

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

PRINTED: 06/13/20
FORM APPROVE
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/07/2014
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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PINE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40504
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F 000 INITIAL COMMENTS
AMENDED 06/13/2014

A Recertification Survey and an Abbreviated Survey investigating KY00021632 was initiated on 05/04/14 and concluded on 05/07/14. KY00021632 was unsubstantiated with no deficiencies cited. Deficiencies were cited during the Recertification Survey with the highest Scope and Severity of a "E".

F 157 483.10(b)(11) NOTIFY OF CHANGES
SS=D (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

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F 000 Resident #1's physician was made aware of the weight gain on May 6, 2014. An order was received and noted on April 22, 2014 to change resident #14's diet order to the RD recommendations

F 157 All residents in the facility that were ordered weights per MD order for diagnosis other than weights obtained per facility policy and MD notification for weight loss/gain reports from dietary were identified. Resident #1 was the only resident on this list. An audit was conducted on all residents' records on May 29, 2014 to ensure that all current diet orders recommended by the RD match the physician's orders and the diet card.

Residents requiring weights for diagnoses other than Cardiac/Pulmonary Program will have a specific MAR written for the weighing process; MD ORDERED WEIGHT MAR, stating why the weights were initiated and when/what days the weights are to be obtained. The MAR also instructs the nurse what lift and sling will be utilized to weight the resident and any re-weight needed and when to notify the

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jamie May</i>	TITLE Administrator	(X6) DATE 6/19/14
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deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 am participation.

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F 157	<p>Continued From page 1 this section.</p> <p>The facility must record and periodically update 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: Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure the Physician was notified when there was a significant change in a resident's physical status and/or a need to alter treatment for two (2) of twenty-three (23) sampled residents (Resident #1 and Resident #14).</p> <p>Although Resident #1 had diagnoses of Cirrhosis of the Liver with Ascites (abnormal accumulation of fluid in the abdominal cavity) and had a history of requiring Paracentesis (procedure to take out fluid that had collected in the abdomen), there was no documented evidence the Physician was notified of a greater than five (5) pound weight gain in three (3) days, as per the Physician's Orders. Review of Resident #1's weights revealed: from 04/04/14 to 04/09/14, revealed there was a eight (8) pound weight gain; from 04/28/14 to 04/30/14 there was a seven and a half (7.5) pound weight gain; and from 04/30/14 to 05/02/14 an eleven (11) pound weight gain with no documented evidence the Physician was notified of the weight gains as per the orders.</p> <p>Additionally, Resident #14 had Dietary Recommendations from the Registered Dietician (RD) to discontinue the resident's high protein, high calorie diet on 02/10/14; however, there was</p>	F 157	<p>physician/ARNP if the weight exceeds parameters ordered. The licensed staff were in serviced on this new policy and procedure on May 29, 2014 by the DON and ADON. The dietary manager will receive a copy of the RD recommendations each week. The unit managers will receive a copy of the recommendations as well. As the unit coordinators get the recommendations approved by the physician, the unit coordinator will write the order and give a copy to the dietary manager. If the physician does not approve the recommendation, the unit coordinators will notify the dietary manager. The unit coordinator will write a nurses note explaining why the physician chose not to follow the recommendation. The RD or dietary manager will attend weekly Standards of Care meetings to discuss the Weight Loss/Gain Report. The Weight Loss/Gain report is used to alert staff of significant weight gain or loss. It is formulated by the RD after the weights have been obtained by the nursing staff.</p>	

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F 157 Continued From page 2
no documented evidence the Physician was notified of the recommendation.

The findings include:

On 05/07/14 at 7:15, a policy related to Physician notification was requested; however, not received.

1. Review of Resident #1's clinical record revealed diagnoses which included Portal Hypertension (an increase in the blood pressure within a system of veins called the portal venous system caused by liver damage with Chronic Ascites, Congestive Heart Failure, Chronic Kidney Disease, and Cirrhosis of the Liver with a History of Paracentesis. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 03/29/14, revealed the facility assessed Resident #1 as having a Brief Interview for Mental Status (BIMS) score of a fifteen (15) out of fifteen (15), indicating no cognitive impairment.

Review of the monthly Physician's Orders dated May 2014, revealed orders to obtain weights three (3) times a week on Monday, Wednesday, and Friday at 6:00 AM. Review of the Orders revealed the Physician was to be notified if there was more than a five (5) pounds weight gain in three (3) days. Additional review of the Orders revealed staff were to measure Resident #1's abdominal girth every morning at 6:00 AM related to a History of Ascites. Continued review revealed the orders were originally written 02/12/14.

Review of Resident #1's Medication Administration Records (MAR) dated April 2014 and May 2014, revealed the following weights

F 157 The Quality Assurance Nurse will complete an audit of MD ordered weights/MD notification weekly for four weeks to ensure compliance is achieved. If 100% compliant, audit results will be taken to the Quality Assurance meeting the next month by the DON to reduce the audit to monthly. After four (4) months of 100% compliance, the DON will take the audit results to the QA committee to be discontinued to semi-annually.

06/20/14

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F 157	<p>Continued From page 3</p> <p>were obtained: on 04/04/14 the resident's weight was 175 pounds and on 04/09/14 the resident's weight was 183 pounds, an eight (8) pound weight gain; a weight obtained on 04/28/14 was recorded as 173.5 and on 04/30/14 the resident's weight was recorded as 181 pounds, a seven and a half (7.5) pound weight gain; on 04/30/14 the resident's weight was recorded as 181 pounds, and on 05/02/14 the resident's weight was recorded as 192 pounds, an eleven (11) pound weight gain.</p> <p>Further review of the clinical record revealed there was no documented evidence the Physician was notified of the greater than five (5) pound weight gains documented on the April and May 2014 MARs as per the Physician's Orders.</p> <p>Interview on 05/07/14 at 2:15 PM, with Licensed Practical Nurse (LPN) #2/Unit Manager (UM) of the unit where Resident #1 resided, revealed the Physician should have been notified of the weight gains on 04/09/14, 04/30/14 and 05/02/14 because the resident had a history of the need for Paracentesis due to a build up of fluid related to Cirrhosis of the Liver.</p> <p>Interview on 05/07/14 at 7:30 PM with the Director of Nursing (DON), revealed it was important for the staff to follow the Physician's Orders for Resident #1 related to the resident's diagnoses of Congestive Heart Failure and Cirrhosis of the Liver with Ascites. The DON stated staff should be monitoring the weights, and notifying the Physician for weight gains as per the parameters set by the Physician.</p> <p>Interview with Resident #1's Physician on 05/07/14 at 5:00 PM, revealed he could not say</p>	F 157		

