

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

PRINTED: 10/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185144	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/25/2014
NAME OF PROVIDER OR SUPPLIER PROVIDENCE HOMESTEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 1608 VERSAILLES ROAD LEXINGTON, KY 40504	

(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 Recertification Survey and an Abbreviated Survey investigating KY00022236 was initiated on 09/23/14 and concluded on 09/25/14. Deficiencies were cited with the highest Scope and Severity of a "D". KY00022236 was unsubstantiated with a related deficiency.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	F 157	It is the intent of this facility to comply with the standard to immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status; a need to alter treatment significantly; a decision to transfer or discharge the resident from the facility; or when there is a significant change or need to alter treatment. On 6-26-14, 6-29-14, and 8-19-14, the nurse followed Physician orders to stabilize the resident's blood sugar. In the event the FSBS falls below seventy (70), the Physician or Advanced Practice Registered Nurse (APRN) will be notified. In the event the resident's Physician/APRN is not	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE Administrator (X6) DATE 11-21-14

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

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F 157	<p>Continued From page 1</p> <p>the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review and of facility policy, it was determined the facility failed to ensure the Physician was notified when there was a significant change or need to alter treatment for one (1) of twenty-four (24) sampled residents (Resident #12).</p> <p>Resident #12's Fingerstick Blood Sugar (FSBS) on 06/26/14 at 7:30 AM was noted to be forty-five (45) and on 08/09/14 at 6:00 AM, the resident's FSBS was documented as thirty-three (33) and the resident was symptomatic with diaphoresis and confusion on both occasions. However, there was no documented evidence the Physician or Advanced Practice Registered Nurse (APRN) was notified although the resident had Physician's Orders to notify the Physician if the resident's blood sugar was less than seventy (70).</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Care Path: Mental Status Change", dated 2010, revealed if a resident was having an acute mental status change with new or increased confusion, a FSBS was to be obtained for diabetics. Further review revealed if the resident's FSBS glucose was less than seventy (70) or greater than four hundred (400), the nurse was to notify the Physician/APRN immediately.</p> <p>Review of the facility's policy titled, "Physician Notification", undated, revealed a significant</p>		<p>available, the Medical Director will be notified. If the Medical Director is unavailable, and the resident's condition is severe, the resident will be sent to the Emergency Room. The nurse involved was re-educated regarding proper physician notification on 9-26-14. On 10-15-14, Resident #12, the Resident's responsible party, and the Resident's Attending Physician were notified that on 8-9-14, 6-26-14, and 6-29-14 the nurse failed to document that the Physician or APRN was notified regarding the Resident's medical condition.</p> <p>Because all residents have the potential to be affected, on 10-20-14, the DON and facility's Nursing Supervisors' reviewed 133 resident charts to ensure documentation was present indicating the Physician or APRN was notified regarding each resident's medical condition as necessary. It was reported that any charts found to not have proper documentation regarding Physician/APRN notification, the Nursing Supervisors' would present them to the QA Officer for review.</p>		

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F 157	<p>Continued From page 2</p> <p>change in a resident's condition should be reported to the Physician in a timely manner.</p> <p>1. Review of Resident #12's medical record revealed the facility admitted the resident on 01/27/11, and he/she had diagnoses which included Diabetes Mellitus, Non-Alzheimer's Dementia and Cerebrovascular Accident (CVA). Review of the Quarterly Minimum Data Set (MDS) Assessment dated 07/24/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of a nine (9) out of fifteen (15) indicating moderate cognitive impairment.</p> <p>Review of the Monthly Physician's Orders dated June 2014, revealed orders for: Lantus 100 Units/ML (milliliter) Insulin (long acting insulin), inject forty (40) units SQ (subcutaneously) once daily; Metformin Extended Release (oral antidiabetic medication) 500 MG (milligram) SR (sustained release) once daily with a meal; and accuchecks (FSBS) twice daily.</p> <p>Review of the Nurse's S-BAR (Situation-Background-Assessment-Recommendation) Progress Note dated 06/26/14 at 7:30 AM, all documentation was written by Registered Nurse (RN) #4, revealed Resident #12's blood sugar was forty-five (45), the resident was alert, drank juice with sugar packets in it and ate a "fair" breakfast. Continued review of the Note revealed a late entry for 8:30 AM which stated the resident's blood sugar was two hundred and ten (210) and the resident was alert and oriented with no complaints of pain. The Note revealed the nurse attempted to notify APRN #1 at 10:00 AM, however the nurse had to leave a message for the APRN. A Note written at 3:35 PM revealed</p>		<p>It was found that three (3) out of the 133 resident charts reviewed did not have proper documentation indicating Physician/APRN notification. To ensure proper interventions are in place, despite the missing documentation indicating the Physician notification, the DON and Nursing Supervisors' audited Physician orders to ensure that proper orders were given by the Physician to treat the three (3) residents' medical condition as necessary. There were Physician orders present for all three (3) of the residents', indicating the Physician treated each residents' medical condition as necessary; however, the nurse who attempted to contact the Physician failed to properly document his/her attempt to notify. The nurses' who failed to provide proper documentation were re-educated on the facility policy to notify the Physician on 10-20-14.</p> <p>To ensure immediate compliance with the cited deficiency, on 10-20-14, the Staff Development Coordinator initiated re-education for all RNs, LPNs, and SRNAs from all three (3) shifts, both weekdays and weekends, on the state and federal requirements, and facility policy, to ensure proper Physician notification. It was taught</p>		

