

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

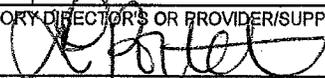
PRINTED: 09/07/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/29/2011
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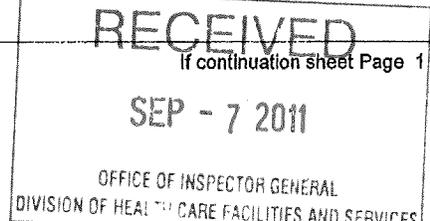
NAME OF PROVIDER OR SUPPLIER  PEMBROKE NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266
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F 000	<p>INITIAL COMMENTS</p> <p>AMENDED SOD 09/07/11</p> <p>An abbreviated survey investigating KY16791 was initiated on 07/26/11 and concluded on 07/29/11. Immediate Jeopardy was identified on 07/27/11 and was determined to exist on 07/24/11. The facility was notified of Immediate Jeopardy on 07/27/11. KY16791 was substantiated and deficiencies were cited at 42 CFR 483.15 Social Services (F250), 42 CFR 483.20 (F272) Resident Assessment and (F280 Care Plan Revision), 42 CFR 483.25 (F323) Accidents, 42 CFR 483.75 (F490) Administration and (F520) Quality Assurance at a Scope and Severity (S/S) of a "J". In addition, 42 CFR 483.20 (F279) Developing Care Plan was cited at a S/S of a "D".</p> <p>After supervisory and quality review it was determined F279 would be cited at a S/S of a "J".</p> <p>The facility failed to ensure the resident received adequate supervision to prevent accidents for Resident #1. The facility failed to identify risks associated with a history of mental illness, a previous suicide attempt and verbalizations to staff regarding feeling better off dead. In addition, the facility failed to implement interventions to include supervision and to reduce the risk of an accident. The facility discovered the resident deceased in bed with a plastic bag covering the entire head and face on 07/24/11 at 6:45 AM. The staff last observed the resident alive at 12:45 AM on 07/24/11.</p> <p>The facility provided a credible allegation of compliance (AOC) on 07/28/11 with a removal</p>	F 000	<p>Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 9/7/2011
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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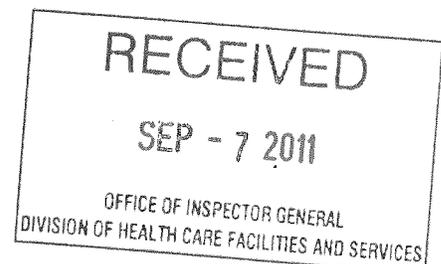
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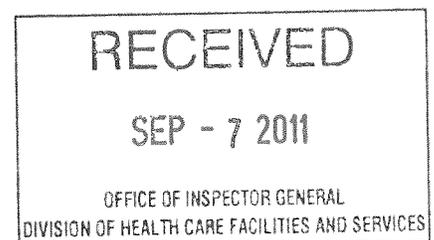
F 000	Continued From page 1 date of 07/28/11. Immediately Jeopardy was verified as removed on 07/28/11; however, non compliance continued at F250, F272, F280, F323, F490 and F520 at a scope and severity of a "D", while the facility's Quality Assurance monitors the completion of training and psychiatric resident safety.	F 000	F250 Provision of Medically Related Social Service	
F 250 SS=J	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE  The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, closed record review and review of the facility's social services job description, it was determined the facility failed to provide medically related social services for four (4) of six (6) sampled residents (Resident #1, #2, #4 and #6). The facility failed to ensure social service staff was provided adequate orientation in order to effectively meet State and Federal regulations; failed to address specific resident behaviors; failed to identify and implement specific social service interventions to assist with resident goal achievement; failed to provide evidence of social service interventions successfully addressing resident needs; failed to document monitoring of resident progress; and failed to assess the effectiveness of antipsychotic medications. Resident #1, having a history of suicidal attempt in 1995, and verbalizing suicidal ideations during his/her residence, committed	F 250	In addition to the attached acceptable Allegation of Compliance on July 28, 2011, the center has taken the following actions: 1. Resident #1 no longer resides at center. Resident #2's care plan has been updated to reflect urinating on the floors. No documentation is present in residents #2's medical record indicating resident hits staff during care as statement of deficiencies indicates was in SS noted dated 2/18/11 and 4/28/11. Resident #2 has no SS notes on these dates. Social Service Director (SSD) and Interdisciplinary Team (IDT) assessed resident #4 and developed interventions to address the resident's mood swings, obsession with a staff member, agitation and threatening behaviors. Resident #4's care plan interventions were reviewed by IDT to determine effectiveness. SSD reviewed effectiveness of resident #4's antipsychotic medications. SSD reviewed effectiveness of resident #6's antipsychotic medications. Care plan was developed by IDT to protect residents from harm related to resident #6's hitting behaviors. 2. Documented history of psychiatric problems/diagnosis and psychotropic drug use reviewed by SSD and IDT to ensure current care needs are identified and interventions are in place to address current concerns affecting the residents daily functioning and quality of life and those with the potential to affect the resident or other residents daily functioning and quality of life. All current resident's receiving antipsychotic medications were reviewed by SSD for effectiveness of medications. 3. SSD has received additional training by mentor SSD to include requirement to address specific resident behaviors, to identify and implement social service interventions to assist resident with goal achievement, to provide evidence of social	08/20/2011



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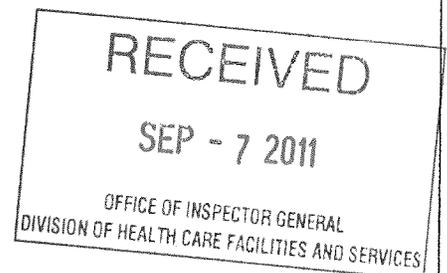
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F 250	<p>Continued From page 2 suicide in the facility on 07/24/11.</p> <p>The facility provided a credible allegation of compliance on 07/28/11. The state agency verified Immediate Jeopardy was removed 07/28/11 prior to exit on 07/29/11; which lowered the scope and severity to a "D" at 42 CFR 483.15 Social Services (F250), 42 CFR 483.20 (F272) Resident Assessment, (F279) Develop Comprehensive Care Plans, (F280) Revise Care Plans, 42 CFR 483.25 (F323) Accidents, 42 CFR 483.75 (F490) Administration and (F520) Quality Assurance, while the facility's administration and the Quality Assurance Committee complete training and monitoring for psychiatric residents safety.</p> <p>The findings include:</p> <p>Review of the job description for the Social Services Director (SSD), dated 08/07/06, revealed the SSD was responsible for initiating and maintaining a comprehensive social services program, assisting residents to achieve and maintain their maximum psychosocial functioning and independence, coordinated behavior management programs and maintained resident records in accordance with state and federal regulations.</p> <p>1. Review of the closed clinical record revealed Resident #1's history and physical from a psychiatric hospital, dated 09/23/10, documented the resident tried to overdose in 1995. The resident experienced delusions, hallucinations and would sometimes refuse medication and</p>	F 250	<p>service interventions successfully addressing resident needs, to document monitoring of resident progress; and to assess effectiveness of antipsychotic medications. SSD was provided additional orientation by mentor SSD to ensure competency and ability to effectively meet State and Federal regulations. Target Behaviors and interventions for psychotropic medications and all behavior occurrences documented in Care Tracker will be reviewed daily Monday thru Friday by SSD and care plans will be revised as indicated.</p> <p>4. Mentoring SSD will visit center weekly for a minimum of four weeks and then monthly to ensure SSD remains in compliance with state and federal regulations. Any noted non-compliance will result in immediate re-education and disciplinary action up to and including termination. Results of weekly audits will be reviewed with ADM and QA committee to ensure continued compliance and for further recommendations.</p>		



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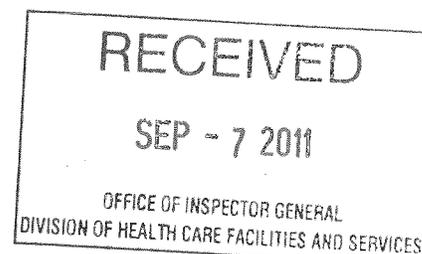
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F 250	<p>Continued From page 3</p> <p>care. The Comprehensive Evaluation For Mental Illness and Mental Retardation (PASRR) Level II, completed on 11/11/10, revealed the resident had a history of numerous psychiatric hospital admissions and was extremely anxious, had poor insight/judgement and had difficulty sorting thoughts and explaining how she/he felt. The document detailed Resident #1 had diagnoses of Paranoid Schizophrenia and Hypertension. The PASRR indicated the resident required physical or environmental management (structure) for confusion and mild agitation and supportive nursing care to prevent deterioration. The social worker documented the antipsychotic medications during the admission assessment; however, there was no documented evidence the social worker implemented care plan interventions to address the resident's mental condition related to history of attempted suicide.</p> <p>Review of the hospital's History and Physical (H&amp;P) revealed, on 01/14/11, the resident was admitted having the chief complaint of refusing to eat and stating he/she wanted to die. The document revealed the resident was admitted related to suicidal ideations, paranoid schizophrenia, dehydration and possible urinary tract infection.</p> <p>The resident was readmitted to the facility on 01/19/11. Review of the comprehensive care plan, dated 01/20/11, two months after the resident was admitted, revealed the facility identified the resident's mood and behaviors, that might be harmful to self, as schizophrenia, psychosis, hallucinations, delusions and paranoia; however, reality orientation, psychotropic medications, and providing the</p>	F 250			



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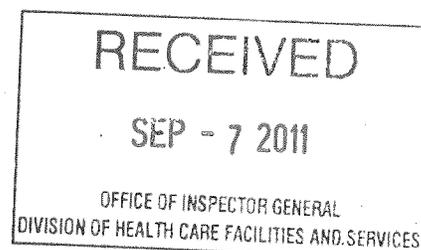
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F 250	<p>Continued From page 4</p> <p>resident with foods he/she liked were the only documented interventions provided by the facility. There was no evidence the facility documented specific details or interventions related to addressing the resident's risk of suicide. Review of the January 2011 social services notes revealed no documented evidence that social services assessed the resident related to her suicidal ideation after the hospitalization of 01/14/11.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/08/11, revealed the facility assessed the resident as having continuous disorganized thinking, felt little pleasure or interest in doing things, was feeling down, was depressed, felt hopeless, had little energy, was feeling bad about him/herself and was having thoughts that he/she would be better off dead. The assessment detailed the resident felt this way nearly every day of the assessment period. There was no documented evidence the facility added interventions or made changes to the care plan to reduce the resident's risk of suicide. Interview with Licensed Practical Nurse (LPN) #1, on 07/26/11 at 11:00 AM, revealed Resident #1 had moods. She detailed reality orientation and redirection failed to bring the resident back to reality. She stated once the resident was in his/her world, nothing could bring him/her back. In addition, the resident would refuse psychotropic medication.</p> <p>Review of the Psychological Progress Note and Treatment Plan, dated 02/26/11, revealed Resident #1 had increased agitation, anxiety, crying, depressed, paranoid delusions, and auditory hallucinations. The Psychologist trained</p>	F 250		



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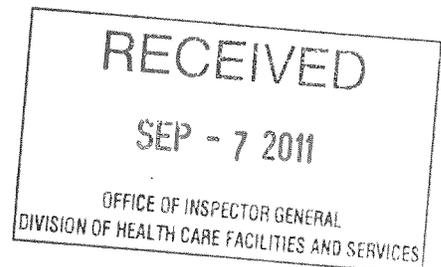
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F 250	Continued From page 5 the resident on relaxation skills, and developed psychosocial interventions to be used when the resident exhibited resistance to care, anxiety, agitation, and delusions. Record review revealed no evidence social services implemented the pschosocial interventions the Psychologist recommended to use. Review of the Psychologist visit with the resident on 04/26/11 revealed the resident stated "I just don't want to live". Record review revealed no documented evidence the Social Services addressed the resident's continued verbalizations of suicidal ideation. The psychologist saw the resident again on 05/19/11 at which time the Psychologist determined the resident had increased anxiety, increased delusions, visions of demons, and increased auditory hallucinations.  Review of the Physician notes, dated 05/20/11, revealed the resident had complaints of anxiousness/stress at all times, hallucinations-paranoid schizophrenia, worrying-about everything, and visual and auditory hallucinations.  Review of the Social Service progress notes, dated 05/23/11, revealed Resident #1 had behaviors over the weekend and received post acute monitoring for three (3) days and the care plan was reviewed and updated. However, there was no evidence of documentation regarding the type of behavior the resident was having, what interventions were not effective, or what was being monitored or what actually occurred over the weekend. In addition, there was no documented evidence the resident's psychotropic medications were reviewed for efficacy.	F 250			



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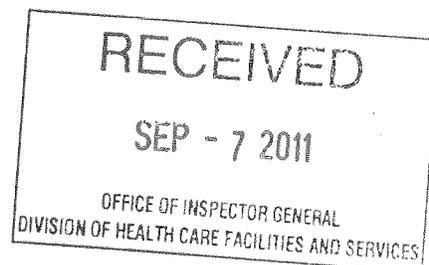
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F 250	Continued From page 6 Review of the June and July 2011 Medication Administration Records (MAR) revealed the resident was compliant with the administration of an injectable antipsychotic used to treat the symptoms of schizophrenia, delusions and hallucinations. The resident refused other oral antipsychotic medications. There was no evidence provided to demonstrate the facility assessed the effectiveness of the resident's antipsychotic medication.	F 250			
	Continued review of the Psychological Progress Note and Treatment Plan, revealed the resident exhibited a reduction in behaviors/thoughts/sensory issues/mood; however, the resident continued to see evil people when seen on 07/10/11. Review of the Social Services notes and care plan revealed there was no evidence the facility assessed the frequency of behaviors, the effectiveness of the behavior interventions or attempted different interventions to address the residents' behaviors.  Record review of nurses notes dated 07/24/11 revealed facility staff found Resident #1 dead with a trash bag over his/her head, having committed suicide.  Refer to F323.  Interview with the Social Services Director, on 07/28/11 at 11:10 AM, revealed she utilized the MDS, psychiatrist notes, staff documentation, behavior notes, and progress notes to assess residents and to develop a care plan and interventions for each resident. She stated she				