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F 157	<p>Continued From page 4</p> <p>he was notified of the weight gains if there was no documentation. He stated this resident gained and lost weight from the abdomen and has had frequent Paracentesis. The Physician stated the reason weights were ordered three (3) times a week was to see if the abdomen was accumulating fluid and to assess for Ascites due to Cirrhosis of the Liver. Further interview revealed it was his expectation for the Physician's orders to be followed related to obtaining Resident #1's weights and notifying him of weight gains as ordered.</p> <p>2. Review of Resident #14's clinical record revealed diagnoses which included Hypertension, Hyperlipidemia, Breast Cancer, and Alzheimer's Dementia. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 03/26/14, revealed the facility assessed Resident #14 as having a Brief Interview for Mental Status (BIMS) score of a fifteen (15) out of fifteen (15), indicating no cognitive impairment. Additional record review revealed Resident #14's documented height was sixty-two (62) inches, and his/her last weigh obtained one hundred and twelve (112) pounds.</p> <p>Continued review of the clinical record revealed a "Consultant Dietitian Weight Change Report: Gain/Loss" dated 02/10/14, and Nutrition Progress Notes dated 02/10/14, completed by the facility's former RD, revealed recommendations to discontinue a dietary supplement, and Resident #14's High Protein/High Calorie diet as the resident's weight was considered stable and his/her caloric intake was greater than caloric expenditure. Record review revealed no documented evidence the Physician was notified of the RD's recommendations. Review of the</p>	F 157		

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F 157	<p>Continued From page 5</p> <p>Physician's Orders for February, March and April 2014, revealed Resident #14 a High Protein/High Calorie diet was still ordered for the resident until 04/21/14. Further record review revealed a Nutrition Progress Note dated 04/21/14 which noted the current RD's recommendation was also to discontinue the High Calorie/High Protein diet. Review of Resident.#14's."Diet Order and Communication" report dated 4/22/14, revealed the current RD's recommendation for the discontinuance of the High Calorie/High Protein diet.</p> <p>Interview with the current RD on 05/06/14 at 10:11 AM, revealed the process for making recommendations for residents was for the RD to complete a recommendation on the "Consultant Dietitian Weight Change Report: Gain/Loss" form. She stated this form is submitted to the resident's Physician, nurses, and Dietary Manager. The RD stated she put her recommendations in the mailbox of the Dietary Manager and copies were distributed to the Physician and nurses. She stated the "Consultant Dietitian Weight Change report: Gain/Loss" form showed if or when a special diet should have been discontinued. According to the RD, based on her review of Resident #14's dietary records, the resident should have had the High Calorie/High Protein diet discontinued in February 2014 as per the former RD's recommendations. She indicated she was not sure if the Physician received the former RD's recommendations in February 2014.</p> <p>Interview with the DON on 05/06/14 at 11:46 AM, revealed the former RD's recommendation in February 2014, was missed because it was not discontinued through dietary orders as it should have been. She stated it was her expectation</p>	F 157		

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F 157	<p>Continued From page 6</p> <p>when the RD wrote a recommendation copies should be given to her, the Assistant Director of Nursing (ADON), and both UMs, as well as, the Dietary Manager. The DON stated distribution of the RD's recommendation were missed on the Physician's Order and carried over until 04/21/14. However, she indicated Resident #14's Physician should have been notified of the former RD's High Calorie/High Protein diet discontinuation recommendation.</p> <p>Interview with Resident #14's Physician on 05/07/14 at approximately 5:10 PM, revealed he usually signed off on the RD's recommendation unless he did not agree with it. He stated the RD had done "her job" on 02/10/14; however, a "disconnect" happened between the Dietary Manager and the nurses notification of the recommendation. However, he indicated he should have been notified of the RD's recommendation.</p>	F 157		
F 241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>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 promote care for residents in a manner and an environment which enhanced each resident's dignity for six (6) of twenty-three (23) sampled residents (Residents #16, #15, #1, 14,</p>	F 241	<p>Corrective action could not be accomplished with resident #1, #14, #15, #16, #18, and #19 because notification to facility of these interviews occurred at exit conference May 7, 2014. The residents were all talked to by the DON and Administrator on May 8, 2014 to explain the procedure that was going to be implemented where no staff member passed by a call light ringing without answering it.</p>	

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F 241	<p>Continued From page 7 #18 and #19).</p> <p>Interview revealed call lights were not answered timely which resulted in an incontinent episode for Resident #16.</p> <p>Interview with Resident #15 revealed he/she had experienced embarrassment when incontinent of bowel while waiting on someone to assist after he/she rang the call light.</p> <p>Interview with Resident #1 revealed call lights were not answered timely resulting in her/him having to wait long periods of time before receiving incontinence care.</p> <p>Interview with Resident #14 revealed he/she had to wait long periods of time to get assistance with toileting and/or incontinence care.</p> <p>Interview with Resident #18 revealed he/she often felt "neglected" when staff did not answer his/her call light.</p> <p>Interview with Resident #19 revealed waiting for staff to respond to his/her call light for toileting assistance made him/her feel bad and anxious.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Residents Rights", undated, revealed each resident should be treated with consideration, respect, and full recognition of his/her dignity and individuality.</p> <p>Review of the facility's policy titled, "Call Lights, Use of", no date, revealed: all personnel were to be aware of call lights at all times; answer all call lights promptly whether or not you are assigned to</p>	F 241	<p>The Social Services department interviewed all current residents in facility with a BIMS score of 8 or above on May 27, 2014 to ensure call bells were answered in a timely manner and toileting needs were met in a timely manner. Restorative Nurse completed a bowel and bladder audit of all residents currently residing in the facility on May 28, 2014. All residents were found to have a toileting program if needed, a check and change schedule per facility protocol for residents unable to gesture/verbalize or did not have a definite voiding pattern, and residents choosing not to participate in a program. A three day bowel and bladder voiding diary was initiated on May 28, 2014 for resident #16, #19, and #1 to assess for changes in current toileting program or if resident needs a toileting program. Interviews will be done at the time of assessment.</p>	

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F 241 | Continued From page 8
the resident; and answer all call lights in a prompt, calm, and courteous manner.