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F 157	<p>Continued From page 3</p> <p>APRN #1 had been called and a message left for her in reference to Resident #12's low blood sugar that morning, and gave Lantus Insulin as ordered later in the morning with no adverse symptoms noted.</p> <p>Review of the Medication Administration Record (MAR) dated June 2014 revealed Resident #12 had a FSBS of forty-five (45) on 06/26/14 at 8:00 AM. Additional review of the MAR dated June 2014 revealed Resident #12 also had a FSBS of sixty-eight (68) on 06/29/14 at 8:00 AM. Continued review of the record revealed no documented evidence further attempts were made by facility nurses to contact the Physician or APRN #1 regarding Resident #12's low FSBS on 06/26/14, and no documented evidence nurses contacted APRN #1 or the Physician regarding the resident's low FSBS on 06/29/14. Review of a Physician's Note dated 07/09/14 written by APRN #1 revealed Resident #12 was having low blood sugars in the AM (morning), especially if he/she did not have a snack before bedtime. Review of the Physician's Orders written on 07/09/14 and signed by APRN #1 on 07/09/14, revealed an order to change Resident #12's Lantus insulin to thirty-eight (38) units SQ at 8:00 AM related to low AM FSBS.</p> <p>Interview, on 09/25/14 at 3:20 PM, with RN #4 revealed the Physician's Orders for June 2014 stated the Physician was to be notified if Resident #12's FSBS was less than 70. RN #4 stated she attempted to call APRN #1, who she was to call in the daytime from 8:00 AM to 5:00 PM, on 06/26/14 two (2) times; however, she was unable to reach the APRN and left messages on her voice mail. Continued interview revealed she made no further attempts to call the APRN or to</p>		<p>that prompt resident Physician (APRN, NP, PA) notification will be made in the event of a critical lab value report. If Physician (APRN, NP, PA) notification is unsuccessful the Medical Director will be contacted. If a phone message is left and the resident's Physician (APRN, NP, PA) or the Medical Director does not return the call and the resident's condition is declining, the resident will be sent to the ER along with Physician, POA/family member, and DON notification. Nursing documentation will include times each attempt was made and to whom. If a new Physician's Order is required regarding a critical lab or glucose value, the Physician and POA/family member will be notified and documented.</p> <p>To ensure ongoing compliance, beginning the week of 11-17-14, the DON and Nursing Supervisors' from all three (3) shifts, both weekdays and weekends, initiated weekly audits of five (5) resident medical records from each of the six (6) nursing stations to ensure proper Physician notification. This audit will be conducted by the Nursing Supervisors' and DON, checking written documentation from all three (3) shifts both weekdays and</p>	
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F 157	<p>Continued From page 4</p> <p>contact the Physician. She revealed although there was a Physician's Order for Physician notification of a FSBS less than 70, Resident #12 had responded to interventions which included juice with sugar packets in it and the resident had eaten a good breakfast, so she did not feel it was urgent to reach the Physician or APRN since the resident's blood sugar came up. She stated if Resident #12's blood sugar had not come up, she would have contacted the Physician who was the back up for APRN #1.</p> <p>Interview, on 09/25/14 at 4:05 PM, with APRN #1 revealed there were Physician's Orders covering what to do if Resident #12 had a low blood sugar to include notifying the provider. She stated however, if a message was left for her stating Resident #12's blood sugar came back up she might not have returned the call. She further stated, if Resident #12's blood sugar had not come up, she would have expected the nurse to keep trying until she reached a provider.</p> <p>2. Further review of Resident #12's Monthly Physician's Orders dated August 2014, revealed orders for Lantus thirty-eight (38) Units SQ once daily in the AM, Metformin ER 500 MG every day with a meal, and Glutose 15 40% (forty percent) Gel (used to treat a hypoglycemic reaction before unconsciousness occurs), one (1) tube by mouth as needed for FSBS less than seventy (70) and symptomatic, alert, and able to swallow.</p> <p>Review of the Nurse's Note dated 08/09/14 revealed: at 6:00 AM, Resident #12 was diaphoretic and confused and the resident's FSBS was 33 with a tube of Glutose Gel given and the resident was to be monitored; at 6:30 AM, the resident's FSBS was 111 and he/she was</p>		<p>weekends. The audit will continue for eight (8) weeks. The results of these audits will be submitted to the QA Officer for tracking and review. If it is discovered that the Physician (APRN, NP, PA) has not been properly notified, the QA Officer will immediately notify the Physician (APRN, NP, PA) regarding the resident's change of condition as well as in-service the nurse who did not follow the facility policy to properly notify the Physician. The QA Officer will bring the results of the audits to the QA Committee for review. The QA Committee consists of the following members of the interdisciplinary team: Director of Nursing, Medical Director, Infection Control, Nursing Supervisor, Social Worker, Activities Coordinator, Consultant Pharmacist, Dietary Manager, Rehabilitation Director, and Administrator. The QA Committee will then determine if more frequent audits are necessary and the time frame the audits will continue.</p> <p>The results of the DON and Nursing Supervisor's eight (8) week audit, or thereafter, will be brought to the QA Committee by the QA Officer for interdisciplinary review. Any deficiencies will be corrected in a</p>		

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F 157	<p>Continued From page 5</p> <p>eating a peanut butter sandwich and was alert and cooperative; at 6:45 AM a voice mail message was left for APRN #2 and a note was left in the APRN's book. Further review of these Notes revealed they were all written by RN #5. However, continued record review revealed no documented evidence further attempts were made by facility nurses to contact APRN #1 or the Physician regarding Resident #12's low FSBS on 08/09/14. Record review revealed on 08/12/14, a Physician's Order was written to change Resident #12's Lantus insulin to thirty-six (36) Units SQ each 8:00 AM.</p> <p>Interview, on 09/25/14 at 4:30 PM, with RN #5 revealed she had attempted to call APRN #2 and left a voice mail message, and had written a note in the APRN #1's book related to Resident #12's low blood sugar on 08/09/14. However, she stated she did not feel it was an urgent situation since the resident's blood sugar came back up after administration of the Glucose Gel and the resident was also eating. RN #5 stated nurses called the Director of Nursing (DON) if they couldn't get "hold" of a provider, but it was an unusual situation not to be able to get hold of a provider. She indicated she had asked the "on-coming" nurse if she would "keep trying to call" the provider.</p> <p>Interview with Resident #12's Attending Physician on 09/25/14 at 5:53 PM, revealed he was not sure of the facility policy, but he would expect the nurse to follow the Physician's Orders related to low blood sugar, such as Glucose Gel and also attempt to get the resident to eat and nurses could call him. Continued interview revealed if the low blood sugars were a continued problem he would expect the nurses to ensure the</p>		<p>timely manner and reviewed for any further corrective action. The QA Committee will authorize any change to the plan of correction for frequency of audits or further needed interventions.</p> <p>Completion Date: 11-27-14</p>		
		F226	<p>It is the intent of this facility to comply with the standard to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>On 9-24-14, the facility submitted to the appropriate State Agencies a final five (5) day report for Resident #8, Resident #9, and Resident #10; as per the facility policy.</p> <p>Because all residents have the potential to be affected by this, on 11-1-14, the facility's QA Officer audited OIG/APS investigation files that have been submitted to OIG/APS in the last three (3) months to ensure a proper five (5) day follow-up report was filed. The QA Officer audited, in total, six (6) investigation files. The QA Officer concluded that a five (5) day follow-</p>		

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F 157	Continued From page 6 provider was notified. Interview with the DON on 09/25/14 at 5:30 PM, revealed she expected the nurses to verbally speak with a provider regarding a resident's low blood sugar immediately if the blood sugar did not come up with interventions. She stated she expected the nurses to verbally speak to a provider within twenty-four (24) hours if the resident's blood sugar was stable with the interventions ordered. She further stated if the provider did not return the call within twenty-four (24) hours the Medical Director should be contacted.		up report was submitted for each of the six (6) reports audited. To ensure immediate compliance with the cited deficiency, on 11-1-14, the Administrator and DON decided to elect the Administrator and DON as the Abuse Coordinators. It will be the responsibility of the Abuse Coordinators to submit a five (5) day follow-up report. On 11-17-14, the QA Officer initiated educated of all staff from each of the three (3) shifts, both weekdays and weekends, of the following procedure regarding five (5) day follow-up reports: In the event of an alleged incident of abuse, the initial twenty-four (24) hour report will be submitted to the Abuse Coordinators. Upon receiving this report, the Abuse Coordinators will set the date of the five (5) day report, track progress of the investigation and submit the five (5) day report by the fifth day. The five (5) day report will include a report of all investigation findings and appropriate action taken within five (5) days of the occurrence of the incident.		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based interview, record review and review of the facility policy, it was determined the facility failed to implement their abuse policy related to reporting of findings of the investigation within five (5) days of the investigation for three (3) of three (3) sampled residents (Residents #8, #9 and #10). Allegations of misappropriation of property were made by Resident #8, Resident #9 and Resident #10; however, the facility provided no documented evidence a final five (5) day reports was sent after completion of the investigation to the State Agencies as per the facility policy.				

