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

PRINTED: 02/28/13
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(x1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185225	A. BUILDING _____ B. WING _____	C 02/14/13

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEDALE MANOR	4250 GLENN AVENUE COVINGTON, KY 41015

(X4) ID PREFIX TAG	SUMMARY OF 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 000	INITIAL COMMENTS An abbreviated survey investigating KY#00019737, KY#00019751 and KY#00019764 was initiated 02/06/13 and concluded on 02/14/13. KY#00019737 and KY#00019764 were substantiated with deficiencies cited. KY#00019764 was substantiated with no deficiencies cited.	F 000	**PLAN OF CORRECTION:** The filing of the Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This plan of correction is filed as evidence of the facility's intent to comply with the requirements of participation to provide quality resident care.	
F 157	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	**483.10(b)(11) NOTIFY OF CHANGES (INJURY/ DECLINE/ ROOM,ETC.)** Rosedale Manor is committed to immediately informing the resident; consulting with the resident's physician; and if known, notifying 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). Rosedale Manor is also committed to promptly notifying the resident and, 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.	3/29/13

RECEIVED MAR 7 2013 BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sonda Knollman	Administrator	3/7/13

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 patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable after 90 days following the date of the survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure the Responsible Party was notified of a change in the condition for two (2) of three (3) sampled residents (Resident #1 and Resident #4). Resident #1 had skin breakdown and the family was not notified of Resident #1's condition change. Resident #4 was hospitalized and obtained a fracture of the right humorous and neither guardianship nor the Adult Day Care Center Resident #4 attended was notified. The finding includes: Review of the facility's policy titled, "Change of Resident Condition, Family and Physician Notification", revised 11/19/11, revealed it was the expectation that the Physician and responsible, if known would be notified regarding any significant change in a resident regardless of code status. The medical record will reflect Physician and responsible party notification or any attempts thereof. The facility commits to making notification of one person listed on the face sheet. At the point where contact was made not just voicemail, the facility had met it's obligation of notification. The facility staff should to continue attempts to notify the family of a condition change or transfer to the hospital until actual notification has been made regardless of the length of time.	F 157	Rosedale Manor is also committed to recording and periodically updating the address and phone number of the resident's legal representative or interested family member.	

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F157	Continued From page 2 1. Record review revealed the facility admitted Resident #1 to the facility on 08/31/09 with diagnoses which included, Alzheimer's Disease, Parkinson's Disease, Rheumatoid Arthritis, Dyphosis and Senile Dementia. Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 12/20/12, revealed the Brief Interview of Mental Status (BIMS) of four (4) out of fifteen (15), indicating the resident was cognitively impaired. Continued review of Resident #1's MDS revealed Resident #1 required assistance of two (2) staff members for bed mobility, transfer, toilet use and bathing. The facility has also assessed Resident #1 as being at risk for pressure ulcers, requiring pressure reducing device for Resident #1's bed and chair, a turning/repositioning program and applications of ointment/medications. Review of the clinical record revealed a Certified Nursing Assistant (CNA) #6 reported a change to the wound on Resident #1's back. An order was obtained for a dry dressing to unstageable area to mid back for protection every day and as needed; however, there was no documented evidence that the responsible party had been notified. Interview with the Neighborhood Manger for Resident #1, on 02/11/13 at 4:00 PM, revealed the area on Resident #1 was a chronic area on his/her back; she stated it was pink or red most of the time. She stated the cream was ordered 01/27/12 and at that time the family had been notified of the order. She stated Resident #1 had no other skin problems that she was aware. She stated usually the nurse who notices the change in condition or receives the new order notifies the family.	F157	With regards to resident #1, she is 93 years old and suffers from many compounding medical conditions, one of which is kyphosis. Due to this resident's kyphosis, she is at risk of repeated issues with skin concerns on her back. Even without any pressure placed on her back from the outside, her spinal curvature places such pressure on her back from the inside that prevention of pressure related issues is unavoidable. On 2/2/13, staff observed the re-development of a chronic, intact, non-blanchable area to her mid-back. The physician was immediately notified and a new treatment order was obtained on 2/2/13. A call was placed to the resident's son on 2/2/13 at 9:36 pm with a message to return the call regarding a change in his mother's condition. No return call was received. The resident continued to receive appropriate treatment for the chronic wound area. Although it is unclear as to whether or not direct contact was not made with the family, it is well documented previously that the family is aware of the chronic skin issues that occur with resident #1. On 2/3/13, resident #1 experienced a decline in condition and was sent to the hospital. She was subsequently admitted. Resident #1 passed away in the hospital on 2/14/13 from unrelated issues.	

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F 157	Continued From page 3 2. Record review revealed the facility admitted Resident #4 on 02/29/06 with diagnoses which included Cerebral Vascular Accident, Left Hemiplegia, Convulsions, Mental Retardation and Osteoarthritis. Continued record review revealed Resident #4 had been hospitalized from 01/14/13 through 01/25/13 for Altered Mental Status and Urinary Tract Infection and returned from the hospital with a Proximal Fracture of the Left Humerus. Review of the nursing progress note for 01/14/13 revealed, Resident #4 was sitting in her/his wheelchair and was noted not to be able to hold her/his cup as usual and Resident #4 was twitching. The documentation revealed the Physician was notified and the decision was made to send Resident #4 to the emergency department. There was no documentation that the responsible party was notified or an attempt was made to notify the responsible party. Further record review revealed a late entry made by the Unit Coordinator on 01/16/13 for 01/15/13 which read, "Call placed to State Guardianship and message left regarding resident being sent to Emergency Room and admitted. Request to return call". There were no other attempts made to notify the responsible party in the documentation or when the resident returned from the hospital with the fractured humerus. Interview with the Responsible Party/Guardian, on 02/12/13 at 4:22 PM, revealed there were no messages from the facility; she stated she and a coworker had gone through all their messages. She stated the only way she found out about the hospitalization and the fractured arm was from an	F 157	With regards to resident #4, on 1/14/13, the resident was noted by staff to not be able to hold her cup as she normally could. She was also noted to be 'acting differently'. The physician was immediately notified and 911 was promptly called. The LPN Charge nurse verified that on 1/14/13, she had left a message with the receptionist at the Legal Guardian's office to return the call regarding the status of resident #4. This nurse also reported that she failed to document the notification. During review of the transfer by the Clinical Care Coordinator (Nurse Manager) on 1/15/13, after not seeing the proper notification documented, she placed a call to the legal guardian and left a message for a return call. Although no further documentation occurred as per policy in the chart, the Clinical Care Coordinator did have documentation in her personal tracking log of other call attempts to the legal guardian. This resident did suffer a fracture during her hospitalization. The resident had a series of 3 x-rays taken during this hospitalization. The third of those three x-rays revealed the fracture. The radiologist identified the fracture, in comparison to the two most recent x-rays as new. After the fracture was identified in the hospital, the documentation reflects that the resident was exhibiting signs and symptoms of pain, not indicated prior to that date, such as guarding of the extremity. Since the fracture occurred at the hospital and the hospital identified the fracture as an acute fracture, notification to the legal guardian about the presence of the fracture was the hospital's responsibility.	