1. Review of Resident #16's clinical record revealed the facility admitted the resident on 01/20/14 with diagnoses which included a History of Urinary Tract Infection, Generalized Muscle Weakness, and Anxiety.

Review of the Admission Minimal Data Set (MDS) Assessment dated 01/27/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a fifteen (15), which indicated no cognitive impairment. Further review of the MDS revealed the facility assessed the resident as occasionally incontinent and as requiring extensive assistance of one (1) person for toileting.

Review of the Initial/Interim Care Plan dated 01/20/14, revealed Resident #16 required two (2) assist with ambulation, transfers and toileting.

Review of the "Resident Daily Toileting Diary" and "Summary Of Bowel/Bladder Diary Results" revealed the documents contained inconsistent value reports as evidenced by Day 1 of the Diary, 01/22/14, revealed three (3) urinary incontinent episodes documented; however, review of the Summary of the Diary for Day 1 revealed six (6) urinary incontinent episodes noted. Review of Day 2 of the Diary, 01/23/14, revealed staff noted four (4) urinary incontinent episodes; however, review of the Summary of the Diary for Day 2 revealed seven (7) urinary incontinent episodes noted. Review of Day 3 of the Diary, 01/24/14, revealed seven (7) urinary incontinent episodes documented; however, review of the Summary of the Diary for Day 3 revealed eight (8)

F 241 | On May 27, 2014 an in service was initiated by the DON on the expectations of timely response to call lights. The expectation is that all employees will answer call lights and that no call light will be turned off until the need is met. The expectation is that no employee will walk by a call light without response. All staff will be in serviced by June 1, 2014 by DON/ADON/Staff Development Nurses/Supervisors. Continuous Quality Improvement Rounds were initiated on May 27, 2014. 7-3 facility staff members are assigned to 3 rooms each for a daily round. Areas reviewed during rounds include resident condition, the room condition, and care areas. Rounds are to be done daily Monday-Friday. For 3-11 and 11-7 Monday through Friday the shift supervisor will select 3 rooms from Unit 1 and 3 rooms from Unit 2 and complete a CQI round sheet. On weekends, supervisors will choose 3 rooms from each unit for each shift and complete a CQI Round sheet. Staff was educated on the importance of addressing complaints or requests immediately and asking resident if there is anything you can do for them or get them anything before the staff leaves the room. Completed CQI round sheets are submitted to the

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urinary incontinent episodes noted.

Interview with Resident #16 on 05/06/14 at 11:22 AM, revealed on the evening shift, it had taken thirty (30) to sixty (60) minutes for staff to respond to his/her call light before and this had resulted in several incontinent episodes. Resident #16 stated this made him/her feel terrible to "wet" on himself/herself. According to Resident #16, this would not have to happen, if he/she could have been taken to the bathroom in time. Resident #16 indicated he/she could use the toilet and preferred to do so.

Interview with Certified Nursing Assistant (CNA) #12 on 05/07/14 at 2:30 PM, revealed there was not enough staff and call lights did not get answered timely due to the lack of staff on the floor. CNA #12 further revealed she knew Resident #16 had "wet" himself/herself while waiting on the call light to be answered.

Interview with CNA #9 on 05/07/14 at 5:10 PM, revealed Resident #16 had been "wet" when she answered his/her call light. CNA #9 stated there was not enough staff to meet the residents' needs.

Interview with Licensed Practical Nurse (LPN) #3 on 05/07/14 at 10:48 AM, revealed everybody was responsible for answering call lights. LPN #3 stated if resident's call light should not be turned off. She stated the call light should be left on until the resident received the help he/she required. However, she stated she had residents complain about the slow response of staff to their call lights.

Interview with Registered Nurse (RN) #2 on

F 241 DON for review by DON/ADON. After review the forms will be given to the unit coordinators for follow up at the next morning meeting. Restorative Nurse will in service all nursing staff on the three day voiding diary and the correct completion of the voiding diary by June 1, 2014.

Social services will interview weekly for four weeks the 54 residents that responded to the questionnaire on May 27, 2014. The same questionnaire will be used for the audit. If greater than 90% improvement is noted, audit will be changed to monthly with 10 residents (5 from each unit) with BIMS score of 8 or higher being interviewed with the same questionnaire. QA nurse will audit 5 round sheets from each unit coordinator monthly for 3 months. If 100% compliant the audit will be changed to quarterly. If the audit remains 100%, the DON will take the audit results to the QA committee the next month and asked that the audit be discontinued. The QA nurse will audit call bell response for timeliness by pushing a call bell and recording response by facility staff. This audit will be done by the QA nurse weekly for four weeks. If 100% compliance is met, the audit will be changed to monthly for three months. The audit will be taken to the QA committee the next month by the DON and asked to

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PINE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40504
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05/07/14 at 11:28 AM, revealed everyone was responsible to answer call lights as soon as possible. RN #2 stated a resident should never have to wait more than five (5) minutes, regardless of what was going on.

2. Review of Resident #15's record revealed the resident was admitted by the facility on 01/21/08 with diagnosis which included Constipation, Hypertension, Diabetes, Depression, and Schizophrenia. Record review revealed Resident #15's Quarterly MDS, dated 03/15/14 revealed a Brief Interview Mental Status (BIMS) score of fourteen (14), which indicated the resident was cognitively intact. Review of Resident #15's care plan, dated 07/25/13, revealed the resident was occasionally incontinent of bladder. Further review of the care plan revealed Resident #15 needed assistance to the bathroom for elimination per toileting schedule. Review of Resident #15's last Bowel/Bladder Assessment dated 03/15/14, revealed Resident #15 was checked to have two (2) or more episodes of bowel incontinence, but at least one (1) continent Bowel Movement (BM). Continued review of the Bowel/Bladder Assessment revealed Resident #15 experienced seven (7) or more incontinent episodes of urine, and at least one (1) continent of urine episode.

