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

PRINTED: 11/03/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185242		C 10/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR CARE CENTER	125 STERLING WAY MOUNT STERLING, KY 40353

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F 000	INITIAL COMMENTS An Abbreviated Survey investigating ARO #KY00015454, KY00015472; and, KY00015285 was initiated on October 14, 2010 and concluded on October 20, 2010. KY00015472 was found to be unsubstantiated. KY00015285 and KY0005454 were substantiated. Deficiencies were cited with the highest scope and severity being "D".	F 000	The following constitutes the facility's response to the findings of the Department for Health Services and does not constitute an admission of the facts alleged or conclusions set forth on the summary statement of deficiencies.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	This plan of correction is prepared as required by the provisions of the Health Safety code, 42 CFR and constitutes the facility's written credible allegation of compliance. RECEIVED DEC - 2 2010 BY: F 157 Resident # 1's incident report was completed, POA notified 10/11/10 and physician notified 10/21/10 of probable fall. Other resident's conditions were reviewed and staff interviews were conducted to ensure all other required reports were completed and the MD/POA were notified of all changes in condition. No other incidents were noted. Audit	

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

Administrator 12-2-10

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 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to immediately inform the resident's physician and legal representative of an accident with the potential for alteration in treatment for one (1) of eleven (11) sampled residents (Resident #1). Resident #1 alleged having an unobserved fall on September 30, 2010, the unit nurse was notified; however the resident's physician or legal representation was not notified of the fall for Resident #1. The findings include: Review of Resident #1's medical record revealed diagnoses which included Hypertension, Congestive Heart Failure, Hypothyroidism, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, Anxiety, Depression, Senile Dementia, Psychosis, and Alzheimer's Disease. Review of the Comprehensive Care Plan for Resident #1 revealed the facility assessed the resident to be at risk for falls. Interview with Resident #1 on 10/19/10, at 11:30 AM, revealed the resident was unable to say if a fall had occurred. The resident was able to answer simple yes and no questions; however the resident became easily confused. Interview with Resident #1's family on 10/19/10, at 11:30 AM, revealed the resident told the family of the fall sometime at the end of September,	F 157	conducted by unit managers, MDS coordinators and completed 11/1/10 Nurse's re-education initiated 10/08/10 and completed 11/01/10 on incident reporting, documentation and MD/POA notification. Conducted by DNS, QA nurse and weekend supervisor Residents changes in condition forms will be reviewed daily (Monday through Friday)by members of the QA committee or designee and six random chart reviews will be conducted weekly x 8 weeks and then monthly thereafter utilizing the QA audit tool by DON, QA Nurse or designee to ensure notification of changes were conducted.	11-2-10

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F 157	Continued From page 2 2010. The family stated the Director of Nursing (DON) was notified by the family of the fall on 10/11/10, at which time the DON stated to the family an investigation would be completed. Interview with Certified Nurse Assistant (CNA) #1, and CNA #2 on 10/19/10, at 5:05 PM and 5:15 PM, revealed Resident #1 had reported falling to the CNAs. Further interview revealed the CNAs had reported the fall to the unit manager on the hall way that Resident #1 resided. According to the CNAs, Resident #1 did not have any injuries that were visible, and the resident denied any complaints of pain, other than what was usual for the resident. Interview with the Unit Manager (UM) of Sterling Place (unit where the resident resided) on 10/19/10, at 2:00 PM, revealed, the CNAS had reported that Resident #1 had fallen sometime on 09/30/10; however, the UM stated the UM was unsure if Resident #1 had fallen related to the close proximity of Resident #1's room to the nursing station, and no complaints from Resident #1 were voiced. The UM stated no investigation was initiated, the physician was not contacted, and the responsible party was not contacted regarding any fall. Interview with the Director of Nursing (DON) on 10/20/10, at 3:00 PM, revealed when Resident #1's family notified the DON of the alleged fall, an investigation was conducted which included a review of Resident 1's medical record, x-ray reports, diagnoses from the hospital, Nursing Notes, transfer summary, and pain medication. The DON interviewed CNAs and Nurses who work on the Sterling Place hall way and concluded that a "fall occurred most likely, and	F 157		