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F 226	<p>Continued From page 7</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Resident Abuse/Neglect Policies and Procedures, Abuse Investigation", revised 02/08/12, and "Reporting Abuse to State Agencies and Other Entities/Individuals Policy Statement", revised 03/21/14, revealed the Administrator or his/her designee would provide the State Survey Agency with a report of all investigation findings and appropriate action taken within five (5) days of the occurrence of the incident.</p> <p>Review of the facility's, "Long Term Care Facility-Self Reported Incident Form, Initial Report" dated 09/08/14 revealed: Resident #8 had reported an allegation of missing money on 09/07/14; Resident #9 had reported an allegation of a missing purse containing credit cards on 09/08/14; and Resident #10 had reported an allegation of missing money from his/her wallet on 09/07/14. However, after request by the Surveyor, the facility provided no documented evidence of the final five (5) day investigation report findings having been sent to the State Survey Agency as per the facility policy.</p> <p>1. Record review for Resident #8 revealed the facility assessed the resident on 08/31/14 to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) indicating he/she was cognitively intact and interviewable.</p> <p>Interview, on 09/23/14 at 10:00 AM, with Resident #8 revealed she had reported missing money to facility staff and had been questioned about the money. Resident #8 stated he/she knew who took the money; however, would not tell who it</p>		<p>To ensure ongoing compliance, the QA Officer will be responsible to audit the reporting procedure. Every time an initial report is submitted to OIG/APS by the Abuse Coordinators, the Abuse Coordinators will present the report to the facility's morning stand-up meeting so that the interdisciplinary team is made aware. The members of the interdisciplinary team present at the facility's morning stand-up meeting includes the following: Administrator, DON, Nursing Supervisor, QA Officer, Dietary Manager, Social Worker, Housekeeping Manager, Admissions Coordinator, and Rehab Director. The QA Officer will check with the Abuse Coordinators to ensure the fifth day has been determined. On the fifth day, the QA Officer will audit the OIG/APS investigation files to ensure the five (5) day follow-up report was submitted. This audit will be standard practice and continue indefinitely for each incident reported to OIG/APS. If the QA Officer finds any errors made during the audit, he/she will present them to the QA Committee for interdisciplinary review. The QA Committee consists of the following members of the interdisciplinary team: Director of Nursing, Medical</p>		

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F 226	Continued From page 8 was because "God" would "handle it". 2. Record review for Resident #9 revealed the facility assessed the resident on 07/25/14 to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) indicating he/she was cognitively intact and interviewable. Interview, on 09/23/14 at 11:15 AM, with Resident #9 revealed he/she had reported her missing "Coach" purse which was "expensive" having been taken from his/her closet to facility staff and an investigation had been started. Resident #9 stated the police had found his/her "belongings" which had been in the purse, but had not found the purse. 3. Record review for Resident #10 revealed the facility assessed the resident on 07/17/14 to have a Brief Interview for Mental Status (BIMS) score of ten (10) indicating he/she was moderately cognitively impaired and interviewable. Interview, on 09/23/14 at 10:30 AM, with Resident #10 revealed he/she had reported missing money to facility staff; however, indicated he/she could not recall if he/she had been interviewed about it. Interview with the Social Worker (SW) on 09/24/14 at 8:50 AM and 9:00 AM, revealed she had completed the facility's investigation into Resident #8's, Resident #9's and Resident #10's allegations, and indicated she had interviewed the residents during the investigation. She stated the police were notified of Resident #8's missing money allegation, Resident #9's missing purse and credit cards allegation and Resident #10's allegation of missing money. Per interview, however, the police had not finished their		Directory, Infection Control, Nursing Supervisors, Social Workers, Activities Coordinator, Consultant Pharmacist, Dietary Manager, Rehabilitation Director, QA Officer and Administrator. Any deficiencies will be corrected in a timely manner; this will consist of ensuring a five (5) day follow-up report is immediately submitted to OIG/APS. The findings of the QA checks will be documented and submitted at the monthly QA Committee meeting for further review or corrective action. The QA Committee will authorize any change to the plan of correction for frequency of audits or further needed interventions. Completion Date:	11-22-14	
		F 282	It is the intent of this facility to comply with the standard to ensure that services are provided or arranged by qualified persons in accordance with each resident's written plan of care.		

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F 226	<p>Continued From page 9</p> <p>Investigation which was ongoing, and that was why the final five (5) day report regarding Resident #8's, Resident #9's and Resident #10's allegations of misappropriation of property was not faxed to the State Survey Agency yet. Additional interview with the SW on 09/24/14 at 10:50 AM, revealed she was the only SW who worked for the facility, and the facility reported misappropriation of resident property to the State Survey Agency, State Adult Protection Agency (APS) and to the police. The SW reported during this interview she "thought" the final five (5) day investigation report had been faxed by the Director of Nursing (DON) to the State Survey Agency after she (SW) had turned the completed investigation into her (DON).</p> <p>Interview with the DON on 09/24/14 at 11:40 AM and on 09/25/14 at 5:30 PM, revealed the facility's process was for: an incident report to be completed by the nurse and the nurse was to call her; the SW investigated incidents and allegations; the incident reports were taken to the daily meeting and discussed to see what happened and what could be done to prevent further incidents; and the facility had five (5) days to file a final investigation report with the State Agencies. The DON indicated she had not faxed the final five (5) day reports regarding Resident #8's, Resident #9's and Resident #10's allegations of misappropriation of property to the State Survey Agency as per facility policy. She stated the SW would have sent the final five (5) day investigation reports to the State Agencies after she completed the investigations regarding the residents' allegations. However, interview with the SW revealed she had turned the investigation results into the DON to fax to the State Survey Agency.</p>		<p>On 9-24-14, nursing staff provided Resident #18 derma sleeves for upper and lower extremities. The resident refused. The staff completed a "Refusal Form" which was placed into the Resident's chart. On 9-24-14, Dycem was placed above and below Resident #18's wheelchair cushion to reduce the risk of sliding out from the chair.</p> <p>On 10-15-14, Resident #12's blood sugar levels were tested to ensure they were above seventy (70). In the event they drop below seventy (70), the staff has been educated to follow the written plan of care to notify the Physician. Additionally, the responsible party for Resident #12 was notified that although there was a Physician's Order to be notified if the resident's blood sugar dropped below seventy (70), there was no documented evidence the care plan was followed regarding Physician notification.</p> <p>Because all residents' have the potential to be affected by this, on 10-20-14, the facility's DON and Nursing Supervisors' completed an audit of 133 resident charts/written plans of care to ensure they are being followed accurately. The audit consisted of</p>		

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F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy, it was determined the facility failed to ensure the Comprehensive Plan of Care was followed for three (3) of twenty-four (24) sampled residents (Residents #12 and #18).</p> <p>Resident #18's Comprehensive Care Plan revealed interventions for Derma Sleeves (devices which protect fragile skin) to the upper and lower extremities and for Dycem (non slip material) above and below the wheelchair cushion; however, observation on 08/25/14 revealed the resident was not wearing the Derma Sleeves, nor was Dycem above or below the wheelchair cushion.</p> <p>Resident #12's Fingertstick Blood Sugar (FSBS) on 06/26/14 at 7:30 AM was forty-five (45) and on 08/09/14 at 6:00 AM, the resident's FSBS was 33 and the resident was symptomatic with diaphoresis and confusion. Although there was a Physician's Orders to notify the Physician if the resident's Blood Sugar was less than seventy (70), and an intervention on the resident's Care Plan for the resident to have fingerstick blood sugars within normal limits and consult the Physician as needed, there was no documented evidence the Care Plan was followed related to ensuring notification.</p>		<p>visual observations of care provided as well as review of resident care plans. It was reported that any discrepancy between the resident's written plan of care and actual care-provided were to be clarified, promptly corrected, and updated. Any discrepancies found were to be reported by the DON and Nursing Supervisor to the QA Officer. Ultimately, the DON and Nursing Supervisor's audit and observation of resident care plans found that three (3) of the 133 resident care plans weren't followed properly. Of the three (3); one (1) resident didn't have a wheelchair cushion in place, one (1) was wearing regular shoes instead of heal lift boots, and one (1) resident wasn't wearing derma sleeves. The DON promptly corrected each issue found; the wheelchair cushion was placed on the resident's wheelchair, heal lift boots were put on the resident wearing regular shoes, and derma sleeves were put on the resident for ADL care. All RNs, LPNs, and SRNAs were re-educated regarding these residents' care plans. Education was initiated on 10-20-14.</p>		