Interview with Resident #15 on 05/06/14 at 11:30 AM, revealed he/she had been incontinent of bowel approximately three (3) times, while waiting for his/her call light to be answered. Resident #15 stated this caused him/her embarrassment. Additional interview with Resident #15 on 05/07/14 at approximately 2:50 PM, revealed he/she while waiting in his/her wheelchair in his/her room he/she had waited for staff to

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be discontinued if 100% compliance is maintained. The Restorative nurse will audit three day voiding diary for all new admissions, new annuals and significant change residents for 6 months. If 100% compliant, the audit will be taken to the next QA committee meeting for discontinuation after six (6) months.

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respond to the call light and had soiled himself/herself while waiting. Resident #15 indicated this made him/her feel embarrassed.

Interview with RN #3 on 05/07/14 at 7:36 AM, revealed Resident #15 had stated to staff he/she had waited for awhile for his/her call light to be answered. She reported Resident #15 has had to wait before to get the help he/she needs. Continued interview with RN #3 revealed staff was told to answer the call lights; however, if the resident's request was out of the scope of practice, then staff would turn the resident's call light off and go get the appropriate staff to assist the resident. She stated when the facility was short staffed, she would answer the resident's call light and have a CNA assist the resident later. RN #3 reported some nights, it had been difficult to answer call lights with the limited number of staff. She reported call lights go off non-stop during night shift and some residents have had to wait sometimes over ten (10) minutes before staff could assist with their care needs.

3. Review of Resident #1's clinical record revealed diagnoses which included Congestive Heart Failure, Chronic Kidney Disease, and Chronic Cystitis. Review of the Quarterly MDS Assessment dated 03/29/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status of a fifteen (15) out of fifteen (15), indicating no cognitive impairment. Further review revealed the facility assessed the resident as requiring extensive assistance of one (1) staff for transfers, toilet use, and personal hygiene, and as always incontinent of bowel and bladder.

Review of the Quarterly Assessment Form (Bowel/Bladder Assessment) form revealed the

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F 241	<p>Continued From page 12</p> <p>resident did not toilet, was a heavy wetter, and was always incontinent of bowel and bladder. Continued review revealed the resident did not voice or gesture the need to void or defecate and the resident was to be checked and changed per facility policy. The Form stated the resident was alert, but did not voice toileting needs and would proceed to care plan.</p> <p>Review of Resident #1's Comprehensive Plan of Care dated 01/08/14, revealed the resident had incontinent episodes. The approaches included toilet per schedule on daily care plan and as needed.</p> <p>Review of the "My Daily Care Plan", (form which the CNAs referred to for providing care) dated May 2014, revealed the resident was incontinent of bowel and bladder and wore adult containment products. Continued review revealed the resident was to receive incontinence care as needed.</p> <p>Interview with Resident #1 on 05/05/14 at 3:00 PM revealed sometimes it took a long time for staff to answer the call lights; however, he/she could not say if the problem was worse at a certain time of day or how long it actually took for the call light to be answered. He/She stated the main reason he/she would ring the call light was when needing incontinence care. Continued interview with Resident #1 revealed the resident was unable to tell when he/she needed to be toileted because he/she had no urge to urinate or have a bowel movement. However, the resident stated he/she could tell when he/she was wet and needed incontinence care.</p> <p>Resident #1's daughter, who observed the interview with the resident on 05/05/14 at 3:00</p>	F 241		

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PM, revealed she visited daily and had observed it took as long as an hour for the call light to be answered at times. She stated the call light problem was ongoing. She reported it did not occur more on any particular shift or day of the week.

Interview with CNA #1 on 05/06/14 at 10:00 AM, revealed she was assigned to Resident #1 and stated the resident transferred with the assist of one (1) and was offered toileting every two (2) hours. Continued interview revealed Resident #1 was incontinent of bowel and bladder and wore briefs and sometimes preferred the bed pan instead of getting up on the toilet.

4. Review of Resident #14's Quarterly MDS Assessment dated 03/26/14, revealed the facility assessed the resident as having a BIMS of fifteen (15), indicating no cognitive impairment. Continued review of the MDS revealed the facility assessed Resident #14 to require extensive assistance for Activities of Daily Living (ADL) with the support of one (1) person. Review of Resident #14's Bowel/Bladder Assessment on the MDS revealed the facility assessed the resident to be frequently incontinent of bladder and always continent of bowel. Continued review revealed the resident was not considered per the MDS to be a candidate for a toileting program for bowel or bladder.

Record review of Resident #14's Comprehensive Care Plans dated 02/05/14 revealed the resident was care planned to receive extensive assistance for ADLs. Continued review revealed staff were to use the schedule on the "Daily Care Plan". Review of Resident #14's May 2014 "Daily Care Plan", revealed the resident was incontinent of