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F 157	Continued From page 3 was not addressed". The DON stated re-education was initiated with the unit manager, nurses and CNAs that worked on the Sterling hallway. The DON stated that an investigation, physician notification, and the responsible party must be notified when any fall/alleged fall occurred. Review of the facility's policy for physician/family notification policy/procedure dated September 1, 2006 stated the physician and family must be notified of any fall, with/without injury, as well as an investigation into the cause of the fall.	F 157		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to identify and conduct a comprehensive Minimum Data Set (MDS) Significant Change assessment for two (2) of eleven (11) sampled residents	F 274	F 274 Resident #1 was in the process of having a significant change assessment completed with an ARD of 10/15/10 was completed on 10/21/10 by the MDS coordinator per RAI guidelines and submitted to CMS. Resident #6 had a full MDS and RAPS completed that did address the significant change in condition but was coded as an annual instead of a significant change. The assessment	

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F 274	Continued From page 4 (Residents #1, and #6). Resident #1 had a quarterly review dated September 10, 2010 which did not reflect a persistent level of pain, and reflected a decline in activities of daily living including bathing hygiene, and changes in mood from the previous annual assessment dated March 23, 2010. In addition, Resident #6 had a quarterly review dated 06/02/10, then had a decline in multiple activities of daily living after a fall on 08/15/10. However the next assessment dated 08/26/10, was coded as an annual assessment instead of a significant change assessment. The findings include: 1. Review of the medical record for Resident #1 revealed, physician's orders for pain management regarding lower back pain dated August 26, 2010 with Lortab (narcotic pain medication) 5/500 milligrams (mgs) every eight (8) hours. The physicians orders were changed related to continued pain on August 31, 2010 to Lortab 7.5/500 mg every six (6) hours scheduled for pain. Further review revealed on September 3, 2010 orders were written for Lortab 10/500 mg every eight (8) hours for pain, and on September 19, 2010 orders were written for Percocet (narcotic pain medication) 5/325 mg every four (4) hours as needed to be alternated with Lortab 10/500 mg every eight (8) hours routine, and schedule an MRI (magnetic resonance imaging) of the back, on September 30, 2010 discontinued Lortab, and changed Percocet to 10/325 mg every six (6) hours routine. Further review of the medical record revealed Resident #1 was exhibiting a decline in walking to the dining room for meals, an increase in confusion, and mood swings.	F 274	was transmitted and accepted. Unable to correct coding in system related to time frame, the coding error did not result in negative outcome for the resident. Change in condition was noted and care planned appropriately. The MDS coordinators and unit manager utilizing the quality indicator report reviewed the residents that triggered to ensure that a significant change of status was performed per the RAI guidelines. Review was completed on 11/1/10 The MDS coordinators were in-serviced on the definition of a significant change in status, time frames for completing a significant change, completing care plans when a change occurs, how to document significant change assessments and the difference between an annual assessment and a significant change assessment per the RAI guidelines on 10/28/10 by the Regional Nurse Consultant. Nurses were educated on the condition change form and the condition change policy. Education	