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F 282	<p>Continued From page 11</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Resident Care Plan", undated, revealed residents' Care Plans contained directions for the individual resident's care and staff were required to follow the Care Plan as written.</p> <p>1. Review of Resident #18's medical record revealed the facility admitted the resident on 08/31/11, with diagnoses which included Senile Dementia, Psychosis, Adult Failure to Thrive, and Seizure Disorder. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 07/29/14, revealed the facility assessed Resident #18 as having a Brief Interview for Mental Status (BIMS) score of a five (5) out of fifteen (15) indicating severe cognitive impairment.</p> <p>Review of the Monthly September 2014 Physician's Orders revealed orders for Derma Sleeves (arm and leg protector sleeves for those who bruise easily such as the elderly) to the bilateral upper and lower extremities at all times for protection. Further review revealed orders for Dycem (a non-slip material) to the wheelchair above and below the wheelchair cushion.</p> <p>Review of the Comprehensive Care Plan initiated 05/05/14, revealed Resident #18 was at risk for falls due to the resident being non-ambulatory and diagnoses including Dementia with Behaviors, Psychoses, Seizures, and Weakness. Continued review of the at risk for falls care plan revealed the interventions included Dycem above and below the wheelchair cushion. Additional review of the Comprehensive Plan of Care revealed Resident #18 was also at risk for</p>		<p>To ensure immediate compliance with the cited deficiency, on 10-20-14, the Staff Development Coordinator initiated re-education of all RNs, LPNs, and SRNAs to follow the comprehensive plan of care. It was taught that adherence to the residents' plan of care by all staff is required; should any restorative, protective device (such as Derma Sleeves or Dycems), or any treatment be noted on the individual resident's plan of care, these treatments will be implemented; should the resident refuse such treatments, refusal forms will be completed as soon as possible and placed in the resident's record.</p> <p>To ensure ongoing compliance, on 11-17-14, Nursing Supervisors', from both weekday and weekend shifts, and the QA Officer will conduct weekly audits of five (5) residents' care plans from the six (6) nursing stations for eight (8) consecutive weeks. The audits will include nurse aid care plans, comprehensive care plans, physician orders for any items that pertain to care plans, and visual observations to ensure that care provided to residents' is in accordance with the written plan of care. Any trends found will be reported to the DON. It will be the responsibility of</p>	
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F 282	<p>Continued From page 12</p> <p>Pressure Ulcers and had obtained skin tears on 05/25/14 and 08/10/14. Continued review of the at risk for Pressure Ulcers care plan revealed the interventions included Derma Sleeves to be utilized to Resident #18's bilateral upper and lower extremities.</p> <p>Review of the September 2014 "My Care Plan" for Resident #18, utilized for daily provision of care, revealed the intervention for Derma Sleeves to the bilateral upper and lower extremities at all times was present, and the Derma Sleeves might be removed for Activities of Daily Living (ADL's), then reapplied. Further review of the "My Care Plan" revealed the intervention for Dycem above and below the wheelchair cushion.</p> <p>Observation of Resident #18 on 09/25/14 at 2:45 PM, revealed the resident was in bed lying on her/his back with covers pulled up to the chin, a bed alarm was on the bed frame and a mat on the floor on the left side of the bed. Interview with State Registered Nursing Assistant (SRNA) #11 at the time of the observation, revealed she was assigned to Resident #18's care that day and was familiar with the resident. Observation revealed SRNA #11 checked to ensure Resident #18's Derma Sleeves were in place to the upper and lower extremities as per the care plan. However, SRNA #11 stated Resident #18 did not have the Derma Sleeves in place on the upper or lower extremities as care planned. Further observation revealed SRNA #11 checked Resident #18's wheelchair which was in the resident's bathroom, and stated there was no Dycem on top or below the wheelchair cushion as per the care plan. SRNA #11 revealed she used "My Care Plan" which was the Nurse Aide Care Plan on the inside of the resident's door for reference in provision of</p>		<p>the DON to monitor these trends on a weekly basis. In the event that discrepancies are found, they will be immediately corrected and the DON will bring those issues to the monthly QA meeting for review by the interdisciplinary team.</p> <p>The DON will present the results of the eight (8) week audits to the QA Committee for interdisciplinary review. Any deficiencies will be corrected in a timely manner and the findings of the QA checks will be documented and submitted to the monthly QA Committee meeting for further review or corrective action. If the results of the audits indicate written plans of care are not being followed, the QA Committee will authorize any change to the plan of correction for frequency of audits or further needed interventions.</p> <p>Completion Date:</p>	11-22-14	

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F 282	<p>Continued From page 13</p> <p>care of residents. The SRNA stated SRNA's were to check "My Care Plan" on the inside of resident's doors as needed and at the beginning of the shift. Further observation revealed SRNA #11 checked the "My Care Plan" which was hanging on the inside of Resident #18's bathroom door, and confirmed the resident was to have Derma Sleeves to his/her upper and lower extremities, and to have Dycem to the wheelchair cushion. She stated she had not realized Resident #18 was to have these interventions in place even though she was to have checked the resident's "My Care Plan" at the beginning of her shift.</p> <p>Interview with Licensed Practical Nurse (LPN) #6 on 09/25/14 at 3:00 PM, revealed the nurses checked to ensure devices were in place such as Derma Sleeves and Dycem throughout the shift; however, they did not use a reference or audit sheet. Continued interview revealed the nurses used the Treatment Administration Record (TAR) for reference when checking for residents' devices. Review of the September 2014 TAR revealed the Derma Sleeves were on the TAR as an FYI (for your information). Further interview with LPN #6 revealed the Derma Sleeves were on the TAR as an FYI and the nurses did not sign off for those. LPN #6 further stated the Dycem was not on the TAR. LPN #6 stated the SRNA's were to follow the nurse aide care plan.</p> <p>Interview, on 09/25/14 at 5:30 PM, with the Director of Nursing (DON) revealed the SRNA's were to follow the Nurse Aide Care Plan which was located inside Resident #18's bathroom door. She stated nurses were to supervise the SRNA's to ensure the care plan was followed and interventions implemented.</p>	F 323	<p>It is the intention of this facility to ensure the residents' environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>On 1-14-14, the QA Officer conducted a root cause analysis to attempt to determine the cause of Resident #9's fall in order to implement appropriate interventions to prevent future falls. The root cause analysis consisted of review of the Incident Report filed by the Charge Nurse at the time of the incident, an interview with the resident in question, an interview with staff present at the time of the incident, and an assessment of the physical environment. The Incident Report and interview indicated that the resident requested privacy while washing in the restroom. The Nurse's assessment of the physical environment indicated that while the resident was left in privacy, a puddle of water gathered on the tile in the Resident's bathroom causing the resident to slip and fall. As an intervention, on 1-14-14, the QA Officer applied non-skid tape to the Resident's bathroom floor to prevent future falls. The responsible party for Resident #9 was informed on 10-16-14</p>	