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F 250	<p>Continued From page 7</p> <p>was not aware Resident #1 had suicidal ideation, though she had reviewed the clinical record.</p> <p>2. Record review for Resident #2 revealed the facility admitted the resident with diagnoses of Bipolar Disorder, Schizophrenia, and Antisocial Personality Disorder on 03/06/09. Social Service notes, dated 02/18/11 and 04/28/11, revealed the resident was unhappy at the facility, cursed and hit staff during care and voided on the floors; however, review of Resident #2's care plan, dated 07/05/11, revealed the facility did not develop a plan of care for the resident urinating on the floors and a plan to protect other residents from harm related to the resident's hitting behaviors. Progress notes, dated 07/06/11, revealed the resident was urinating on the floors; however, the quarterly MDS assessment, dated 07/09/11, revealed the resident had no behaviors.</p> <p>3. Review of the clinical record for Resident #4 revealed the facility admitted the resident with diagnoses of Paranoid Schizophrenia, Psychosis, and Schizoaffective Disorder on 11/23/10. The PASRR II completed 11/23/10 revealed the resident sustained a self-inflicted gun shot wound to the head at the age of thirteen (13). The resident had a history of threatening behaviors, saw demons, was easily agitated and delusional. The PASRR indicated the resident needed to be monitored for mood swings. The psychologist visit on 04/07/11 revealed the resident had an obsession with an employee. The quarterly MDS assessment completed by the facility on 05/23/11 revealed the resident had no behaviors. Social Services progress notes, dated 05/27/11 revealed the resident resisted care and hallucinated and</p>	F 250		



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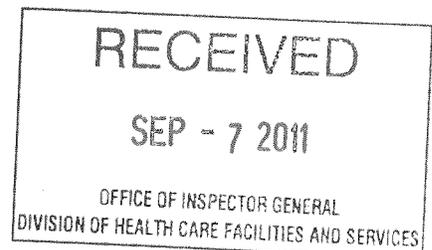
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F 250	Continued From page 8 staff needed to remind the resident of the facility being a safe environment. There was no evidence provided to demonstrate the facility assessed and developed interventions to address the resident's mood swings, obsession with a staff member, agitation or threatening behaviors were assessed and interventions on the care plan were effective or not effective. In addition, there was no evidence documented to determine the effectiveness of the resident's antipsychotic medications.	F 250		
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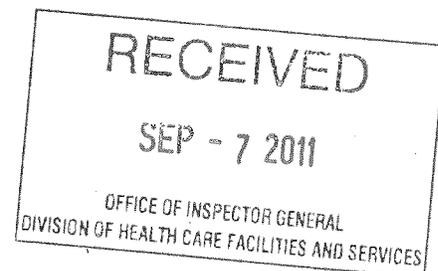
	<p>4. Review of the clinical record for Resident #6 revealed the facility admitted the resident with diagnoses of Paranoid Schizophrenia, Anxiety, and Chronic Obstructive Pulmonary Disease on 10/10/10. Review of the care plan, dated 06/20/11, revealed the resident had delusions, was distracted, restless, resisted care, and easily agitated. Review of the quarterly MDS assessment, dated 07/04/11 revealed the resident had no behaviors during the assessment period. Social Service notes, dated 07/12/11, revealed the resident received antipsychotic medications; however, there was no documentation which demonstrated the facility assessed the effectiveness of the medications. Review of the behavior section of the social services notes revealed no documentation. On 07/19/11, the nursing progress notes indicated the resident was combative to staff during care. The facility failed to develop a care plan to protect residents from harm related to the resident's hitting behaviors.</p> <p>Interview with the Social Services Director, on</p>			
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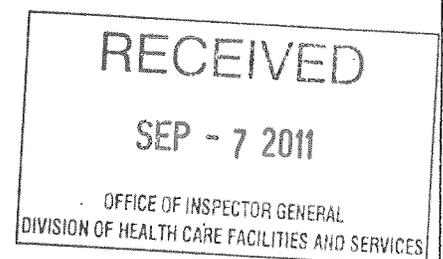
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F 250	Continued From page 9 07/28/11 at 11:10 AM, revealed she was responsible to manage resident concerns, needs, assessments, psychosocial care plans, referrals, moods and behaviors. She stated she had no experience as a Social Services Director; however, she had worked in a nursing home before as a nurse aide. She stated she utilized the MDS, psychiatrist notes, staff documentation, behavior notes, and progress notes to assess the residents and develop a care plan and interventions for each resident.	F 250		
X	<p>Review of the social service's orientation documents revealed the SSD was hired on 05/02/11 and visited with a SSD from another facility for orientation on an unknown date. A Social Services Competency was completed on 05/17/11 indicating the SSD was evaluated and competent in all areas. No other evidence of orientation or follow-up specific to social services was provided by the facility.</p> <p>Interview with the Administrator, on 07/28/11 at 11:50 AM, revealed there were plans for the SSD to receive further orientation to the position. She stated the SSD was hired three (3) months ago.</p> <p>Review of the allegation of compliance, dated 07/29/11, with an alleged removal date of 07/28/11 and interview with the Administrator on 11/28/11 at 11:50 AM and the Regional Consultant on 07/28/11 at 10:30 AM revealed the facility took the following immediate actions:</p> <p>1. All residents were audited to ensure they received the appropriate level of supervision.</p>			



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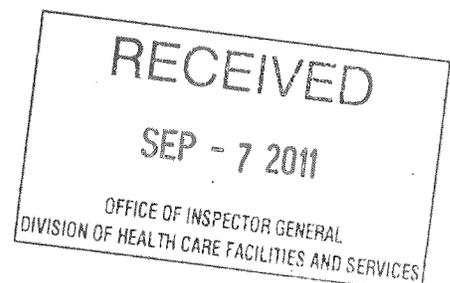
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F 250	Continued From page 10  2. All residents clinical records were audited for histories of suicide attempts or suicidal ideation and a list of high risk residents was developed.  3. All high risk residents had their care plans updated and individualized interventions were developed by the care plan team based on individual resident history.  4. All residents determined to be high risk of suicide were assessed to ensure there were no items present in the room that would present a danger to the resident and included removal of plastic trash bags.  5. No staff had worked past 07/27/11 without having received education regarding psychotic symptoms, and suicide prevention to include detection of early warning signs of major mood changes or possible suicidal ideation and the procedure to obtain and provide appropriate interventions.  6. A list of high risk residents is now listed at the nursing stations and on the nurse aide assignment sheets with interventions included on the nurse aide assignment sheets and plan of care.  7. Staff were educated to report immediately any warning signs of major mood changes and/or	F 250			



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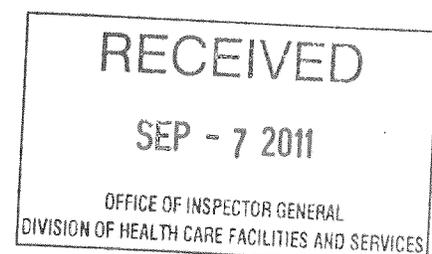
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F 250	<p>Continued From page 11</p> <p>possible suicidal ideation to their immediate supervisor and at a minimum, residents exhibiting warning signs will be placed immediately on increased supervision. The resident's environment will be assessed for safety and any objects which could be used for self harm will be removed. The resident's family and physician will be notified. The interdisciplinary team will review the resident to ensure appropriate interventions and goals are in place.</p> <p>8. No nursing staff has worked or will work past 07/27/11 without having received education on the requirement to never leave <u>plastic bags</u> unattended and not in use.</p> <p>9. No nursing staff have worked or will work past 07/27/11 without having received education regarding the requirement to conduct rounds every two (2) hours and visualize the resident by CNAs and nurses. The completed rounds are documented every two (2) hours, however, the CNAs and nurses are responsible for ensuring these rounds are documented. The Administrator will review the completed documents to ensure rounds are being made every two (2) hours. Any noted noncompliance will result in disciplinary action, up to and including termination.</p> <p>10. All members of the interdisciplinary team (Social Service Director, Interim Director of Nursing, Clinical Reimbursement Coordinator, Life Enrichment Director and Nutrition Services Manager) were educated by the Regional Director of Clinical Services regarding the Behavior ?</p>	F 250			



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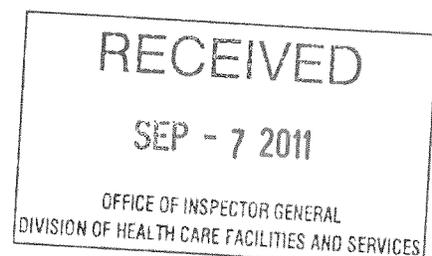
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F 250	Continued From page 12 Review Process which includes admission and readmission review of behavior residents and ongoing behavior reviews to include the care planning completion process and interdisciplinary development and revision of care plans based upon resident history and current conditions and assessments. The Quality Assurance Committee met on 07/27/11 and reviewed the plan and the state agency's determination. The Medical Director was in attendance at the meeting.	F 250		
F 272 SS=J	483.20(b)(1) COMPREHENSIVE ASSESSMENTS  The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures;	F 272	F272 COMPREHENSIVE ASSESSMENTS  In addition to the attached acceptable Allegation of Compliance on July 28, 2011, the center has taken the following actions:  1. Resident #1 no longer resides at center. Resident #2 has been reviewed by IDT to identify risk factors and ensure appropriate interventions are developed through care plan to address resident's identified risk factors. 2. Documented history of psychiatric problems/diagnosis and psychotropic drug use reviewed by SSD and IDT to ensure current care needs are identified and interventions are in place to address current concerns affecting the residents daily functioning and quality of life and those with the potential to affect the resident or other residents daily functioning and quality of life. 3. All staff members responsible for completion of RAI and CAA process were re-educated by Regional Director of Clinical Reimbursement on 8/4/11, regarding the RAI and CAA processes and requirement to make a comprehensive assessment of a resident's needs, using the RAI specified by the state.	08/20/2011



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F 272	Continued From page 13 Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	4. Regional Director of Clinical Reimbursement will review all CAAs completed through RAI process for two months and then three full assessments per month to ensure risk factors are identified and appropriate interventions are developed through the care plan to address resident's identified risk factors. Any noted non-compliance will result in immediate re-education and disciplinary action up to and including termination. Results of audits will be reviewed with ADM and QA committee to ensure continued compliance and for further recommendations		
	<p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, closed record review and facility policy review, it was determined the facility failed to conduct a comprehensive assessment of each residents' functional capacity for two (2) of six (6) sampled residents (Resident #1 and #2). The facility failed to document care area assessment (CAA) summary information completed on triggered care areas resulting in the facility's failure to identify and address all resident needs. Residents #1 and #2 were admitted to the facility with active psychiatric care needs. The facility failed to use available resources in the medical record to complete additional assessments as required. Resident #1 had a history of a previous suicide attempt and was not identified in the CAA summary for psychotropic medications. Resident #1 committed suicide on 07/24/11.</p> <p>The facility provided a credible allegation of compliance on 07/28/11. The state agency verified Immediate Jeopardy was removed 07/28/11 prior to exit on 07/29/11; which lowered</p>				



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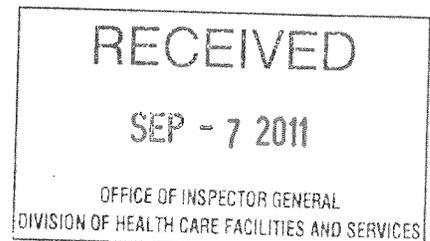
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F 272	Continued From page 14 the scope and severity to a "D" at 42 CFR 483.15 Social Services (F250), 42 CFR 483.20 (F272) Resident Assessment, (F279) Develop Comprehensive Care Plans, (F280) Revise Care Plans, 42 CFR 483.25 (F323) Accidents, 42 CFR 483.75 (F490) Administration and (F520) Quality Assurance, while the facility's administration and the Quality Assurance Committee complete training and monitoring for psychiatric residents safety.	F 272		
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	The findings include:  The facility used the MDS 3.0 Manual as their policy. All residents will have triggered areas assessed using the CAAs. Interview with the Regional Director of Clinical Services, on 07/27/11 at 10:30 AM, revealed the MDS CAAs were to be completed on triggered care areas.			
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	1. Review of the closed clinical record for Resident #1 revealed the facility admitted the resident with diagnoses of Paranoid Schizophrenia and Anxiety on 11/16/10. The admission Comprehensive Evaluation For Mental Illness and Mental Retardation (PASRR) Level II, dated 11/11/10 revealed the resident had a history of mental illness with numerous psychiatric hospital stays. The resident attempted to overdose in 1995, had extreme anxiety, and difficulty sorting thoughts and attempting to talk about concerns. On 11/23/10, the facility completed an admission Minimum Data Set (MDS) assessment which indicated the resident			
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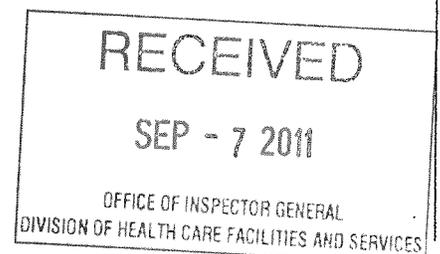
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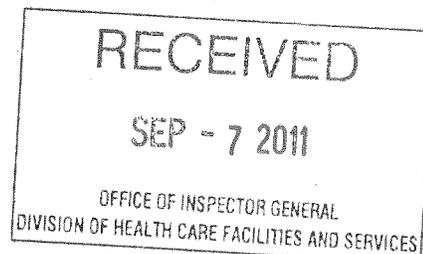
F 272	<p>Continued From page 15</p> <p>had no behaviors during the assessment period. Review of the triggered Care Area Assessment (CAA) section of the MDS for psychotropic medications, revealed no evidence the facility identified the resident's risk for suicide. This failure prevented the facility from ensuring appropriate interventions were developed through care plan to address the resident's risk for suicide.</p> <p>Review of the nursing notes for 07/24/11 at 6:45 AM, revealed Resident #1 was found in bed with a plastic trash bag covering the head with a hand clenched around the bag. 911 was called as the resident was a full code and the facility staff initiated cardiopulmonary resuscitation (CPR) until emergency medical staff (EMS) took over and later pronounced the resident dead.</p> <p>Refer to F323.</p> <p>2. Review of the clinical record for Resident #2 revealed the facility admitted the resident with diagnoses of Bipolar Disorder and Schizoaffective Disorder on 03/06/09. The resident had periods of noncompliance with medications, hit staff when he/she ran out of cigarettes, and urinated on the floors. The facility completed an annual MDS assessment, dated 01/08/11, which revealed psychotropic medications were triggered as an area for further assessment of care needs. Review of the CAA assessment for psychotropic medications revealed the facility did not complete a summary and did not identify behaviors associated with the use of psychotropic medications.</p>	F 272		
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F 272	Continued From page 16  Interview with the MDS Coordinator, on 07/28/11 at 10:30 AM, revealed CAA's were used to develop care plans for residents. She stated she did not know why the CAA summary was not completed for Residents #1 and #2. She stated each discipline had certain MDS items to complete and the risk factors were considered for each triggered area. She stated she was responsible for nursing and the social worker was responsible for mood and behavior CAAs. She stated she could not do their work for them.  Interview with the Social Services Director, on 07/28/11 at 11:10 AM, revealed she was not employed at the facility until March 2011 and did not realize Resident #1 had a problem with a past suicide attempt, though she stated she did review the resident's clinical record.  Review of the allegation of compliance, dated 07/29/11, with an alleged removal date of 07/28/11 and interview with the Administrator on 11/28/11 at 11:50 AM and the Regional Consultant on 07/28/11 at 10:30 AM revealed the facility took the following immediate actions:  1. All residents were audited to ensure they received the appropriate level of supervision.  2. All residents clinical records were audited for histories of suicide attempts or suicidal ideation and a list of high risk residents was developed.	F 272			