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F 241	<p>Continued From page 14</p> <p>bowel and bladder at times, wore an adult brief and required toileting assistance one (1) hour before and after meals and every two (2) hours after 9:00 PM.</p> <p>Interview with Resident #14 on 05/05/14 at 10:58 AM, revealed the resident had concerns with how long it took for staff to respond to his/her call light when he/she rang it. Resident #14 stated it took a long time to get to the bathroom or to get help after he/she was incontinent. Continued interview with Resident #14 revealed he/she believed there was not enough staff and that was the reason it took so long for call lights to be answered. Resident #14 stated sometimes it took too long for staff to answer and he/she could not wait and used his/her walker to attempt to get to the bathroom on his/her own. Resident #14 indicated when this occurred he/she almost did not make it in time.</p> <p>5. Review of Resident #18's clinical record revealed diagnoses which included Hip Fracture, Depression, and Chronic Kidney Disorder. Review of Resident #18's Quarterly MDS Assessment dated 02/11/14, revealed the facility assessed the resident to have a BIMS of fifteen (15), indicating no cognitive impairment. Continued review of the MDS revealed the facility assessed Resident #18 to require extensive assistance for toilet use with the support of one (1) person.</p> <p>Interview with Resident #18 on 05/07/14 at 6:01 PM, revealed he/she was frustrated when no one responded to call light requests. Resident #18 stated sometimes the "aides" and nurses, did not answer the call light. According to Resident #18, sometimes the staff closed the room door and</p>	F 241		
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F 241	<p>Continued From page 15</p> <p>when that happened they rarely responded. Resident #18 stated when they closed the room door it took "forever" for them to respond to when he/she rang the call light and this made him/her feel "neglected".</p> <p>6. Review of Resident #19's clinical record revealed diagnoses which included Neurogenic Bladder, Parkinson's Disease, Anxiety and Depression. Review of the Quarterly MDS Assessment dated 04/07/14, revealed the facility assessed Resident #19 to have a BIMS score of fifteen (15), indicating no cognitive impairments. Continued review revealed the facility assessed Resident #19 to require limited assistance with ADL's with support of one (1) person. Further review of the MDS revealed the facility assessed Resident #19 to require "supervision with set up" for toileting.</p> <p>Review of Resident #19's Comprehensive Care Plan dated 05/20/13, revealed the resident had a history of intermittent episodes of incontinence. Interventions for Resident #19 included: for staff to monitor input and output; assist with toileting needs; assist with perineal care needs; prompt for toileting per schedule outlined on the Daily Care Plan; provide urinal at bedside and empty as needed and monitor bowel movements.</p> <p>Review of Resident #19's Daily Care Plan dated April 2014, revealed the resident used the bathroom independently, however often experienced incontinent episodes. Review of Resident #19's Bowel and Bladder Assessment dated 04/07/14, revealed the resident was assessed to have complete control of his/her bowel and bladder.</p>	F 241		

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Interview with Resident #19 on 05/07/14, and at 05/07/14 at 6:17 PM, revealed he/she had to wait two (2) hours for call light assistance when he/she rang the call light. Resident #19 stated most of the time he/she just wanted his/her urinal emptied for future use. According to Resident #19, waiting for staff to respond to his/her call light made him/her "feel bad" and anxious. Resident #19 stated "what if you have a heart attack", will they respond? Resident #19 stated he/she called "the State" when the facility staff failed to assist him/her with walking for three (3) days. Resident #19 indicated he/she thought "maybe they were short-staffed" and that was the reason it took so long for them to answer the call lights.

Interview with LPN #2 on 05/05/14 at 4:00 PM, revealed her expectation was for staff to answer call lights even if it was not their assigned resident.

Observation on 05/07/14 at 11:20 AM through 11:30 AM, of the nurse's station call light system revealed the call light for room 505 rang and the light over the room door of room 505 lit up as well. Observation revealed LPN #4, LPN #2 and LPN #5 were observed passing the nurse's station and passing room 505 without entering to determine the resident's needs, while the call light continued to ring. Further observation revealed after ten (10) minutes LPN #5 went into room 505 to determine the resident's needs.

Interview with LPN #4 on 05/07/14 at 11:46 AM, revealed she had been employed with the facility for eleven (11) years. She stated the process for answering call light requests was to go into the room and if it was something the staff person

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F 241	<p>Continued From page 17</p> <p>could not address they should request assistance. LPN #4 stated if it required more than one (1) person, the call light was to be left on and staff were to get someone to assist. She stated leaving the light on allowed staff to determine resident's need for assistance. She stated a buzzer could be heard from the nurse's station call light system and it would tell which room required assistance. She stated a red light over the room door meant an emergency situation. She stated she had no reason as to why she did not respond to the call light in room 505 earlier.</p> <p>Interview with LPN #5 on 05/07/014 at 11:53 AM, revealed when the light came on staff were to respond as soon as possible, within a minute or so of realizing it was on. LPN #5 stated when the call light went off, he went into the room of the resident to see what their needs were. He stated some residents can tell you what their needs were and some resident's could not and would require assessment of needs. LPN #5 reported the only time staff were to pass a resident's room with an active call light on was when a bed or chair alarm was sounding. He stated he did not notice the call light in room 505 was turned on when passing the room the first several times. According to LPN #5, when he returned to the hallway, he noticed the call light in room 505 and responded. He reported the call light system at the nurse's station lit up call light rang which sounded like a telephone. LPN #5 stated when he passed room 505 the first few times. He stated the volume on the call light system at the nurse's station, should not be turned down. During the interview LPN #5 listened to the call light system at the nurse's station and indicated it could not be heard. He stated this was an issue</p>	F 241		

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because staff could not hear when resident's had requests for assistance.

Interview with LPN #2/Unit 2 Coordinator on 05/07/14 at 12:31 PM, revealed everyone had a responsibility for answering residents' call lights. She stated the CNAs who work the hallway were to respond to the call lights, and if they could not respond, others were to assist. LPN #2/Unit 2 Coordinator reported if the call light system sounded and the resident's door was shut, staff were to knock on the door, ask the resident how to assist, then help them. She stated if a resident required assist of two (2) persons, then staff should explain that to the resident and inform the resident they would return with help to assist them. According to LPN #2/Unit 2 Coordinator, staff should the call light on if going to get help; however, if the resident did not require two (2) person assist the call light could be turned off when providing for the resident's needs. She stated notification of the resident's need was determined by the light at the resident's room door, and the box which rang at the nurse's station indicating the resident's room number when the call light was rang. LPN #2/Unit 2 Coordinator revealed emergencies were the only reason staff should ever walk past a ringing call light in a resident's room. Continued interview with LPN #2/Unit 2 Coordinator revealed if there were only two (2) staff working the hallway, it would be hard to answer the call lights promptly. She stated she did not notice the light was on in Room #505 before and that was why she had not answered it. LPN #2/Unit 2 Coordinator reported she had just taken another resident to the recreational room. She stated the volume on the call light system could not be turned down. However, observation of the call light system box