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F 282	<p>Continued From page 14</p> <p>2. Review of Resident #12's medical record revealed the facility admitted him/her on 01/27/11, and he/she had diagnoses which included Non-Alzheimer's Dementia and Diabetes Mellitus. Review of the Quarterly MDS Assessment dated 07/24/14, revealed the facility assessed Resident #12 to have a BIMS score of nine (9) out of fifteen (15) which indicated moderate cognitive impairment.</p> <p>Review of Resident #12's Comprehensive Care Plan initiated 05/08/14, revealed the resident was care planned for his/her diagnosis of Diabetes Mellitus with a stating the resident would be free from any signs and symptoms of hyperglycemia. Continued review of the care plan for Diabetes Mellitus revealed interventions which included the resident would have Fingerstick Blood Sugars (FSBS) within normal limits, and a Physician consult as needed.</p> <p>Review of the June 2014 Monthly Physician's Orders revealed orders for: Lantus Insulin (long acting insulin) 40 units SQ (subcutaneous) once daily; Metformin Extended Release (oral antidiabetic medication) 500 MG (milligram) SR (sustained release) once daily with a meal; and FSBS two (2) times daily.</p> <p>Record review revealed on 06/26/14 Registered Nurse (RN) #4 documented at 7:30 AM Resident #12's FSBS was forty-five (45) and the resident drank juice with additional sugar added and he/she was alert and had eaten a "fair" breakfast. A late entry for 8:30 AM revealed Resident #12's FSBS was now two hundred and ten (210). Review revealed the nurse had attempted to call Advanced Practice Registered Nurse (APRN) #1,</p>	2	<p>of the citation related to the accident on 1-14-14. The Resident's care plan was reviewed and updated, on 1-14-14, indicating the need for non-skid tape in the resident's bathroom in order to prevent future falls. Additionally, an assessment of Resident #9 was completed on 9-23-14 to address right-sided numbness and weakness if he/she stood for an extended period of time. The Physician approved Physical Therapy Plan of Care addressed these issues through an evaluation of strength of all extremities', balance, and cognition. This evaluation reinforced the need for non-skid tape in the resident's restroom as well as a front wheeled walker for safe ambulation to prevent future falls.</p> <p>Because all residents' have the potential to be affected by the cited deficiency, on 10-20-14, the QA Officer initiated an audit of residents' Incident Reports from the last fifteen (15) falls to determine if proper root-cause analysis was completed. It was found that although interventions were put in place for each resident to prevent future falls, fifteen (15) out of the fifteen (15) Incident Reports were missing documentation of a thorough root-cause analysis. On 10-20-14, the</p>	
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F 282 Continued From page 15
and had to leave a message regarding Resident #12's low FSBS. Additionally, at 3:35 PM the nurse noted she again called and left a message for APRN #1 regarding Resident #12's low FSBS that morning, and she had given the resident's Lantus Insulin as ordered later in the morning.

Review of Resident #12's June 2014 Medication Administration Record (MAR) revealed the resident also experienced a FSBS of sixty-eight (68) on 06/29/14 at 8:00 AM. However, review of Resident #12's record revealed no documented evidence RN #4 or other nurses made further attempts to consult the Physician as per the care plan. Record review revealed on 07/09/14, APRN #1 documented Resident #12 had been experiencing low blood sugars, especially if he/she had not had a bedtime snack. Review of a Physician's Orders dated 07/09/14 revealed an order to decrease Resident #12's Lantus Insulin to thirty-eight (38) units SQ at 8:00 AM related to his/her morning low FSBS.

Review of Resident #12's August 2014 Monthly Physician's Orders revealed orders for Lantus Insulin thirty-eight (38) Units SQ once daily in the morning and Glucose 15 40% Gel (used to treat a hypoglycemic episodes prior to unconsciousness), one (1) tube by mouth as needed for FSBS less than seventy (70) if the resident was symptomatic, alert, and able to swallow.

Record review revealed on 08/09/14, RN #5 documented at 6:00 AM, Resident #12 had symptoms of low blood sugar of diaphoresis and confusion, her/his FSBS was 33 and the nurse administered Glucose Gel. RN #5 noted at 6:30 AM Resident #12's was alert, eating a peanut

facility's QA Officer reviewed all fifteen (15) of the residents written plans of care to make sure that proper interventions were in place preventing future falls, despite the fact that a root-cause analysis wasn't completed. The results of this review show that fall prevention measures are in place for each of the residents' at risk for a fall.

To ensure immediate compliance with the cited deficiency, on 10-20-14, the Staff Development Coordinator initiated re-education for all RNs, LPNs, and SRNAs from all three (3) shifts, both weekdays and weekends, of the facility's "Incident Report Policy and Procedure". It was taught that the Incident Report Policy and Procedure was updated to include a thorough investigation and root cause analysis in order to establish appropriate interventions are in place to prevent future falls. It will be the responsibility of the Charge Nurse to do an evaluation of the resident's physical condition at time of incident to check for injury. Furthermore, it was taught that the investigation will be the responsibility of the QA Officer, and will include an interview with the resident in question, collection of the Incident Report completed by the Charge Nurse at the

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F 282	Continued From page 16 butter sandwich and his/her FSBS was 111. At 6:45 AM RN #5 documented she had left a voice mail message for APRN #2, and had entered a note in the APRN's communication book. However, continued review of Resident #12's record revealed no documented evidence RN #5 or other nurses made further attempts to consult the Physician as per the care plan. On 08/12/14, a Physician's Order was received to change Resident #12's Lantus Insulin to thirty-six (36) Units SQ at 8:00 AM each day. Interview with RN #5 on 09/25/14 at 4:30 PM, revealed she had felt Resident #12's low blood sugar was an urgent event as his/her blood sugar came up. RN #5 revealed she had asked the nurse she gave report to, if she would continue to try to call the APRN. Interview, on 09/25/14 at 5:30 PM, with the Director of Nursing (DON) revealed she would expect nurses to verbally speak with an APRN or Physician regarding a resident's low blood sugar if the blood sugar did not respond to interventions, but if after interventions the resident's blood sugar was stable the provider could be contacted in twenty-four (24) hours of the low blood sugar event. However, the DON stated it was her expectation for residents' care plans to be followed, and this was the nurse's responsibility.		time of incident, interview with the Nurse who completed the report, and any other staff members who were present when the incident occurred, and an assessment of the physical environment. The results of this investigation will be documented on the Root-Cause Analysis Form and kept for a period of fifteen (15) months. To ensure ongoing compliance, on 10-20-14, the QA Officer created a Root-Cause Analysis Form for each resident to provide written documentation explaining the cause of each fall. The root-cause analysis will be the responsibility of the QA Officer, and will include an interview with the resident in question, collection of the Incident Report, interview with the Nurse who completed the report and any other staff members who were present when the incident occurred, and an assessment of the physical environment. The results of this investigation will be documented on the Root-Cause Analysis Form and kept for a period of fifteen (15) months. The results of each root-cause analysis will be presented at the daily Stand-up Meeting. The daily Stand-up Meeting consists of the following members of the Interdisciplinary		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to				

