

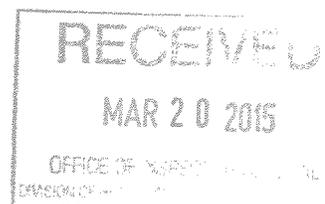
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2015
---	---	--	--

NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
--	--

(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 323	Continued From page 42 incident. Additional interview with the Administrator, on 02/13/15 at 2:28 PM, revealed she had not identified any of the doors in the building to be of a concern and had not had any elopements in the building since she had been the Administrator. The Administrator stated she had not identified the front doors as a risk that would allow for an elopement. The Administrator stated the Receptionist was at the front lobby to greet visitors, to help with resident trust, to answer any questions and to monitor residents to ensure approval was given to exit the building. The Administrator stated there were no supervision concerns identified and she felt the facility was staffed appropriately. The Administrator stated she did not identify the staffing on the unit as a concern, but the concern she did have was the alarm not sounding on the unit when the resident left through the unit door.	F 323	accounted for and were safe. Our census was 127 and all 127 residents were accounted for and were safe. On 1/21/2015 all exits were checked initially by the charge nurses on duty. The wander guard doors were manned and continuously monitored by facility staff until 01/22/15. The Plant Operations Director was notified and immediately came to the facility and checked all exits. One door on the 2 nd floor 2 North was adjusted by Plant Operations Director as there was a slight gap in closing; all other exit doors were found to be functioning properly. This resident resides on the first floor so this could not have been a door she used to exit the facility. Upon investigation by the charge nurses on 01/21/15, it was determined that Residents #1's wander guard tag had a low battery. Further investigation on 01/21/15 by the Administrator, Director of Nursing, and Plant Operations Director confirmed that the wander guard tag had a low battery. On 1/21/15 all resident wander guards were checked for placement and functioning by the Charge Nurses on duty followed by Plant Operations Director and all were properly functioning. On 2/04/15, Plant Operations Director and Regional Plant Operations Director,	
	Review of the acceptable Allegation of Compliance (AOC), dated 02/11/15, revealed the facility took the following immediate actions: 1. Resident #1 was assessed by the Charge Nurse on 01/21/15 at approximately 12:45 AM. The Responsible Party and Physician were notified of the incident by the Charge Nurse on 01/21/15. The care plan was updated by the Director of Nursing on 01/21/15 to reflect the recent incident. 2. Resident #1 was placed on 15 minute checks which were completed by the resident's Charge Nurse upon returning to the facility. The RN removed the Accutech tag, checked it, and			



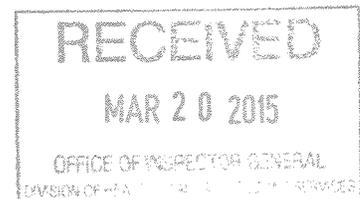
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2015
---	---	--	--

NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
--	--

(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 323	Continued From page 43 determined the battery was low. A new Accutech tag was immediately placed by the RN. 3. A head count of the entire facility was conducted on 01/21/15 by the charge nurses with the Administrator and DON oversight to ensure all residents were accounted for and were safe. 4. On 01/21/15 all exits were checked initially by the charge nurses on duty. The Accutech doors were manned and continuously monitored by facility staff until 01/22/15. The Plant Operations Director was notified and immediately came to check all exit doors. One door on the 2nd floor Two North was adjusted by the Plant Operations Director as there was a slight gap in closing; all other exit doors were found to be functioning properly. 5. On 01/21/15, the Administrator, Director of Nursing and Plant Operations Director confirmed the Accutech tag had a low battery. 6. On 01/21/15 all resident Accutech tags were checked for placement and function by the Charge Nurses on duty and the Plant Operations Director. 7. On 02/04/15, the Plant Operations Director and Regional Plant Operations Director utilized an outside vendor to adjust the front interior lobby doors. A keypad lock was activated and the doors would lock automatically at 9:00 PM daily and would unlock at 8:00 AM daily. The doors were wired so that anyone attempting to exit without the door code during the hours of 9:00 PM and 8:00 AM would set off an alarm which would be audible at the nurses stations. The monitoring panel at each nurses station would also visibly	F 323	utilized an outside vendor to adjust the front interior lobby doors. A keypad lock was activated and these doors will lock automatically at 9 p.m. daily and will unlock at 8 a.m. daily. The doors were wired so that anyone attempting to exit without the staff code during the hours of 9 p.m. and 8 a.m. will set off an alarm which will be audible at the nurses' stations. The monitoring panel at each nurse's station will also visibly show that the front door is being opened without the staff code between the hours of 9 p.m. and 8 a.m. The delayed egress system is in place on these doors. A receptionist will be at the front desk from 8 a.m. to 9 p.m. seven days a week. On 2/03/15, staff were placed at the front receptionist desk for 24/7 monitoring. This monitoring will end on 2/06/15 after all staff education is completed. Beginning 01/21/15, nursing and social services staff followed up with the resident daily for 72 hours to identify and address any psychosocial needs this resident might have. No issues were identified. The entire facility consisting of 127 residents were reassessed for risk of elopement on 1/21/2015 by Assistant Director of Nursing, Director of Nursing, Social Services Assistant, or Social	



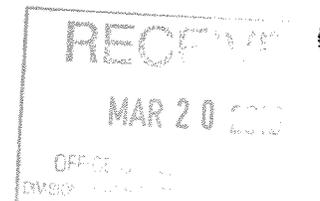
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2015
---	---	--	--

NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
--	--

(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 323	Continued From page 44 show that the front door was being opened without the door code between the hours of 9:00 PM and 8:00 AM. The Delayed egress system was in place on these doors. A Receptionist would be at the front desk from 8:00 AM to 9:00 PM seven days a week. 8. On 02/03/15, staff were placed at the front receptionist desk for 24/7 monitoring. This monitoring would end on 02/06/15 after all staff education was completed. 9. Beginning 01/21/15 the nursing and Social Services staff would follow up with the resident daily for seventy-two hours to identify and address any psychosocial needs Resident #1 may have.	F 323	Services Director. No new residents were identified as elopement risk. Care plans and nursing assistant care record were updated for 16 residents identified as being at risk for elopement on 1/21/2015 by Director of Nursing, Signature Care Consultant, Assistant Director of Nursing, or Unit Manager. The five binders which identify residents who are at risk for elopement were reviewed by the Administrator and Director of Nursing to ensure that they were updated and in place at each nurse's station and at the receptionist's desk on 1/21/2015, all were correct. The Administrator and Director of Nursing were reeducated via phone by the Signature Care Consultant, Regional Vice President, and Chief Nurse Executive on 01/21/15 on the elopement policy, missing resident policy including how to respond to door alarms, complete head counts, check wanderguard functioning of door and tags, and implement care plans related to triggered areas including elopement risk assessments. There were no revisions to our elopement and missing person policy and procedure. This education was completed prior to education being initiated with staff on 1/21/15. 113 staff was trained on 01/21/15. 34 staff was trained on 01/22/15. 17 staff	
	10. On 01/21/15, all 127 residents were reassessed for risk of elopement by the Assistant Director of Nursing (ADON), Director of Nursing (DON) and Social Services Assistant.			
	11. Care plans and nursing assistant care records were updated for sixteen (16) residents who were identified as being at risk for elopement on 01/21/15 by the DON, Facility Consultant, and the ADON.			
	12. On 01/21/15, the five (5) binders which identified eighteen (18) residents who were at risk for elopement were reviewed by the Administrator and DON to ensure they were updated and in place at each nurses station and at the receptionist desk.			
	13. On 01/21/15 The Administrator and DON were reeducated via phone by the Facility Consultant, Regional Vice President and Chief			



