

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

PRINTED: 08/26/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185205	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  08/12/2010
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NAME OF PROVIDER OR SUPPLIER  GREEN VALLEY HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1206 ELEVENTH STREET CARROLLTON, KY 41045
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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
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F 000	INITIAL COMMENTS  A standard health survey was conducted on 08/10/10 - 08/12/10 and a Life Safety Code Survey was conducted on 08/11/10. Deficiencies were cited with the highest scope and severity of an "E" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.  A complaint investigation (KY# 14648) was conducted with the standard survey and was found to be substantiated and deficiencies were cited.	F 000		
F 167 SS=B	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE  A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.  The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.  This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to post the required notice informing the residents' of their rights to review Federal or State survey results and the plan of correction.  The findings include:  Observation during initial tour on 08/10/10 at 8:25am revealed there was no posting regarding	F 167	A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.  The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.  1. All survey results for the past 3 years were prominently displayed in visitor lounge by administrator on 8/11/10.  2. All survey results for the past 3 years were prominently displayed in visitor lounge by administrator on 8/11/10.  3. Administrator will ensure survey results are prominently displayed in visitor lounge not less than weekly.  4. Administrator will report results to QA on 9/25/10 and not less than quarterly thereafter.	9/25/10 24 mz 9/9/10 per facility

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 9/9/10
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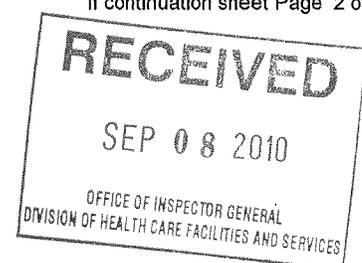
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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SEP 06 2010  
OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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F 167	Continued From page 1 the location of the survey book.  Interview on 08/10/10 at 3:30pm with Residents from the Group Council Meeting revealed Residents #5, #17, #18, #19, #20, #21, #22, and #23 had never seen a posting regarding the location of the survey results or the plan of correction.  Interview on 08/12/10 at 4:30pm with the Administrator and DON revealed they had not placed the survey results and the plan of correction in the front entrance since it was remodeled.	F 167	A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.  The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.	9/25/10 24 mz 9/9/10 per facility
F 168 SS=B	483.10(g)(2) RIGHT TO INFO FROM/CONTACT ADVOCATE AGENCIES  A resident has the right to receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.  This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to place the State and Federal survey results in a location readily accessible to the residents. In addition, the facility failed to provide information of the results for the survey conducted 01/20/10. The Administrator was unable to locate the information.  The findings include:  Observation of the facility on 08/10/10 at 8:45am during initial tour revealed there was no survey book located in accessible areas to the residents.	F 168	1. All survey results for the past 3 years were prominently displayed in visitor lounge by administrator on 8/11/10.  2. All survey results for the past 3 years were prominently displayed in visitor lounge by administrator on 8/11/10.  3. Administrator will ensure survey results are prominently displayed in visitor lounge not less than weekly.  4. Administrator will report results to QA on 9/25/10 and not less than quarterly thereafter.	



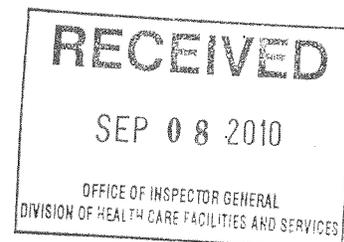
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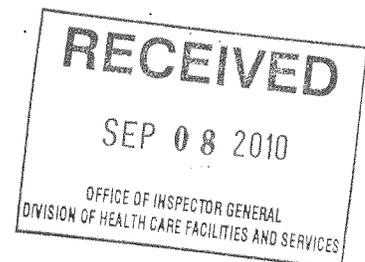
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F 168	Continued From page 2 However, on 08/10/10 at 11:00am the survey book was observed in a room behind the receptionist desk.  Interview on 08/10/10 at 3:30pm with Residents from the Group Council Meeting revealed Residents #5, #17, #18, #19, #20, #21, #22, and #23 were not aware of the location of the survey results.  Interview on 08/12/10 at 4:30pm with the Administrator and DON revealed the survey book was placed in the room behind the receptionist desk to prevent residents from tearing or removing pages.	F 168		
F 203 SS=E	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE  Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section.  Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.  Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more	F 203	Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section.  Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.  Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more	9/25/10 MZY 9/9/10 per facility