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F 323	<p>Continued From page 17 prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure supervision to prevent accidents for one (1) of twenty-four (24) sampled residents (Resident #9). Resident #9 sustained a fall on 01/14/14; however, there was no documented evidence the facility conducted a thorough investigation and performed a root cause analysis regarding the fall in order to ensure appropriate interventions were in place to prevent further falls.</p> <p>The findings include: Review of the facility's policy titled, "Fall Prevention Policy & Prevention", udated, revealed the facility would take measures to assess each resident for risk of falls and intervene to try to prevent falls. Review after a resident experienced a fall an Incident Report was completed by the nurse for "in-house communication purposes". Per the Policy, the Incident Report included assessment to review what was currently in place for fall prevention, and if any new interventions were possible to prevent additional falls. Continued review of the Policy revealed every shift follow up assessment charting was to be performed for seventy-two (72) hours after a fall. Further Policy review revealed falls were "reviewed in the resident daily safety meeting to again assess for new interventions". However, review of the Policy revealed no documented evidence the facility would perform a</p>		<p>Team: DON, Nursing Supervisor, QA Officer, Dietary Manager, Activities Director, Housekeeping Supervisor, Social Worker, Rehabilitation Director, and Administrator. The Interdisciplinary Team will be responsible to ensure and approve the appropriate intervention. Furthermore, it will be the responsibility of the DON to audit the Root-Cause Analysis Form following each fall to ensure the QA Officer completed a thorough investigation and proper interventions are in place. The DON will present the results of the audit to the QA Committee for review.</p> <p>The DON and QA Officer will bring the results of the Root-Cause Analysis From audits to the QA Committee. Any deficiencies will be corrected in a timely manner and reviewed for further corrective action. The Quality Assurance committee will authorize any change to the plan of correction for frequency of audits or further needed interventions.</p> <p>Completion Date:</p>	11-22-14	

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F 323	Continued From page 18 root cause analysis to attempt to determine the cause of a resident's falls in order to identify appropriate interventions to prevent future falls. Review of the facility's policy titled, "Incident Report Policy and Procedure", undated, revealed the facility assessed residents after falls for signs of injury. Policy review revealed incident reports would be "started" upon numerous incidents which included alleged resident falls by the nurse assigned as Charge Nurse for the resident involved. Per the Policy, the Charge Nurse was to report all incidents including falls to the Nursing Supervisor and Director of Nursing (DON). The Policy revealed all incident reports were to be forwarded to the DON and were to be discussed in the "safety meeting". Continued review of the Policy revealed the incident reports would then be forwarded to the facility's Quality Assurance Department and "logged" on the "event log". The Policy further revealed after the incident reports were "logged" on the "event log", the incident reports were destroyed within seventy-two (72) hours. However, further review of the Policy revealed no documented evidence the facility would perform a root cause analysis after a resident's fall to attempt to determine the cause of the fall and in order to implement appropriate interventions to prevent future falls. Record review revealed the facility admitted Resident #9 on 11/14/13, with diagnoses which included Muscle Weakness, History of Falls, Dementia, Debility, Osteoarthritis and Spinal Stenosis. Review of the Admission Minimum Data Set (MDS) Assessment dated 11/21/13, revealed the facility assessed Resident #9 to have a Brief Interview for Mental Status (BIMS) score of thirteen (13) which indicated the resident	F 325	It is the intent of this facility to maintain the standard set forth by CMS to 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. Resident #4 was discharged to home, as planned, from the facility on 9-27-14; therefore, no further monitoring will be necessary for Resident #4's daily nutritional intake. Because other residents have the potential to be affected by the cited deficiency, on 10-28-14, the Director of Nursing initiated an audit of fifteen (15) resident weights for the past month to ensure that all weights were obtained and reported per the facility's "Resident Weights" policy. The audit consisted of review of the residents medical records and daily nutritional intake, looking specifically for residents with a		

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F 323	<p>Continued From page 19</p> <p>was cognitively intact. Continued review of the MDS Assessment revealed the facility assessed Resident #9 to require extensive assist of one (1) staff for transfers, ambulation, toileting and bathing Activities of Daily Living (ADLs). Review of Resident #9's Comprehensive Care Plan dated 11/15/13, revealed the facility care planned the resident as a high risk for falls or injury related to being unsteady, muscle weakness, confusion at times and Osteoarthritis. Continued review of the fall risk care plan revealed interventions included: extensive assistance of one (1) to two (2) staff support was to be provided for transfers and ambulation; call light to be in reach; encourage the resident to call for help and not to attempt unsafe self transfers.</p> <p>Interview with Resident #9 on 09/23/14 at 4:23 PM, revealed he/she fell in the bathroom one (1) day while standing at the bathroom sink to "wash up". Resident #9 revealed he/she was left alone in the bathroom after telling a female staff person, who he/she could not recall the name of, he/she had right-sided numbness and weakness and could not stand for long periods of time.</p> <p>Continued interview revealed Resident #9 while he/she was standing at the sink washing up, his/her right side became numb and he/she fell to the floor where the resident reported laying for "at least fifteen (15) minutes" before a male staff person came and found him/her. Resident #9 reported he/she had told the female staff person prior to going to the bathroom, he/she wanted to "wash up" by the bed, but the female staff person told him/her he/she could not do that.</p> <p>Continued record review revealed a Nurse's Note dated 01/14/14 at 11:45 AM which noted a State Registered Nursing Assistant (SRNA) had come</p>		<p>weight gain or loss of five (5) lbs. Of the fifteen (15) resident weights audited, five (5) residents were found to have a weight change of +/- 5 lbs. These charts were examined to determine whether the Registered Dietician (RD), responsible party, and Physician were notified as well as re-weighing each resident to ensure accuracy of the initial weight. It was determine that the RD, responsible party, and Physician were notified of the weight change for each of the five (5) residents'. Furthermore, a re-weight and review of nutritional intake of each of the (5) residents' confirmed the accuracy of the initial weight; therefore, ensuring proper nutritional parameters and accuracy of weight obtained.</p> <p>To ensure immediate compliance with the cited deficiency, on 10-20-14, the Staff Development Coordinator initiated re-education for the staff involved with weight and nutrition management. The staff involved with weight and nutrition management include the Dietary Manager, Registered Dietician, Nursing Supervisor, DON, and QA</p>		

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to the nurse to report finding Resident #9 sitting on the floor between the bathroom sink and commode. The Note revealed the nurse assessed Resident #9, and the resident told her he/she had been "washing off" and had requested the SRNA with him/her "shut" the bathroom door. Further review of the Note revealed a "request" was "put in for maintenance" to apply non-skid strips to the bathroom floor, and every fifteen (15) minute checks "were started as well". In addition, the Note revealed the nurse documented: Resident #9 was "also encouraged to ask for assistance as much as possible"; had a personal safety alarm to his/her bed and recliner; and staff would continue to monitor the resident. However, further review of the Note and medical record revealed no documented evidence Resident #9 was interviewed regarding the cause of his/her fall, even though the facility had assessed the resident to be cognitively intact, and in interview with the Surveyor he/she had stated the fall was related to right-sided numbness and weakness and he/she could not stand for long periods of time.

Review of the facility's "Event Log" dated 01/14/14 at 11:45 AM, revealed Resident #9 had experienced a fall; however, further review of the Log revealed no documented evidence the facility had attempted to perform a root cause analysis of the resident's fall in order to identify appropriate interventions.

Continued review of Resident #9's Comprehensive Care Plan dated 11/15/13, revealed the fall risk care plan was revised on 01/14/14 to include interventions which included non-skid strips by the bathroom sink and every fifteen (15) minute checks of the resident.

Officer. It was taught that if there is a variance +/- five (5) lbs. from the previous weight, a re-weight will be obtained, documented, and further review of the resident's nutritional parameters will be conducted. In the event a resident has a significant weight gain or weight loss, the Director of Nursing, Nursing Supervisor, Dietary Manager, and Registered Dietician will review consumption, intake, and status to determine the root cause of the weight change.

