions.	