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F 274	Continued From page 5 Interview with the MDS Coordinator on 10/20/10 at 3:00 PM, revealed the quarterly review for Resident #1 was due on 09/10/10 and the Coordinator was watching for a significant change and hoping Resident #1 would "pull out". However, the resident went to the hospital on October 4, 2010- October 8, 2010 and returned on Medicare. The MDS Coordinator stated he/she was not satisfied the significant change was needed. The MDS Coordinator stated a Nurse Assessment Coordinator (NAC) note was usually generated and attached to the MDS; however no NAC note was generated or attached to the September 10, 2010 quarterly assessment. The MDS coordinator stated the MDS was due and the MDS 3.0 assessments were starting in September, and the significant change was not done. The MDS coordinator stated the significant change should have been completed for Resident #1 on September 10, 2010. 2. Record review revealed Resident #6 was admitted to the facility on 03/17/09 with diagnoses which included Diabetes Mellitus and Osteoporosis. Review of the quarterly MDS dated 06/02/10, revealed the facility assessed the resident as being independent in bed mobility, requiring supervision with transfers, ambulation, dressing, toileting, hygiene, and bathing. Observation of Resident #6 on 10/19/10 at 11:15 AM revealed the resident was alert and oriented and sitting in a recliner chair in his/her room. Interview with Resident #6 at that time revealed the resident sustained a fall on 08/15/10 and fractured the left tibia. Interview further revealed he/she felt like the fracture occurred and caused the fall.	F 274	was completed on 11/01/10 by DNS and QA nurse. Resident changes in condition forms will be reviewed daily by the QA committee members or designee, any resident that meets the criteria for a significant change in status per RAI guidelines will be documented at the QA meeting and the DON or designee will direct MDS coordinators to complete a significant change assessment Readmissions will be reviewed by the QA team on the next business day to ensure that if a resident has had a significant change, that the proper assessment is completed by the MDS coordinator per the RAI guidelines. The MDS coordinator is responsible for compliance. The DON, QA Nurse or designee will conduct six chart reviews weekly x 8 weeks and monthly thereafter for significant changes in condition per the QA audit tool and the audits will be reviewed with the QA committee	11-2-10

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F 274	Continued From page 6	F 274		
	Review of the next MDS assessment dated 08/26/10 revealed the facility coded the assessment as an annual assessment even though they assessed the resident as having a decline to extensive assistance in bed mobility, transfers, dressing, toileting, personal hygiene, and bathing.			
	Interview with the MDS Nurse on 10/20/10 at 10:15 AM revealed she was aware Resident #6 had a decline after the fall but felt the coding in the annual assessment would reflect the significant change in activities of daily living. She further stated the MDS should have been coded as a significant change assessment.			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280	F280	
	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.		Resident #1's care plan was updated to include current nutrition approaches and refusal to wear oxygen, as well as an overall review of the care plan to ensure accurate care planning by the MDS coordinator on 10/15/10	
	A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.		Resident #8's floor mat was added to care plan approaches on 10/21/10 by the unit manager	
			Continued on pg 8	

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F 280	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure Comprehensive Plans of Care were reviewed and/or revised for two (2) of eleven (11) sampled residents (Residents #1 and #8). Resident #1 sustained a thirteen (13) pound weight loss, which was seven and three tenths percent (7.3%) loss, from October 8 to October 20, 2010. Physician's orders were obtained for Ensure three (3) times a day between meals; however, the Comprehensive Plan of Care was not revised to include that intervention. In addition, Resident #1 had oxygen ordered via nasal canula at two (2) liters per minute; however, Resident #1 frequently removed oxygen from nostrils and the Comprehensive Plan of Care did not reflect the resident's frequent refusals to wear oxygen as ordered. Resident #8 had a fall mat in place however, the Comprehensive Plan of Care was not revised to include that intervention. The findings include: 1. Review of Resident #1's medical record revealed the resident was re-admitted to the facility on October 8, 2010. Admission weight was documented to be one hundred seventy-six (176) pounds. Review of a physician's order, dated October 12, 2010, revealed an order for Ensure supplements three times daily. Review of the resident's Comprehensive Care Plan, dated September 2010 revealed the resident's Comprehensive Care Plan had not been revised to include the ensure supplement	F 280	Other care plans for residents receiving supplements, oxygen and residents that had fall preventions in place were reviewed, by the unit managers and QA Nurse 10/22/10 through 11/1/10 to ensure care plans were updated accordingly All residents care plans were reviewed as a whole to ensure accurate care plan revisions were completed. Review completed 10/22/10 through 11/1/10 by the MDS Coordinators and designated unit manager. The MDS coordinators were in-serviced on 10/28/10 by the Regional Nurse Consultant on updating care plans as needed to reflect the residents current status, updating care plans with new orders as indicated, making sure the approaches and goals are realistic, completing resident centered care plans, reviewing new orders and the 24 hour shift reports daily Monday through Friday, and change of condition policy.	