To ensure ongoing compliance with the cited deficiency, the Dietary Manager or Dietary Manager Assistant will audit the nutritional intake and weights for every resident and present this information to the weekly Standards of Care Committee for review and any further needed intervention. The Standards of Care Committee consists of the DON, Nursing Supervisor, QA Officer, Dietary Manager, Registered Dietician, Therapy Department, and Social Services. This audit will continue each week moving forward as part of the Standards of Care Committee. Additionally, if any

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F 323	Continued From page 21 Interview with Licensed Practical Nurse (LPN) #3 on 09/24/14 at 6:28 PM, revealed Resident #9 had experienced a fall in January shortly after he/she was admitted to the facility. LPN #3 revealed Resident #3 had been in the bathroom at the time of the fall, she had assessed the resident who had no injury, completed an incident report and notified the Physician and family. LPN #3 indicated she had not interviewed Resident #9 about the reason for his/her fall. Interview with State Registered Nursing Assistant (SRNA) #2 on 09/25/14 at 12:50 PM, revealed she was assigned to Resident #9 on the day of his/her fall. SRNA #2 stated she ambulated Resident #9 to the bathroom to the commode with assistance and once in the bathroom the resident asked the SRNA to close the bathroom door for privacy. SRNA #2 stated she closed the door as request, but left it cracked slightly, and told the resident to let her know when he/she was finished. Per interview, however, the resident attempted to get up without assistance from off the commode to wash his/her hands and fell. SRNA #2 indicated the resident had been using the toilet, not washing up at the sink. However, interview with Resident #9 revealed he/she had been assisted to the bathroom to "wash up" by an SRNA prior to his/her fall. Interview with the Quality Assurance (QA) Nurse on 9/25/14 at 4:10 PM, revealed there was no documentation regarding a root cause analysis after Resident #9's fall on 01/14/14, because this was done verbally in discussion with the Interdisciplinary Team (IDT), and then the IDT determined the interventions to be put into place. Per interview, the interventions the IDT put in		trends relevant to this cited deficiency are found, the QA Officer or Dietary Manager will present them to the QA Committee for further interdisciplinary review. Any deficiencies will be corrected in a timely manner, and, if necessary, authorize any change to the plan of correction for frequency of audits or further needed interventions. Completion Date:	11-22-14	
		F 441	It is the intent of this facility to comply with the minimum standard to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. On 9-24-14, SRNA #12 was promptly re-inserviced by the Staff Development Coordinator on the facility's Hand Hygiene Policy and peri-care. Resident #3 was put under continuous observation evaluating signs and symptoms of infection and change in vital sign or condition over		

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F 323	Continued From page 22 place for Resident #9 after his/her fall were for non-skid strips by the bathroom sink and commode. The QA Nurse stated the interventions were then documented and implemented and had been effective "to present" date. Interview with the DON on 09/25/14 at 5:30 PM revealed the QA Nurse goes to every unit to read incident reports, care plans and Nurses Notes when a resident experiences a fall. She stated the incident of the fall was discussed in the morning "safety meetings", to see what could be done to keep the incident from happening again. Per interview, a fall would be discussed in the "safety meeting" with root cause analysis, although the root cause analysis would not be specified in documentation because there was the Nurses Notes, fall "event log" and incident notes to refer to. The DON revealed any staff that was involved in the incident were interviewed and these interviews documented on the incident report. Further interview with the DON, revealed incident reports were shredded after seventy-two (72) hours, but the Nurses Notes should reflect documentation of injuries, range of motion, interviews and notification of the Physician and family. However, no documented evidence Resident #9 was interviewed after his/her fall on 01/14/14 or of a root cause analysis for the resident's fall in review of the resident's medical record and review of the facility's "event log", furthermore, there was no documented evidence of an incident report provided after Surveyor request.		the next thirty (30) days, no changes occurred. Vital signs were checked weekly and remained within normal limits. Resident #3 remains a-symptomatic for fever, change in mental status, urinary pain, and abnormal urine odor. Additionally, Resident #3's room was examined by an RN to ensure a safe, sanitary and comfortable environment to prevent the spread of disease and infection. The examination showed a safe, sanitary and comfortable environment to prevent the spread of disease and infection. Because other residents have the potential to be affected, on 10-20-14, the Director of Nursing identified eighty (80) incontinent residents who could possibly be at risk of infection due to poor hand hygiene related to improper peri-care. The DON identified these residents and reviewed the nurse aid care plans, Infection Control Log, and the daily Physician orders. The resident audits conducted on 10-20-14 revealed no new residents symptomatic for fever, change in mental status, urinary pain, and abnormal urine odor.		
F 325 SS=D	483.25(l) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE				

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F 325

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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, record review and review of the facility's policy, it was determined the facility failed to ensure residents maintained acceptable parameters of nutritional status for one (1) of seven (7) sampled residents (Resident #4), assessed for weight issues, of twenty-four (24) total sampled residents.

Review of Resident #4's weights revealed an admission weight on 08/06/14 of 154 pounds, and the next weight obtained by the facility on 08/25/14 was 167 pounds, a gain of thirteen (13) pounds in nineteen (19) days. Interviews and record review revealed however, the facility failed to perform a validation re-weight to ensure accuracy of the weight obtained on 08/25/14.

The findings include:
Review of the facility's policy titled, "Resident Weights", revised 06/25/12, revealed resident's weights were to be recorded and monitored related to residents' weight changes had significant nutritional implications. The Policy

To ensure immediate compliance with the cited deficiency, on 10-20-14, the Staff Development Coordinator initiated re-education for all RNs, LPNs, and SRNAs from all three (3) shifts, both weekdays and weekends, on hand hygiene protocols and perineal care. It will be taught that at any time hands are considered contaminated hand hygiene protocols must be performed; this includes the following steps:

- (1) If gloves are on the hands, they must be removed
- (2) A paper towel will be used to turn on the faucet
- (3) Watches will be pulled up to upper forearm
- (4) Wet hands proximal to distal without touching any part of the hand or arm in the wash basin
- (5) Apply soap to hands
- (6) With a 15-20 second scrub, cleaning under the finger nails and all surfaces of the distal forearm and hands. Check to ensure fingertips are scrubbed well.

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F 325	<p>Continued From page 24</p> <p>revealed if a resident had more than a five (5) pound gain or loss, a re-weight was to be performed to validate the obtained weight.</p> <p>Review of Resident #4's medical record revealed the facility admitted the resident on 08/06/14, with diagnoses which included Malnutrition, Heart Failure, Chronic Obstruction Pulmonary Disease, Diabetes Mellitus, Anemia, Alzheimer's Disease, and Dysphagia (difficulty swallowing). Review of the Admission Minimum Data Set (MDS) Assessment dated 08/13/14, revealed the facility assessed Resident #4 to be moderately cognitively impaired.</p> <p>Continued record review of Resident #4's recorded weights revealed an admission weight dated 08/06/14 of one hundred and fifty-seven (157) pounds and the next weight recorded on 08/18/14 was one hundred and sixty-seven (167) pounds, a weight gain of thirteen (13) pounds in a nineteen (19) day period. However, continued review of the recorded weights revealed no documented evidence a re-weight was performed after the 08/18/14 to ensure accuracy of the weight obtained, until 08/25/14, when a weight was recorded of one hundred and sixty-seven and a half pounds (167.5) pounds, seven (7) days later. Further review of the recorded weights revealed Resident #4's weights remained stable: on 09/01/14 weight was one hundred and seventy and a half pounds (170.5); on 09/09/14 weight was one hundred and sixty-eight (168) pounds; and on 09/16/14 weight was one hundred and sixty-eight (168) pounds.</p> <p>Interview with the Dietician on 09/25/14 at 12:58 PM, revealed when a resident was admitted the facility tried to schedule weekly weights to better</p>		<p>(7) Hands will be rinsed proximal to distal without touching surface of bowl, and rinsed thoroughly.</p> <p>(8) Dry hands with a clean paper towel; drying proximal to distal.</p> <p>(9) A clean paper towel will be used to turn of the faucet.</p> <p>To ensure ongoing compliance, on 11-17-14 the Nursing Supervisor and QA Officer initiated a weekly visual observation of five (5) nurse aids providing perineal care for a period of eight (8) consecutive weeks. During observation, the Nursing Supervisor will monitor compliance with peri-care. Facility peri-care compliance consists of hand washing, changing gloves, proper technique, hand hygiene, and changing water during treatment. For those found to not be in compliance with the facility's Hand Hygiene Policy, immediate intervention and re-education will be conducted by the Nursing Supervisor. Additionally, the QA Officer will review the Infection Control Logs weekly for UTIs, cross contamination, or signs of the same</p>		