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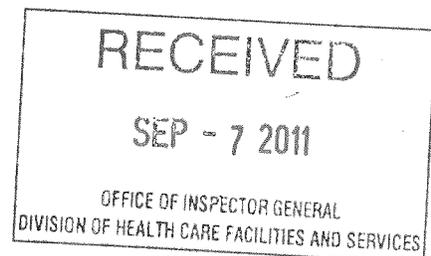
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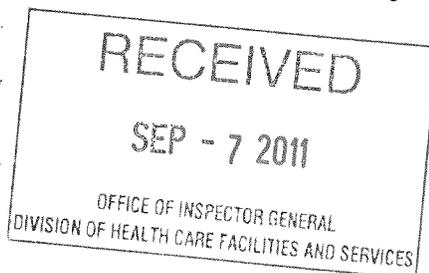
F 272	<p>Continued From page 17</p> <p>3. All high risk residents had their care plans updated and individualized interventions were developed by the care plan team based on individual resident history.</p> <p>4. All residents determined to be high risk of suicide were assessed to ensure there were no items present in the room that would present a danger to the resident and included removal of plastic trash bags.</p> <p>5. No staff had worked past 07/27/11 without having received education regarding psychotic symptoms, and suicide prevention to include detection of early warning signs of major mood changes or possible suicidal ideation and the procedure to obtain and provide appropriate interventions.</p> <p>6. A list of high risk residents is now listed at the nursing stations and on the nurse aide assignment sheets with interventions included on the nurse aide assignment sheets and plan of care.</p> <p>7. Staff were educated to report immediately any warning signs of major mood changes and/or possible suicidal ideation to their immediate supervisor and at a minimum, residents exhibiting warning signs will be placed immediately on increased supervision. The resident's environment will be assessed for safety and any objects which could be used for self harm will be removed. The resident's family and physician will</p>	F 272		
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F 272	<p>Continued From page 18</p> <p>be notified. The interdisciplinary team will review the resident to ensure appropriate interventions and goals are in place.</p> <p>8. No nursing staff has worked or will work past 07/27/11 without having received education on the requirement to never leave plastic bags unattended and not in use.</p> <p>9. No nursing staff have worked or will work past 07/27/11 without having received education regarding the requirement to conduct rounds every two (2) hours and visualize the resident by CNAs and nurses. The completed rounds are documented every two (2) hours, however, the CNAs and nurses are responsible for ensuring these rounds are documented. The Administrator will review the completed documents to ensure rounds are being made every two (2) hours. Any noted noncompliance will result in disciplinary action, up to and including termination.</p> <p>10. All members of the interdisciplinary team (Social Service Director, Interim Director of Nursing, Clinical Reimbursement Coordinator, Life Enrichment Director and Nutrition Services Manager) were educated by the Regional Director of Clinical Services regarding the Behavior Review Process which includes admission and readmission review of behavior residents and ongoing behavior reviews to include the care planning completion process and interdisciplinary development and revision of care plans based upon resident history and current conditions and assessments. The Quality Assurance Committee</p>	F 272			



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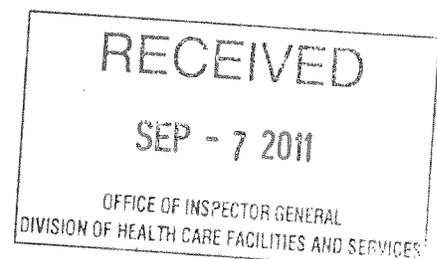
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F 272	Continued From page 19 met on 07/27/11 and reviewed the plan and the state agency's determination. The Medical Director was in attendance at the meeting.	F 272		
F 279 SS=J	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  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.  The care plan must describe the services that are 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 interview, record review, closed record review and facility policy review, it was determined the facility failed to develop comprehensive care plans for two (2) of six (6) sampled residents (Resident #1 and #2). Residents #1 and #2 were admitted to the facility with histories of behaviors which were not	F 279	F279 Develop Comprehensive Care Plans  1. Resident #1 no longer resides at center. Resident #2's comprehensive care plans were reviewed by IDT on 8/5/11 and interventions were implemented to monitor the effectiveness/noneffectiveness of the resident's psychotropic medication and to manage the resident's behaviors. 2. Documented history of psychiatric problems/diagnosis and psychotropic drug use reviewed by SSD and IDT to ensure current care needs are identified and interventions are in place to address current concerns affecting the residents daily functioning and quality of life and those with the potential to affect the resident or other residents daily functioning and quality of life. All current resident's receiving antipsychotic medications were reviewed by SSD for effectiveness of medications. 3. On 7/27/11, All members of the Interdisciplinary Team (IDT) (SSD, Interim Director of Nursing, Clinical Reimbursement Coordinator, Life Enrichment Director and Nutrition Services Manager) were educated by the Regional Director of Clinical Services regarding the Behavior Review Process which included admission and readmission review of behavior residents and ongoing behavior reviews to include the care planning completion process and interdisciplinary development and revision of care plans based upon resident history	08/20/2011



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/29/2011
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NAME OF PROVIDER OR SUPPLIER  PEMBROKE NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266
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F 279	<p>Continued From page 20</p> <p>addressed by the admission Minimum Data Set (MDS) assessments resulting in the facility failing to develop individualized care plans.</p> <p>The facility provided a credible allegation of compliance on 07/28/11. The state agency verified Immediate Jeopardy was removed 07/28/11 prior to exit on 07/29/11; which lowered the scope and severity to a "D" at 42 CFR 483.15 Social Services (F250), 42 CFR 483.20 (F272) Resident Assessment, (F279) Develop Comprehensive Care Plans, (F280) Revise Care Plans, 42 CFR 483.25 (F323) Accidents, 42 CFR 483.75 (F490) Administration and (F520) Quality Assurance, while the facility's administration and the Quality Assurance Committee complete training and monitoring for psychiatric residents safety.</p> <p>The findings include:</p> <p>The facility's policy for Care Plans, dated October 2008, revealed the appropriate plan of care would be initiated and individualized for the resident. In addition the facility utilized the MDS Manual for care planning.</p> <p>1. Review of the closed clinical record for Resident #1 revealed the facility admitted the resident with Paranoid Schizophrenia on 11/16/10. Review of the admission Comprehensive Evaluation For Mental Illness and Mental Retardation (PASRR) Level II, dated 11/15/10 revealed the resident had a long history of psychiatric hospitalizations with a suicide attempt in 1995. The PASRR revealed the resident had a history of noncompliance,</p>	F 279	<p>and current conditions and assessments. A comprehensive care plan review meeting will be conducted with the IDT following completion of each MDS assessment to develop, review and revise the resident's comprehensive plan of care based on results of assessment.</p> <p>4. The Regional Director of Clinical Services and/or Regional Director of Clinical Reimbursement will review two records per week for four weeks, and then four random records per month following comprehensive care plan review by IDT to ensure a comprehensive plan of care is developed, reviewed and revised based on results of assessment. Results of audits will be reviewed with ADM and QA committee to ensure continued compliance and for further recommendations</p>	
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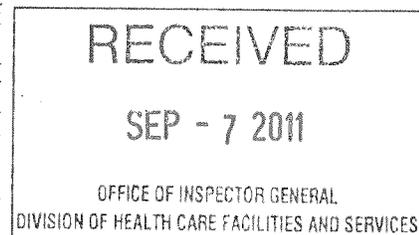
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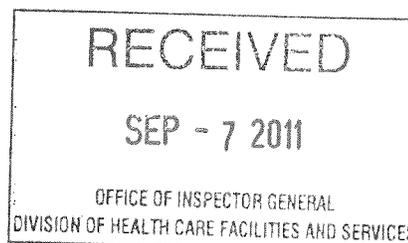
F 279	Continued From page 21 delusional thinking, poor insight/judgement and extreme agitation. The facility completed an admission MDS assessment, on 11/23/10, which indicated the resident rejected care one (1) to three (3) days per week and received psychotropic medication ordered by the physician for a history of mental illness and behaviors that included agitation, anxiety, delusional thinking and hallucinations. Review of the Care Area Assessment (CAA) revealed the resident's resistance to care triggered behaviors for further assessment. The CAA for psychotropic medications was triggered for further assessment related to the resident's reliance on antipsychotic and antianxiety medication to control symptoms of paranoid schizophrenia and anxiety which included, agitation, anxiety, delusional thinking and hallucinations. Review of the CAA summary for behaviors revealed the resident rejected care and had periods of hallucinations. There was no evidence to demonstrate the facility identified the resident's risk of suicide. Review of the CAA summary for psychotropic medications revealed the resident received an antipsychotic for schizophrenia. There was no evidence provided to demonstrate the facility assessed the medication for effectiveness. A visit by the psychologist on 12/04/10, revealed the resident was anxious and had an agitated mood.  Review of the comprehensive care plan developed from the admission MDS assessment, dated 11/23/10, revealed the facility did address the psychotropic medications; however, there was no evidence provided to demonstrate how the facility planned to monitor the medications for effectiveness/noneffectiveness. There was no evidence the facility planned interventions to	F 279		
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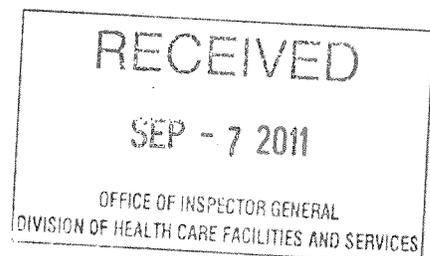
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F 279	<p>Continued From page 22</p> <p>manage the resident's behaviors or protect the resident from another suicide attempt, except for reality orientation, psychotropic medications, and providing food the resident liked.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 07/26/11 at 11:00 AM, revealed Resident #1 had moods and reality orientation and redirection failed to bring the resident back to reality. She stated once the resident was in his/her world, nothing could bring him/her back. In addition, the resident would refuse psychotropic medication.</p> <p>2. Review of the clinical record for Resident #2 revealed the facility admitted the resident with diagnoses of Bipolar Disorder and Schizoaffective Disorder on 03/06/09. The resident had periods of noncompliance with medications, hit staff when he/she ran out of cigarettes, and urinated on the floors. The facility completed an annual MDS assessment, dated 01/08/11, which revealed psychotropic medications were triggered as an area for further assessment of care needs. The facility provided no evidence a CAA assessment for psychotropic medications was completed.</p> <p>Review of the comprehensive care plan revealed no evidence the facility implemented interventions to monitor the effectiveness/noneffectiveness of the resident's psychotropic medication or to manage the resident's behaviors.</p> <p>Interview with the MDS Coordinator, on 07/28/11 at 10:30 AM, revealed she did not know why</p>	F 279		



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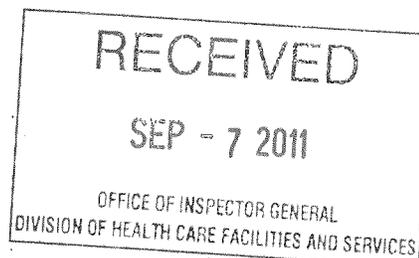
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F 279	<p>Continued From page 23</p> <p>comprehensive care plans addressing behaviors for Residents #1 and #2 were not completed. She stated the Social Services person would be responsible for completing any behavior care plans. She stated it was not her job to oversee other disciplines' work.</p> <p>Interview of the Social Services Director, on 07/28/11 at 11:10 AM, revealed she was not hired by the facility until March 2011. She stated she had reviewed Resident #1 and #2's care plans since March 2011; however, she did not notice any problems with those care plans.</p> <p>Interview with the Regional Director of Clinical Services, on 07/27/11 at 10:30 AM, revealed Resident #1's suicide attempt was in the past and the care plan team felt the resident was stable and not at risk for suicide.</p> <p>Review of the allegation of compliance, dated 07/29/11, with an alleged removal date of 07/28/11 and interview with the Administrator on 11/28/11 at 11:50 AM and the Regional Consultant on 07/28/11 at 10:30 AM revealed the facility took the following immediate actions:</p> <ol style="list-style-type: none"> <li>All residents were audited to ensure they received the appropriate level of supervision.</li> <li>All residents clinical records were audited for histories of suicide attempts or suicidal ideation and a list of high risk residents was developed.</li> </ol>	F 279			