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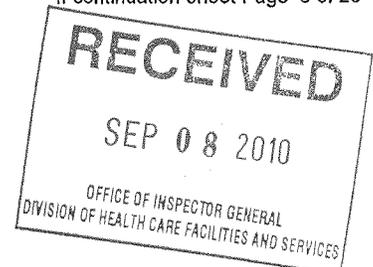
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F 203	Continued From page 3 immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.  The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.  This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to provide appropriate notices of discharge to two residents (#3 and #8) of the twenty three (23) sampled residents.  The findings include:	F 203	immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.  The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.  <b>1. Appropriate discharge notice given res #3 on 3/24/10 with address indicated by Social Services Director. No third notice given to res #8 after guardian refused to sign notice #2. Both notices rescinded by Administrator after judgments</b>	



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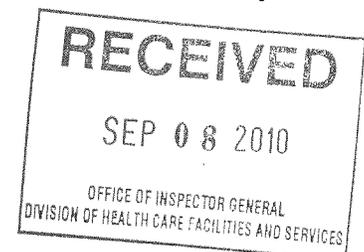
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F 203	<p>Continued From page 4</p> <p>Review of the facility policy on Transfer and Discharge dated 05/01/08 revealed the written notice of discharge would contain the following: a) the reason for the transfer; b) the effective date of the transfer or discharge; c) the location to which the resident is being transferred or discharged; d) a statement that the resident has the right to appeal the action to the Cabinet of Health and Family Services; e) the name, address, and telephone number of the State Long Term Care Ombudsman; f) if the resident has a developmental disability, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmental disabled individuals; and g) if the resident is mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals.</p> <p>Review of the clinical record for Resident #3 revealed an admission date of 03/14/09 with diagnoses of Depression, Spina Bifida, Cigarette Addiction, Congestive Obstructive Pulmonary Disease and Scoliosis. The Quarterly MDS dated 05/19/10 revealed the resident was alert and oriented and had no behavior or mood issues.</p> <p>Review of the notice of discharge dated 02/03/10 provided to and signed by the resident on 02/03/10 revealed the resident was to be discharged on 03/03/10 due to the safety of the other residents or individuals in the facility being endangered, with an additional note at the bottom, stating the resident was found to have an illegal substance in their system. The notice did not contain where the resident would be discharged to on 03/03/10.</p> <p>Review of the Order of Summary Reversal dated</p>	F 203	<ol style="list-style-type: none"> <li>2. All discharge notices audited for prior year by Administrator on 8/19/10. All notices were completed accurately and appropriately.</li> <li>3. Administrator will review all discharge notices prior to issue to ensure documents are completed correctly.</li> <li>4. Administrator will report results of reviews to QA on 9/25/10 and not less than quarterly thereafter.</li> </ol>	



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F 203	<p>Continued From page 5</p> <p>02/23/10 indicated the discharge notice included a blank line on which the facility may record the location to which the resident will be discharged; however, the facility failed to complete this essential component of the notice. The purported discharge was defective and must be held for naught. The discharge by the facility of Resident #3 was reversed for failure to comply with the notice requirements set forth in 900 KAR 2:050, Section 5(c).</p> <p>Review of a second notice of discharge dated 02/23/10 revealed the resident would be discharged on 03/24/10 with an address indicated.</p> <p>Record review for Resident #8 revealed an admission date of 12/21/08 and diagnoses of Ruptured Aneurysm, Left Parietal Intercranial Hemorrhage, Status Epilepticus, Chronic Pain, Immobilization Syndrome and Cigarette Addiction. The Quarterly MDS dated 06/04/10 indicated the resident was alert and oriented with short term memory deficit and had no behavior or mood issues.</p> <p>Review of the Notice of Discharge dated 02/03/10 revealed the resident was to be discharged on 03/03/10 due to the safety of the other residents or individuals in the facility being endangered. In addition, a note at the bottom of the notice stated the resident was found to have an illegal substance in their system. The notice did not indicate where the resident was to be discharged to.</p> <p>Review of the Show Cause Order and Order Staying Discharge dated 04/06/10 indicated the facility did not include the location to which the</p>	F 203			