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE HOMESTEAD			STREET ADDRESS, CITY, STATE, ZIP CODE 1808 VERSAILLES ROAD LEXINGTON, KY 40504		
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F 325	<p>Continued From page 25</p> <p>understand the resident's consumption trends and overall status. The Dietician revealed, after reviewing Resident #4's recorded weights, a re-weight should have been done on 08/18/14 per facility policy, because the resident's weight difference was thirteen (13) pounds. She revealed according to policy if there was more than a five (5) pound change from the prior weight staff were supposed to do a re-weight. Per interview, she stated it was important staff obtained the re-weight because Resident #4 was a new admit, and the second weight was "out of line" with the admit weight but not with the other recorded weights. In addition, she stated nursing was to assess residents' if there was a significant weight change and were to contact the Physician if the resident was symptomatic.</p> <p>Interview with Licensed Practical Nurse (LPN) #1/Unit 500 Supervisor #1 on 09/25/14 at 3:41 PM, revealed nurses got a copy of residents' weights and documented if a re-weight was needed due to a significant weight change. She stated according to hospital records the facility had received Resident #4 weighed one hundred and forty-six (146) pounds on 08/02/14, had poor intake and was malnourished, so the admit weight of one hundred and fifty-four (154) pounds was "probably" accurate. LPN #1/Unit 500 Supervisor stated staff should have performed a re-weight on 08/18/14, because of the significant weight difference from the admit weight. She stated however, review of other weights obtained revealed Resident #4 had no significant weight change from the 08/18/14 weight. In addition, she stated head to toe assessments were performed daily on the unit, and no cardiovascular changes or negative outcome due to Resident #4's weight change was noted.</p>		<p>organism between roommates or residents on the same unit. Review of the Infection Control Logs will be done each week. Additionally, the QA Officer will track trends/patterns of infection throughout the building and document these trends on a facility map indicating where the infections are in the building and determine whether trends exist within any of the six (6) nursing stations. The result of the Nursing Supervisor and Infection Control Log audits will be presented to the Standards of Care Committee each week for eight (8) consecutive weeks. It will be the responsibility of the Nursing Supervisor and QA Officer to present these audits to the weekly Standards of Care Committee.</p> <p>The QA Officer will present the results of the Nursing Supervisor and Infection Control Log audits found and discussed by the Standards of Care Committee to the monthly QA Committee for interdisciplinary review. Any deficiencies will be corrected in a timely manner and the findings reviewed for any further corrective action. The Quality Assurance committee will authorize</p>		

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185144	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2014
NAME OF PROVIDER OR SUPPLIER PROVIDENCE HOMESTEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 1608 VERSAILLES ROAD LEXINGTON, KY 40504		
(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 26 Interview with the Director of Nursing (DON) on 09/25/14 at 6:52 PM, revealed if Resident #4 had a weight change of more than five (5) pounds staff should have done a re-weight as per the policy to ensure the weight was accurate. The DON indicated Resident #4 should have had a re-weight after the weight obtained on 08/18/14 due to it being greater than a five (5) pound difference. The DON stated if the State Registered Nursing Assistant (SRNA) was aware there was a weight change when the weight was obtained, a re-weight was done.		any change to the plan of correction for frequency of audits or further needed interventions. Completion Date:	11-21-14
F 441 SS=D	483.85 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a			

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE HOMESTEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 1608 VERSAILLES ROAD LEXINGTON, KY 40504		
(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 441	<p>Continued From page 27</p> <p>communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility policy, it was determined the facility failed to ensure staff removed soiled gloves and washed their hands after provision of perineal care and prior to touching objects in the resident's environment for one (1) of five (5) sampled residents (Resident #3), observed for perineal care and/or skin assessments, out of total twenty-four (24) sampled residents.</p> <p>Observation of perineal/incontinence care for Resident #3 revealed after providing part of the care the State Registered Nursing Assistant (SRNA) touched objects while wearing the soiled gloves used during the care, such as the door knob to the bathroom and the sink faucet. The SRNA then, without removing the soiled gloves or washing her hands, continued to provide further perineal care to the resident.</p> <p>The findings include:</p>	F 441		

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE HOMESTEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 1608 VERSAILLES ROAD LEXINGTON, KY 40504		
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F 441	<p>Continued From page 28</p> <p>Review of the facility's, "Providing Perineal Care for a Resident" Protocol, undated, revealed perineal care performed properly would reduce the risk of Urinary Tract Infections (UTI's) which could lead to bladder and kidney infections. The Protocol revealed the steps included: asking the resident to open his/her legs if able, using a washcloth and warm water, gently cleanse the skin of the perineal area moving from front to back, and dry the area thoroughly. Further review of the Protocol revealed no documentation of it addressing rinsing after washing during perineal care.</p> <p>Review of the facility's policy titled, "Procedure of Handwashing", undated, revealed several instances in which hands were to be washed which included: whenever hands were obviously soiled; after contact with any body fluids; and after handling any contaminated items.</p> <p>Review of Resident #3's medical record revealed diagnoses which included Senile Dementia, Psychosis, and a History of UTI's. Review of the Annual Minimum Data Set (MDS) Assessment dated 09/17/14, revealed the facility assessed the resident as having both short and long term memory problems.</p> <p>Observation on 09/24/14 at 4:00 PM, of perineal care provided for Resident #3, by SRNA #12, revealed she cleansed the resident's perineal area and buttocks/rectum areas with soapy water, then with the same soiled gloves on, opened the resident's bathroom door by touching the door knob and went to the sink to pour the wash basin of soapy water out. Continued observation revealed SRNA #12 turned on the sink faucet in the sink using the same soiled gloves, and filled</p>	F 441		

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE HOMESTEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 1608 VERSAILLES ROAD LEXINGTON, KY 40804
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F 441	<p>Continued From page 29</p> <p>the wash basin with rinse water. Further observation revealed SRNA #12 carried the wash basin of rinse water back to the resident's bedside and began to rinse the resident's perineal area without removing the soiled gloves, washing her hands and donning new gloves.</p> <p>Interview with SRNA #12 on 09/24/14 at 4:10 PM, revealed she should have washed her hands and donned new gloves prior to rinsing the resident's perineal area since she had touched objects in the room with her soiled gloves including the bathroom door knob and the sink faucet. Continued interview revealed she should have removed her soiled gloves after providing the perineal care/incontinence care for Resident #3, and prior to going into the bathroom because she could have contaminated the door knob and sink faucet by touching them with her soiled gloves.</p> <p>Interview, on 09/25/14 at 5:30 PM, with the Infection Control Nurse revealed SRNA #12 should have removed her gloves after providing care and prior to touching objects in the resident's room. The Infection Control Nurse stated SRNA #12 should have washed her hands and donned new gloves prior to rinsing Resident #3's perineal area since she had touched objects in the resident's room.</p> <p>Interview on 09/25/14 at 6:17 PM with the Staff Development Nurse, revealed they provided inservices related to perineal care on hire, yearly, and as needed.</p>	F 441		
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