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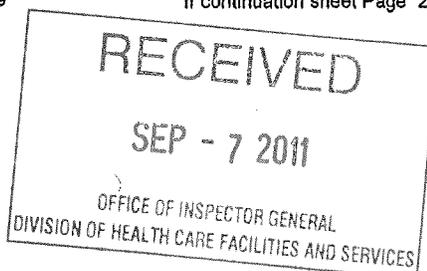
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F 279	Continued From page 24  3. All high risk residents had their care plans updated and individualized interventions were developed by the care plan team based on individual resident history.  4. All residents determined to be high risk of suicide were assessed to ensure there were no items present in the room that would present a danger to the resident and included removal of plastic trash bags.  5. No staff had worked past 07/27/11 without having received education regarding psychotic symptoms, and suicide prevention to include detection of early warning signs of major mood changes or possible suicidal ideation and the procedure to obtain and provide appropriate interventions.  6. A list of high risk residents is now listed at the nursing stations and on the nurse aide assignment sheets with interventions included on the nurse aide assignment sheets and plan of care.  7. Staff were educated to report immediately any warning signs of major mood changes and/or possible suicidal ideation to their immediate supervisor and at a minimum, residents exhibiting warning signs will be placed immediately on increased supervision. The resident's environment will be assessed for safety and any	F 279		



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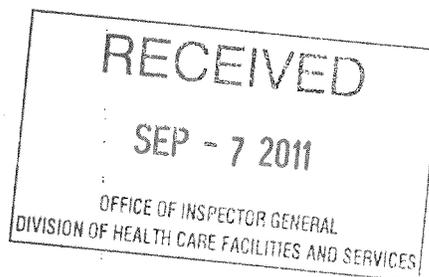
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F 279	<p>Continued From page 25</p> <p>objects which could be used for self harm will be removed. The resident's family and physician will be notified. The interdisciplinary team will review the resident to ensure appropriate interventions and goals are in place.</p> <p>8. No nursing staff has worked or will work past 07/27/11 without having received education on the requirement to never leave plastic bags unattended and not in use.</p> <p>9. No nursing staff have worked or will work past 07/27/11 without having received education regarding the requirement to conduct rounds every two (2) hours and visualize the resident by CNAs and nurses. The completed rounds are documented every two (2) hours, however, the CNAs and nurses are responsible for ensuring these rounds are documented. The Administrator will review the completed documents to ensure rounds are being made every two (2) hours. Any noted noncompliance will result in disciplinary action, up to and including termination.</p> <p>10. All members of the interdisciplinary team (Social Service Director, Interim Director of Nursing, Clinical Reimbursement Coordinator, Life Enrichment Director and Nutrition Services Manager) were educated by the Regional Director of Clinical Services regarding the Behavior Review Process which includes admission and readmission review of behavior residents and ongoing behavior reviews to include the care planning completion process and interdisciplinary development and revision of care plans based</p>	F 279			



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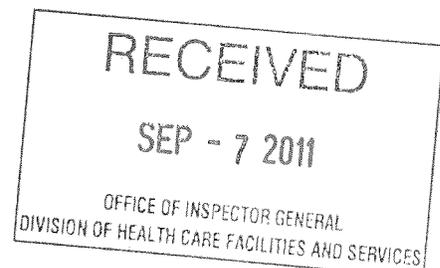
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F 279	<p>Continued From page 26</p> <p>upon resident history and current conditions and assessments. The Quality Assurance Committee met on 07/27/11 and reviewed the plan and the state agency's determination. The Medical Director was in attendance at the meeting.</p> <p>During an interview with LPN #2, on 07/28/11 at 9:20 AM, he revealed the nurse was responsible for monitoring rounds every two hours and documenting the rounds. He stated a list of high risk residents was developed and posted at each nursing station. He stated staff were trained to recognize the signs of possible suicide and report to the nurse right away.</p> <p>During an interview with LPN #3, on 07/28/11 at 9:40 AM, the LPN revealed all staff were trained on the signs of possible suicide and behaviors and to report this information to the nurse.</p> <p>Review of the in-service attendance records was completed and all nursing staff were trained on making rounds and seeing the resident every two (2) hours and completing the documentation. The nurse was to supervise and sign off. The Administrator will monitor.</p> <p>Review of the in-service attendance records was completed and all nursing staff were trained on psychotic signs and symptoms and suicide prevention, interventions, and the reporting process. Observation of A High Risk for suicide list of residents, based on the MDS, physician notes, and history, was posted at both nursing</p>	F 279			



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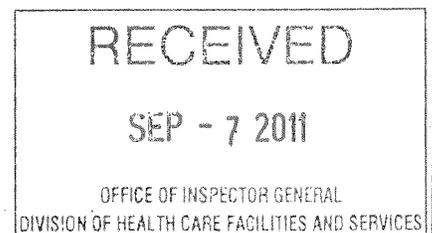
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F 279	Continued From page 27 stations and was on the CNA assignment sheet along with interventions.  Observation of the high risk resident rooms, 07/28/11 at 2:30 PM, revealed any self-harm objects were removed. All plastic trash bags were removed, long electrical cords were tied with plastic ties to shorten the length of the cords, plastic bags covering respiratory and suction equipment were removed and items were covered with clean towels. All staff were trained not to leave plastic trash bags around that were not in use.  Review of the attendance record for a Quality Assurance Committee meeting held on 07/27/11, addressing the facility's Immediate Jeopardy and the actions taken to resolve the jeopardy, were reviewed and the medical director, staff and managers were present.	F 279		
F 280 SS=J	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,	F 280	F280 Right to Participate Planning Care-Revise CP  In addition to the attached acceptable Allegation of Compliance on July 28, 2011, the center has taken the following actions:  1. Resident #1 no longer resides at center. 2. Documented history of psychiatric problems/diagnosis and psychotropic drug use reviewed by SSD and IDT to ensure current care needs are identified and interventions are in place to address current concerns affecting the residents daily functioning and quality of life and those with the potential to affect the resident or other residents daily functioning and quality of life..	08/20/2011



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F 280	<p>Continued From page 28</p> <p>and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, closed record review, psychiatric hospital history and physical and facility policy review, it was determined the facility failed to revise a comprehensive care plan for one (1) of six (6) sampled residents (Resident #1). The facility admitted Resident #1 on 11/16/10 having paranoid schizophrenia and a history of a failed suicide attempt. On 01/14/11, the facility transferred the resident to the hospital related to his/her chief complaint including wanting to die. On 02/09/11, the facility assessed the resident as having feelings of being better off dead. On 04/21/11, the resident expressed he/she wanted to die. The facility failed to revise/update the care plan and implement interventions to address the resident's mental decline. On 07/24/11 at 6:45 AM, the facility found the resident deceased, having successfully committed suicide.</p> <p>The facility provided a credible allegation of compliance on 07/28/11. The state agency verified Immediate Jeopardy was removed 07/28/11 prior to exit on 07/29/11; which lowered the scope and severity to a "D" at 42 CFR 483.15 Social Services (F250), 42 CFR 483.20 (F272) Resident Assessment, (F279) Develop</p>	F 280	<p>3. On 7/27/11, All members of the Interdisciplinary Team (IDT) (SSD, Interim Director of Nursing, Clinical Reimbursement Coordinator, Life Enrichment Director and Nutrition Services Manager) were educated by the Regional Director of Clinical Services regarding the Behavior Review Process which included admission and readmission review of behavior residents and ongoing behavior reviews to include the care planning completion process and interdisciplinary development and revision of care plans based upon resident history and current conditions and assessments. A comprehensive care plan review meeting will be conducted with the IDT following completion of each MDS assessment to develop, review and revise the resident's comprehensive plan of care based on results of assessment.</p> <p>4. The Regional Director of Clinical Services and/or Regional Director of Clinical Reimbursement will review two records per week for four weeks, and then four random records per month following comprehensive care plan review by IDT to ensure a comprehensive plan of care is developed, reviewed and revised based on results of assessment. Results of audits will be reviewed with ADM and QA committee to ensure continued compliance and for further recommendations.</p>		



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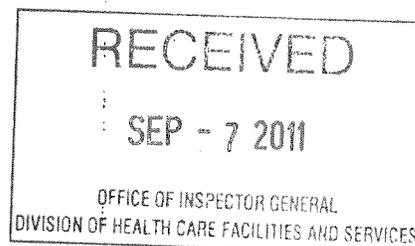
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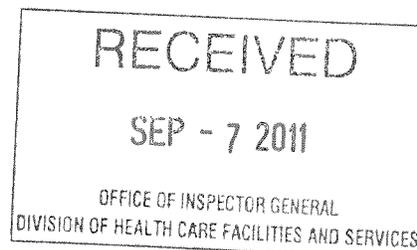
F 280	Continued From page 29 Comprehensive Care Plans, (F280) Revise Care Plans, 42 CFR 483.25 (F323) Accidents, 42 CFR 483.75 (F490) Administration and (F520) Quality Assurance, while the facility's administration and the Quality Assurance Committee complete training and monitoring for psychiatric residents safety.  The findings include:  Review of the facility policy for Care Plans, dated October 2008, revealed the facility documented the date the resident's need was identified, the need identified, measurable goals and specific individualized interventions.  Review of the closed clinical record for Resident #1 revealed the facility admitted the resident on 11/16/10 with diagnoses of Paranoid Schizophrenia, a long history of psychiatric hospitalizations, and an attempt suicide in 1995. The admission MDS assessment completed by the facility and dated 11/23/10 revealed the resident refused care one (1) to three (3) times per week. On 01/14/11, the resident was admitted to the hospital related to refusing to eat and stating she wanted to die. The resident was readmitted to the facility on 01/19/11. Review of the care plan, dated 01/12/11 revealed no documented evidence the facility developed interventions related to the 01/14/11 hospital admission where the resident was refusing to eat and wanting to die. The quarterly MDS assessment, dated 02/08/11, revealed the facility assessed the resident as having continuous disorganized thinking, felt little pleasure or interest in doing things, felt down, depressed,	F 280		
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F 280	Continued From page 30  hopeless, had little energy, was feeling bad about him/herself and was having thoughts that he/she would be better off dead. Review of the comprehensive care plan, dated 01/20/11, revealed the facility had identified the resident's behaviors, that might be harmful to self, as schizophrenia, psychosis, hallucinations, delusions and paranoia; however, reality orientation, psychotropic medications, and providing the resident with foods he/she liked were the only documented interventions provided by the facility. There was no evidence provided to demonstrate the resident's hospital stay, related to not eating and suicidal ideation, resulted in added interventions.  Interview with Licensed Practical Nurse (LPN) #1 on 07/26/11 at 11:00 AM, revealed Resident #1 had moods and reality orientation and redirection failed to bring the resident back to reality. She stated once the resident was in his/her world, nothing could bring him/her back. In addition, the resident would refuse psychotropic medication.  Review of the psychologist's notes, dated 02/26/11, revealed the resident exhibited anxiety, increased agitation, depression, refused oral medication, and had fixed paranoid delusions. Review of the notes dated 04/25/11 revealed the resident told the psychologist he/she "just did not want to live".  Refer to F323.  Interview with the Social Services Director, on 07/28/11 at 11:10 AM, revealed she was not employed at the facility until March 2011 and did not realize Resident #1 had a problem with a past	F 280		



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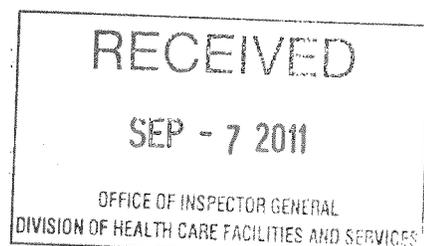
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/29/2011
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NAME OF PROVIDER OR SUPPLIER  PEMBROKE NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266
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F 280	<p>Continued From page 31</p> <p>suicide attempt. She stated she did review the resident's clinical record; however, she did not remember reading the PASRR or the hospital history.</p> <p>Interview with the MDS Coordinator, on 07/28/11 at 10:30 AM, revealed the information on the MDS was reviewed during the care plan meeting and compared to previous assessments. She stated each discipline had their own part of the care plan they were responsible for completing. She stated the mood and behavior care plans were managed under social services and not her responsibility. She stated she did not realize the MDS Coordinator was responsible to ensure the MDS process was carried out as required. She stated the Director of Nursing signed off on each MDS.</p> <p>Interview with the Regional Director of Clinical Services, on 07/27/11 at 10:30 AM, revealed the care plan team felt Resident #1 was stable and therefore, a revision to the care plan was not made.</p> <p>Interview with the Acting Director of Nursing, on 07/27/11 at 10:30 AM, revealed he was from another skilled facility and had been here for two (2) weeks. He stated he reviewed each MDS prior to signing off.</p> <p>There was no documented evidence that the facility reviewed the resident's assessments, interview results, and psychologist's notes to revise the care plan with effective interventions to address the resident's mental health concerns and the risk of suicide.</p>	F 280		
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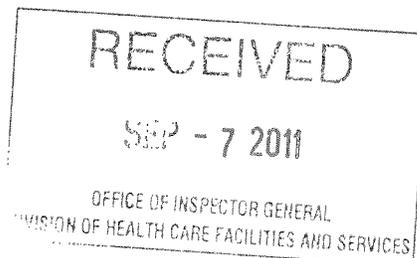
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F 280	Continued From page 32 Review of the allegation of compliance, dated 07/29/11, with an alleged removal date of 07/28/11 and interview with the Administrator on 11/28/11 at 11:50 AM and the Regional Consultant on 07/28/11 at 10:30 AM revealed the facility took the following immediate actions:  1. All residents were audited to ensure they received the appropriate level of supervision.  2. All residents clinical records were audited for histories of suicide attempts or suicidal ideation and a list of high risk residents was developed.  3. All high risk residents had their care plans updated and individualized interventions were developed by the care plan team based on individual resident history.  4. All residents determined to be high risk of suicide were assessed to ensure there were no items present in the room that would present a danger to the resident and included removal of plastic trash bags.  5. No staff had worked past 07/27/11 without having received education regarding psychotic symptoms; and suicide prevention to include detection of early warning signs of major mood changes or possible suicidal ideation and the procedure to obtain and provide appropriate interventions.	F 280			