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F 241	<p>Continued From page 19</p> <p>with LPN #2/Unit 2 Coordinator revealed the volume was turned down and could barely be heard. She stated it had never been that low before and she would notify maintenance to look at it.</p> <p>Interview on 05/07/14 at 7:30 PM with the Director of Nursing (DON), revealed it was a dignity issue if a resident could not be toileted or receive incontinence care in a timely manner. She stated it could be "detrimental" in an emergency situation if the call bells were not answered timely. Further interview revealed there had been a complaint in the family counsel meeting and she was also aware of one (1) resident related to answering call bells during meal service. She stated as a result of the complaints the facility made changes. The DON stated now the Unit Managers were to pass meal trays to free the SRNA's up to answer call bells and on the weekends the weekend Supervisor who was responsible for overseeing the house on the first and second shift was to assist in the dining room to free up more nurses and SRNA's to assist with dining and answering call bells. Further interview revealed the facility was now staffing through agency and the agency staff were placed in orientation prior to working on the floor. She stated one agency staff group had already been oriented and there was another class for orientation which was scheduled. Also, she stated the facility had implemented a "call in" policy in which if a staff member called in related to illness or other reasons, they would be obligated to work their next scheduled day off to make up the day they missed. Continued interview revealed she did not do set rounds; however, tried to talk to residents when doing rounds to see if there was any concerns. She</p>	F 241		

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F 241	Continued From page 20 stated she and the Associate Director of Nursing needed to start routine rounds after the morning meeting to talk to residents to ask about any concerns or issues. Further interview revealed the facility was aware there had been issues with the call bells being answered and had done routine call bell inservices. She stated the Quality Assurance (QA) Nurse had a call bell audit which she completed; however, she was unsure how often this was done. She stated the audit was taken to the QA Meetings and discussed there and the last audit which was recent was "pretty good". Continued interview revealed the QA Nurse had gone home and she was unable to reach her at this time.		Resident #13 and Resident #14's bedside commodes were cleaned and disinfected; and bedside commode liners were placed in the BSC with extra liners in the residents' closets. Room 502 (resident #14) bathroom was cleaned and disinfected and all unbagged and unlabeled items were removed.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior for two (2) of twenty (20) sampled residents (Resident #13 and Resident #14. Observation revealed Resident #13's bedside toilet had not been emptied after assisted use. Also, observation of resident room 502's bathroom revealed unbagged and unlabeled bed	F 253	An audit of all ordered bedside commodes was completed on May 8, 2014 by the Unit Coordinators. No other residents were identified. Facility wide change out of all bath pans, bed pans, and urinals was completed on May 6, 2014. All of these items were dated with the month and year and resident room and bed # and placed in a clean trash bag. Continuous Quality Improvement (CQI) Rounds were initiated on May 27, 2014. 7-3 facility staff members are assigned to 3 rooms each for a daily round. Areas reviewed during rounds include resident condition, the room condition, and care areas. Rounds are to be done daily Monday-Friday. For 3-11 and 11-7 Monday through Friday the shift supervisor will select 3 rooms from Unit 1 and 3 rooms from Unit 2 and complete a CQI round sheet. On weekends, supervisors will choose 3 rooms from each unit for each shift and complete a CQI Round sheet. Staff will focus attention to the residents' surroundings, particularly the bedside area and the sink area for hazardous chemicals and	

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F 253 Continued From page 21
pans on the bathroom floor and a bed pan and measuring toilet hat placed between the hand rail and wall in the shared bathroom which was unlabeled and unbagged, for Resident #14.

The findings include:

Review of the facility's policy titled, "Bed Pan/Urinal Cleaning", with a revision date of 10/20/08, revealed to minimize the risk of infection (cross contamination) all bedpans and urinals must be marked with a black marker labeled with the resident's name and room number. According to the Policy, once the contents of the bedpan/urinal was emptied, place the bedpan/urinal in a clean trash bag, take the bedpan/urinal in the trash bag to the soiled utility room (wearing gloves), empty the bedpan/urinal contents into the hopper and clean and disinfect the bedpan/urinal before leaving the soiled utility room. Further review revealed the disinfected bedpan/urinal was to be placed in a clean trash bag and returned to the resident's room.

1. Observation on 05/05/14 at 2:55 PM of resident room #405 revealed Resident #13's bedside toilet had not been emptied.

Interview with State Registered Nurse Aide (SRNA) #5 on 05/05/14 at 2:58 PM revealed the bed side toilet should have been emptied after Resident #13 was assisted with toileting and she would get someone to take care of it.

Interview with Licensed Practical Nurse (LPN) #2/Unit Coordinator/UC on 05/05/14 at 4:00 PM revealed Resident #13 received help for toileting. She stated the toilet should have been emptied after assisted use.

F 253
toiletries as part of the room condition portion of the CQI round. Completed CQI round sheets are submitted to the DON for review by DON/ADON. After review the forms will be given to the unit coordinators for follow up. Monthly change out to include correct labeling with room # and date of change out (month and year) of the bath pans, bed pans, and urinals will be done on 11-7 by the 5th of every month. All nursing staff will be in serviced by June 1, 2014 by the DON/ADON.

The QA Nurse will conduct a Resident Room Infection Control audit of 10 rooms each week for 4 weeks and if 100% compliant, the audits will be taken to the QA committee by the DON and asked to change to monthly audits.

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F 253 Continued From page 22

2. Observation of Room #502's bathroom on 05/05/14 at 3:45 PM revealed a soiled large adult brief and soiled wash cloth was on the floor; a bed pan was on the floor, unlabeled and unbagged; and a bed pan and urinary measuring hat was placed between the handrail and the wall, unlabeled and unbagged.

Interview, with Licensed Practical Nurse (LPN) #2, at the time of the observation revealed the soiled brief and washcloth should not be left in the bathroom floor. LPN #2 further stated the urinary measuring hat should not be stored in the shared bathroom. She also stated, because the bed pans were unlabeled and unbagged, they needed to be removed from the bathroom and replaced.

Interview on 05/07/14 at 8:01 PM with the Director of Nursing(DON), revealed the bed pans and urinary measuring hats were not to be stored in the resident's shared bathroom after use. She stated the urinary measuring hats was a one-time use items and should be disposed of after use. She further stated the bed pans were to be stored properly after rinsing (i.e. disinfecting). Continued interview revealed the bed pans were to be bagged and labeled.