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F 157	Continued From page 4 electronic message from the Adult Day Care Center Resident #4 attended three (3) days a week. Interview with the Licensed Practical Nurse (LPN) #1, on 02/12/13 at 4:30 PM, revealed she had notified the receptionist at the Responsible Party's office. She stated she had forgotten to document the telephone call. Interview with the Administrator and the Director of Nursing, on 02/13/13 at 3:00 PM, revealed it is the facility's policy to notify the responsible party of a change in a resident's condition and in the case of Resident #4, the Adult Day Care Center should also have been notified of the fractured arm.	F 157	The statement made that a message was not left for the legal guardian was not made by resident #4's actual legal guardian, but rather by another legal guardian representative in the same office. Despite their denial, messages were left for their return call. As of the date of the survey, the legal guardian was aware of the change in condition, transfer to the hospital, and return to the facility on 1/25/13 with a fractured humerus that did not occur at our facility. The policy and procedure on Change of Resident Condition, Physician and Family Notification, was reviewed by the Director of Nursing on 3/4/13. The policy was updated to reflect the following: "If the resident attends regular activities (i.e. School / Adult Day, etc.) and the resident has experienced a significant change in condition that would impact the manner in which they care for our resident, notification must be made to them as well". The issue was not related to the policy process, itself, but rather failure to follow the policy as written. All nursing staff will be inserviced by the ADON, Clinical Care Coordinators, RAI Nurses, and Staff Development as of 3/29/13 on the Change of Resident Condition, Physician and Family Notification policy. This education will emphasize the fact that leaving a message does not constitute notification and repeated attempts must be made until direct contact with a family member or legal representative is made.	

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F 157		F 157	An audit will be completed before 3/29/13 by the DON, ADON, Clinical Care Coordinator, RAI nurse or their designee for all accident and incidents, order changes, and hospital transfers beginning 2/1/13, to ensure that proper notification was made and documented. If it is determined that any necessary notification was not made or not documented, notification will be made at that time. Quality assurance monitoring will be completed by the ADON, Clinical Care Coordinator or their designee related to notification of changes in resident condition (samples to be pulled from accidents and incidents, hospital transfers, and order changes). Monitoring will be completed for at least 10 residents per neighborhood once a month for 4 months, and then as needed based upon recommendations from the Quality Assurance / Process Improvement (QAPI) Committee. This monitoring should include physician notification, family / responsible party notification, and notification of outside entities (such as School and Adult Day) as appropriate. This facility has QA/QI meetings every month. Issues concerning notification of changes will be reviewed at the regular QA/QI meetings and, as necessary, at any subsequent special meeting called to insure ongoing compliance.	

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F 157		F 157	Compliance with notification of changes will be reviewed and analyzed at the QA/PI meetings for 6 months. Based upon analysis, subsequent plans of correction may be developed & implemented as needed.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure one (1) of six (6) sampled residents, Resident #4, who was unable to carry out her/his activities of daily living (ADL), received the necessary services to maintain good grooming and clothing appropriate for the weather. The findings include:	F 312	**483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS** Rosedale Manor is committed to insuring that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	3/29/13

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F 312	Continued From page 5 Interview with the Administrator, on 02/14/13 at 3:30 PM, revealed the facility had no policy on groom or ADLs. Record review revealed the facility admitted Resident #4 on 02/29/06 with diagnoses which included Cerebral Vascular Accident, Left Hemiplegia, Convulsions, Mental Retardation and Osteoarthritis and with a recent diagnosis of a Proximal Fracture of the Left Humerus. Review of Resident #4's Quarter Minimum Data Set (MDS) Assessment, dated 11/13/12 revealed the facility assessed Resident #4 with a Brief Interview for Mental Status (BIMS) score of ninety-nine (99) indicating Resident #4 was unable to complete the test and was severly cognitively impaired. Review of the CAA dated 03/06/12 under the category, Activities of Daily Living Functional Status/Rehabilitation Potential, the facility assessed Resident #4 as having Mental Retardation and having left hemiplegia with contractures, requiring extensive to total assist in all areas of ADL's with the exception of eating. The decision was made to care plan. Review of Resident #4's comprehensive plan of care revealed Resident #4 attended an Adult Care Center every Monday, Wednesday and Friday via bus. Interview with Adult Mentor #1 from the Adult Day Care Center, on 02/12/13 at 9:35 AM, revealed Resident #4 came to the day center one day and his/her hair was a matted mess. She stated the daycare staff could not get a comb through it. She stated Resident #4's clothes always seemed dirty	F 312	During the interview that occurred with the state surveyor, the Administrator, and the DON, just prior to the surveyor exiting the facility, which encompassed the 3:30 pm time frame, there was no comment made that indicated Rosedale does not have a policy on grooming or ADL's. In fact, we have approximately 17 policies related to grooming and ADL's, one specifically titled Activities of Daily Living. With regards to the comments made about Resident #4 by Adult Mentor #1, Adult Mentor #2, the Bus Driver, and the ADCC, regarding their perceived care issues, the dates of concern are unclear and make it difficult to provide specific information. However, knowing Resident #4 as we do, having cared for her since March 29, 2006, we can confidently provide the following information. Resident #4 sits upright in a high back wheelchair throughout the day. Due to her functional limitations, her head often rests directly on the head rest of that wheelchair. Resident #4 consistently turns her head from side to side, and regularly drags her hands through her hair, typically starting at the bottom of the back and pulling her hair upwards. The consistent rubbing of her head against the head rest results in almost continuous matting of her hair. Resident #4 used to wear her hair long, but it was cut shorter to aide in keeping her hair from matting as severely. Staff at Rosedale frequently comb Resident #4's hair, but also recognize that there is an issue with keeping her hair managed. The Clinical Care Coordinator placed a call to Resident #4's legal guardian on 3/7/13 to discuss options to minimize the matting of Resident #4's hair. We completely understand that, although we do comb Resident #4's hair prior to her leaving for school, that during her transport to	