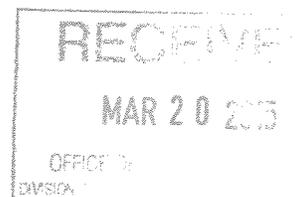
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2015
---	---	--	--

NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
--	--

(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 323	Continued From page 45 Nurse Executive on the elopement policy, missing resident policy, including how to respond to door alarms, complete a head count, checking the wander-guard function of the doors, Accutech tags and implementation of care plans related to triggered areas including elopement risk assessments. There were no revisions to the elopement and missing person policy and procedure. This education was completed prior to the education being initiated with staff on 01/21/15. 14. Education regarding the elopement policy, missing resident policy including how to respond to door alarms, completing head counts, checking the wander-guard function of the doors, Accutech tags and implementation of care plans related to triggered areas including elopement risk assessments were provided by the Administrator and the DON on 01/21/15 to all the Administrative staff who were to provide education. Education was completed for nursing, housekeeping, laundry, therapy, dietary and plant operations that included 183 staff. Post tests were completed by 02/02/15. 15. Education and return demonstrations on use of Accutech Transmitter (device to check function) to ensure staff competency of the wander-guard function and battery checks were initiated on 01/21/15 by the Plant Operations Director or Plant Operations Assistant for licensed nurses. A post test was given to staff that received the education in which a passing score of 100 % had to be obtained. If a score of 100 % on the test was not obtained the staff member would be re-educated on the spot and a new post-test would be given. Forty-two (42) licensed nurses were educated.	F 323	was trained on 01/23/15. 9 staff was trained on 01/24/15. 3 staff was trained on 01/25/15. 1 staff was trained on 01/28/15. 1 staff was trained on 01/30/15. 2 staff was trained on 01/31/15. 1 staff was trained on 02/01/15. This training was on the above mentioned in above #14. Education on elopement policy, missing resident policy including how to respond to door alarms, complete head counts, check wander-guard functioning of door and tags, and implement care plans related to triggered areas including elopement risk assessments was initiated to staff on duty on 1/21/15 will continue prior to staff working by Administrator, Director of Nursing, Staff Development Coordinator, Quality of Life Director, Social Services Director, Social Services Assistant, Chaplain, Customer Experience Director, Dietary Services Manager, Admissions Director, Plant Operations Director, Plant Operations Assistant, or Business Office Manager. The Administrator and Director of Nursing trained these educators on the material to cover for the education. This education was completed for nursing, administrative, housekeeping, laundry, therapy, dietary, plant	



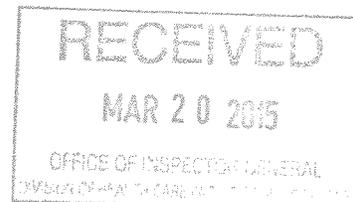
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2015
---	---	--	--

NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
--	--

(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 323	Continued From page 46	F 323	operations for 181 staff. Post tests were completed by 02/02/15.	
	16. Staff that were not working on 01/21/15, would be educated prior to taking their assignment upon return to work. A post test would be given in which a passing score of 100% had to be obtained. If 100% was not obtained the staff member would be re-educated and a post test would be reissued.		Education and return demonstration on use of Accutech transmitter (device to check function) to ensure staff competency of wander guard function and battery checks was initiated on 01/21/15 by the Plant Operations Director or Plant Operations Assistant for licensed nurses. A post test was be given to staff that received the education in which a passing score of 100% must be obtained. If staff did not receive a score of 100% on test the staff member will be re-educated on the spot and a new post-test will be given.	
	17. Staff who were PRN (as needed staff) or Family Leave Medical Act (FMLA) or on leave would be issued a certified letter by the Administrator with a return receipt on 01/26/15 alerting them that they must receive an education on the elopement policy, missing resident, care plans and Accutech before being allowed to work. There were 33 PRN and 3 FMLA on 01/21/15. The facility does not utilize Agency Staff.		42 licensed nurses were educated. Staff that were not working on 1/21/2015 will be educated on the elopement policy and procedure, missing resident, care plan and Accutech by Administrator, Director of Nursing, Staff Development Coordinator, Quality of Life Director, Social Services Director, Social Services Assistant, Dietary Services Manager, Chaplain, Customer Experience Director, Admissions Director, Plant Operations Director, Plant Operations Assistant, or Business Office Manager prior to taking their assignment upon return to work. A post test will be given in which a passing score of 100% must be obtained. If 100% not obtained the	
	18. On 02/06/15 the ADON and Minimum Data Set (MDS) Coordinator were re-educated by the Administrator and DON on completion of care plans upon admission, quarterly and with changes of condition, including care plans to reflect the nursing assessment.			
	19. New procedures were implemented on dating Accutech Tags when received in the facility and placed on residents. The Plant Operations Director was opening and dating new wander-guard tags when they arrived to the facility. Manufacturers recommendations state that the Accutech tag would last at least twelve (12) months or longer. The Accutech tags would be replaced at eleven (11) months. The Plant Operations Director and DON would each keep a roster of dates that the Accutech tags were placed on each resident with the activation date and when they needed to be replaced. The Plant			