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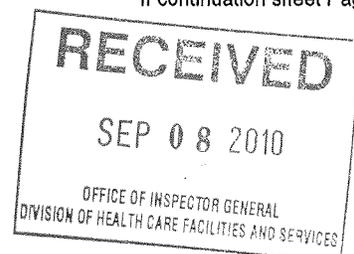
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F 203	Continued From page 6 resident was being transferred or discharged. As a result, the notice of discharge was insufficient. The facility was ordered to show cause why the discharge should not be summarily reversed because it did not comply with 900 KAR 2:050. In addition, the discharge of the resident from the premises of the facility was stayed.  Review of the second notice of discharge to Resident #8 dated 04/15/10 indicated a discharge date of 05/14/10 with no signature of the resident or legal guardian.  Interview with Resident #3 on 08/11/10 at 9:00am revealed he/she was issued a notice of discharge for smoking marijuana out in the parking lot with another resident. The resident appealed the notice and the facility let him/her stay.  Interview with Resident #8 on 08/11/10 at 8:05am revealed he/she did not remember receiving a notice of discharge or why the facility issued it. The resident also did not remember the legal guardian appealing the notice.  Interview with Social Services on 08/11/10 at 10:00am revealed she was not involved in the notice of discharge letter provided to Residents #3 and #8.  Interview with the Administrator on 08/11/10 at 3:00pm revealed the notices of discharge were rescinded and the facility did not appeal the judgment for both Residents #3 and #8.	F 203			
F 205 SS=B	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR  Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic	F 205			



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F 205	<p>Continued From page 7</p> <p>leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.</p> <p>At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to provide one (1) of twenty three (23) sampled residents (Resident #14) with a copy of the bed-hold policy at the time of transfer to an acute care hospital on three (3) different occasions.</p> <p>The findings include:</p> <p>Record review for Resident #14 revealed the resident was admitted to the facility on 04/29/10 with diagnoses of Pneumonia, Urinary Tract Infection, Diabetes, and Atrial Fibrillation.</p> <p>The resident was admitted to the hospital on 05/10/10, 05/26/10, and 06/17/10 for respiratory distress. The facility could not provide evidence that the resident was given a copy of bed-hold</p>	F 205	<p>Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.</p> <p>At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.</p> <ol style="list-style-type: none"> <li>1. Res # 14 was discharged from facility on 4/29/10.</li> <li>2. All discharges audited for prior 60 days by Administrator on 8/19/10. All residents transferred without appropriate notice of bed hold were informed of this right.</li> </ol>	<p>9/25/10 24 MZF 9/19/10 pm facility</p>



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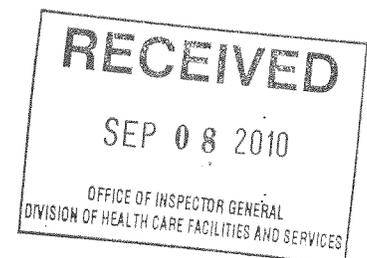
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F 205	Continued From page 8 policy prior to being hospitalized.  Interview with Licensed Practical Nurse Floor Supervisor on 08/12/10 at 9:20am revealed that if a resident is transferred to an acute facility, nursing staff does not provide a copy of the bed-hold policy to the resident. The floor supervisor further revealed that social services are responsible for providing a copy of the bed-hold policy to the resident.  Interview with Social Service Assistant on 08/12/10 at 10:40am revealed that a copy of the bed-hold policy is only given upon admission to the facility.	F 205	3. Social Services Director educated by Administrator on 8/16/10 regarding bed hold policy upon transfer to ensure appropriate procedures observed.  4. Social Services Director will audit 25% of all bed holds upon transfer to ensure policy followed and will report results of audit to QA on 9/25/10 and not less than quarterly thereafter.	
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to develop abuse policies to include checking out of state nurse aide abuse registries when that information is made known to the facility. The facility failed to check out of state nurse aide abuse registries for two (2) out of ten (10) employee files sampled.  The findings include:  Review of the facility's policy on Abuse Prohibition, not dated, revealed all individuals/applicants will be interviewed and may	F 226	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  1. Abuse registry check performed by Office Manager on 8/13/10 on two employees cited. Neither were listed on the abuse registries of their respective states.  2. All employee records were audited by Office Manager by 8/20/10 to ensure abuse registry checks performed in all states of residence. All current employees met this compliance standard.	9/25/10 24 MJS 9/9/10 per facility