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F 280	Continued From page 8 intervention, related to an intervention for weight loss. Further review of the resident's medical record revealed on October 20, 2010, the resident's weight was documented to be one hundred sixty-three (163) pounds, a thirteen (13) pound, weight loss, which was a seven and three tenths percent (7.3) loss. Observation of Resident #1 on October 19, 2010 at 11:30 AM revealed a four (4) ounce ginger ale on bed side table and water pitcher with a straw and ice water available to drink. There was no Ensure observed to be provided for the resident on October 19, 2010. Interview with Resident #1's family, at the time, revealed staff who brought the snacks provided a ginger ale for Resident #1 to drink, not Ensure. Interview with CNAs #1, #2, #3, #4, and #5 on October 19, 2010 from 1:45 PM until 5:50 PM, revealed no Ensure was provided on the trays for Resident #1, or at snack times. Further review of physician's orders revealed an order for oxygen at two (2) liters per minute via nasal cannula. Observation of Resident #1 on October 19, 2010 at 11:30 AM, 1:20 PM, and on October 20, 2010, at 9:00 AM, 11:30 AM, and 2:00 PM, revealed oxygen was in place and on two (2) liters per minute. However, interview with Resident #1's family on October 19, 2010 at 11:30 AM revealed Resident #1 frequently took off the oxygen from the resident's nose and laid the tubing aside. Interview with Certified Nursing Assistants (CNAs)	F 280	Nurses were in-serviced on 11/1/10 by the DNS and QA Nurse on the new change of condition policy, completing the change of condition form which includes the care plan update section, the new supplement policy. All change in condition forms will be reviewed daily by the DON, QA nurse or designee to ensure care plan updates are completed. The MDS Coordinators will review care plans during the care plan meetings and with significant changes to ensure that care plans reflect the resident's current status. The QA committee will review resident charts re-admitted to the facility to ensure care plans are updated to reflect current status The DON, QA Nurse or designee will randomly review six care plans weekly x 8 then monthly thereafter utilizing the QA audit tool, to ensure care plans reflect current resident condition. The QA audits will be reviewed through the QA processes after audits completed.	11-2-10

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F 280	Continued From page 9 #1, #2, #3, #4, and #5 on October 19, 2010 from 1:45 PM until 5:50 PM, revealed Resident #1 took the oxygen from his/her nostrils and threw the tubing on floor. The staff stated the resident required monitoring for the oxygen to remain in place. Review of the Comprehensive Care Plan, dated September, 2010 revealed no documented evidence the Care Plan had been revised to include interventions related to the resident's frequent removal of the physician ordered oxygen. Interview with the Director of Nursing (DON) on October 20, 2010 at 4:30 PM revealed the Care Plan should be updated at each quarterly and comprehensive review by the Minimum Data Set (MDS) Coordinators. The DON stated when a nurse wrote a physician's order, the orders contained three (3) parts, with one part to be put into the resident's medical record and used to update the Care Plan. The DON was unaware Resident #1's Care Plan had not been revised. 2. Review of Resident #8's medical record revealed diagnoses which included Dementia, and Osteoporosis. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 07/21/10, revealed the facility assessed the resident as being severely impaired in cognitive skills for decision making and required extensive to total assistance with all Activities of Daily Living. Observation of Resident #8 on 10/19/10 at 11:25 AM, 1:30 PM, 1:50 PM, and 2:15 PM revealed the resident was in the bed. Fall interventions were noted which included a perimeter mattress, a pressure alarm, bolster pillows on either side of	F 280		