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F 312	Continued From page 6 or stained. She stated the facility sent Resident #4 in short sleeves without a coat. She stated for a while they had a problem with the facility sending Resident #4 with house dresses without a bra. Interview with the bus driver, on 02/13/13 at 8:15 AM, revealed he had been transporting Resident #4 to the Adult Day Care Center for the last three (3) months. He stated sometimes Resident #4 would not have his/her coat on, but would be covered with a blanket. He stated occasionally Resident #4's hair would be all over the place, but in generally Resident #4 looked dishevel. Interview with the Assistant Director at the Adult Day Care Center (ADCC), on 02/14/13 at 10:15 AM, revealed Resident #4 came in with matted hair, came in dirty and with a strong urine odor or with breakfast spills on his/her clothing. Interview with Adult Mentor #2 from the ADCC, on 02/14/13 at 10:30 AM, revealed Resident #4 came in with dirty clothes and uncombed hair. She stated the facility sometimes sent him/her without outwear with short sleeves with a blanket covering the legs. Interview with MDS Coordinator, on 02/08/13 at 10:00 AM, revealed everyone from the Certified Nursing Assistants (CNA's), to the nurses on the unit, to the Coordinator, to herself were all responsible for insuring Resident #4 was clean and well groomed after eating breakfast and prior to going to the Adult Day Care Center. Interview with CNA #4, on 02/13/13 at 9:00 AM, revealed Resident #4 received his/her baths on	F 312	school, it is going to become matted and appear as though it hasn't been combed. Since resident #4 routinely runs her hand through her hair, it is very likely that her hair might be 'all over the place' and that, in and of itself, does often make her appear disheveled. Rosedale staff does observe all resident's clothing for stains and damage and we request replacements as needed. Resident #4 does not wear a coat, but rather wears a cape. She wears this cape due to her functional limitations and the fact that it doesn't require her to put her arms into sleeves. There is a hood that covers her head, and the cape covers her and the back of her wheelchair. The cape was purchased specifically related to Resident #4's individual needs. As this cape does function in place of a coat, it does occur that Resident #4 wears short sleeves underneath of it. Although resident #4 does have mental and physical limitations, she is able to make her needs known through gestures. She does wear house dresses at times, and has been known to refuse to wear her bra. Resident #4 has also been known to refuse to wear her cape, when this occurs she may be sent out with a cover. Although covered when she leaves here, with Resident #4's involuntary and voluntary movements, the cover may become displace and would need to be reapplied before taking her off of the bus. Interviews were completed by the Director of Nursing during the survey with CNA's, nurses, unit coordinators, nurse managers, and the receptionist that sits at the front entrance. These interviews revealed that this resident is regularly noted to be dressed appropriately and covered with her cape or a blanket as needed when going out.	

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F 312	Continued From page 7 the evening shift. She stated the evening should should dry Resident #4's hair prior to putting him/her to bed. Interview with the Administrator, on 02/14/13 at 3:30 PM, revealed she had never seen Resident #4 leave the facility without outer wear or without being well groomed. She stated she would ensure all complaints about Resident #4's grooming came to her instead of the floor.	F 312	Throughout the survey process, during discussions with the surveyor, she shared that she had not seen issues with Resident #4's appearance, that she appeared clean. The surveyor further stated that she did observe the residents hair to be combed and then quickly became matted and messy in appearance. She further stated that she observed staff tending to Resident #4 on a regular basis and that she had observed no concerns while here. The RAI nurse updated Resident #4's care plan on 3/7/13 to indicate the chronic issues with her hair, to clarify that the resident expresses her wishes through gestures, and that when the resident refuses to wear undergarments, we will honor that request. The care plan will also reflect that when the weather dictates and the resident refuses to wear the cape, she should be covered with a blanket to shield her from the elements. With regards to the alleged statement regarding the Administrator ensuring that all complaints would come to her instead of the floor, it is unrealistic to expect that all complaints of this nature will go first to the Administrator. The Administrator did indicate that she was concerned that she had not been contacted by the School and would try to make contact with them to open the lines of communication should they have further concerns in the future. Our policy is that the Administrator is notified of any care related issues. The Clinical Care Coordinators and Nursing Supervisors were inserviced by the DON on 3/7/13 regarding the necessity to notify the DON and Administrator immediately of any care related concerns. The Director of Nursing at Rosedale has made	

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NAME OF PROVIDER OR SUPPLIER ROSEDALE MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4250 GLENN AVENUE COVINGTON, KY 41015	

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F 312		F 312	attempts to contact the ADCC at School to open the lines of communication so that both organizations can work together in the best interest of Resident #4. As of 3/6/13, a return call has not been received. The DON will attempt to make contact with the ADCC on an on-going weekly basis to discuss any concerns that may arise. The policy and procedure titled "Activities of Daily Living was reviewed by the Director of Nursing on 3/6/13. The following additions were made to the policy: 1) The resident's right to clothing selection and attire should be honored. If a resident prefers to not wear undergarments, that right should be honored. 2) If a resident's clothing is noted to be in disrepair or stained, social services should be notified to contact the family or responsible party regarding replacements. 3) Any resident who leaves the facility for an outside appointment should be dressed appropriately for the weather. Should a resident choose to dress out of season, the care plan should reflect the resident's wishes and a progress note should indicate education to the resident and or legal representative. 4) Any resident who leaves the facility for an outside appointment should have their hair combed prior to leaving and should display good hygiene. If the resident chooses not to do so, their refusal should be care planned and the issues should appear in the progress notes. 5) Any resident who leaves the facility during cold weather should have something in place to shield them from the elements (i.e., coat, cape, cover, blanket, etc). All residents should be encouraged to follow this and their refusal to do so should be documented and care planned. 6) The Director of Nursing and Administrator should be notified of all resident care complaints.	

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

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F 312		F 312	All nursing staff and social service staff will be inserviced as of 3/29/13 by the ADON, Clinical Care Coordinators, RAI Nurses, or other designees regarding the updated ADL policy. Quality assurance monitoring will be completed by the ADON, Clinical Care Coordinator, RAI nurse, charge nurses, or nursing assistants to ensure that Resident #4 is dressed appropriately, appears and smells clean, and looks presentable. This monitoring will be completed for Resident #4 every day for one month, then every Monday, Wednesday, and Friday for 4 months, and then as needed based upon recommendations from the Quality Assurance / Process Improvement (QAPI) Committee. Random quality assurance monitoring of at least 10 residents per neighborhood per month will be completed by the ADON, Clinical Care Coordinator, RAI nurse, charge nurses, or nursing assistants for other residents to make sure they are dressed appropriately, appear and smell clean, and look presentable. This monitoring will occur monthly for 4 months, and then then as needed based upon recommendations from the Quality Assurance / Process Improvement (QAPI) Committee. This facility has QA/QI meetings every month. Issues concerning residents receiving proper assistance with Activities of Daily Living will be reviewed at the regular QA/QI meetings and, as necessary, at any subsequent special meeting called to insure ongoing compliance. Compliance with performance of Activities of Daily Living will be reviewed and analyzed at the QA/PI meetings for 6 months and based upon	