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

PRINTED: 03/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2015
NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748	
(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 323	Continued From page 47 Operations Director and DON would notify nursing staff when to replace the Accutech tag at the eleventh (11) month mark. Anytime an Accutech tag was replaced, the tag would be labeled "BAD" and given to the Plant Operations Staff and logged in their Maintenance log in the Maintenance Binder at each nurses station. 20. On 01/21/15, the Quality Assurance (QA) team met consisting of the Administrator, DON, two (2) Regional Nurse Consultants, and Medical Director in regards to root cause of event, education, interventions and plans to prevent reoccurrence. The elopement policy and procedure was reviewed and no revision were made. 21. On 2/04/15, a QA meeting was held with the Medical Director to review the procedure changes related to the front door monitoring. 22. On 02/06/15, a QA meeting was held with the Medical Director to review the elopement plan. 23. The DON and Regional Nurse Consultant reviewed 113 incident and accident reports for the last three (3) months on 01/21/15 for any other concerns of elopement or wandering. None were identified. 24. Beginning 01/24/15 and going through 01/30/15, daily audits would be completed each shift for Accutech tag function on all identified residents, return demonstration by four (4) licensed staff on wander-guard functioning and twelve (12) staff members each shift would be given the post test for elopement by the Administrative staff. A score of 100 % would be required.	F 323	staff member will be re-educated and a post test will be reissued. Staff who are PRN, on FLMA or on leave will be issued a certified letter by Administrator with return receipt on 1/26/2015 alerting them that they must receive an education on elopement policy, missing resident, care plans and Accutech (device to check wander guard function) before being allowed to work. There were 33 PRN staff and 3 FMLA on 1/21/15. The facility does not utilize agency staff. Staff will be educated on the new front door procedure by the Administrator, Director of Nursing, Staff Development Coordinator, Quality of Life Director, Administrative Assistant, Admissions Director, Business Office Manager, Human Resources Director, Dietary Manager, Quality of Life Assistant, Chaplain, or Assistant Director of Nursing. 200 staff was educated and this was completed on 02/06/15. Assistant Directors of Nursing, and MDS Coordinators were reeducated by the Administrator and Director of Nursing on 02/06/15 on completion of care plans on admission, quarterly, and with changes of condition, including that care plans should reflect nursing assessments. Elopement and missing person policy and procedure were reviewed on	



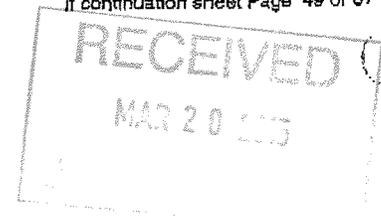
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2015
---	---	--	--

NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
--	--

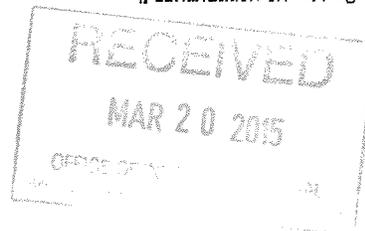
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 48 25. Daily for two (2) weeks beginning 01/21/15, the Plant Operations Director and the Plant Operations Assistant would check the exit doors in the facility for correct function and place on their log. 26. Daily for two (2) weeks beginning 01/21/15, the Plant Operations Director or Plant Operations Assistant would check the function of the Accutech tags on all identified residents. 27. Charts for residents with a change of condition, new orders, new admissions, discharges, or transfers to the hospital were reviewed at the daily clinical meeting five (5) days a week by the clinical team. 28. The Regional Care Consultant Staff were providing oversight to the audits four (4) times a week beginning 01/21/15 and continued through 02/13/15. 29. The elopement policy and procedure, missing resident, care plans and Accutech system would be in-serviced in orientation for all new hires beginning 01/23/15 in which a post test would be given and a score of 100 % must be obtained. The Staff Development Coordinator would be responsible for the orientation. The State Survey Agency validated the AOC on 02/13/15 through observation, interview and record review prior to exit as follows: 1. Interview with the Charge Nurse (RN #1), on 02/06/15 at 1:08 PM, revealed she notified the family and physician of Resident #1 the morning of the incident. Record review of the incident	F 323	1/21/15 and no revisions were made to the policies. A new procedure was implemented on dating wanderguard tags when received in the facility and placed on residents. The Plant Operations Director is opening and dating new wanderguard tag when they arrive at the facility. Manufacturers recommendations state that the wanderguard tag will last at least 12 months or longer. Wanderguard tags will be replaced at 11 months. The Plant Operations Director and Director of Nursing are each keeping a roster of dates that wanderguards are placed on residents with their activation date and when they need to be replaced. The Plant Operations Director or Director of Nursing will notify nursing staff when to replace a tag at the 11 month mark. Anytime a wander guard tag is replaced, the tag is to be labeled "BAD" and given to the Plant Operations Staff and logged in their maintenance log in the maintenance binder at each nurses station. See attached procedure 1. A QA meeting was held in the afternoon on 1/21/2015 and attended by ADMIN, DON, two Regional Nurse Consultants, and Medical Director in regards to root cause of event, education, interventions and plans to prevent reoccurrence. The elopement policy and procedure was reviewed and no revisions were made.	



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

PRINTED: 03/02/2015
FORM APPROVED
OMB NO. 0938-0391

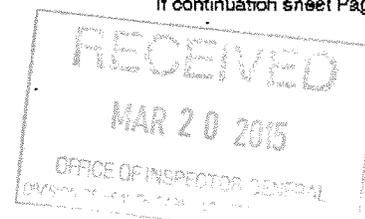
STATEMENT OF DEFICIENCIES PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/13/2015
NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748		
(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 323	Continued From page 49 Report dated 01/21/15 at 1:00 AM, revealed the Physician was called at 01/21/15 at 3:00 AM and the Family was called on 01/21/15 at 1:20 AM.	F 323	A QA Meeting was held on 02/04/15 with the Medical Director to review procedure changes related to front door monitoring (See attached). A QA meeting was held on 02/06/15 with the Medical Director to review elopement plan. No further issues were identified. Director of Nursing or Regional Nurse Consultant reviewed 113 incident and accident reports for the last 3 months on 1/21/2015 for any other concerns of elopement or wandering. None were identified. Beginning 01/24/15 and going through 01/30/15, daily audits will be completed each shift for wanderguard functioning on all identified residents, return demonstration by four licensed staff on wanderguard functioning, and 12 staff members each shift will be given the post test for elopement by the Administrator, Business Office Assistant, Human Resources Director, Dietary Services Manager, Quality of Life Director, Admissions Director, Chaplain, Environmental Services Director, Social Services Director, Business Office Manager, Plant Operations Director or Social Services Assistant. A score of 100% was required, if less than 100% employee were reinserviced and then given the post- test again until 100% compliance		
	2. Review of the fifteen (15) minutes checks revealed Resident #1 was monitored every fifteen (15) minutes starting at 1:15 AM on 01/21/15 through 01/27/15. Interview with RN #1, on 02/02/15 at 10:35 PM, revealed Resident #1 was monitored every fifteen (15) minutes once the resident was back in the building.				
	3. Interview with Licensed Practical Nurse (LPN) #5, on 02/02/15 at 10:00 PM, revealed on the night of 01/21/15 she had completed a head count of all residents on her unit. Interview with RN #1, on 02/02/15 at 10:35 PM, revealed a head count of all residents occurred through out the building. Interview with the Director of Nursing (DON), on 02/05/15 at 9:40 AM, revealed she instructed the staff to ensure all residents were accounted for the day of 01/21/15 at about 1:00 AM. Interview with the Administrator, on 02/05/15 at 10:10 AM, revealed she instructed the staff to complete a head count when she received a phone call from RN #1 on 01/21/15.				
	4. Interview with LPN #3, on 02/02/15 at 10:12 PM, revealed she helped with the check of the doors and found that the Two North needed to be manned by staff and all other doors were monitored every fifteen (15) minutes. Interview with RN #1 on 02/02/15 at 10:35 PM, revealed she helped with checking that all doors were secure. RN #1 stated the doors were checked every fifteen (15) minutes and later on that day someone manned all of the doors. Interview with the Plant Operations Director, on 02/03/15 at 4:40 PM, revealed the morning of the incident he				