F 253

F 276 483.20(c) QUARTERLY ASSESSMENT AT
SS=D LEAST EVERY 3 MONTHS

A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.

F 276

Resident #16 had a quarterly assessment completed 5/8/14 by the MDS Personnel.

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F 276 Continued From page 23
This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and review of the Resident Assessment Instrument (RAI) User Manual Version 3.0, it was determined the facility failed to ensure residents were assessed using the Quarterly Assessment review instrument not less frequently than every three (3) months for one (1) of twenty-three (3) sampled residents (Resident #16). Review of Resident #16's Minimum Data Set (MDS) Assessments revealed, the Quarterly MDS had not been completed every three (3) months as specified.

The finding include:

Interview with the MDS Coordinator, on 05/07/14 at 6:00 PM revealed, the facility did not have a policy related to the completion of the MDS.

Review of the RAI User Manual Version 3.0, revised May 2011, revealed the Assessment Reference Date (ARD) referred to the "last day of the period of time the MDS Assessment" covered for that "particular assessment for that particular resident". Review of the Manual revealed the assessment scheduling moved through a cycle of three (3) Quarterly Assessments followed by an Annual (Comprehensive) Assessment after completion of the Admission (Comprehensive) Assessment. Further review revealed Quarterly Assessments were to be completed at least every ninety-two (92) days from the last assessment of any type.

Review of Resident #16's clinical record revealed the facility admitted the resident on 01/20/14, with diagnoses which included Dementia, Urinary Tract Infection, Muscle Weakness, Altered Mental

F 276 All current residents in the facility had their MDS audited by the MDS personnel on April 25, 2014 to ensure a quarterly assessment was completed. The MDS staff were in serviced by a MDS coordinator from a sister facility May 8, 2014 on scheduling assessments. Any resident missing an assessment was scheduled for the appropriate assessment with an ARD of no later than May 2, 2014. The last of these assessments were completed May 8, 2014.

MDS staff will schedule residents for a new assessment as the current assessment is completed. Upon transmission of assessments, the MDS Coordinator will verify that the resident has a future assessment scheduled no greater than 92 days ahead. A second MDS nurse will review the schedule and compare to the list of transmitted assessments to verify the same.

Quality Assurance will audit the MDS master schedule weekly for four weeks to ensure the MDS department has scheduled all residents for quarterly assessments no greater than 92 days from the previous quarterly assessment or admission. If the audit is 100% compliant the audit results will be taken to the QA committee the next month to ask that the audit be changed to quarterly.

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F 276	<p>Continued From page 24 Status, Hypertension, Dysphagia and Anxiety.</p> <p>Continued review of Resident #16's clinical record revealed an Admission MDS Assessment with an ARD of 01/27/14. Further review revealed no documented evidence the Quarterly MDS Assessment, due ninety-two (92) days after the Admission MDS Assessment, was completed.</p> <p>Interview with the MDS Coordinator on 05/07/14 at 6:00 PM, revealed the facility had not completed the Quarterly MDS Assessment for Resident #16. Further interview revealed, the Quarterly MDS Assessment was late due to the previous MDS staff terminating their position.</p> <p>Interview, with the Director of Nursing (DON) on 05/07/14 at 6:10 PM, revealed she was aware the MDS Department was behind in completing the MDS Resident Assessments and the facility had hired new MDS staff. Further interview revealed Resident #16's MDS Assessment should have been completed on time.</p>	F 276		
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are</p>	F 279	<p>Residents #6 and #16 had care plans developed by the MDS staff on May 7, 2014.</p> <p>MDS personnel audited all residents care plans on May 28, 2014 to ensure that each resident had a comprehensive care plan in place.</p>	

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F 279 Continued From page 25
to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure the comprehensive care plan was developed for two (2) of twenty-three (23) sampled residents (Resident #6 and #16). Although Resident #6 was admitted to the facility on 03/17/14 and Resident #16 was admitted on 01/20/14, there was no documented evidence the Comprehensive Care Plans were developed for these residents.

The findings include:
Review of the facility's policy, titled, "Care Plan Policy & Procedure", undated, revealed upon a resident's admission to the facility an Interim care plan was to be developed and a comprehensive care plan was to be developed within seven (7) days after completion of the comprehensive assessment. Further review revealed the care plan must be reviewed and updated after each quarterly/annual assessment and any significant change in condition.

1. Review of Resident #6's clinical record revealed the facility admitted the resident on

F 279
The MDS department was hired new to the facility in April, 2014. On May 8, 2014, the MDS department was in serviced by a MDS nurse from a sister facility on ensuring care plans were developed on residents. The MDS department include care plan due dates on the master schedule to ensure that a care plan is developed within 21 days from admission and 14 days from the ARD for current residents.

Quality Assurance will audit the MDS weekly for one month to ensure that care plans are written within seven days of the completed comprehensive assessment. The audit will check the ARD of the MDS, the date the care plan was due and the date the care plan was put in to place. If the audit is 100% compliant the first month, the DON will take the audit results to the QA committee the next month and ask that the audit be changed to quarterly.

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F 279 Continued From page 26
03/17/14 with diagnoses which included; Coronary Artery Disease, Heart Failure, Hypertension, Renal Insufficiency, Urinary Tract Infection, Diabetes Mellitus, and Thyroid Disorder.

F 279

Review of the Admission Minimum Data Set (MDS) dated 03/24/14 revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a thirteen (13) which revealed minimal cognitive impairment. Further review revealed the facility assessed Resident #6 as requiring extensive assist of two (2) persons for bed mobility, total dependence of two (2) persons for transfers, extensive assist with one (1) person with toileting, personal hygiene, dressing and bathing, supervision and set up help for eating, and as ambulation not occurring. Continued review revealed the facility assessed the resident as always incontinent of bladder and occasionally incontinent of bowel.

Review of the MDS Care Area Assessment (CAA) Summary dated 03/29/14, revealed the following areas triggered; Activities of Daily Living (ADL) functional/rehabilitation, urinary incontinence, falls, nutritional status, dehydration fluid maintenance, pressure ulcer, psychotropic drug use. The Care Area Worksheet dated 03/29/14 for each of these areas was completed stating a decision was made to care plan each area. However, continued review revealed no documented evidence a Comprehensive Care Plan was developed for this resident for any of the above triggered areas except Nutrition which was completed by the Registered Dietician.