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F 280	Continued From page 10 the resident, and the bed in low position. There was a folded mat standing upright against a wall. Further observation of the resident on 10/19/10 at 3:00 PM revealed the resident was in the bed with the mat on the floor on the left side of the bed. Review of the Comprehensive Plan of Care dated 05/20/09 revealed the resident was at risk for injury due to falls related to a history of dizziness, a history of attempting to self transfer, was non-ambulatory, unsteady on her/his feet, received pain medications and psychotropic medications, incontinence of bowel and bladder, and had a History of Falls. Further review of the Plan of Care revealed the fall interventions did not include the use of a fall mat. Interview on 10/20/10 at 10:15 AM with Certified Nursing Assistant (CNA) #10 revealed she was assigned to the resident on the day shift on 10/19/10. She stated someone else had assisted the resident back to bed and she did not realize the mat was not on the floor until she did rounds shortly before 3:00 PM. Review of the Nursing Assistant Plan of Care dated 10/10 revealed there was no fall intervention noted for the use of a fall mat. Interview on 10/20/10 at 3:00 PM with MDS Coordinator #1 revealed the nurse who initiated the fall mat should have revised the Plan of Care to include the fall mat. She further stated she also revised the Care Plans during Quarterly and Comprehensive MDS review. She stated, she reviewed the resident records, and observed the residents for any fall interventions when revising a Plan of Care. Further review, revealed she was unsure why the fall mat was not on the Care Plan.	F 280		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 11 Interview on 10/20/10 at 4:10 PM and 4:20 PM with the Director of Nursing(DON) revealed the falls were reviewed weekly in the Fall Meeting and the Plans of Care were reviewed and updated at that time for new falls. She was unsure why the fall mat was not on the Care Plan. Further interview with the DON on 10/20/10 at 4:20 PM revealed she had just called and spoken with the nurse who assessed the resident after the resident sustained a fall on 07/28/10. She stated the nurse had initiated the fall mat and had failed to revise the Plan of Care and communicate the intervention to nursing.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide services to meet professional standards of quality for two (2) of eleven (11) sampled residents (Resident #1, and #2). Resident #1 sustained a significant weight loss of thirteen (13) pounds, seven and three tenths percent (7.3%) from October 8 to October 20, 2010. Physician's orders, dated October 12, 2010, revealed Resident #1 was to receive Ensure supplements three times daily. There was no evidence the resident received the supplements as ordered. In addition, Resident # 2's Physician's Orders were not followed regarding a motion detector for prevention of falls, Physical Therapy, and	F 281	F281 Resident # 1's care plan was updated to include current approaches and the facility ensured that the resident was receiving the ensure as ordered by the nurse manager on 10/19/10 Resident # 2's motion detector was repaired on 10/20/10 by the unit nurse manager. Resident #2's therapy order was clarified to meet resident's current restorative needs on 10/21/10 by the physical therapist director. Restorative nursing program level 3 re initiated on 10/21/10 per MD order.	

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F 281	Continued From page 12 Restorative Nursing. The findings include: 1. Review of Resident #1's medical records revealed Resident #1 was re-admitted to the facility on October 8, 2010 with an admission weight of one hundred seventy-six (176) pounds. The medical record further revealed a dietary recommendation from the Registered Dietician (RD), on October 11, 2010, which resulted in a physician's order dated October 12, 2010, for Ensure three (3) times per day between meals. Further review of the weight record for Resident #1 revealed a weight of 170 pounds on October 15, 2010. A physician communication form was completed and faxed to Resident #1's physician stating, "Resident has had approximately twenty (20) pound weight loss since acute illness and low back pain, current weight is 170 pounds". Orders were obtained for Megace ES 625 mg every day from Resident #1's physician. Resident #1's weight was 163 pounds on October 20, 2010, a total weight loss of thirteen (13) pounds since readmission from the hospital on October 8, 2010. Observations on October 19, 2010 revealed Resident #1 did not receive the ensure supplement at the 10:00 AM snack. An interview with the Registered Dietician (RD) on October 19, 2010, at 4:00 PM, revealed Resident #1 returned from the hospital on October 8, 2010. The RD stated Ensure was recommended for Resident #1 three (3) times a day, between meals, to be given as a snack at 10:00 AM, 2:00 PM, and 8:00 PM.	F 281	Other charts were reviewed to ensure that all residents with orders for supplements were receiving them per MD orders. No other discrepancies were noted, conducted 10/20/10 through 11/1/10 by the unit managers and the QA Nurse. Other residents with alarms/motion detectors were reviewed to ensure that the equipment was functioning properly. No other discrepancies noted, completed 10/21/10 by the unit managers and MDS Coordinators. The dietician reviewed all residents receiving supplements on 10/26/10 through 10/28/10. Supplements were reviewed to ensure that they were ordered and if the residents still required the supplements in order to switch over to our new supplement policy. Therapy Director on 10/22/10 reviewed residents that had been discharged in the past 30 days to ensure that the orders were written appropriately	