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

PRINTED: 03/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2015
NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748	
(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)	(X6) COMPLETION DATE
F 323	Continued From page 50 received a call and made sure there were staff monitoring the doors until he was sure that the doors were working appropriately. The door on Two North had to be readjusted. The doors were found to be functioning appropriately.	F 323	was obtained. Beginning 01/31/15, these audits were completed three times a week through 02/28/15 and then weekly times 24 weeks. The Administrator or DON are reviewing the Post Tests given daily for any noted concerns. Any concerns will be addressed immediately. Daily for two weeks beginning 01/21/15, the Plant Operations Director and the Plant Operations Assistant will check the exit doors in the facility for correct functioning and place on their log. It will continue to be checked seven days a week by Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Restorative Coordinator, Customer Experience Director, Business Office Assistant, Human Resources Director, Dietary Services Manager, Quality of Life Director, Admissions Director, Chaplain, Environmental Services Director, Social Services Director, Business Office Manager, Plant Operations Director or Social Services Assistant. Daily for two weeks beginning 01/21/15, the Plant Operations Director or Plant Operations Assistant Department checked the functioning of Wander guards on all identified residents. Charts for residents with a change of	
	5. Interview with the Plant Operations Director, on 02/03/15 at 4:40 PM, interview with the DON, on 02/05/15 at 9:40 AM and interview with the Administrator, on 02/05/15 at 10:10 AM, revealed when they had observed Resident #1's Accutech tag it was found to have a low battery.			
	6. The State Agency validated through interview with RN #1 on 02/06/15 at 1:08 PM and interview with the Plant Operations Director, on 02/05/15 at 2:22 PM, revealed all resident wander-guards were checked.			
	7. Review a list of items completed to fix the front door from the Regional Plant Operations Director, on 02/04/15, revealed he came to meet with a technician to have him add an additional alarm at the nurses station that would sound when the front corridor door was opened without a code, it would remain in alarm mode until an employee reset the keypad. The System was installed with a timer to automatically lock the door from 9:00 PM until 8:00 AM and the timer was programmable. Interview with the Plant Operations Director, on 02/06/15 at 2:19 PM, revealed on 02/04/15 the front lobby corridor would be locked down after 9:00 PM and the staff would have to utilize a key pad to get out. The delayed egress system was in place on these doors. A Receptionist would be at the front desk Interview with the Administrator, on 02/04/15 at 3:36 PM, revealed she adjusted the monitoring of the front door to the hours of 8:00 AM to 9:00 PM			



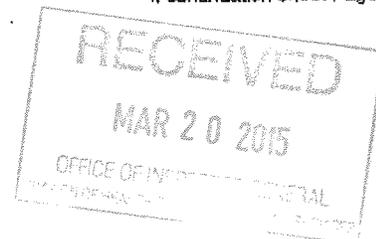
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2015
---	---	--	--

NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
--	--

(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 323	Continued From page 51 Monday through Sunday which was seven (7) days a week. Observation on 02/05/15 at 8:30 AM, revealed a key pad outside of the front corridor and a sign which stated if in an emergency situation hit the red button to the right to exit. 8. Interview with the Receptionist, on 02/12/15 at 3:47 PM, revealed she could remember staff having to man the front lobby 24/7 to ensure residents were safe. Receptionist #1 stated she would stay until 10:00 PM and would be relieved by another staff member. She stated now the doors were locked automatically after a certain time. Interview with the Administrator, on 02/4/15 at 5:01 PM, revealed on 02/03/15 through 02/06/15, she placed someone at the receptionist desk 24/7. The front interior lobby door was adjusted with a keypad to lock automatically after 9:00 PM. 9. Review of Resident #1's nurses notes revealed, the staff documented behaviors for Resident #1 on an ongoing basis, shift to shift. Review of Resident #1's fifteen (15) minute checks revealed he/she was checked from 1:00 AM on 01/21/15 through 01/27/15 at 10:00 PM. Interview with Social Services on 02/12/15 at 2:33 PM, revealed she attended morning clinical meetings and went over behaviors and wondering concerns of the staff. She also reviewed change of condition to monitor the residents of any changes. Social Services reviewed the Nurses Notes, Incident Reports, twenty-four (24) hour report, admissions, and discharges for any changes. 10. Record review of Residents' #1, #3, #8, #10, #11, #12, #13 and #14 Elopement Risk	F 323	condition, new orders, new admits, discharges, or transfers to the hospital are reviewed at the daily clinical meeting five days a week by the clinical team which consists of Director of Nursing, Assistant Directors of Nursing, Medical Records Clerk, Dietary Services Manager, Restorative Nurse Coordinator, Quality of Life Director, Administrator, Chaplain, Staff Development Coordinator, Social Services Director, Social Services Assistant, or Customer Experience Director. These staff will review care plans to ensure they are updated appropriately. Regional Care Consultant Staff are providing oversight to the audits four times a week beginning 01/21/15 and continuing through 02/13/15. The elopement policy and procedure, missing resident, care plans and Accutech system were in serviced in orientation for all new hires beginning 01/23/15 in which a post test will be given and a score of 100% must be obtained. Staff Development Coordinator is responsible for orientation. The elopement binders are being brought to the weekly at risk meeting, checked and updated as needed by the Social Services Director or Social	



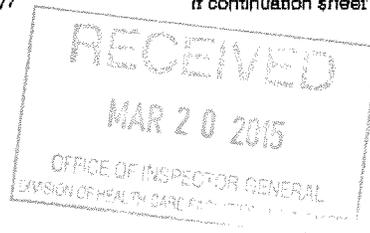
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2015
FORM APPROVED
OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES (X1) PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2015
--	---	--	--

NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
--	--

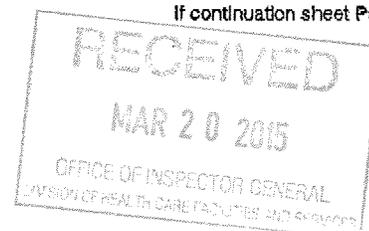
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 52 Assessments revealed all the assessments were re-evaluated on 01/21/15. Interview with the Interim ADON, on 02/12/15 at 1:13 PM, interview with the DON, on 02/12/15 at 4:12 PM and interview with Social Services, on 02/12/15 at 2:33 PM, revealed they reassessed all residents for the risk of elopement on 01/21/15. 11. Record review of Residents' #1, #3, #8, #10, #11, #12, #13 and #14 were all identified to have elopement concerns and all care plans were validated to be up-to-date as of 01/21/15. Interview with the ADON #2 on 02/12/15 at 1:45 PM, interview with DON, on 02/12/15 at 4:12 PM and the Facility Consultant, on 02/12/15 at 3:00 PM, revealed the Care plans and the nursing assistant care records were updated for residents who were identified to be an elopement risk. 12. Observations revealed five (5) binders containing eighteen (18) residents were present on each unit and at the receptionist desk on 02/05/15 at 9:00 AM. Interview with the DON, on 02/12/15 at 4:12 PM, revealed she took the elopement binders to the daily clinical meetings to make sure the binders were up-to-date. Interview with the Administrator, on 02/12/15 at 5:01 PM, revealed there were five (5) elopement binders and they were being reviewed daily in the clinical morning meeting. 13. Interview with the Facility Consultant, on 02/12/15 at 3:00 PM, revealed she provided education to the Administrator and the DON via phone on the morning of 01/21/15 and then came in around 7:00 AM on 01/21/15. The Facility Consultant stated she educated the Administrator and DON, on the elopement policy, validated that they followed the policy and checked all doors.	F 323	Services Assistant. The At Risk Team will review the binders during the meeting. The At Risk team consists of Director of Nursing, Assistant Directors of Nursing, Social Services Director, Social Services Assistant, Dietary Manager, Restorative Coordinator, or Quality of Life Director. The QAPI Committee will review the results of elopement prevention plan post test and audits upon completion of the seven days to determine if there are any trends or concerns. The QAPI committee will then continue post test and audits three days week for one week, then weekly for two weeks at which time based upon the findings will determine the continued frequency of the above audits.	



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

PRINTED: 03/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2015
NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748	
(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 323	Continued From page 53 She also ensured the bracelets were checked along with their batteries. She educated the Administrator and DON on the missing resident policy. Interview with Chief Nurse Executive, on 02/13/15 at 12:42 PM, revealed she had educated the DON and Administrator on 01/21/15. She educated them on the elopement policy, missing person policy and checking the Accutech tags, how to complete a head count, update care plans and resident assessments. Interview with the DON, on 02/12/15 at 4:12 PM and the Administrator on 02/12/15 at 5:01 PM, revealed they were educated by the Facility Consultant, Regional Vice President and the Chief Executive on 01/21/15.	F 323	3. Staff were educated on the new front door procedure by the Administrator, Director of Nursing, Staff Development Coordinator, Quality of Life Director, Administrative Assistant, Admissions Director, Business Office Manager, Human Resources Director, Dietary Manager, Quality of Life Assistant, Chaplain, or Assistant Director of Nursing. This was completed on 02/13/15. The Plant Operations Director and Director of Nursing are each keeping a roster of dates that wanderguards are placed on residents with their activation date and when they need to be replaced and alerting nursing staff as appropriate.	3/19/15
	14. Interview with the Plant Operations Director, on 02/12/15 at 3:05 PM, revealed he received training from the DON and Administrator on the elopement policy and missing resident policy. He was also educated on the door alarms, completing a head count, checking Accutech tags and implementing a care plan. The Plant Operations Director stated he had to complete a post test. Interview with Receptionist #1, on 02/12/15 at 3:47 PM, revealed she received training on elopement and when to call a code green by the Administrator. Record review of the training record for the elopement and missing resident policy, revealed there were 161 staff who were trained in person and twenty-two (22) persons who were called by phone. Record review of the training on the front doors, revealed 112 staff members were trained in person and seventy-one (71) staff members were trained by phone. Interview with Certified Nursing Assistant (CNA)		4. Regional Care Consultant Staff are providing oversight to the audits four times a week beginning 01/21/15 and continuing through 02/13/15 then bimonthly times six months. The elopement policy and procedure, missing resident, care plans and the elopement binders are being brought to the weekly at risk meeting, checked and updated as needed by the Social Services Director or Social Services Assistant. The At Risk Team will review the binders during the meeting. The At Risk team consists of Director of Nursing, Assistant Directors of Nursing, Social Services Director,	3/19/15



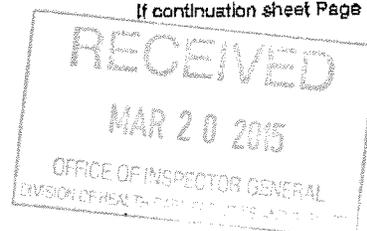
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2015
---	---	--	--

NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
--	--

(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 323	Continued From page 54 #17, on 02/13/15 at 4:02 PM, revealed she originally was educated by phone in regards to the front door on 02/06/15. CNA #17 stated she was educated in person on 02/12/15 to obtain education on the doors. CNA #17 stated she was taught that the doors would lock down after 9:00 PM at night and that staff would have to utilize a code to get out. If the alarm was to go off at the front door the alarm would alert at the nurses station. Interview with a Physical Therapist Assistant (PTA), on 02/13/15 at 4:05 PM, revealed she was educated on the front doors and the elopement policy by phone. The PTA stated she was asked to come in on 02/13/15 to receive education in person. She stated she had received training by the Dietary Manager and the Chaplain. The PTA stated the Dietary Manager educated her on the elopement policy and how they must assess why the door was alarming. He stated if they did not find a resident to complete a head count, call a code green and grab the elopement binder to see who was missing. The PTA stated she was educated by the Chaplain in regards to the front door locking after 9:00 PM. Interview with the Supply Clerk, on 02/13/15 at 4:10 PM, revealed she received a phone call about education on both the elopement policy and the front door policy. The Supply Clerk stated she obtained education by the Dietary Manager on 02/13/15. The Supply Clerk stated they went over code green and procedures to ensure resident safety. The Supply Clerk was also educated on how the front doors would lock down after 9:00 PM, the door would alarm if a code was not utilized which would alarm at the nurses station.	F 323	Social Services Assistant, Dietary Manager, Restorative Coordinator, or Quality of Life Director. The Admissions Director, Customer Experience Director, Medical Records Clerk, Assistant Business Office Manager, Business Office Manager, Human Resources Director, Social Services Assistant, Social Services Director, Unit Secretary, Chaplain, Quality of Life Director, or Dietary Services Manager will complete audits, weekly times eight weeks then monthly times six months. These audits will include validating the function of wanderguard tags on identified residents, return demonstration on how to check the functioning of wanderguard tags, and post tests on elopement with 12 staff. The Administrator will review the results of elopement post test and audits upon each week to determine if there are any trends or concerns. The results of these audits will be forwarded to the QA Committee for further review and recommendations. Completion Date: 3/20/15	