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F 312		F 312	analysis, subsequent plans of correction may be developed and implemented as necessary.	
F 441 SS=D	483.65 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 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441	**483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS** Rosedale Manor has established and is committed to maintaining 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 by: (a) Establishing an infection control program under which< (1) We investigate, control, and prevent infections in the facility; (2) We decide what procedures, such as isolation, should be applied to an individual resident; and (3) We maintain a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection by: (1) Isolating the resident when the infection control program determines that a resident needs isolation to prevent the spread of infection; (2) Prohibiting employees with a communicable disease or infected	3/29/13

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F 441	Continued From page 8 (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to establish and maintain an effective infection control program designed to prevent the development and transmission of disease and infection for two (2) of six (6) sampled residents, (Residents #3 and #4). The facility failed to ensure staff washed hands between glove changes during resident care and during a dressing change observation, as per the facility's policy. In addition, observation revealed staff put dressing supplies that were not used during a dressing change back in the treatment cart. The findings include: Review of the facility's policy titled, "Hand Washing /Hand hygiene", with a revision date of 01/17/12, revealed hands should be thoroughly washed before and after providing resident care. Proper hand-washing techniques must be followed at all times. Under when to wash hands it stated to wash hands before and after wearing loves.	F 441	skin lesions from direct contact with resident or their food, if direct contact will transmit the disease. (3) Requiring staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Handling, storing, processing and transporting linens so as to prevent the spread of infection.	

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F 441	Continued From page 9 Record review revealed the facility admitted Resident #4 on 02/29/06 with diagnoses which included Cerebral Vascular Accident, Left Hemiplegia, Convulsions, Mental Retardation and Osteoarthritis. Observation, on 02/13/13 at 8:05 AM, revealed Certified Nursing Assistant (CNA) #3 and CNA #4 took Resident #4 back to her/his room to change his/her top due to the top getting soiled while Resident #4 ate breakfast. Both CNA's washed their hands prior to care. After removing the top CNA #4 put the top in a laundry bag, took off her gloves and downed clean gloves without washing or sanitizing her hands. Interview with CNA #4, on 02/13/13 at 9:00 AM, revealed she was aware she was supposed to wash or sanitize hands between glove changes. She stated usually she carried hand sanitizer in her pocket, but left the hand sanitizer in her car. Record review revealed the facility admitted Resident #3 on 06/15/12 with admission diagnoses which included Diabetes Mellitus, Debility, Muscle Weakness Dysphagia and Depression. Review of the current Comprehensive Plan of Care for Resident #3 revealed he/she was at risk for impaired skin integrity related to the recent left hip fracture, limited mobility and episodes of incontinence. Continued record review revealed Resident #3 had an unstageable necrotic area to the right out ankle and was placed on antibiotic therapy on 02/05/13.	F 441	With regards to CNA #3 and CNA #4 applying gloves to change Resident #4's soiled shirt, then removing their gloves without washing their hands or applying hand sanitizer before applying clean gloves; the procedure completed did not require the use of gloves. Gloves are only required when the potential to come into contact with blood or other potentially infectious materials is present. However, our policy does indicate that when gloves are used, hands are to be washed before and after their use. The Clinical Care Coordinator immediately educated CNA #3 and CNA #4 on 2/13/13 about the proper procedure for washing their hands with glove use. CNA #4 was educated by the Clinical Care Coordinator on 2/13/13 that hand sanitizer is readily available throughout the facility and leaving your hand sanitizer in your car is no excuse not to use it.	

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F 441	Continued From page 10 Observation of Resident #3's wound care, on 02/12/13 at 9:20 AM, revealed Licensed Practical Nurse (LPN) #6 removed the old dressing and removed her gloves and downed a clean pair of gloves without washing or sanitizing hands. After completing the treatment LPN #6 removed her gloves and left the room without washing her hands. Upon return to Resident #3 room, LPN #6 then washed her hands. She picked up the Santyl ointment, six (6) normal saline in hard plastic, a stack of non sterile four by fours, a package of non sterile two by twos and packets of skin prep and put the items back in the treatment cart. Interview with LPN #6, on 02/12/13 at 9:35 AM, revealed she was aware she should have washed her hands between glove changes and stated it was an infection control issue. She stated there was nothing wrong with putting the unused items back in the treatment cart. Interview with the Assistant Director of Nursing (ADON) and the Infection Control/Quality Improvement Nurse, on 02/14/13 at 12:30 PM, revealed staff was taught to wash or sanitize hands after each glove change. She stated good practice was to use or leave unused supplies in the room. She stated the facility had monthly inservices on handwashing. She stated not every staff member went to each inservice. She stated the Unit Manager set aside time monthly to monitor the staff for infection control issues.	F 441	With regards to Resident #3 and LPN #6 not following our policy related to hand washing / hand hygiene during the process of a dressing change; LPN #6 was immediately educated by the Clinical Care Coordinator on 2/12/13 of the proper procedure. As verified by the surveyor, LPN #6 was aware of the policy and was aware of her error. LPN#6 indicated she was nervous being observed by the surveyor. Resident #3 was observed by the Skin Care Coordinator on 3/6/13 and has experienced no signs and symptoms of infection related to this dressing change. The Clinical Care Coordinator observed LPN#6 during a dressing change on 3/7/13 and no infection control issues were noted. LPN #6 washed her hands between gloves, after removing her gloves and before leaving the room and did not remove any treatment items from the room and return them to the cart. The ADON educated LPN #6 on 2/12/13 that only those treatment items needed to complete a procedure are to be taken into the room. Any items that are not used may be left in the room, if appropriate for later use, or must otherwise be discarded. The policy and procedure on hand washing / hand hygiene was reviewed by the DON on 3/6/13. The policy and procedure is appropriate. The issue was not related to the policy process itself, but rather a failure to follow the policy as written. As of 3/29/13, all staff will be educated by the ADON, Staff Development, Clinical Care	

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F 441		F 441	Coordinators, Supervisors, RAI nurses, and ancillary department supervisors on the policy and procedure for hand washing / hand hygiene. Quality assurance monitoring will be completed by the ADON, Staff Development, Clinical Care Coordinators, Supervisors, RAI nurses, and ancillary department supervisors to ensure that hand washing / hand hygiene is properly completed. This monitoring will be completed once a week for 4 weeks, then once a month for 4 months, and then as needed based upon recommendations from the Quality Assurance / Process Improvement (QAPI) Committee. This facility has QA/QI meetings every month. Issues concerning hand washing / hand hygiene will be reviewed at the regular QA/QI meetings and, as necessary, at any subsequent special meeting called to insure ongoing compliance. Compliance with hand washing / hand hygiene will be reviewed and analyzed at the QA/PI meetings for 6 months and based upon analysis, subsequent plans of correction may be developed and implemented as necessary.	