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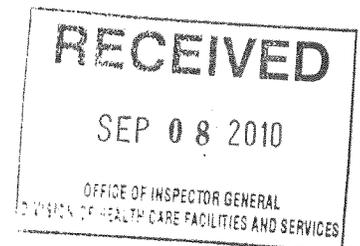
PRINTED: 08/26/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185205	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  08/12/2010
NAME OF PROVIDER OR SUPPLIER  GREEN VALLEY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 ELEVENTH STREET CARROLLTON, KY 41045	
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F 226	Continued From page 9 be hired after an investigation that includes measures that are within the facility's control. Inquires are made to determine the individual's status on the Kentucky Abuse Registry.  Review of ten (10) employee personnel files revealed one nursing assistant hired 05/18/10 had previously lived and worked in California. In addition, one nursing assistant hired 07/16/10 had lived and worked in Arkansas. Neither of the files had evidence of nurse aide abuse registry checks from either state.  Interview with the Administrator on 08/11/10 at 2:45pm revealed it was not in the abuse policy. The break in the system occurred when the criminal record check comes back and no one checks it for out of state addresses. The policy would have to be changed.	F 226	3. Policy amended by Administrator on 8/12/10 to include abuse registry checks in all states of residence for all new staff. Office Manager educated by Administrator regarding new policy and procedure.  4. Office Manager will audit 25% of records of all new hires to ensure new policy and procedure observed, and will report results of audit at QA on 9/25/10 and not less than quarterly thereafter.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure maintenance and housekeeping services necessary to maintain a clean, sanitary environment was provided on one (1) of three (3) residential units in the facility.  The findings include:  Observation during the survey tour of the facility on 08/10/10 at 8:45am revealed wallpaper peeling	F 253	The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  1. Wallpaper and linoleum will be repaired by Maintenance Director by 9/25/10.  2. Maintenance Director inspected entire facility on 8/13/10 for instances of peeled wallpaper and separated linoleum and found nothing in disrepair.  3. Maintenance Director educated by Administrator on 8/13/10 regarding the safety hazard peeled wallpaper and raised linoleum may pose. Maintenance Director will inspect wallpaper and flooring monthly for any area needing repair.	9/25/10 24 mzg 9/9/10 pm facility

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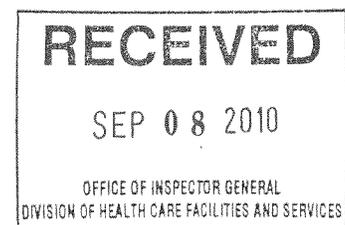
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F 253	Continued From page 10 from a wall on the skilled nursing unit. Further observation during the initial tour on 08/10/10 at 8:55am also revealed linoleum which was raised and separated from the floor in front of room 37 and 42.  An interview on 08/12/10 at 10:00am with the Housekeeping Director, during the environmental tour of the skilled unit, revealed she had been employed with the facility for two (2) months and she stated the wallpaper had been peeling since her hire. She also stated the floor linoleum had been glued down by maintenance staff but that it continuously popped back up. She stated this could be a falls hazard.  Interview with the Maintenance Director on 08/12/10 at 10:00am, during the environmental tour on the skilled unit, revealed the wallpaper had been on the walls since 1989. He also stated that he applied glue to the back of the wallpaper to reattach it to the wall when he was notified of it peeling. The Maintenance Director stated the reason the linoleum was separating and raised from the floor was due to it not having been cut and laid properly. He also stated he had been re-gluing the linoleum to seal it but it loosened over time, and he stated he recognized the loose linoleum could be a falls hazard.	F 253	4. Maintenance Director will present results of monthly inspections at QA on 9/25/10 no less than quarterly thereafter.		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed	F 280	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.	9/25/10 24 M3 9/9/10 per facility	



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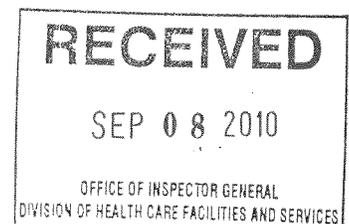
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F 280	<p>Continued From page 11</p> <p>within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other 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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to revise the comprehensive care plan for one (1) of twenty-three (23) sampled residents. Resident #6 had an order to discontinue the code alert for elopement on 04/07/10, and the facility failed to remove it from the comprehensive care plan and the nursing assistant care plan.</p> <p>The findings include:</p> <p>A review of the facility policy for Resident Assessment Instrument (RAI) Process and Care Planning revealed that care plans are to be used by all staff and updated as necessary to reflect care provided.</p> <p>Observation of Resident #6 on 08/10/10 at 11:30am revealed a well groomed resident who was ambulating to the dining room with a walker independently. There was no code alert/Wandergard on the resident.</p>	F 280	<p>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 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.</p> <ol style="list-style-type: none"> <li>1. The code alert was removed from both the comprehensive care plan and the nurse aide care plan by MDS Coordinator on 8/12/10.</li> <li>2. Care plans for all residents with code alerts audited to ensure accuracy and consistency by MDS Coordinator on 8/13/10.</li> <li>3. MDS Coordinator educated regarding importance of accuracy of documentation to resident care by Administrator on 8/13/10. MDS Coordinator will audit 25% of all residents with code alerts quarterly to ensure correct documentation.</li> </ol>	