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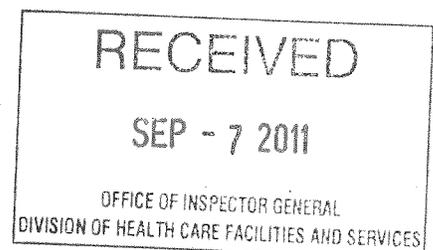
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F 280	Continued From page 33  6. A list of high risk residents is now listed at the nursing stations and on the nurse aide assignment sheets with interventions included on the nurse aide assignment sheets and plan of care.  7. Staff were educated to report immediately any warning signs of major mood changes and/or possible suicidal ideation to their immediate supervisor and at a minimum, residents exhibiting warning signs will be placed immediately on increased supervision. The resident's environment will be assessed for safety and any objects which could be used for self harm will be removed. The resident's family and physician will be notified. The interdisciplinary team will review the resident to ensure appropriate interventions and goals are in place.  8. No nursing staff has worked or will work past 07/27/11 without having received education on the requirement to never leave plastic bags unattended and not in use.  9. No nursing staff have worked or will work past 07/27/11 without having received education regarding the requirement to conduct rounds every two (2) hours and visualize the resident by CNAs and nurses. The completed rounds are documented every two (2) hours, however, the CNAs and nurses are responsible for ensuring these rounds are documented. The Administrator will review the completed documents to ensure rounds are being made every two (2) hours. Any	F 280			



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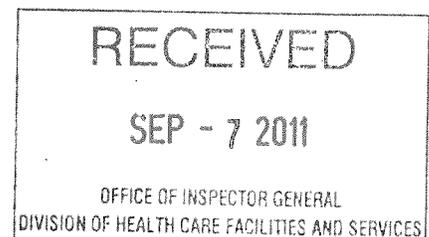
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F 280	<p>Continued From page 34</p> <p>noted noncompliance will result in disciplinary action, up to and including termination.</p> <p>10. All members of the interdisciplinary team (Social Service Director, Interim Director of Nursing, Clinical Reimbursement Coordinator, Life Enrichment Director and Nutrition Services Manager) were educated by the Regional Director of Clinical Services regarding the Behavior Review Process which includes admission and readmission review of behavior residents and ongoing behavior reviews to include the care planning completion process and interdisciplinary development and revision of care plans based upon resident history and current conditions and assessments. The Quality Assurance Committee met on 07/27/11 and reviewed the plan and the state agency's determination. The Medical Director was in attendance at the meeting.</p> <p>Interview with CNA #6, on 07/28/11 at 8:15 AM, revealed she received training to make rounds and see each resident every two (2) hours and to document these rounds. She stated she was trained on recognizing the signs of possible suicide thinking and was to report immediately to the nurse. She also received training on using the CNA assignment sheet for information on taking care of high risk residents.</p> <p>Interview with CNA #4, on 07/28/11 at 9:00 AM, revealed she received training on the list of residents considered high risk for behaviors and possible suicide. This list is at the nursing station and on the CNA assignment sheet with actions to</p>	F 280			



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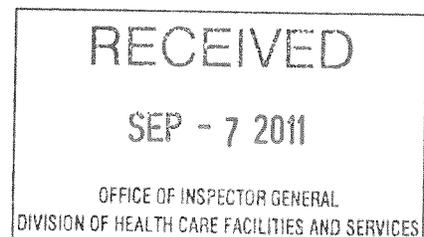
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F 280	<p>Continued From page 35</p> <p>take. She stated any sign was to be reported to the nurse. There are to be no plastic bags around unless we are using them. She indicated the high risk residents' rooms were reviewed for possible dangerous items and they were removed. Staff must make rounds every two (2) hours and see the resident then document on the sheet.</p> <p>Interview with LPN #2, on 07/28/11 at 9:20 AM, revealed the nurse was responsible for monitoring rounds every two hours and documenting the rounds. He stated a list of high risk residents was developed and posted at each nursing station, as well as on the CNA assignment sheet with actions to take. He indicated these residents rooms were reviewed for potentially dangerous items and these items were removed and plastic bags were not to be left around the facility. He stated staff were trained to recognize the signs of possible suicide and report to the nurse right away.</p> <p>Interview with LPN #3, on 07/28/11 at 9:40 AM, revealed all staff were trained on the signs of possible suicide and behaviors and to report this information to the nurse. She stated a list of residents at high risk for suicide was developed and posted at the nursing station and on the CNA assignment sheet along with interventions to take. She stated rounds were to be made by the CNA and the nurse and the nurse was to make sure the rounds were made and all staff were to sign off on the rounds. She indicated resident rooms were reviewed, high risk, and any dangerous items were removed.</p>	F 280			



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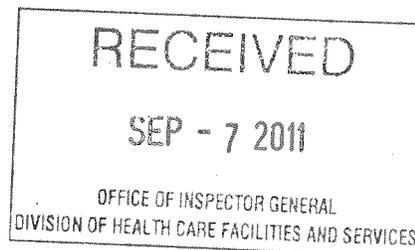
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F 280	<p>Continued: From page 36</p> <p>Review of the in-service attendance records was completed and all nursing staff were trained on making rounds and seeing the resident every two (2) hours and completing the documentation. The nurse was to supervise and sign off. The Administrator will monitor.</p> <p>Review of the in-service attendance records was completed and all nursing staff were trained on psychotic signs and symptoms and suicide prevention, interventions, and the reporting process. Observation of A High Risk for suicide list of residents, based on the MDS, physician notes, and history, was posted at both nursing stations and was on the CNA assignment sheet along with interventions.</p> <p>Observation of the high risk resident rooms, 07/28/11 at 2:30 PM, revealed any self-harm objects were removed. All plastic trash bags were removed, long electrical cords were tied with plastic ties to shorten the length of the cords, plastic bags covering respiratory and suction equipment were removed and items were covered with clean towels. All staff were trained not to leave plastic trash bags around that were not in use.</p> <p>Review of the attendance record for a Quality Assurance Committee meeting held on 07/27/11, addressing the facility's Immediate Jeopardy and the actions taken to resolve the jeopardy, were reviewed and the medical director, staff and</p>	F 280			



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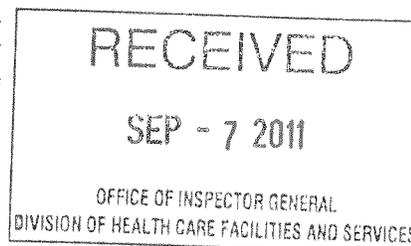
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F 280	Continued From page 37 managers were present.	F 280		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on interview, closed record review and hospital history and physical review, it was determined the facility failed to ensure one (1) of six (6) sampled residents (Resident #1) had a safe environment as free of accident hazards as possible; and that each resident received adequate supervision to prevent accidents. The facility failed to ensure staff was trained and knowledgeable regarding caring for residents with psychiatric diagnoses and how to recognize the signs/symptoms of suicidal ideations or risks. The facility failed to identify and evaluate Resident #1's risk for suicide based on history of suicidal attempt in 1995, suicidal ideations expressed on 01/14/11, 02/08/11, and 04/25/11. The facility failed to identify potential hazards that could be utilized for suicidal acts in the resident's environment. The facility failed to implement interventions, including the need for supervision, to reduce the risk of suicide. The facility failed to make rounds and visualize the resident between the hours of approximately 12 AM and 6:45 AM	F 323	F323 Free of Accident Hazards/Supervision/Devices  In addition to the acceptable Allegation of Compliance on July 28, 2011, the center has taken the following actions:  1. Resident #1 no longer resides at center. 2. On 7/25/11, the IDT reviewed behavior notes and current nurses notes of all current residents to ensure all residents are receiving the appropriate level of supervision. On 7/27/11, all current resident's clinical records were reviewed to identify any residents with a history of suicide attempts or suicidal ideations and a list of high risk residents was developed. All high risk residents were reviewed by IDT on 7/27/11 and their care plans were updated and individualized interventions were developed based on individual resident history. All residents determined to be high risk of suicide were assessed to	08/20/2011



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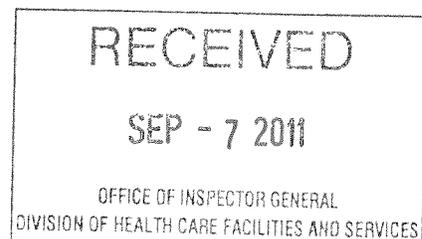
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F 323	<p>Continued From page 38 on 07/24/11 at which time staff discovered the resident had committed suicide.</p> <p>The facility's failure to ensure residents with psychiatric diagnoses and behaviors were provided with as safe an environment as possible; failure to provide adequate supervision to residents at risk; failure to identify hazards and risks; failure to evaluate and analyze hazards and risks; failure to implement interventions to reduce hazards and risks and failure to train staff to provide care to psychiatric residents, may have contributed to Resident #1's suicide and was likely to contribute to other residents' injury, harm, impairment or death. Immediate Jeopardy was determined to exist from 07/24/11 at F 250 S/S "J", F272 S/S "J", F 272 S/S "J", F280 S/S "J", F323 S/S "J", F490 S/S "J", and F520 S/S "J".</p> <p>The facility provided a credible allegation of compliance on 07/28/11. The state agency verified Immediate Jeopardy was removed 07/28/11 prior to exit on 07/29/11; which lowered the scope and severity to a "D" at 42 CFR 483.15 Social Services (F250), 42 CFR 483.20 (F272) Resident Assessment, (F279) Develop Comprehensive Care Plans, (F280) Revise Care Plans, 42 CFR 483.25 (F323) Accidents, 42 CFR 483.75 (F490) Administration and (F520) Quality Assurance, while the facility's administration and the Quality Assurance Committee complete training and monitoring for psychiatric residents safety.</p> <p>The findings include:</p>	F 323	<p>ensure there were no items in the room that would present a danger to the resident and included removal of plastic trash bags.</p> <p>3. No staff have worked past 7/27/11 without having received education regarding psychotic symptoms, and suicide prevention to include detection of early warning signs of major mood changes or possible suicidal ideation and the procedure to obtain and provide appropriate interventions. A list of high risk residents is now posted at the nursing stations and on the nurse aide assignment sheets with interventions included on the nurse aide assignment sheets and plan of care. Staff were educated to report immediately any warning signs of major mood changes and/or possible suicidal ideation to their immediate supervisor and at a minimum, residents exhibiting warning signs will be placed on increased supervision and their environment will be assessed for safety and any objects which could be used for self harm will be removed. The IDT will review the resident to ensure appropriate interventions and goals are in place. No nursing staff has worked or will work past 7/27/11 without having received education on the requirement to never leave plastic bags unattended and not in use. No nursing staff have worked or will work past 7/27/11 without having received education regarding the requirement to conduct rounds every two hours and visualize the resident by CNAs and nurses. The completed rounds are documented every two hours and CNAs and nurses are responsible for ensuring these rounds are documented. The ADM will review the completed documents to ensure rounds are being made every two hours. Any noted non-compliance will result in disciplinary action, up to and including termination. On 7/27/11, All members of the Interdisciplinary Team (IDT) (SSD, Interim Director of Nursing, Clinical Reimbursement Coordinator, Life Enrichment Director and Nutrition</p>	



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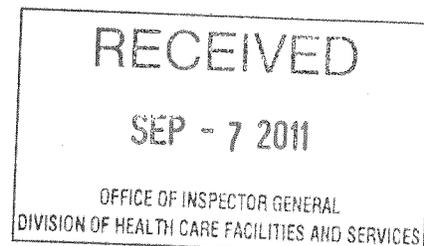
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F 323	<p>Continued From page 39</p> <p>Interview with the Regional Director of Clinical Services, on 07/28/11 at 1:00 PM, revealed the facility had reviewed clinical records and developed a list of residents, on 07/27/11, the facility considered high risk for possible suicide. The facility identified twelve (12) residents as high risk.</p> <p>Continued interview with the Regional Director of Clinical Services, on 07/27/11 at 6:30 AM, revealed the facility had no written policy for nursing to conduct rounds to monitor residents every 2 hours. However, interview with Registered Nurse (RN) #1, on 07/27/11 at 9:45 AM, revealed the facility policy was to make rounds on residents every two (2) hours. Interview with Licensed Practical Nurse (LPN) #1, on 07/26/11 at 11:00 AM, revealed the facility required nursing rounds to be made on resident's every two hours and more often as needed, and she expected CNAs to do the same. Interview with CNA #2, on 07/27/11 at 5:30 AM, revealed she was trained to check residents every two (2) hours and provide the care needed. Interview with CNA #1, on 07/27/11 at 5:15 AM, revealed she checked on residents every two (2) hours.</p> <p>Review of the closed clinical record for Resident #1 revealed the facility admitted the resident with diagnoses of Schizophrenia, Chronic Paranoid Type and Chronic Anxiety on 11/16/10. Review of the Comprehensive Evaluation For Mental Illness and Mental Retardation (PASRR) Level II completed on 11/11/10 revealed the resident had a long history of mental illness with numerous psychiatric hospitalizations and an attempted suicide in 1995. The resident was extremely anxious, experienced difficulty sorting out</p>	F 323	<p>Services Manager) were educated by the Regional Director of Clinical Services regarding the Behavior Review Process which included admission and readmission review of behavior residents and ongoing behavior reviews to include the care planning completion process and interdisciplinary development and revision of care plans based upon resident history and current conditions and assessments. A comprehensive care plan review meeting will be conducted with the IDT following completion of each MDS assessment to develop, review and revise the resident's comprehensive plan of care based on results of assessment. New admissions will be reviewed by IDT to identify any risk factors that put them at high risk and will be added to "high risk" list as identified.</p> <p>4. Department heads and nurses are conducting rounds every two hours to ensure that at risk residents environments remain free from hazards that could be used for self harm. ADM is conducting daily rounds Monday thru Friday to ensure that at risk residents environments remain free from hazards that could be used for self harm. Regional Director of Clinical Services will review new admissions weekly for 8 weeks to ensure any risk factors are identified and appropriate interventions implemented. Results of audits will be reviewed with ADM and QA committee to ensure continued compliance and for further recommendations.</p>	