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N 000	INITIAL COMMENTS A complaint survey investigating KY#00019737, KY#00019751 and KY#00019764 was initiated 02/06/13 and concluded on 02/14/13. KY#00019737 and KY#00019764 were substantiated with deficiencies cited. KY#00019764 was substantiated with no deficiencies cited.	N 000	**PLAN OF CORRECTION:** The filing of the Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This plan of correction is filed as evidence of the facility's intent to comply with the requirements of participation to provide quality resident care.	
N 018	902 KAR 20:300-3(2)(i)1.b. Section 3. Resident Rights (2) Notice of rights and services. (i) Notification of changes. 1. Except in a medical emergency or when a resident is incompetent, a facility shall consult with the resident immediately and notify the resident's physician, and if known, the resident's legal representative or interested family member within twenty-four (24) hours when there is: b. A significant change in the resident's physical, mental, or psychosocial status; 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 the Responsible Party was notified of a change in the condition for two (2) of three (3) sampled residents (Resident #1 and Resident #4). Resident #1 had skin breakdown and the family was not notified of Resident #1's condition change. Resident #4 was hospitalized and obtained a fracture of the right humorous and neither guardianship nor the Adult Day Care Center Resident #4 attended was notified. The finding includes:	N 018	**902 KAR 20:300-3(2)(i)1.B. Section 3. Resident Rights** 3/29/13 Rosedale Manor is committed to consulting with the resident immediately and notifying the resident's physician , and if known, the resident's legal representative or interested family member within twenty-four (24) hours when there is a significant change in the resident's physical, mental, or psychosocial status. RECEIVED MAR - 7 2013 BY:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Linda Knollman TITLE Administrator (X6) DATE 3/4/13

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N 018	Continued From page 1 Review of the facility's policy titled, "Change of Resident Condition, Family and Physician Notification", revised 11/19/11, revealed it was the expectation that the Physician and responsible, if known would be notified regarding any significant change in a resident regardless of code status. The medical record will reflect Physician and responsible party notification or any attempts thereof. The facility commits to making notification of one person listed on the face sheet. At the point where contact was made not just voicemail, the facility had met it's obligation of notification. The facility staff should to continue attempts to notify the family of a condition change or transfer to the hospital until actual notification has been made regardless of the length of time. 1. Record review revealed the facility admitted Resident #1 to the facility on 08/31/09 with diagnoses which included, Alzheimer's Disease, Parkinson's Disease, Rheumatoid Arthritis, Dyphosis and Senile Dementia. Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 12/20/12, revealed the Brief Interview of Mental Status (BIMS) of four (4) out of fifteen (15), indicating the resident was cognitively impaired. Continued review of Resident #1's MDS revealed Resident #1 required assistance of two (2) staff members for bed mobility, transfer, toilet use and bathing. The facility has also assessed Resident #1 as being at risk for pressure ulcers, requiring pressure reducing device for Resident #1's bed and chair, a turning/repositioning program and applications of ointment/medications. Review of the clinical record revealed a Certified Nursing Assistant (CNA) #6 reported a change to the wound on Resident #1's back. An order was obtained for a dry dressing to unstageable area to	N 018	With regards to resident #1, she is 93 years old and suffers from many compounding medical conditions, one of which is kyphosis. Due to this resident's kyphosis, she is at risk of repeated issues with skin concerns on her back. Even without any pressure placed on her back from the outside, her spinal curvature places such pressure on her back from the inside that prevention of pressure related issues is unavoidable. On 2/2/13, staff observed the re-development of a chronic, intact, non-blanchable area to her mid-back. The physician was immediately notified and a new treatment order was obtained on 2/2/13. A call was placed to the resident's son on 2/2/13 at 9:36 pm with a message to return the call regarding a change in his mother's condition. No return call was received. The resident continued to receive appropriate treatment for the chronic wound area. Although it is unclear as to whether or not direct contact was not made with the family, it is well documented previously that the family is aware of the chronic skin issues that occur with resident #1. On 2/3/13, resident #1 experienced a decline in condition and was sent to the hospital. She was subsequently admitted. Resident #1 passed away in the hospital on 2/14/13 from unrelated issues.	

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N 018	Continued From page 2 mid back for protection every day and as needed; however, there was no documented evidence that the responsible party had been notified. Interview with the Neighborhood Manger for Resident #1, on 02/11/13 at 4:00 PM, revealed the area on Resident #1 was a chronic area on his/her back; she stated it was pink or red most of the time. She stated the cream was ordered 01/27/12 and at that time the family had been notified of the order. She stated Resident #1 had no other skin problems that she was aware. She stated usually the nurse who notices the change in condition or receives the new order notifies the family. 2. Record review revealed the facility admitted Resident #4 on 02/29/06 with diagnoses which included Cerebral Vascular Accident, Left Hemiplegia, Convulsions, Mental Retardation and Osteoarthritis. Continued record review revealed Resident #4 had been hospitalized from 01/14/13 through 01/25/13 for Altered Mental Status and Urinary Tract Infection and returned from the hospital with a Proximal Fracture of the Left Humerus. Review of the nursing progress note for 01/14/13 revealed, Resident #4 was sitting in her/his wheelchair and was noted not to be able to hold her/his cup as usual and Resident #4 was twitching. The documentation revealed the Physician was notified and the decision was made to send Resident #4 to the emergency department. There was no documentation that the responsible party was notified or an attempt was made to notify the responsible party. Further record review revealed a late entry made by the Unit Coordinator on 01/16/13 for 01/15/13 which read, "Call placed to State Guardianship and	N 018	With regards to resident #4, on 1/14/13, the resident was noted by staff to not be able to hold her cup as she normally could. She was also noted to be 'acting differently'. The physician was immediately notified and 911 was promptly called. The LPN Charge nurse verified that on 1/14/13, she had left a message with the receptionist at the Legal Guardian's office to return the call regarding the status of resident #4. This nurse also reported that she failed to document the notification. During review of the transfer by the Clinical Care Coordinator (Nurse Manager) on 1/15/13, after not seeing the proper notification documented, she placed a call to the legal guardian and left a message for a return call. Although no further documentation occurred as per policy in the chart, the Clinical Care Coordinator did have documentation in her personal tracking log of other call attempts to the legal guardian. This resident did suffer a fracture during her hospitalization. The resident had a series of 3 x-rays taken during this hospitalization. The third of those three x-rays revealed the fracture. The radiologist identified the fracture, in comparison to the two most recent x-rays as new. After the fracture was identified in the hospital, the documentation reflects that the resident was exhibiting signs and symptoms of pain, not indicated prior to that date, such as guarding of the extremity. Since the fracture occurred at the hospital and the hospital identified the fracture as an acute fracture, notification to the legal guardian about the presence of the fracture was the hospital's responsibility.	