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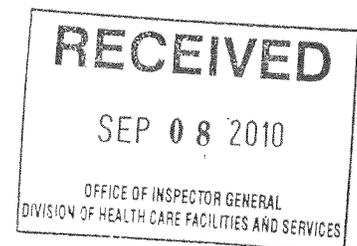
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F 280	Continued From page 12  An interview with Resident #6 on 08/10/10 at 2:30pm revealed the resident thought he/she had only been at the facility a couple of months. The resident stated he/she wanted to get back home to the apartment where the resident used to live.  A review of the medical record for Resident #6 revealed the resident was admitted on 01/06/09 with diagnoses including Dementia with behaviors, Convulsions, and Squamous Cell Carcinoma of the scalp. A review of the annual Minimum Data Set (MDS) assessment dated 12/28/09 revealed the resident was assessed with a cognition of independent with decision making. Review of the Quarterly MDS dated 06/18/10 revealed no change in cognition, an improvement in ambulation and bed mobility, and independent with set up help only.  A review of the Elopement Risk Assessment revealed Resident #6 was determined to be a high risk for elopement on admission and throughout the quarterly reviews until 06/14/10 because the resident is physically able to leave the facility and the resident exhibits periods of confusion. On 06/14/10 Resident #6 was assessed as not making attempts at elopement. The code alert was removed from the Elopement Risk Assessment.  A review of the Physician's orders revealed on 04/07/10 the code alert was discontinued.  A review of the Comprehensive Care Plan for Resident #6 updated on 01/06/10, 03/31/10 and 06/30/10 revealed the resident was at risk for elopement with interventions including wander guard alarm, test wander guard every night to	F 280	4. Care Plan Coordinator will report results of audits to QA on 9/25/10 and no less than quarterly thereafter.		



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F 280	Continued From page 13 ensure properly working. and redirect the resident away from doors. The wandergard/code alert was not discontinued from the care plan.  A review of the Certified Nursing Assistant care plan for August 2010 revealed that Resident #6 was checked for a Code Alert.  A review of the Treatment Administration Record (TAR) for Resident #6 revealed an order to check code alert every shift for the months of April, May, June, and July, that the nurses had signed off every shift.  An interview with the (MDS) nurse on 08/12/10 at 9:15am revealed the system for removing orders included the standard practice that the nurse who removes the order should take it off the care plan and TAR. She stated a yellow copy of the order goes to the Medical Records person and they check to make sure the order was taken off. She stated the order just got missed.  An interview with the Medical Records staff on 08/11/10 at 4:20pm revealed she double checks all the new orders each day. She stated that it did not get taken off the April orders, so the order was hand written back in on the TAR.  Interview with Registered Nurse (RN) #2 revealed that Resident #6 has periods of confusion, and the resident forgets why he/she is at the facility. The RN stated the resident has never attempted to leave the facility. In addition, the RN verbalized that once an order is received to discontinue the Wander Guard then that information is given to the Assistant Director of Nursing.	F 280			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309			



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F 309	Continued From page 14  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to follow Physician orders for two (2) of twenty-three (23) sampled residents (#2 and #12). Resident #2 had a Physician's order for Thrombo Embolic Deterrent (TED) hose that was not followed. Resident #12 had an order for weekly Hemoglobin and Hematocrit (H&H) that was not completed for sixteen (16) days.  The findings include:  1. Record review revealed a Physician's order was received on 08/05/10 for TED hose for Resident #2 to be applied in the AM and off in the PM. The medical record revealed Resident #2 was re-admitted from the hospital on 08/05/10. Resident #2's Diagnoses included Paranoid Schizophrenia, Hearing Loss and Pneumonia.  Observation on 08/10/10 at 11:50am revealed Resident #2 in bed with no TED hose present. Continued observations on 08/10/10 revealed at 12:25pm, 12:35pm, 2:07pm, 2:50pm, and 4:08pm the resident had no TED hose in place.  Observation of Resident #2 on 08/11/10 at	F 309	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  1. TED hose applied to resident #2 by Unit Nurse on 8/12/10. H&H obtained on resident #12 on 8/6/10.  2. ADON completed a lab audit of all residents on 8/13/10. All care plans and MARS audited by MDS Coordinator on 8/13/10 to ensure treatment orders completed and correct.  3. Staff in-servicing performed on placement of equipment and devices by Director of Nursing on 8/17/10. Staff in-serviced on lab procedures by DON on 8/17/10. Procedures amended to check all returned labs against lab board to ensure accuracy.  4. Assistant Director of Nursing will audit 10% of all labs and 10% of all residents with assistive devices monthly for accuracy and report results to QA on 9/25/10 and no less than quarterly thereafter.	9/25/10 24 M2 9/9/10 per facility