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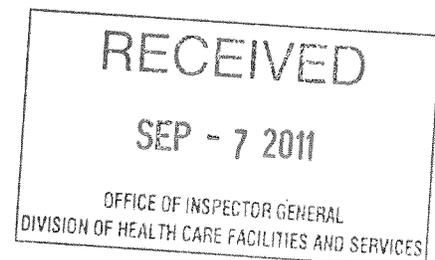
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F 323	<p>Continued From page 40</p> <p>thoughts and trying to explain feelings. The resident was found to have poor insight/judgement and a history of refusing medications and meals. The resident required nursing supervision for medications and management of physical needs and monitoring of agitation, paranoia and delusional thinking.</p> <p>Review of the admission Minimum Data Set (MDS) assessment completed by the facility on 11/23/10 revealed Resident #1 rejected care one (1) to three (3) days per week. Behaviors and psychotropic medications were triggered for further assessment by the Care Area Assessments (CAA). Review of the behavior CAA revealed the facility identified the resident's refusal of care and periods of hallucinations were related to the psychotic disorder. There was no documented evidence the facility identified and detailed as part of further assessment the resident's agitation, anxiety, delusional thinking, numerous psychiatric hospitalizations, and attempted suicide when the behavior CAA was completed. Review of the CAA for psychotropic medications revealed the resident received an antipsychotic medication. There was no documented evidence that the facility assessed and determined whether the resident's medication was effective or noneffective since admission.</p> <p>Review of the admission comprehensive care plan developed from the admission MDS assessment, dated 11/23/10, revealed the facility addressed the resident's psychotropic drug use and the potential for side effects related to agitation, psychosis and schizophrenia; however, there was no specific plan, goal or interventions</p>	F 323			



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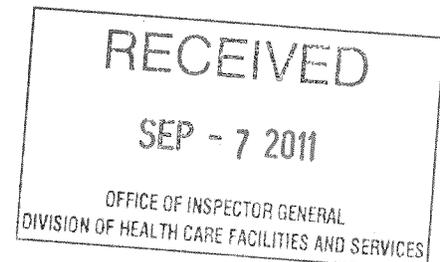
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F 323	<p>Continued From page 41</p> <p>documented to address the resident's history of suicide attempts, hallucinations or delusional thinking.</p> <p>Review of the Psychologist's notes, dated 12/04/10, revealed Resident #1 had anxiety, had an agitated mood and was acutely psychotic with delusional thinking. The resident refused medications frequently. Facility staff were provided with psychosocial interventions including: supportive listening, invite to activities, use soothing voice and praise compliance; however, there was no evidence these interventions were integrated into the resident's comprehensive care plan.</p> <p>Review of the hospital history and physical (H&amp;P), dated 01/14/11, revealed the facility had transferred Resident #1 to the hospital with the chief complaint that the resident was "refusing to eat, stating [he/she] wants to die." The H&amp;P revealed the hospital admitted Resident #1 with suicidal ideation, dehydration, history of paranoid schizophrenia and possible urinary tract infection.</p>	F 323		
	<p>Record review revealed the facility re-admitted Resident #1 on 01/19/11. Review of the comprehensive care plan revealed the facility developed a care plan for behavior symptoms that may be harmful to self or others as evidenced by schizophrenia, cognitive deficits, resists care and false allegation that food is being poisoned. The facility established goals that the resident would not injure self or others, would accept care, reduce the frequency of behavior symptoms, would exhibit socially appropriate behaviors and would eat food. Further review revealed the facility detailed only two</p>			



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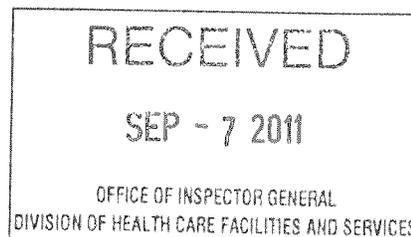
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F 323	<p>Continued From page 42</p> <p>interventions which were to offer alternative foods from the kitchen that are on the resident "likes" list and to see Psychosocial well-being care plan. Review of the Psychosocial well-being care plan developed on 01/21/11 revealed problems were identified as hallucinations, delusions, and suspiciousness/paranoia with goals detailed to maintain safety with activity of daily livings skills and will not cause injury to self. The facility developed the following interventions: when having hallucinations/delusions provide reality orientation, as needed medications, psychotropic medications and refer to the psychotropic medication care plan. Further review revealed there were no specific details related to the resident's history of suicide attempts, suicidal ideations during the hospital visit of 01/14/11 and no interventions detailed to address specific actions to reduce the resident's risk for attempting suicide.</p> <p>Review of the Quarterly MDS Assessment, dated 02/08/11, revealed the facility assessed Resident #1 as feeling bad regarding self, had little to no interest in doing things, and feeling he/she would be better off dead nearly every day during the assessment period. Review of the care plan following the quarterly MDS assessment, dated 02/09/11, revealed there was no documented evidence the facility made revisions to reflect the resident's verbalizations of suicidal ideations and there were no changes to interventions previously established and no new interventions had been added to the care plan to protect the resident from harming him/herself.</p> <p>Record review of Psychologist's notes, dated 04/25/11, revealed Resident #1 was agitated,</p>	F 323			



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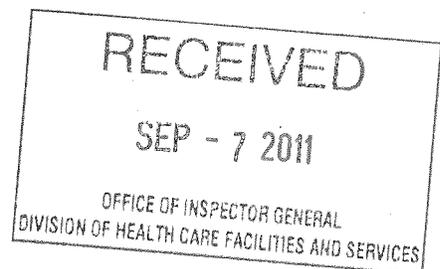
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F 323	Continued From page 43 anxious, had increased depression, and verbalized "I just don't want to live" to the psychologist. Review of the care plan revealed there was no documented evidence the facility revised the care plan interventions to address the resident's verbalizations of suicidal ideations.  Interview with Licensed Practical Nurse (LPN) #1, on 07/26/11 at 11:00 AM, revealed she reported to work, on 07/24/11 at 6:20 AM, and received report from the off-going nurse. She stated a Certified Nurse Aide (CNA) came to her crying and said we need you in Resident #1's room. She went into the resident's room and found the resident with a plastic trash bag over the resident's head with the bottom just above the resident's open mouth. She could not remember if the resident held the bag or not. She indicated the resident was pale, sweaty, cool to the touch and CPR was started; however, no response was noted during the CPR. She stated EMS arrived at the facility and took over CPR until approximately 7:15 AM when they pronounced the resident dead. Interview with Registered Nurse (RN) #1, on 07/27/11 at 9:45 AM, revealed she reported for duty on Resident #1's hall, on 07/23/11 at 6:00 PM, to do a twelve (12) hour shift. She observed Resident #1 at approximately 12:00 midnight and did not see the resident again until 6:45 AM when a CNA discovered the resident had expired. She stated rounds were not made during the night due to issues with other residents needing care. She assumed CNA #3 made rounds throughout the shift as assigned. She went to the resident's room when she heard what had happened and saw the resident in bed with a plastic bag up by	F 323			



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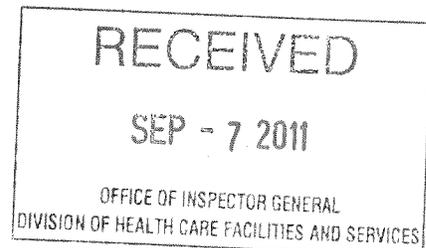
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F 323	<p>Continued From page 44</p> <p>the head and staff started CPR. She stated EMS pronounced the resident dead. Review of the nursing notes, for 07/24/11 at 6:45 AM, revealed Resident #1 was found in bed with a plastic trash bag covering his/her head with a hand clenched around the bag. 911 was called as the resident was a full code and the facility staff initiated cardiopulmonary resuscitation (CPR) until emergency medical staff (EMS) took over and later pronounced the resident dead. Telephone interview with the County Coroner, on 07/28/11 at 2:50 PM, revealed the resident expired at approximately 12:00 Midnight based on the rigor mortis noted in the body.</p> <p>Interview with the Regional Director of Clinical Services, on 07/27/11 at 10:30 AM, revealed she was present when CNA #3 was interviewed and verified she worked with Resident #1 and had last seen the resident around 12:45 AM on 07/24/11. She stated CNA #3 did not make rounds on Resident #1. She indicated CNA #3 was no longer employed by the facility.</p> <p>Further interview with RN #1 revealed she had no knowledge Resident #1 had attempted suicide in the past or had verbalized thoughts of harming self. She stated this information was important and it was not readily available to staff as she was sure it was not on the CNA assignment sheet.</p> <p>Continued interview with LPN #1 revealed she did not remember hearing of Resident #1's comment on suicide or threat to cause harm to self and was not aware of the resident's history or recent comments to the psychologist or the care plan</p>	F 323		



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F 323	<p>Continued From page 45</p> <p>team regarding suicide. She indicated she did not remember anything specific regarding care on the resident's care plan; however, she was sure there was nothing on the care plan regarding suicide.</p> <p>Interview with CNA #1, on 07/27/11 at 5:15 AM, revealed she did not remember anything regarding suicide on the CNA assignment sheet or instructions to check the resident more often than every two (2) hours and she was not aware Resident #1 had verbalized thoughts regarding harming self. Interview with CNA #2, on 07/27/11 at 5:30 AM, revealed she was not aware Resident #1 had a past suicide attempt or had verbalized to staff feelings regarding harming self. She indicated Resident #1's care plan did not mention the past suicide attempt. Interviews with CNAs #4, #5 and #6, on 07/27/11 at 1:30 PM, revealed they indicated they had provided care for Resident #1 in the past and approaches were listed on the CNA assignment sheet to talk calmly, invite to activities and be positive when the resident exhibited behaviors; however, were not aware the resident had attempted suicide in the past or talked about harming self.</p> <p>Continued interviews with CNAs #1, #2, #4, #5 and #6 revealed they had not received training on caring for psychiatric or suicidal residents. The facility was unable to provide documented evidence that they had provided training to staff to ensure their knowledge on how to provide care to residents with psychiatric diagnoses and residents at risk for suicide.</p> <p>Continued interview with the Regional Director of Clinical Services, on 07/27/11 at 6:30 AM,</p>	F 323		



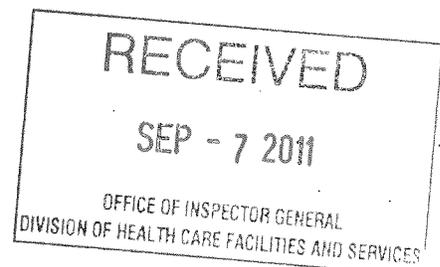
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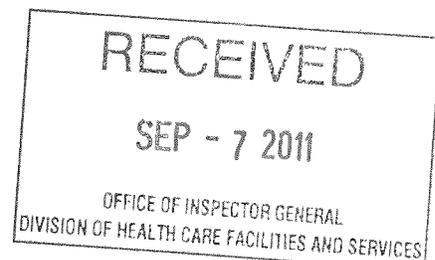
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F 323	Continued From page 46 revealed Resident #1 had not required rounds every two (2) hours. However, interview with the Administrator, on 07/28/11 at 11:50 AM, revealed the when the Resident #1's brother was notified of Resident's suicide, he told her the resident had talked about suicide for many years.  Review of the allegation of compliance, dated 07/29/11, with an alleged removal date of 07/28/11 and interview with the Administrator on 11/28/11 at 11:50 AM and the Regional Consultant on 07/28/11 at 10:30 AM revealed the facility took the following immediate actions:  1. All residents were audited to ensure they received the appropriate level of supervision.  2. All residents clinical records were audited for histories of suicide attempts or suicidal ideation and a list of high risk residents was developed.  3. All high risk residents had their care plans updated and individualized interventions were developed by the care plan team based on individual resident history.  4. All residents determined to be high risk of suicide were assessed to ensure there were no items present in the room that would present a danger to the resident and included removal of plastic trash bags.	F 323		



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F 323	<p>Continued From page 47</p> <p>5. No staff had worked past 07/27/11 without having received education regarding psychotic symptoms, and suicide prevention to include detection of early warning signs of major mood changes or possible suicidal ideation and the procedure to obtain and provide appropriate interventions.</p> <p>6. A list of high risk residents is now listed at the nursing stations and on the nurse aide assignment sheets with interventions included on the nurse aide assignment sheets and plan of care.</p> <p>7. Staff were educated to report immediately any warning signs of major mood changes and/or possible suicidal ideation to their immediate supervisor and at a minimum, residents exhibiting warning signs will be placed immediately on increased supervision. The resident's environment will be assessed for safety and any objects which could be used for self harm will be removed. The resident's family and physician will be notified. The interdisciplinary team will review the resident to ensure appropriate interventions and goals are in place.</p> <p>8. No nursing staff has worked or will work past 07/27/11 without having received education on the requirement to never leave plastic bags unattended and not in use.</p> <p>9. No nursing staff have worked or will work past 07/27/11 without having received education</p>	F 323		



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F 323	Continued From page 48 regarding the requirement to conduct rounds every two (2) hours and visualize the resident by CNAs and nurses. The completed rounds are documented every two (2) hours, however, the CNAs and nurses are responsible for ensuring these rounds are documented. The Administrator will review the completed documents to ensure rounds are being made every two (2) hours. Any noted noncompliance will result in disciplinary action, up to and including termination.	F 323		
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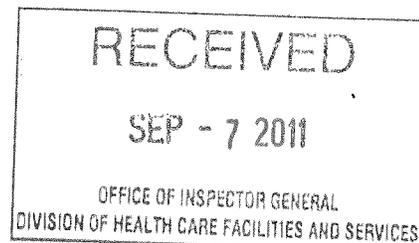
	10. All members of the interdisciplinary team (Social Service Director, Interim Director of Nursing, Clinical Reimbursement Coordinator, Life Enrichment Director and Nutrition Services Manager) were educated by the Regional Director of Clinical Services regarding the Behavior Review Process which includes admission and readmission review of behavior residents and ongoing behavior reviews to include the care planning completion process and interdisciplinary development and revision of care plans based upon resident history and current conditions and assessments. The Quality Assurance Committee met on 07/27/11 and reviewed the plan and the state agency's determination. The Medical Director was in attendance at the meeting.			
	Interview with CNA #6, on 07/28/11 at 8:15 AM, revealed she received training to make rounds and see each resident every two (2) hours and to document these rounds. She stated she was trained on recognizing the signs of possible suicide thinking and was to report immediately to the nurse. She also received training on using the CNA assignment sheet for information on			