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F 281	Continued From page 13 An interview with the Assistant Dietary Manager on October 19, 2010 at 3:50 PM, revealed the tray cards for Resident #1 indicated the resident was to receive the Ensure supplement. The assistant Dietary Manager stated staff in the kitchen sent supplements to the floor, as ordered, and the floor staff distributed the snacks for residents. An interview with CNA #6 on October 19, 2010 at 4:00 PM, revealed snacks were passed at 10:00 AM., 2:00 PM, and a snack was passed on the second shift at 8:00 PM.. CNA #6 was responsible for distributing hydration snacks and ordered supplements. This CNA was unaware Ensure was ordered for Resident #1 until the family asked about the supplement. CNA #6 stated snacks were prepared in the kitchen, the CNAs on the floor obtained the snack cart from the kitchen and distributed what was on the cart. The CNA stated all residents with supplements ordered had their name, date and the time the supplement was due on the side of the supplement. An interview with the Kitchen employees #1 and #2, on October 20, 2010 at 10:20 AM until 10 :30 AM., revealed kitchen staff prepared snacks on separate trays with the residents name, date, and time the supplement was due on a sticker affixed to the side of the supplement. Kitchen employees #1 and #2 were unaware of the physician's order for Ensure supplements for Resident #1 until October 20, 2010 when Resident #1's family notified the staff of the physician's order. The kitchen employees stated Ensure snacks were set aside for Resident #1 starting on October 20, 2010, when they became aware of the physician's order.	F 281	Physician's orders were reviewed for the last 30 days to ensure orders were being followed. Reviewed by the unit managers 10/22/10 through 11/1/10 no other discrepancies noted. The interdisciplinary team was in-serviced by the Regional Nurse Consultant on 10/28/10 on the equipment check procedure, the new supplement policy/ system change. Nurses were in-serviced by the DON and QA Nurse on 11/1/10 on the new equipment check policy, transcribing and carrying out the orders, completing the condition change form and the new supplement policy. Therapy director was in-serviced on 10/21/10 by his regional director and the other therapists were in-serviced by the rehab director on 10/25/10 on the policy and procedure for writing discharge orders.	

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F 281	Continued From page 14 An interview with the Assistant Dietary Manager (ADM) on October 20, 2010 at 10:35 AM revealed the Ensure order was placed in the computer by the Dietary Manager and reflected on the tray cards to be given at 10 AM, 2 PM, and 8 PM. The ADM stated staff who perform the tray line services were different from the snack line service, and staff distributing snacks were unaware Resident #1 had orders for Ensure to be given between meals until October 20, 2010 when the family of Resident #1 told CNA #6 that Resident #1 had not received the Ensure. 2. Review of Resident #2's medical record revealed diagnoses which included Dementia, and Cerebral Vascular Disease. Review of the Minimum Data Set (MDS) Assessment dated 08/26/10 revealed the facility assessed the resident as sustaining falls in the past thirty (30) days and thirty-one to one hundred eighty (31-180) days, and received restorative nursing for Active Range of Motion (AROM) and ambulation for the past seven (7) days. Review of the Physician's Orders dated 10/10 revealed Orders for a bed motion detection to the bed, and to check placement and function every shift. Observation of Resident #2 on 10/20/10 at 9:00 AM revealed the resident was in the bed with two (2) one half (1/2) side rails up and a bed alarm in place. Interview with the Certified Nursing Assistant (CNA) #11 who was emptying the trash on the resident's side of the room, revealed she was sometimes assigned to the resident; however, was not assigned to him/her that day. She stated she was assisting another CNA who	F 281	The nursing assistants were in-serviced on documenting the restorative programs and reporting refusals to the nurse starting 10/22/10 and completed 11/1/10 by the QA nurse, night shift nurse and the weekend supervisor. Supplements have been added to the medication record for nursing to provide and document amount taken, the DON, QA Nurse or designee will audit the medication records weekly x4, then twice monthly and monthly thereafter to ensure compliance with the system change. Audits will be reviewed through the QA processes. Alarms/motion detectors will be audited by department supervisors daily as assigned utilizing the safety device audit tool to ensure placement and functioning. QA audits tools will be reviewed at the daily (Monday thru Friday) QA meeting for compliance. The QA committee will review the current processes and modify as needed. Restorative documentation sheets added to the unit manager's task list to review weekly with any trends to be reported to the QA committee.	