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N018		N018	The statement made that a message was not left for the legal guardian was not made by resident #4's actual legal guardian, but rather by another legal guardian representative in the same office. Despite their denial, messages were left for their return call. As of the date of the survey, the legal guardian was aware of the change in condition, transfer to the hospital, and return to the facility on 1/25/13 with a fractured humerus that did not occur at our facility. The policy and procedure on Change of Resident Condition, Physician and Family Notification, was reviewed by the Director of Nursing on 3/4/13. The policy was updated to reflect the following: "If the resident attends regular activities (i.e. School / Adult Day, etc.) and the resident has experienced a significant change in condition that would impact the manner in which they care for our resident, notification must be made to them as well". The issue was not related to the policy process, itself, but rather failure to follow the policy as written. All nursing staff will be inserviced by the ADON, Clinical Care Coordinators, RAI Nurses, and Staff Development as of 3/29/13 on the Change of Resident Condition, Physician and Family Notification policy. This education will emphasize the fact that leaving a message does not constitute notification and repeated attempts must be made until direct contact with a family member or legal representative is made.	

Office of the Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(x1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100269	(x2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 02/14/13
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N018		N018	An audit will be completed before 3/29/13 by the DON, ADON, Clinical Care Coordinator, RAI nurse or their designee for all accident and incidents, order changes, and hospital transfers beginning 2/1/13, to ensure that proper notification was made and documented. If it is determined that any necessary notification was not made or not documented, notification will be made at that time. Quality assurance monitoring will be completed by the ADON, Clinical Care Coordinator or their designee related to notification of changes in resident condition (samples to be pulled from accidents and incidents, hospital transfers, and order changes). Monitoring will be completed for at least 10 residents per neighborhood once a month for 4 months, and then as needed based upon recommendations from the Quality Assurance / Process Improvement (QAPI) Committee. This monitoring should include physician notification, family / responsible party notification, and notification of outside entities (such as School and Adult Day) as appropriate. This facility has QA/QI meetings every month. Issues concerning notification of changes will be reviewed at the regular QA/QI meetings and, as necessary, at any subsequent special meeting called to insure ongoing compliance.	

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N 018	Continued From page 3 message left regarding resident being sent to Emergency Room and admitted. Request to return call". There were no other attempts made to notify the responsible party in the documentation or when the resident returned from the hospital with the fractured humerus. Interview with the Responsible Party/Guardian, on 02/12/13 at 4:22 PM, revealed there were no messages from the facility; she stated she and a coworker had gone through all their messages. She stated the only way she found out about the hospitalization and the fractured arm was from an electronic message from the Adult Day Care Center Resident #4 attended three (3) days a week. Interview with the Licensed Practical Nurse (LPN) #1, on 02/12/13 at 4:30 PM, revealed she had notified the receptionist at the Responsible Party's office. She stated she had forgotten to document the telephone call. Interview with the Administrator and the Director of Nursing, on 02/13/13 at 3:00 PM, revealed it is the facility's policy to notify the responsible party of a change in a resident's condition and in the case of Resident #4, the Adult Day Care Center should also have been notified of the fractured arm.	N 018	Compliance with notification of changes will be reviewed and analyzed at the QA/PI meetings for 6 months. Based upon analysis, subsequent plans of correction may be developed & implemented as needed.	
N 144	902 KAR 20:300-6(7)(b)2.a. Section 6. Quality of Life (7) Environment. (b) Infection control and communicable diseases. 2. The facility shall establish an infection control program which: a. Investigates, controls and prevents infections in the facility;	N 144	**902 KAR 20:300-6(7)(b)2.a. Section 6. Quality of Life** 3/29/13 Rosedale Manor has established and is committed to maintaining 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 by: (a) Establishing an infection control program under which (1) We investigate, control, and prevent infections in the facility;	

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N 144	Continued From page 4 This requirement is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to establish and maintain an effective infection control program designed to prevent the development and transmission of disease and infection for two (2) of six (6) sampled residents, (Residents #3 and #4). The facility failed to ensure staff washed hands between glove changes during resident care and during a dressing change observation, as per the facility's policy. In addition, observation revealed staff put dressing supplies that were not used during a dressing change back in the treatment cart. The findings include: Review of the facility's policy titled, "Hand Washing /Hand hygiene", with a revision date of 01/17/12, revealed hands should be thoroughly washed before and after providing resident care. Proper hand-washing techniques must be followed at all times. Under when to wash hands it stated to wash hands before and after wearing loves. Record review revealed the facility admitted Resident #4 on 02/29/06 with diagnoses which included Cerebral Vascular Accident, Left Hemiplegia, Convulsions, Mental Retardation and Osteoarthritis. Observation, on 02/13/13 at 8:05 AM, revealed Certified Nursing Assistant (CNA) #3 and CNA #4 took Resident #4 back to her/his room to change his/her top due to the top getting soiled while Resident #4 ate breakfast. Both CNA's washed their hands prior to care. After removing the top	N 144	With regards to CNA #3 and CNA #4 applying gloves to change Resident #4's soiled shirt, then removing their gloves without washing their hands or applying hand sanitizer before applying clean gloves; the procedure completed did not require the use of gloves. Gloves are only required when the potential to come into contact with blood or other potentially infectious materials is present. However, our policy does indicate that when gloves are used, hands are to be washed before and after their use. The Clinical Care Coordinator immediately educated CNA #3 and CNA #4 on 2/13/13 about the proper procedure for washing their hands with glove use. CNA #4 was educated by the Clinical Care Coordinator on 2/13/13 that hand sanitizer is readily available throughout the facility and leaving your hand sanitizer in your car is no excuse not to use it. With regards to Resident #3 and LPN #6 not following our policy related to hand washing / hand hygiene during the process of a dressing change; LPN #6 was immediately educated by the Clinical Care Coordinator on 2/12/13 of the proper procedure. As verified by the surveyor, LPN #6 was aware of the policy and was aware of her error. LPN#6 indicated she was nervous being observed by the surveyor. Resident #3 was observed by the Skin Care Coordinator on 3/6/13 and has experienced no signs and symptoms of infection related to this dressing change.	