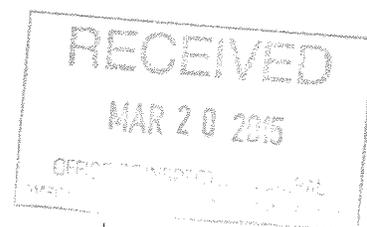
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2015
---	---	--	--

NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
--	--

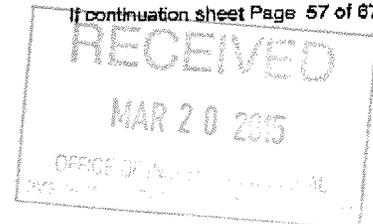
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 55 Interview with the DON, on 02/13/15 at 4:30 PM, revealed there were 183 staff members in total. Five (5) of which would have to have a certified letter sent to them because they were either out of the state or on Family Medical Leave Act (FMLA). Interview with the Administrator, on 02/13/15 at 2:28 PM, revealed she and the Administrative staff had educated staff members via phone on the elopement policy and the front door training. The Administrator stated she was not aware she could not provide education by phone. Those staff members who were educated by phone had "by phone" written next to their name. The Administrator stated she had all of the staff members to come in and receive education, as well as meet with staff at their homes and other places to ensure they were educated in person and would obtain there signature. Record review of the signatures, revealed all but five (5) staff members were not educated and would be upon starting their shift. Review of the post test revealed they were completed by staff on 02/02/15. 15. Review of the signatures of nurses who had obtained the training for how to complete an Accutech Tag function and battery check revealed return demonstrations were performed. Interviews with three (3) Registered Nurses and five (5) Licensed Practical Nurses revealed they had to complete a check off for how to utilize the Accutech tag to check for the function of the battery with the Plant Operations Director. Interview with the Plant Operations Director, on 02/13/15 at 1:36 PM, revealed the nurses had to	F 323		



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

PRINTED: 03/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/13/2015
NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748		
(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 323	Continued From page 56 complete demonstrations on the Accutech Tag devices. He made the nursing staff show him how to activate and deactivate the Accutech Tag and to identify if a tag was good or bad and if the tag was identified as low battery to have the staff document bad on the back of the Tag. Interview with the Plant Operations Assistant, on 02/12/15 at 3:05 PM, revealed he was educated by the Plant Operations Director on how to use the Stad-N device with the Accutech Tag with return demonstration. He then educated the nurses on how to utilize the machines as well. 16. Interview with the DON, on 02/12/15 at 4:12 PM, revealed she and the Administrator trained the staff and the staff members were given a post test which had to be passed with 100%, or re-education would be provided. The DON stated she had one (1) staff member who had to take the test again with re-education. The DON stated the post tests were completed by 02/06/15. Interview with the Administrator, on 02/12/15 at 5:01 PM, revealed she and the DON ensured staff received Post tests to the education that was covered for the when the door alarm sounds and how to respond. What the code for a missing person was and where were the elopement books were located. Review of the Post tests revealed 183 staff members completed post exams of the total 188 staff. 17. Interview with the Receptionist, on 02/12/15 at 3:47 PM, revealed she mailed out thirty-six (36) certified letters to the staff whom could not come into the facility for training through the Administrators directive. Interview with the Administrator, on 02/12/15 at 5:01 PM, revealed she sent out Certified letters to the staff on FMLA and who were PRN. She made sure she received	F 323			



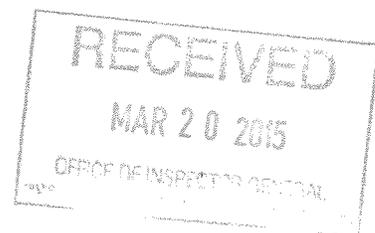
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2015
---	---	--	--

NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
--	--

(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 323	Continued From page 57 responses to ensure the staff had received the letters. 18. Interview with the Interim ADON; on 02/12/15 at 1:13 PM, revealed she was educated by the DON on the care plans and making sure the Doctor's orders, risk for elopement and behaviors matched the care plan. The DON also taught them to ensure the assessments were completed upon admission, quarterly and annually. Interview with the MDS Coordinator #2, on 02/12/15 at 3:30 PM, revealed she had received training by the DON in regards to the care plans, elopement and the assessments to ensure they were completed. The MDS Coordinator #2 stated during the morning clinical meetings staff would ensure that assessments were completed timely. Record review of the signatures for training revealed the Interim ADON and the MDS Coordinator #2 was in attendance for the care plan training that was provided on 01/27/15. Interview with the DON, on 02/12/15 at 4:12 PM; revealed she educated the ADONs and the MDS Coordinators about the care plans and ensuring the care plans matched the orders and assessments. The DON stated now the elopement binders had to come to the clinical meetings to ensure the care plans were up-to-date and all assessments were completed timely. 19. Observation of Residents #12, #13 and #14 on 02/13/15 at 4:30 PM, revealed their Accutech tags had dates of when the Accutech tag was activated. Interview with the Plant Operations Director, on 02/13/15 at 1:36 PM, revealed he had ordered a new batch of Accutech Tags and removed all of the old Accutech Tags from the residents who were identified to be an elopement risk. The Plant Operations Director stated he then	F 323		



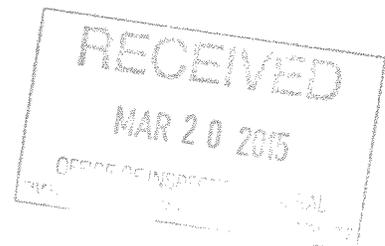
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2015
---	---	--	--

NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
--	--

(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)	(X6) COMPLETION DATE
F 323	<p>Continued From page 58</p> <p>dated the new Accutech tags and placed new ones on all of the residents identified to be an elopement. He stated he has a binder in which now he and the DON keeps track of the Accutech Tags and would be removing them at the eleven (11) month mark to ensure the Accutech tags function at their highest potential. Record review and observation of the Accutech Binder, revealed the binder was in place to keep track of the Accutech Tags. Both the Plant Operations Director and the DON had their own binder. Interview with the DON, on on 02/12/15 at 4:12 PM, revealed when new Accutech tags were received, the Plant Operations Director would date all of the tags and then have them logged into a binder so that they could monitor how old the Accutech tags were. The Nursing staff was not responsible to monitor the dates. The DON stated the Maintenance Director would write "BAD" on any Accutech Tags that were running on low battery or not functioning properly. The DON stated there was a binder in which she and the Plant Operations Director kept up with daily.</p> <p>20. Review of the sign in sheet for the Quality Assurance Meetings, revealed the DON, Administrator, Medical Director and the Regional Nurse Consultants attended QA on 01/21/15. Interview with the DON, on 02/12/15 at 4:12 PM, the Administrator on 02/12/15 at 5:01 PM, the Medical Director, on 02/05/15 at 5:47 PM and the Regional Nurse Consultant, on 02/12/15 at 3:00 PM, revealed all had attended the QA meeting on 01/21/15. The meeting consisted of root cause analysis, education, interventions, plans to prevent elopement and the policies. They also reviewed the audits to ensure there were no trends.</p>	F 323		



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

PRINTED: 03/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2015
---	---	--	--

NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
--	--

(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 323	Continued From page 59 21. Review of the sign in sheet for the QA meeting, held on 02/04/15, revealed the Medical Director attended a QA meeting. Interview with the Medical Director, on 02/05/15 at 5:47 PM, revealed he reviewed the procedures related to the change of the front door monitoring. 22. Review of the sign in sheet for the QA meeting on 02/06/15, revealed the Medical Director was in attendance. Interview with the Medical Director, on 02/05/15 at 5:47 PM, revealed he reviewed the elopement plan and was in agreement with the plan. 23. Interview with the DON, on 02/12/15 at 4:12 PM and the Regional Nurse Consultant, on 02/12/15 at 3:00 PM, revealed they had reviewed 113 incident and accident reports with no concerns with elopement noted. 24. Interview with the Plant Operations Director, on 02/12/15 at 5:05 PM, revealed he assessed the nursing staff on the Accutech Tag daily by doing return demonstrations. Interview with Social Services, on 02/12/15 at 2:33 PM, revealed there were random exams completed on staff daily to ensure competency of the elopement process. Interview with the Administrator, on 02/12/15 at 5:01 PM, revealed the staff completed random exams on staff daily to ensure competency. Record review of the post exams, located in a binder, revealed all 189 staff members were given an exam with a pass rate of 100%. 25. Interview with the Plant Operations Director, on 02/13/15 at 1:36 PM and the Plant Operations Assistant, on 02/12/15 at 3:05 PM, revealed they checked the door function daily and kept a log. Reviews of the Weekly Door Check Log, revealed	F 323		

RECEIVED
MAR 20 2015
OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF HEALTH & HUMAN SERVICES

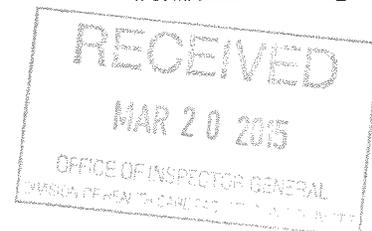
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2015
---	---	--	--

NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
--	--

(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 323	Continued From page 60 the doors were checked daily for functioning. 26. Interview with the Plant Operations Director, on 02/13/15 at 1:36 PM and the Plant Operations Assistant, on 02/12/15 at 3:05 PM, revealed they checked the functioning of the Accutech tags daily of residents who were identified to be an elopement risk.	F 323		
	27. Interview with the MDS Coordinator #2, on 02/12/15 at 3:30 PM, interview with Social Services on 02/12/15 at 2:33 PM, interview with the Interim ADON, on 02/12/15 at 1:13 PM and the DON, on 02/12/15 at 4:12 PM, revealed they all attended morning meetings and reviewed change of condition, new orders, new admissions, discharges and or transfers 5 days a week.			
	28. Interview with the Regional Care Consultant, on 02/12/15 at 3:00 PM, revealed she provided oversight to the audits of post test, door checks and Accutech tag checks, she had not identified any concerns patterns or concerns with the audits. Review of the Accutech tag checks by nursing on 01/21/15 revealed they were completed. Review of the door checks by maintenance revealed they were completed daily.			
	29. Interview with RN #2, on 02/05/15 11:33 AM, revealed she had worked at the facility for three (3) weeks and had obtained training on the Accutech Tag and the elopement procedures during orientation. She was familiar with the fact she had to assess the resident upon admission for elopement. She stated she was checking the Accutech Tags on every shift she worked. She stated if a battery was low she would obtain a new Accutech Tag and apply to the resident. She			



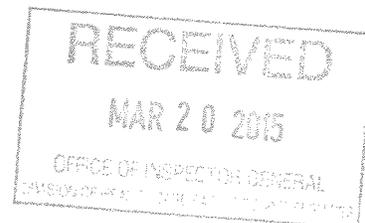
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2015
---	---	--	--

NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
--	--

(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 323	Continued From page 61 stated she was given a post test in which she passed. Interview with the Staff Development Coordinator, on 02/06/15 at 3:32 PM, revealed she educated the new hires on the policies, Accutech Tag, and how to activate and deactivate to assess for battery life. A test was given and the staff had to pass with a 100%.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure Dietician recommendations were acted on and followed through for one (1) of fourteen (14) sampled residents, (Resident #5). The facility documented a weight loss of 4.1% for Resident #5 and the Dietician in consultation made recommendations of which the facility failed to act on. The findings include: The facility did not provide a copy of a policy regarding consultant recommendations.	F 325	F 325 1. Resident #5 is no longer a resident at this facility. Resident #5 discharged from this facility on 01/16/15. 2. The Director of Nursing, Assistant Director of Nursing, Unit Manager, Restorative Nurse, Staff Development Coordinator, Director of Nursing from a sister facility, and MDS nurses are completing an audit to review Dietitian recommendations and new orders pertaining to Registered Dietitian recommendations to ensure orders were obtained. This audit will be completed on 03/19/2015.	1/16/15 3/19/15



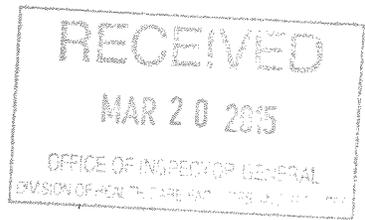
PRINTED: 03/02/2015
FORM APPROVED
OMB NO. 0938-0391

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

ELEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2015
	NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748