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F 281	Continued From page 15 was assigned to the resident. Further interview with CNA #11 revealed the resident did not have a bed motion detector. Observation of the resident on 10/20/10 at 9:20 AM with the Nurse Manager assigned to the resident, revealed there was a motion detector on the bedside table; however, the detector did not alarm with movement in front of the detector. The Nurse Manager checked the detector and stated it was on "chime" and was delayed in alarming. She stated it was set wrong and should have been set on "alarm" in order to alarm with motion in front of the detector. She further stated the nurses and CNAs were to check the function of the motion detectors every shift to ensure they were functioning properly. She stated CNA #12 was assigned to the resident. Interview on 10/20/10 at 9:30 AM with CNA #12 who was assigned to the resident, revealed the resident had a bed alarm, but no motion detector which she was aware. She stated she started her shift at 6:45 AM and was not aware she was assigned to the resident because she had been getting residents up for breakfast all morning. Further interview revealed she did not check bed alarms at the beginning of the shift and was not aware there were any motion detectors in the building. She stated she reviewed the Nurse Aide Care Plans which were in a book at the nurses station when caring for the residents. Review of the Nursing Assistant Plan of Care revealed an intervention for the bed motion detector. Further review of the Physician's Orders dated 10/10 revealed Orders for the Restorative Nursing Program Level two (2) to the upper extremities, participate in exercise group and activities for five	F 281	Therapy supervisor to provide the QA committee with a list of residents discharged from therapy weekly, utilizing the list the restorative manager or designee will conduct a weekly audit to ensure they have a copy of the discharge order and a restorative order as applicable upon discharge. Physician orders will be reviewed daily by the unit managers, weekend supervisor or designee to ensure orders are transcribed correctly. Unit managers or designee will audit orders weekly to ensure orders are being followed	11-3-10

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F 281	Continued From page 16 to seven days per week and Restorative Nursing Program Level three (3) for ambulation with rolling walker five (5) to seven (7) days a week. Further review of the Physician's Orders dated 09/16/10 revealed Orders for Physical Therapy to evaluate and treat four (4) times per week for four (4) weeks and to discontinue the restorative nursing program for the lower extremities. Review of the Daily Documentation for Restorative Nursing for 10/10 revealed a "W" was documented for the minutes for 10/01/10 through 10/18/10 for ambulating the resident to the bathroom with a rolling walker. Interview on 10/19/10 at 2:00 PM with the restorative aide revealed Physical Therapy and Occupational therapy completed level I, the restorative aides completed level II, and the aides on the floor completed level III restorative activities. She further stated the resident attended the exercise program which was considered level II. Continued interview, revealed the resident was level III for ambulation to the bathroom and the aides on the floor were responsible to ensure it was done. Interview on 10/20/10 at 9:30 AM with CNA #12 who was assigned to the resident, revealed she did not ensure the resident was ambulated to the bathroom. She indicated she was unaware the resident was to receive restorative nursing although she was completing the Daily Documentation Sheet for Restorative Nursing. Interview on 10/20/10 at 2:45 PM with CNA #11, who worked on Resident #2's unit revealed she was sometimes assigned to the resident and was	F 281		