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N 144	Continued From page 5 CNA #4 put the top in a laundry bag, took off her gloves and downed clean gloves without washing or sanitizing her hands. Interview with CNA #4, on 02/13/13 at 9:00 AM, revealed she was aware she was supposed to wash or sanitize hands between glove changes. She stated usually she carried hand sanitizer in her pocket, but left the hand sanitizer in her car. Record review revealed the facility admitted Resident #3 on 06/15/12 with admission diagnoses which included Diabetes Mellitus, Debility, Muscle Weakness Dysphagia and Depression. Review of the current Comprehensive Plan of Care for Resident #3 revealed he/she was at risk for impaired skin integrity related to the recent left hip fracture, limited mobility and episodes of incontinence. Continued record review revealed Resident #3 had an unstageable necrotic area to the right out ankle and was placed on antibiotic therapy on 02/05/13. Observation of Resident #3's wound care, on 02/12/13 at 9:20 AM, revealed Licensed Practical Nurse (LPN) #6 removed the old dressing and removed her gloves and downed a clean pair of gloves without washing or sanitizing hands. After completing the treatment LPN #6 removed her gloves and left the room without washing her hands. Upon return to Resident #3 room, LPN #6 then washed her hands. She picked up the Santyl ointment, six (6) normal saline in hard plastic, a stack of non sterile four by fours, a package of non sterile two by twos and packets of skin prep and put the items back in the treatment cart. Interview with LPN #6, on 02/12/13 at 9:35 AM,	N 144	The Clinical Care Coordinator observed LPN#6 during a dressing change on 3/7/13 and no infection control issues were noted. LPN #6 washed her hands between gloves, after removing her gloves and before leaving the room and did not remove any treatment items from the room and return them to the cart. The ADON educated LPN #6 on 2/12/13 that only those treatment items needed to complete a procedure are to be taken into the room. Any items that are not used may be left in the room, if appropriate for later use, or must otherwise be discarded. The policy and procedure on hand washing / hand hygiene was reviewed by the DON on 3/6/13. The policy and procedure is appropriate. The issue was not related to the policy process itself, but rather a failure to follow the policy as written. As of 3/29/13, all staff will be educated by the ADON, Staff Development, Clinical Care Coordinators, Supervisors, RAI nurses, and ancillary department supervisors on the policy and procedure for hand washing / hand hygiene. Quality assurance monitoring will be completed by the ADON, Staff Development, Clinical Care Coordinators, Supervisors, RAI nurses, and ancillary department supervisors to ensure that hand washing / hand hygiene is properly completed. This monitoring will be completed once a week for 4 weeks, then once a month for 4 months, and then as needed based upon recommendations from the Quality Assurance / Process Improvement (QAPI) Committee.	

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N 144	Continued From page 6 revealed she was aware she should have washed her hands between glove changes and stated it was an infection control issue. She stated there was nothing wrong with putting the unused items back in the treatment cart. Interview with the Assistant Director of Nursing (ADON) and the Infection Control/Quality Improvement Nurse, on 02/14/13 at 12:30 PM, revealed staff was taught to wash or sanitize hands after each glove change. She stated good practice was to use or leave unused supplies in the room. She stated the facility had monthly inservices on handwashing. She stated not every staff member went to each inservice. She stated the Unit Manager set aside time monthly to monitor the staff for infection control issues.	N 144	This facility has QA/QI meetings every month. Issues concerning hand washing / hand hygiene will be reviewed at the regular QA/QI meetings and, as necessary, at any subsequent special meeting called to insure ongoing compliance. Compliance with hand washing / hand hygiene will be reviewed and analyzed at the QA/PI meetings for 6 months and based upon analysis, subsequent plans of correction may be developed and implemented as necessary.	
N 207	902 KAR 20:300-8(1)(c) Section 8. Quality of Care (1) Activities of daily living. Based on the comprehensive assessment of a resident, the facility shall ensure: (c) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This requirement is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure one (1) of six (6) sampled residents, Resident #4, who was unable to carry out her/his activities of daily living (ADL), received the necessary services to maintain good grooming and clothing appropriate for the weather. The findings include: Interview with the Administrator, on 02/14/13 at	N 207	**902 KAR 20:300-8(1)(c) Section 8. Quality of Care** 3/29/13 Rosedale Manor is committed to ensuring that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming and personal hygiene.	

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N 207	Continued From page 7 3:30 PM, revealed the facility had no policy on groom or ADLs. Record review revealed the facility admitted Resident #4 on 02/29/06 with diagnoses which included Cerebral Vascular Accident, Left Hemiplegia, Convulsions, Mental Retardation and Osteoarthritis and with a recent diagnosis of a Proximal Fracture of the Left Humerus. Review of Resident #4's Quarter Minimum Data Set (MDS) Assessment, dated 11/13/12 revealed the facility assessed Resident #4 with a Brief Interview for Mental Status (BIMS) score of ninety-nine (99) indicating Resident #4 was unable to complete the test and was severly cognitively impaired. Review of the CAA dated 03/06/12 under the category, Activities of Daily Living Functional Status/Rehabilitation Potential, the facility assessed Resident #4 as having Mental Retardation and having left hemiplegia with contractures, requiring extensive to total assist in all areas of ADL's with the exception of eating. The decision was made to care plan. Review of Resident #4's comprehensive plan of care revealed Resident #4 attended an Adult Care Center every Monday, Wednesday and Friday via bus. Interview with Adult Mentor #1 from the Adult Day Care Center, on 02/12/13 at 9:35 AM, revealed Resident #4 came to the day center one day and his/her hair was a matted mess. She stated the daycare staff could not get a comb through it. She stated Resident #4's clothes always seemed dirty or stained. She stated the facility sent Resident #4 in short sleeves without a coat. She stated for a while they had a problem with the facility sending Resident #4 with house dresses without	N 207	During the interview that occurred with the state surveyor, the Administrator, and the DON, just prior to the surveyor exiting the facility, which encompassed the 3:30 pm time frame, there was no comment made that indicated Rosedale does not have a policy on grooming or ADL's. In fact, we have approximately 17 policies related to grooming and ADL's, one specifically titled Activities of Daily Living. With regards to the comments made about Resident #4 by Adult Mentor #1, Adult Mentor #2, the Bus Driver, and the ADCC, regarding their perceived care issues, the dates of concern are unclear and make it difficult to provide specific information. However, knowing Resident #4 as we do, having cared for her since March 29, 2006, we can confidently provide the following information. Resident #4 sits upright in a high back wheelchair throughout the day. Due to her functional limitations, her head often rests directly on the head rest of that wheelchair. Resident #4 consistently turns her head from side to side, and regularly drags her hands through her hair, typically starting at the bottom of the back and pulling her hair upwards. The consistent rubbing of her head against the head rest results in almost continuous matting of her hair. Resident #4 used to wear her hair long, but it was cut shorter to aide in keeping her hair from matting as severely. Staff at Rosedale frequently comb Resident #4's hair, but also recognize that there is an issue with keeping her hair managed. The Clinical Care Coordinator placed a call to Resident #4's legal guardian on 3/7/13 to discuss options to minimize the matting of Resident #4's hair. We completely understand that, although we do comb Resident #4's hair prior to her leaving for school, that during her transport to	