(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 325	Continued From page 62 Review of Resident #5's closed record, revealed the facility admitted the resident on 07/16/13, with diagnoses of Depressive Disorder, Dementia, Paralysis, Muscle Weakness, Acute Pain, and Cerebral Vascular Accident. Review of the Dietician's Notes, dated 01/05/15, revealed Resident #5 had sustained a 4.1% weight loss. The Dietician then documented recommendations, in the Dietician's Notes, for TwoCal supplement 60 milliliters (ml) two (2) times a day and a Thyroid Stimulating Hormone (TSH) blood level to ensure the level was not contributing to Resident #5's weight loss.	F 325	3. The Staff Development Coordinator will reeducate licensed nurses on notifying the MD and family on any Dietitian recommendations and on obtaining MD orders on the recommendations. This will be completed on 3/19/15. The dietitian will meet weekly with the Interdisciplinary team to review weight loss, interventions, recommendations, and effectiveness of interventions. beginning 3/13/15	3/19/15
	Review of Resident #5's physician orders, revealed no orders were obtained on 01/05/15 or thereafter for a TSH level or for TwoCal supplement. Resident #5 was sent to the ER for evaluation and treatment on 01/16/15 at 9:40 PM for shortness of air. Interview with the Dietician, on 02/11/15 at 10:28 AM, revealed she came to the facility on Mondays and Wednesdays. The Dietician stated on 01/05/15, she gave the ADONs' her recommendations through their mailbox's. The Dietician stated she did not attend care plan meetings or morning clinical meetings. The Dietician stated she did not follow up with her recommendations and relied on the nursing staff to complete the recommendations. The Dietician stated Resident #5 had lost 4.1% but it was not significant based on the Minimum Data Set (MDS) Assessment. If the recommendations were not followed through, then the resident could have continued to lose more weight which could have lead to a more significant concern.		4. The Director of Nursing, Assistant Director of Nursing, Unit Manager, Restorative Nurse, Staff Development Coordinator, and Medical Records Clerk will audit all RD recommendations once a week times 24 weeks to ensure compliance, then will audit ten charts per month to ensure compliance. The results of these audits will be reviewed at the Quality Assurance Meeting for further review and recommendations. Completion Date 3/20/15	3/13/15

If continuation sheet Page 63 of 67



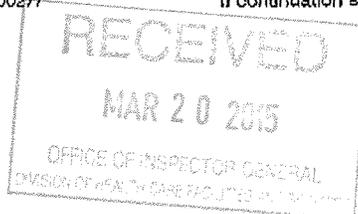
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2015
---	--	--	--

NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
---	--

(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 325	Continued From page 63	F 325		
F 514 SS=D	<p>Interview with the Interim Assistant Director of Nursing (ADON), on 02/10/15 at 3:29 PM, revealed she received the Dietician's recommendations through her mailbox. The Interim ADON stated she did not remember receiving the recommendations for Resident #5. If she had received the recommendations she would have discussed the recommendations with the doctor, obtain orders from the doctor and reported the orders in the morning meeting. The Interim ADON stated she was not sure who was responsible to follow through with the Dieticians recommendations to ensure they were followed. The Interim ADON stated if the recommendations were not followed through the resident could have had more weight loss.</p> <p>Interview with the Director of Nursing (DON), on 02/10/15 at 4:52 PM, revealed the DON did not remember receiving any recommendations from the Dietician regarding Resident #5. Normally the Dietician would place a copy of the recommendations in the ADONs' and DON's mailbox to ensure the form was addressed. The ADONs' would sign off on the recommendation that it was addressed and give the signed recommendation to the DON to ensure the information was followed through. The DON stated if Resident #5 was having weight loss, she would want to follow through to prevent further weight loss.</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional</p>	F 514	<p>F 514</p> <p>1. A Medical Record Review was completed on resident # 7 by the Director of Nursing on 01/10/15 to identify any discrepancies with</p>	01/10/15



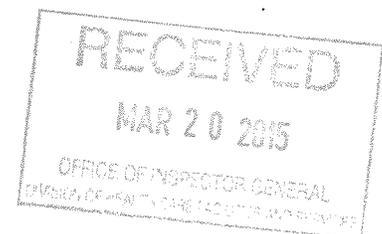
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2015
---	---	--	--

NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 65 #18, on 02/05/15 at 3:55 PM, revealed on 01/10/15 at 10:20 AM, Resident #7 appeared to have shortness of air and diaphoretic. CNA #18 stated she informed Licensed Practical Nurse (LPN) #8 that Resident #7 appeared to be diaphoretic and sweating and having difficulty breathing.	F 514	4. The Director of Nursing, Assistant Director of Nursing, Unit Managers, Customer Experience Director, Staff Development Coordinator, Medical Records Clerk, or Restorative Coordinators completed audits daily from 1/17/15 to 2/1/15 then weekly. The audits have continued weekly. The audits included running Omission Reports from EZMAR, reviewing 24 hour reports, Event Manager reports, and reviewing new MD orders.	02/17/15
	<p>Interview with LPN #8, on 02/05/15 at 4:10 PM, revealed CNA #18 had informed him that Resident #7 was diaphoretic and having some breathing problems. LPN #8 then went to assess Resident #7 and found him/her diaphoretic, so he obtained a temperature and the resident to have a low grade fever of 99.0 degrees Fahrenheit. LPN #8 stated he gave the resident some liquid Tylenol, a breathing treatment and an accucheck just to ensure the residents blood sugar was not elevated. Once he assessed Resident #7 and provided the treatments the resident was found to be resting comfortably. LPN #8 stated he had some difficulty with charting because the computer system would kick him off line quite frequently during his shift. LPN #8 stated when the end of the shift came he had forgotten to document what care he had provided.</p> <p>Review of Resident #7's Medication Administration Record (MAR) and Nurses Notes for 01/10/15, revealed no documentation could be provided for the Tylenol that was given, the blood sugar that was obtained or the nebulizer treatment that was given.</p> <p>Interview with the Unit Manager, on 02/05/15 at 4:49 PM, revealed she called LPN #8 and asked him if he had taken vitals and LPN #8 stated he had taken vitals and obtained a blood sugar. The Unit Manager stated LPN #8 had stated he</p>		<p>5. Completion Date 3/20/15</p>	



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

PRINTED: 03/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES & PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/13/2015
NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	Continued From page 66 documented on the 24 hour report, but did not make a late entry. The Unit Manager stated she had made rounds that day on the unit and did not see anything out of the ordinary with Resident #7. The Unit Manager stated with nursing there was a rule that if you can not prove it then it was not done. She stated with him not charting it would not be an accurate account of the resident and what was provided for him/her. The Unit Manager stated sometimes the computer ran slow, but usually it would come back on and then she would complete a late entry. Interview with the Director of Nursing (DON), on 02/10/15 at 4:27 PM, revealed she remembered talking with the Unit Manager and LPN #8 regarding Resident #7. The DON stated she talked to LPN #8 and he informed her that he had completed a finger stick and a breathing treatment on Resident #7. The DON stated she could not find any evidence that this had occurred. The DON stated they learn in school that if it was not documented then it did not occur and would say that the care provided that day was not reflected in the clinical record, therefore it was not accurate.	F 514			