2. Review of Resident #16's clinical record revealed the facility admitted the resident on 01/20/14 with diagnoses which included

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F 279 Continued From page 27
Hypertension, Urinary Tract Infection, Anxiety, Non Alzheimer's Dementia, and Generalized Muscle Weakness.

Review of the Admission Minimum Data Set (MDS) dated 01/27/14 revealed the facility assessed the resident as having a Brief Interview for Mental Status.(BIMS) of a fifteen (15), which indicated no cognitive impairment. Further review revealed the facility assessed the resident as requiring extensive assistance of two (2) persons for bed mobility, extensive assistance of one (1) person for transfers, ambulating in the corridor, dressing, toilet use, personal hygiene, and bathing. Continued review revealed the facility assessed the resident as requiring supervision and set up for eating.

Review of the MDS Care Area Assessment (CAA) Summary dated 01/27/14 revealed the following area triggered: visual function, communication, ADL functional rehabilitation, urinary incontinence, falls, dehydration/fluid maintenance, pressure ulcers, psychotropic drug use, and return to community referral.

Further record review revealed there was no documented evidence a Comprehensive Plan of Care was developed for any triggered area for this resident.

Interview, with Licensed Practical Nurse (LPN) #7/MDS Coordinator, on 05/07/14 at 6:00 PM, revealed a comprehensive care plan should have been generated within twenty-one days (21) of admission for Resident #16 and Resident #6. Further interview revealed she had just started in the MDS position on 05/05/14 and she was unsure why the Care Plans had not been

F 279

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F 279 Continued From page 28 developed.

Interview, with Director of Nursing (DON) on 05/07/14 at 6:10 PM, revealed the facility's former two (2) MDS nurses resigned their positions at the same time and it took awhile to hire new MDS nurses. The DON further stated the facility had recently hired two (2) new MDS nurses and they would be working to get the MDS Assessments and care plans completed as per the facility's policy.

F 279

F 280 SS=E 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

F 280

Resident #11's care plan was revised by the MDS personnel to include derma savers to lower extremities and a footboard to the wheelchair on May 28, 2014. Also included in the revision for resident #11, was resident's functional ability related to transfers and sensor alarms. Resident #1's care plan was revised May 28, 2014 by the MDS personnel to include weights three times per week, check abdominal girth, notification of MD for weight gain greater than 5 pounds, seizure disorder, antidepressant medication and transfer status. Resident #9's care plan was revised by MDS personnel to include a toileting program and schedule.

This REQUIREMENT is not met as evidenced

All current facility residents will have their care plans reviewed by June 10, 2014 by IDT members to ensure the "My Daily Care Plan" information was identical to the comprehensive care plan.

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F 280	<p>Continued From page 29</p> <p>by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure the Comprehensive Care Plan was revised for three (3) of twenty-three (23) sampled residents (Resident #11, #1, and #9).</p> <p>Resident #11's Care Plan was not revised to include Dermasavers to the lower extremities and a footboard to the wheelchair. In addition Resident #11's care plan was not revised to reflect the resident's functional ability related to transfers, and sensor alarms.</p> <p>Resident #1's Care Plan was not revised related to the Physician's Orders for weights three (3) times a week and to check the resident's abdominal girth every day with notification of the Physician for weights greater than five (5) pounds. In addition Resident #1's care plan was not revised related to his/her Seizure Disorder, antidepressant medication, and transfer status.</p> <p>Resident #9's Care Plan was not revised when the resident was placed on a toileting program with interventions for a specific toileting schedule.</p> <p>The findings include:</p> <p>Review of the facility's, "Care Plan Policy and Procedure", undated, revealed the Comprehensive Care Plan was to be developed within seven (7) days after completion of the Comprehensive Assessment and reviewed and updated after each Quarterly, Annual or Significant Change Assessment. Further review of the Policy and Procedure revealed changes were made on an ongoing basis with use of the</p>	F 280	<p>As new orders are written by the nursing staff, a three part order sheet is filled out by the nurse. The nurse will do a nurse's note, care plan and physician order for the resident. This care plan will be in place until the next care plan review. Any interventions still going on will be transferred to the comprehensive care plan at the time of care plan review. If the care plan problem has been resolved, the</p> <p>problem will not be carried to the comprehensive plan of care. Any orders with care plan interventions will have the interventions placed on the "My Daily Care Plan" as the interventions are written. The "My Daily Care Plan" will be revised with the care plan review each quarter and as needed by the care plan coordinators.</p> <p>Quality Assurance will audit resident care plans weekly to ensure orders written with the care plan interventions were transferred to the "My Daily Care Plan". If compliance is 100% after 4 weeks, the audit will change to monthly for three months. If 100% compliant, the audit will be discontinued.</p>	06/20/14

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PINE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE 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 280	<p>Continued From page 30 three (3) part Physician's Order Sheet.</p> <p>Review of the Certified Nursing Assistant's (CNAs) "Care Plan Policy", dated 11/11/09, revealed it was the facility's policy for each resident to have an individualized care plan, and it was important the caregiver be given clear directions on how to meet the resident's individualized needs and choices. Further review revealed new orders received once the typed care plan was completed would be the nurses' responsibility to update the care plans. The Policy stated, prior to the new month "change over", the CNA care plan would be reviewed and updated for the new upcoming month.</p> <p>1. Review of Resident #11's clinical record revealed diagnoses which included Non-Alzheimer's Disease, Osteoporosis, and Kyphosis. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 04/25/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a nine (9), which indicated moderate cognitive impairment.</p> <p>Review of the monthly May 2014 Physician's Orders revealed orders for a footboard to Resident #11's wheelchair which was initially ordered on 08/08/13, and orders for Derasavers (pressure relieving skin protector) to the bilateral lower extremities which was initially ordered on 12/20/13.</p> <p>Review of the "My Daily Care Plan" (utilized by the facility CNAs for residents' care needs), dated May 2014 revealed interventions for the footboard on the wheelchair; however, there was no documented evidence of the intervention for the</p>	F 280		