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N 207	Continued From page 8 a bra. Interview with the bus driver, on 02/13/13 at 8:15 AM, revealed he had been transporting Resident #4 to the Adult Day Care Center for the last three (3) months. He stated sometimes Resident #4 would not have his/her coat on, but would be covered with a blanket. He stated occasionally Resident #4's hair would be all over the place, but in generally Resident #4 looked dishevel. Interview with the Assistant Director at the Adult Day Care Center (ADCC), on 02/14/13 at 10:15 AM, revealed Resident #4 came in with matted hair, came in dirty and with a strong urine odor or with breakfast spills on his/her clothing. Interview with Adult Mentor #2 from the ADCC, on 02/14/13 at 10:30 AM, revealed Resident #4 came in with dirty clothes and uncombed hair. She stated the facility sometimes sent him/her without outwear with short sleeves with a blanket covering the legs. Interview with MDS Coordinator, on 02/08/13 at 10:00 AM, revealed everyone from the Certified Nursing Assistants (CNA's), to the nurses on the unit, to the Coordinator, to herself were all responsible for insuring Resident #4 was clean and well groomed after eating breakfast and prior to going to the Adult Day Care Center. Interview with CNA #4, on 02/13/13 at 9:00 AM, revealed Resident #4 received his/her baths on the evening shift. She stated the evening should should dry Resident #4's hair prior to putting him/her to bed. Interview with the Administrator, on 02/14/13 at 3:30 PM, revealed she had never seen Resident	N 207	school, it is going to become matted and appear as though it hasn't been combed. Since resident #4 routinely runs her hand through her hair, it is very likely that her hair might be 'all over the place' and that, in and of itself, does often make her appear disheveled. Rosedale staff does observe all resident's clothing for stains and damage and we request replacements as needed. Resident #4 does not wear a coat, but rather wears a cape. She wears this cape due to her functional limitations and the fact that it doesn't require her to put her arms into sleeves. There is a hood that covers her head, and the cape covers her and the back of her wheelchair. The cape was purchased specifically related to Resident #4's individual needs. As this cape does function in place of a coat, it does occur that Resident #4 wears short sleeves underneath of it. Although resident #4 does have mental and physical limitations, she is able to make her needs known through gestures. She does wear house dresses at times, and has been known to refuse to wear her bra. Resident #4 has also been known to refuse to wear her cape, when this occurs she may be sent out with a cover. Although covered when she leaves here, with Resident #4's involuntary and voluntary movements, the cover may become displace and would need to be reapplied before taking her off of the bus. Interviews were completed by the Director of Nursing during the survey with CNA's, nurses, unit coordinators, nurse managers, and the receptionist that sits at the front entrance. These interviews revealed that this resident is regularly noted to be dressed appropriately and covered with her cape or a blanket as needed when going out.	

Office of the Inspector General

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N 207		N 207	Throughout the survey process, during discussions with the surveyor, she shared that she had not seen issues with Resident #4's appearance, that she appeared clean. The surveyor further stated that she did observe the residents hair to be combed and then quickly became matted and messy in appearance. She further stated that she observed staff tending to Resident #4 on a regular basis and that she had observed no concerns while here. The RAI nurse updated Resident #4's care plan on 3/7/13 to indicate the chronic issues with her hair, to clarify that the resident expresses her wishes through gestures, and that when the resident refuses to wear undergarments, we will honor that request. The care plan will also reflect that when the weather dictates and the resident refuses to wear the cape, she should be covered with a blanket to shield her from the elements. With regards to the alleged statement regarding the Administrator ensuring that all complaints would come to her instead of the floor, it is unrealistic to expect that all complaints of this nature will go first to the Administrator. The Administrator did indicate that she was concerned that she had not been contacted by the School and would try to make contact with them to open the lines of communication should they have further concerns in the future. Our policy is that the Administrator is notified of any care related issues. The Clinical Care Coordinators and Nursing Supervisors were inserviced by the DON on 3/7/13 regarding the necessity to notify the DON and Administrator immediately of any care related concerns. The Director of Nursing at Rosedale has made	

Office of the Inspector General

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N 207		N 207	attempts to contact the ADCC at School to open the lines of communication so that both organizations can work together in the best interest of Resident #4. As of 3/6/13, a return call has not been received. The DON will attempt to make contact with the ADCC on an on-going weekly basis to discuss any concerns that may arise. The policy and procedure titled "Activities of Daily Living was reviewed by the Director of Nursing on 3/6/13. The following additions were made to the policy: 1) The resident's right to clothing selection and attire should be honored. If a resident prefers to not wear undergarments, that right should be honored. 2) If a resident's clothing is noted to be in disrepair or stained, social services should be notified to contact the family or responsible party regarding replacements. 3) Any resident who leaves the facility for an outside appointment should be dressed appropriately for the weather. Should a resident choose to dress out of season, the care plan should reflect the resident's wishes and a progress note should indicate education to the resident and or legal representative. 4) Any resident who leaves the facility for an outside appointment should have their hair combed prior to leaving and should display good hygiene. If the resident chooses not to do so, their refusal should be care planned and the issues should appear in the progress notes. 5) Any resident who leaves the facility during cold weather should have something in place to shield them from the elements (i.e., coat, cape, cover, blanket, etc). All residents should be encouraged to follow this and their refusal to do so should be documented and care planned. 6) The Director of Nursing and Administrator should be notified of all resident care complaints.	

Office of the Inspector General

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N 207		N 207	All nursing staff and social service staff will be inserviced as of 3/29/13 by the ADON, Clinical Care Coordinators, RAI Nurses, or other designees regarding the updated ADL policy. Quality assurance monitoring will be completed by the ADON, Clinical Care Coordinator, RAI nurse, charge nurses, or nursing assistants to ensure that Resident #4 is dressed appropriately, appears and smells clean, and looks presentable. This monitoring will be completed for Resident #4 every day for one month, then every Monday, Wednesday, and Friday for 4 months, and then as needed based upon recommendations from the Quality Assurance / Process Improvement (QAPI) Committee. Random quality assurance monitoring of at least 10 residents per neighborhood per month will be completed by the ADON, Clinical Care Coordinator, RAI nurse, charge nurses, or nursing assistants for other residents to make sure they are dressed appropriately, appear and smell clean, and look presentable. This monitoring will occur monthly for 4 months, and then then as needed based upon recommendations from the Quality Assurance / Process Improvement (QAPI) Committee. This facility has QA/QI meetings every month. Issues concerning residents receiving proper assistance with Activities of Daily Living will be reviewed at the regular QA/QI meetings and, as necessary, at any subsequent special meeting called to insure ongoing compliance. Compliance with performance of Activities of Daily Living will be reviewed and analyzed at the QA/PI meetings for 6 months and based upon	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEDALE MANOR	4250 GLENN AVENUE COVINGTON, KY 41015

(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) COMPLETE DATE
N 207	Continued From page 9 #4 leave the facility without outer wear or without being well groomed. She stated she would ensure all complaints about Resident #4's grooming came to her instead of the floor.	N 207	analysis, subsequent plans of correction may be developed and implemented as necessary.	