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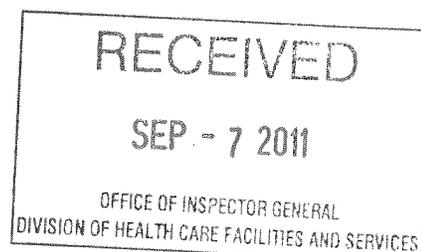
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F 323	Continued From page 49 taking care of high risk residents.  Interview with CNA #4, on 07/28/11 at 9:00 AM, revealed she received training on the list of residents considered high risk for behaviors and possible suicide. This list is at the nursing station and on the CNA assignment sheet with actions to take. She stated any sign was to be reported to the nurse. There are to be no plastic bags around unless we are using them. She indicated the high risk residents' rooms were reviewed for possible dangerous items and they were removed. Staff must make rounds every two (2) hours and see the resident then document on the sheet.  Interview with LPN #2, on 07/28/11 at 9:20 AM, revealed the nurse was responsible for monitoring rounds every two hours and documenting the rounds. He stated a list of high risk residents was developed and posted at each nursing station, as well as on the CNA assignment sheet with actions to take. He indicated these residents rooms were reviewed for potentially dangerous items and these items were removed and plastic bags were not to be left around the facility. He stated staff were trained to recognize the signs of possible suicide and report to the nurse right away.  Interview with LPN #3, on 07/28/11 at 9:40 AM, revealed all staff were trained on the signs of possible suicide and behaviors and to report this information to the nurse. She stated a list of residents at high risk for suicide was developed	F 323			



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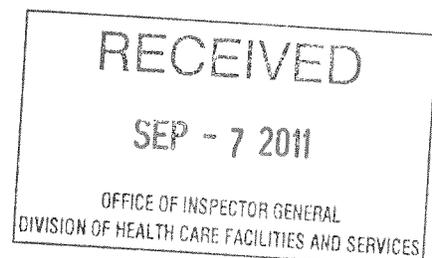
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F 323	Continued From page 50 and posted at the nursing station and on the CNA assignment sheet along with interventions to take. She stated rounds were to be made by the CNA and the nurse and the nurse was to make sure the rounds were made and all staff were to sign off on the rounds. She indicated resident rooms were reviewed, high risk, and any dangerous items were removed.  Review of the in-service attendance records was completed and all nursing staff were trained on making rounds and seeing the resident every two (2) hours and completing the documentation. The nurse was to supervise and sign off. The Administrator will monitor.  Review of the in-service attendance records was completed and all nursing staff were trained on psychotic signs and symptoms and suicide prevention, interventions, and the reporting process. Observation of A High Risk for suicide list of residents, based on the MDS, physician notes, and history, was posted at both nursing stations and was on the CNA assignment sheet along with interventions.	F 323		
	Observation of the high risk resident rooms, 07/28/11 at 2:30 PM, revealed any self-harm objects were removed. All plastic trash bags were removed, long electrical cords were tied with plastic ties to shorten the length of the cords, plastic bags covering respiratory and suction equipment were removed and items were covered with clean towels. All staff were trained not to leave plastic trash bags around that were			



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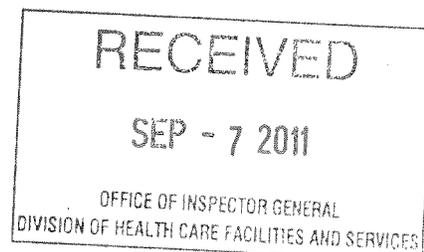
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NAME OF PROVIDER OR SUPPLIER  PEMBROKE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266	
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F 323	Continued From page 51 not in use.	F 323		
F 490 SS=J	<p>Review of the attendance record for a Quality Assurance Committee meeting held on 07/27/11, addressing the facility's Immediate Jeopardy and the actions taken to resolve the jeopardy, were reviewed and the medical director, staff and managers were present.</p> <p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, closed record review, history and physical, and facility investigations it was determined the facility was not administered in a manner that enabled it to attain or maintain the residents' highest well-being for one (1) of six (6) sampled residents (Resident #1). During an abbreviated survey, initiated on 07/26/11 and concluded on 07/29/11, Substandard Quality of Care and Immediate Jeopardy were identified to exist on 07/24/11 at 42 CFR 483.25 (F323) Supervision at a scope and severity level of a "J" related to the facility's failure to identify environmental hazards and individual resident risk of suicide, and failure to implement interventions and provide adequate supervision. Resident #1 was discovered in bed deceased</p>	F 490	<p>F 490 - A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident.</p> <p>In addition to the attached acceptable Allegation of Compliance on July 28, 2011, the center has taken the following actions:</p> <ol style="list-style-type: none"> <li>1. Resident #1 no longer resides at center.</li> <li>2. Following the incident on 7/24/11, the Administrator ensured that all environmental hazards were identified and removed and residents at risk for suicide were identified, interventions implemented, and</li> </ol>	08/20/2011



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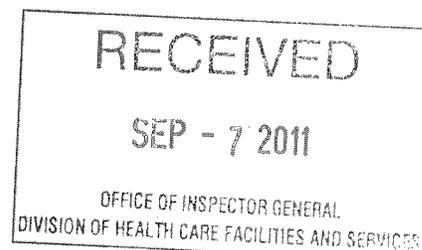
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F 490	<p>Continued. From page 52 with a plastic bag pulled over his/her head on the morning of 07/24/11. Refer to F250, F272, F279, F280, and F520.</p> <p>The facility provided a credible allegation of compliance on 07/28/11. The state agency verified Immediate Jeopardy was removed 07/28/11 prior to exit on 07/29/11; which lowered the scope and severity to a "D" at 42 CFR 483.15 Social Services (F250), 42 CFR 483.20 (F272) Resident Assessment, (F279) Develop Comprehensive Care Plans, (F280) Revise Care Plans, 42 CFR 483.25 (F323) Accidents, 42 CFR 483.75 (F490) Administration and (F520) Quality Assurance, while the facility's administration and the Quality Assurance Committee complete training and monitoring for psychiatric residents safety.</p> <p>The findings include:</p> <p>The facility was unable to provide documented evidence that staff was provided with training on caring for residents with psychiatric diagnoses and how to recognize the signs a resident might be suicidal. Refer to F323. Record review revealed no evidence the facility identified and evaluated Resident #1's risk for suicide based on past history from the Comprehensive Evaluation for Mental Illness and Mental Retardation (PASRR). Review of the comprehensive care plan, revealed the facility did not address specific details or implement interventions related to the</p>	F 490	<p>provided adequate supervision. The Administrator has been retrained on the requirement to identify environmental hazards and individuals at risk for suicide and implement interventions and provide adequate supervision. by the Regional Director of Clinical Services on 7/28/11.</p> <p>4. The Administrator will evaluate comprehensive care plan reviews on a weekly basis to assure the IDT is reviewing risk factors and developing interventions to protect residents from suicide. In addition, the Administrator will make observational rounds of staff completing two hour checks on residents three times a week for four weeks to assure staff are competent in performing this function. The Administrator will complete a walking round daily to ensure environment is free from hazards. The Administrator will ascertain during daily stand up meetings with department heads (Monday - Friday) if there are any behavior issues and ensure IDT reviews and updates plan of care with appropriate interventions. The Regional Director of Operations or Regional Director of Clinical Services will evaluate all plans as it relates to the supervision of residents, identification of environmental hazards, risks or suicide, and implementation of interventions. on a weekly basis to assure compliance with the written plan. The first QAA meeting was held on July 27, 2011 with the Medical Director in Attendance. The QAA Committee Meeting, consisting of at minimum, Medical Director, Director of Nursing, and Administrator, will be held weekly for 4 weeks to ensure sustained compliance. All actions related to the plan of correction will be reviewed monthly by the QAA committee to assure sustained compliance.</p>	



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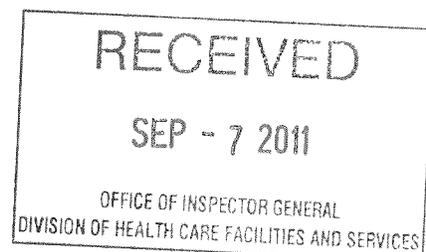
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F 490	Continued From page 53 resident's risk for suicide. Resident #1 made verbalizations of wanting to die or being better off dead on 01/14/11, 02/09/11 and 04/25/11. There was no evidence the facility implemented interventions to address the resident's mental health status or reduce the resident's risk of suicide. On 07/24/11, the facility discovered Resident #1 dead, having committed suicide.  Interview with the Regional Director of Clinical Services, on 07/28/11 at 1:00 PM, revealed the facility had reviewed clinical records and developed a list of residents, on 07/27/11, the facility considered high risk for possible suicide. The facility identified twelve (12) residents as high risk.  Interview with the Psychologist, on 07/28/11 at 10:15 AM, revealed the facility needed to provide training to staff, at orientation and ongoing, to ensure staff provided the appropriate care for psychiatric residents.  Review of the facility investigation revealed employees were questioned and no one reported hearing Resident #1 express suicidal ideations.  Interview with the Administrator, on 07/28/11 at 11:50 AM, revealed she arrived at the facility on 07/24/11 after Resident #1 was discovered dead. She did not have policies and procedures in place to address the care of psychiatric residents or residents with suicidal ideation and staff had not	F 490			



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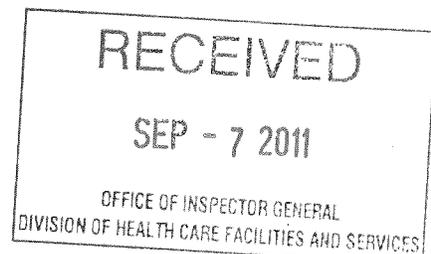
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F 490	Continued From page 54 received training on providing care for these residents. She indicated the facility had no policies addressing the identification of hazards and resident risks or development of individualized interventions to ensure residents were protected from accidents. She stated Resident #1 had no recent history of suicide attempts or suicidal ideation. She was not aware the resident expressed thoughts regarding being better off dead during the assessment for the Minimum Data Set (MDS) completed on 02/08/11 or the psychologist's note, dated 04/25/11, which documented the resident's statement regarding not wanting to live.  Interview with the Regional Director of Clinical Services, on 07/28/11 at 1:00 PM, revealed the facility had reviewed clinical records and developed a list of residents, on 07/27/11, the facility considered high risk for possible suicide. The facility identified twelve (12) residents as high risk.	F 490			
	Review of the allegation of compliance dated 07/29/11 with an alleged compliance date of 07/28/11 and interview with the Administrator on 11/28/11 at 11:50 AM and the Regional Consultant on 07/28/11 at 10:30 AM revealed the facility took the following immediate actions:  1. All residents were audited to ensure they received the appropriate level of supervision.  2. All residents clinical records were audited for				



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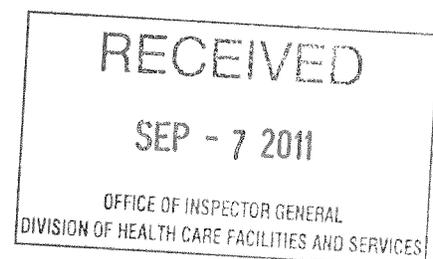
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F 490	Continued From page 55 histories of suicide attempts or suicidal ideation and a list of high risk residents was developed.  3. All high risk residents had their care plans updated and individualized interventions were developed by the care plan team based on individual resident history.  4. All residents determined to be high risk of suicide were assessed to ensure there were no items present in the room that would present a danger to the resident and included removal of plastic trash bags.  5. No staff had worked past 07/27/11 without having received education regarding psychotic symptoms, and suicide prevention to include detection of early warning signs of major mood changes or possible suicidal ideation and the procedure to obtain and provide appropriate interventions.  6. A list of high risk residents is now listed at the nursing stations and on the nurse aide assignment sheets with interventions included on the nurse aide assignment sheets and plan of care.  7. Staff were educated to report immediately any warning signs of major mood changes and/or possible suicidal ideation to their immediate supervisor and at a minimum, residents exhibiting warning signs will be placed immediately on	F 490			



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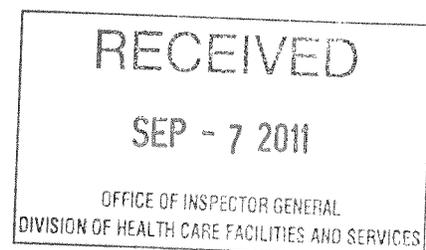
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F 490	Continued From page 56 increased supervision. The resident's environment will be assessed for safety and any objects which could be used for self harm will be removed. The resident's family and physician will be notified. The interdisciplinary team will review the resident to ensure appropriate interventions and goals are in place.  8. No nursing staff has worked or will work past 07/27/11 without having received education on the requirement to never leave plastic bags unattended and not in use.  9. No nursing staff have worked or will work past 07/27/11 without having received education regarding the requirement to conduct rounds every two (2) hours and visualize the resident by CNAs and nurses. The completed rounds are documented every two (2) hours, however, the CNAs and nurses are responsible for ensuring these rounds are documented. The Administrator will review the completed documents to ensure rounds are being made every two (2) hours. Any noted noncompliance will result in disciplinary action, up to and including termination.  10. All members of the interdisciplinary team (Social Service Director, Interim Director of Nursing, Clinical Reimbursement Coordinator, Life Enrichment Director and Nutrition Services Manager) were educated by the Regional Director of Clinical Services regarding the Behavior Review Process which includes admission and readmission review of behavior residents and ongoing behavior reviews to include the care	F 490			



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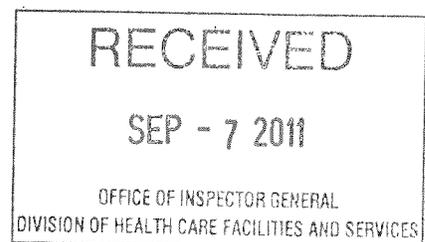
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F 490	Continued From page 57 planning completion process and interdisciplinary development and revision of care plans based upon resident history and current conditions and assessments. The Quality Assurance Committee met on 07/27/11 and reviewed the plan and the state agency's determination. The Medical Director was in attendance at the meeting.  Interview with CNA #6, on 07/28/11 at 8:15 AM, revealed she received training to make rounds and see each resident every two (2) hours and to document these rounds. She stated she was trained on recognizing the signs of possible suicide thinking and was to report immediately to the nurse. She also received training on using the CNA assignment sheet for information on taking care of high risk residents.  Interview with CNA #4, on 07/28/11 at 9:00 AM, revealed she received training on the list of residents considered high risk for behaviors and possible suicide. This list is at the nursing station and on the CNA assignment sheet with actions to take. She stated any sign was to be reported to the nurse. There are to be no plastic bags around unless we are using them. She indicated the high risk residents' rooms were reviewed for possible dangerous items and they were removed. Staff must make rounds every two (2) hours and see the resident then document on the sheet.  Interview with LPN #2, on 07/28/11 at 9:20 AM, revealed the nurse was responsible for monitoring rounds every two hours and	F 490			