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F 281	Continued From page 17 unsure if the resident was to be ambulated. She stated she did not ambulate the resident to the bathroom when she was assigned to the resident. Interview on 10/20/10 at 3:00 PM with CNA #13 revealed she was often assigned to the resident, and she ambulated the resident to the bathroom some days; however, the resident sometimes refused. She stated if the resident refused she would document "W" for withheld on the Daily Documentation Sheet. She stated the resident often refused; however, she had not reported it to the nurse because the nurses were responsible for checking the sheets and should be aware if the resident was refusing. Interview on 10/20/10 at 1:45 PM with the Restorative Nurse revealed the resident was on level III for ambulation and the aides on the floor were to ambulate the resident to the bathroom. She stated the resident attended the level II exercise program and sometimes participated. Continued interview revealed she was unable to tell if the resident was currently receiving Physical Therapy (PT) by record review. She further stated, she was to ensure the aides on the floor were completing the Restorative Nursing Program (RNP); however, she depended on the Nurse Managers to let her know when a resident was no longer getting the RNP due to refusal or decline. Further interview revealed she did not review the Daily Documentation for Restorative Nursing Sheets to ensure the RNP was being carried out, because it was the Nurse Managers responsibility. Interview on 10/20/10 at 1:50 PM with the Nurse Manager revealed she reviewed the hydration and bowel sheets; however, did not review the	F 281		

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F 281	Continued From page 18 Daily Documentation for Restorative Nursing. She further stated she was unaware the intervention to ambulate the resident to the bathroom was being withheld. Continued interview revealed she was unsure if the resident was currently receiving Physical Therapy (PT) and could not tell by record review. She stated, if the resident were receiving PT, the Daily Documentation for Restorative Nursing Sheet should have been pulled out of the book and placed in the book with new interventions at the completion of PT. Interview on 10/20/10 at 4:20 PM with the Director of Nursing, revealed the Restorative Nurse was to check the documentation to ensure the Daily Documentation for Restorative Nursing was being completed and was responsible for ensuring the restorative nursing was completed by the aides for the level II and level III programs. Phone interview with the Physical Therapist and record review of the Physical Therapy (PT) Daily Treatment Record on 10/20/10 at 3:20 PM, revealed the Physical Therapist had been working with the resident in PT from 09/19/10 through 10/06/10. He stated he had failed to complete the discharge summary to included the instructions for restorative nursing and failed to communicate with the restorative nurse. He further stated he should have written instructions for restorative nursing on the Physician's Orders to be signed by the Physician. Continued interview revealed there was a weekly meeting held to discuss whether residents attending PT needed to be discharged to restorative nursing. The meeting included the Administrator, the Director of Nursing, the Unit Mangers, and the Quality Assurance Nurse. He stated the resident had	F 281		

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F 281	Continued From page 19 been discussed in the meeting recently; however, the Physician's Order for restorative nursing did not get written due to it being a "crazy" month.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure services were provided in accordance with each resident's written Comprehensive Plan of Care for one (1) of eight (8) sampled residents (Resident #2). The findings include: Review of Resident #2's medical record revealed diagnoses which included Dementia, and Cerebral Vascular Disease. Review of the Minimum Data Set (MDS) Assessment dated 08/26/10, revealed the facility assessed the resident as sustaining falls in the past thirty (30) days and thirty-one to one hundred eighty (31-180) days. Review of the Comprehensive Plan of Care dated 08/31/10, revealed the resident had a history of falls related to decreased mobility, cognitive status, and bowel and bladder incontinence. Review of the fall interventions revealed an intervention for a bed motion detector.	F 282	F282 Resident #2's motion detector was repaired10/20/10 Other residents with alarms/motion detectors/ fall prevention equipment ordered were reviewed to ensure the equipment in place and functioning, Rooms were checked for any other equipment not ordered. Completed on 10/20/10 by the unit managers and MDS Coordinators All care plans were reviewed by the MDS Coordinators and designated unit manager 10/22/10 through 11/1/10 to ensure care plan interventions are being implemented. The interdisciplinary team was in-serviced by the Regional Nurse Consultant on 10/28/10 on the equipment checklist procedure and the QA audit tool.	