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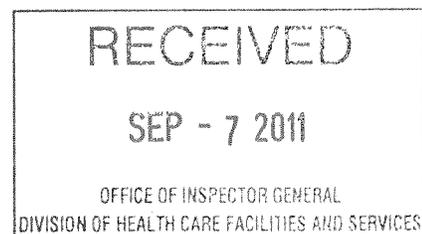
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F 490	Continued From page 58 documenting the rounds. He stated a list of high risk residents was developed and posted at each nursing station, as well as on the CNA assignment sheet with actions to take. He indicated these residents rooms were reviewed for <del>potentially dangerous items and these items</del> were removed and plastic bags were not to be left around the facility. He stated staff were trained to recognize the signs of possible suicide and report to the nurse right away.  Interview with LPN #3, on 07/28/11 at 9:40 AM, revealed all staff were trained on the signs of possible suicide and behaviors and to report this information to the nurse. She stated a list of residents at high risk for suicide was developed and posted at the nursing station and on the CNA assignment sheet along with interventions to take. She stated rounds were to be made by the CNA and the nurse and the nurse was to make sure the rounds were made and all staff were to sign off on the rounds. She indicated resident rooms were reviewed, high risk, and any dangerous items were removed.  Review of the in-service attendance records was completed and all nursing staff were trained on making rounds and seeing the resident every two (2) hours and completing the documentation. The nurse was to supervise and sign off. The Administrator will monitor.  Review of the in-service attendance records was completed, and all nursing staff were trained on psychotic signs and symptoms and suicide	F 490			



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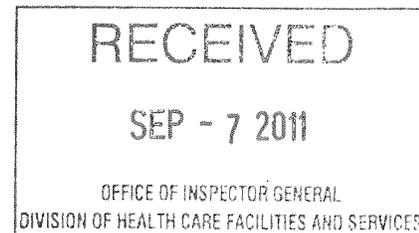
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F 490	Continued From page 59 prevention, interventions, and the reporting process. Observation of A High Risk for suicide list of residents, based on the MDS, physician notes, and history, was posted at both nursing stations and was on the CNA assignment sheet along with interventions.  Observation of the high risk resident rooms, 07/28/11 at 2:30 PM, revealed any self-harm objects were removed. All plastic trash bags were removed, long electrical cords were tied with plastic ties to shorten the length of the cords, plastic bags covering respiratory and suction equipment were removed and items were covered with clean towels. All staff were trained not to leave plastic trash bags around that were not in use.  Review of the attendance record for a Quality Assurance Committee meeting held on 07/27/11, addressing the facility's Immediate Jeopardy and the actions taken to resolve the jeopardy, were reviewed and the medical director, staff and managers were present.	F 490		
F 520 SS=J	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.  The quality assessment and assurance	F 520	F520 QAA Committee-Members/Meet Quarterly/Plan  In addition to the acceptable Allegation of Compliance on July 28, 2011, the center has taken the following actions:  1. Resident #1 no longer resides at center. 2. Following the incident on 7/24/11, the Administrator ensured that all environmental hazards were identified and removed and residents at risk for suicide were identified, interventions implemented, and provided adequate supervision.	08/20/2011



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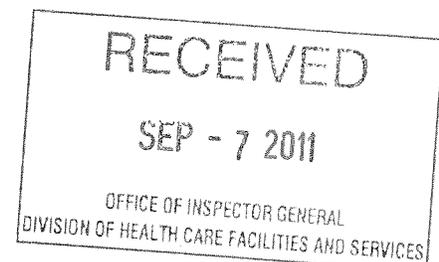
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F 520	Continued From page 60 committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.  A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.  Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.  This REQUIREMENT is not met as evidenced by: Based on interview, training record and closed record review, it was determined the facility failed to identify quality deficiencies regarding quality assessment activities necessary; and to develop and implement appropriate plans of action to address the care of three (3) of six (6) sampled residents admitted with diagnoses of mental illness (Resident #1, #2 and #4). The facility failed to recognize the need to train staff on care of psychiatric residents and to recognize the signs and symptoms of suicidal ideation/history of suicide attempts. The facility failed to recognize the need to develop and implement policies; and to train and evaluate staff compliance with supervision of these residents. The facility failed to recognize the need to identify and correct the lack of comprehensive and accurate Minimum Data Set (MDS) assessments which resulted in failure to develop/revise comprehensive care	F 520	3. No staff have worked past 7/27/11 without having received education regarding psychotic symptoms, and suicide prevention to include detection of early warning signs of major mood changes or possible suicidal ideation and the procedure to obtain and provide appropriate interventions. A list of residents with history of suicidal ideation or past suicide attempts is now posted at the nursing station and on the nurse aide assignment sheets. The center has developed and implemented procedures to include documented two hour rounds on all residents to be completed by nurse and nursing assistant. Any resident exhibiting early warning signs of suicidal ideations will be placed on increased supervision. All staff responsible for completion of the RAI and CAA processes were re-educated by the Regional Director of Clinical Reimbursement on 8/4/11, regarding the RAI and CAA processes and requirement to make a comprehensive assessment of a resident's needs and develop/revise comprehensive plans of care. The Administrator has been retrained on the requirement to identify environmental hazards and individuals at risk for suicide and implement interventions and provide adequate supervision. by the Regional Director of Clinical Services on 7/27/11. The quality assessment and assurance committee will meet at a minimum of monthly on an on-going basis to identify issues with respect to which quality assessment and assurance activities are necessary, including issues identified that affect or have the potential to affect any residents daily functioning and quality of life. The quality assessment and assurance committee will develop and implement appropriate plans of action, including reviewing and revising policies and procedures, to correct any identified quality deficiencies	



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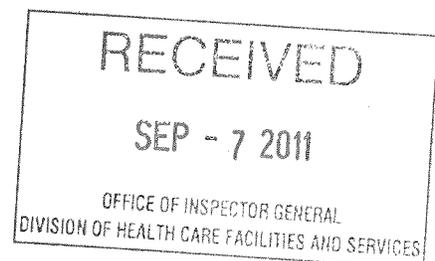
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F 520	Continued From page 61 plans to include interventions recommended by the psychologist (PsychPhD) and interventions by the interdisciplinary care team (IDT) to ensure residents were safe and protected. Resident #1 was admitted with a history of a suicide attempt and paranoid schizophrenia. The resident verbalized thoughts of being better off dead and the facility failed to take actions to address these suicidal ideations. The resident committed suicide on 07/24/11.  The facility identified twelve (12) residents at high risk for suicide.  The facility provided a credible allegation of compliance on 07/28/11. The state agency verified Immediate Jeopardy was removed 07/28/11 prior to exit on 07/29/11; which lowered the scope and severity to a "D" at 42 CFR 483.15 Social Services (F250), 42 CFR 483.20 (F272) Resident Assessment, (F279) Develop	F 520	4. The Administrator will evaluate comprehensive care plan reviews on a weekly basis to assure the IDT is reviewing risk factors and developing interventions to protect residents from suicide. In addition, the Administrator will make observational rounds of staff completing two hour checks on residents three times a week for four weeks to assure staff are competent in performing this function.. The Administrator will complete a walking round daily to ensure environment is free from hazards.. The Administrator will ascertain during daily stand up meetings with department heads (Monday - Friday) if there are any behavior issues and ensure IDT reviews and updates plan of care with appropriate interventions. The Regional Director of Operations or Regional Director of Clinical Services will evaluate all plans as it relates to the supervision of residents, identification of environmental hazards, risks or suicide, and implementation of interventions. on a weekly basis to assure compliance with the written plan. The first QAA meeting was held on July 27, 2011 with the Medical Director in Attendance.. The QAA Committee Meeting, consisting of at minimum, Medical Director, Director of Nursing, and Administrator, will be held weekly for 4 weeks to ensure sustained compliance. All actions related to the plan of correction will be reviewed monthly by the QAA committee to assure sustained compliance. The Regional Director of Operations and/or Regional Director of Clinical Services will attend the QAA committee meeting at a minimum of quarterly to ensure the center is identifying issues with respect to which quality assessment and assurance activities are necessary and that appropriate plans of action are developed and implemented to correct identified quality deficiencies.	
	Comprehensive Care Plans, (F280) Revise Care Plans, 42 CFR 483.25 (F323)-Accidents, 42 CFR 483.75 (F490) Administration and (F520) Quality Assurance, while the facility's administration and the Quality Assurance Committee complete training and monitoring for psychiatric residents safety.  The findings include:  Refer to F250, F272, F280 and F490.  Refer to F323 Based on interview, closed record review and hospital history and physical review, it			



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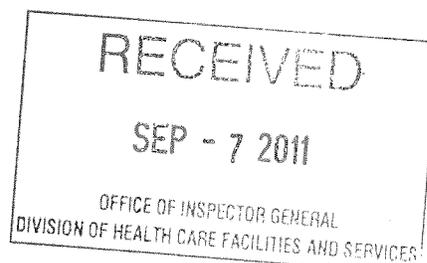
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F 520	Continued From page 62 was determined the facility failed to ensure one (1) of six (6) sampled residents (Resident #1) had a safe environment as free of accident hazards as possible; and that each resident received adequate supervision to prevent accidents. The facility failed to ensure staff was trained and knowledgeable regarding caring for residents with psychiatric diagnoses and how to recognize the signs/symptoms of suicidal ideations or risks. The facility failed to identify and evaluate Resident #1's risk for suicide based on history of suicidal attempt in 1995, suicidal ideations expressed on 01/14/11, 02/08/11, and 04/25/11. The facility failed to identify potential hazards that could be utilized for suicidal acts in the resident's environment. The facility failed to implement interventions, including the need for supervision, to reduce the risk of suicide. The facility failed to make rounds and visualize the resident between the hours of approximately 12 AM and 6:45 AM on 07/24/11 at which time staff discovered the resident had committed suicide.	F 520			
	Review of the facility training records and employee orientation revealed the facility was unable to provide evidence of staff training on the care of psychiatric residents and signs and symptoms of suicidal ideation and behavior. The facility admitted residents with mental illness and behaviors; however, the facility did not identify that staff training was required to ensure appropriate care and services were provided to these residents. Interview with CNA's #4, #5 and #6, on 07/27/11 at 12:10 PM, revealed they had not received training on the care of psychiatric or suicidal residents.				



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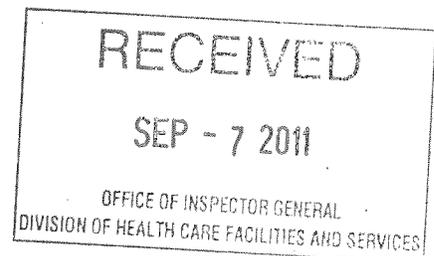
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F 520	<p>Continued From page 63</p> <p>Interview with the Psychologist, on 07/28/11 at 10:15 AM, revealed the facility needed to provide training to staff, at orientation and ongoing, to ensure staff provided the appropriate care for psychiatric residents.</p> <p>Interview with the Administrator, on 07/28/11 at 11:50 AM, revealed she did not have policies and procedures in place to address the care of psychiatric residents or residents with suicidal ideation and staff had not received training on providing care for these residents. She indicated the facility had no policies addressing the identification of hazards and resident risks or development of individualized interventions to ensure residents were protected from accidents. She stated Resident #1 had no recent history of suicide attempts or suicidal ideation. She was not aware the resident expressed thoughts regarding being better off dead during the assessment for the Minimum Data Set (MDS) completed on 02/08/11 or the psychologist's note, dated 04/25/11, which documented the resident's statement regarding not wanting to live.</p> <p>Interview with the Medical Director, on 07/28/11 at 9:45 AM, revealed policies/procedures for care of psychiatric residents and residents with suicidal ideation were not discussed during quality assurance committee meetings until 07/27/11. The facility was not a psychiatric facility and he was not aware nursing staff had not received training regarding how to care for these residents. He stated the facility needed to develop policies to screen residents for mental illness and make the facility safer.</p>	F 520			



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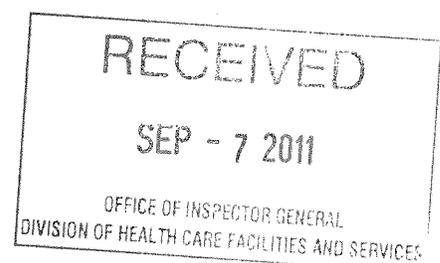
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F 520	<p>Continued From page 64</p> <p>Review of the allegation of compliance dated 07/29/11 with an alleged compliance date of 07/28/11 and interview with the Administrator on 11/28/11 at 11:50 AM and the Regional Consultant on 07/28/11 at 10:30 AM revealed the facility took the following Immediate actions:</p> <ol style="list-style-type: none"> <li>1. All residents were audited to ensure they received the appropriate level of supervision.</li> <li>2. All residents clinical records were audited for histories of suicide attempts or suicidal ideation and a list of high risk residents was developed.</li> <li>3. All high risk residents had their care plans updated and Individualized interventions were developed by the care plan team based on individual resident history.</li> <li>4. All residents determined to be high risk of suicide were assessed to ensure there were no items present in the room that would present a danger to the resident and included removal of plastic trash bags.</li> <li>5. No staff had worked past 07/27/11 without having received education regarding psychotic symptoms, and suicide prevention to include detection of early warning signs of major mood changes or possible suicidal ideation and the procedure to obtain and provide appropriate interventions.</li> </ol>	F 520		



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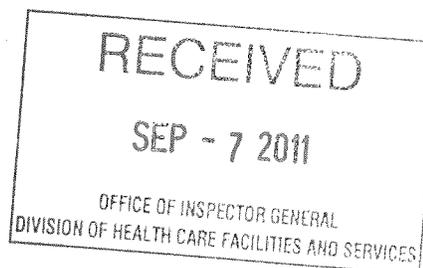
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F 520	Continued From page 65  6. A list of high risk residents is now listed at the nursing stations and on the nurse aide assignment sheets with interventions included on the nurse aide assignment sheets and plan of care.  7. Staff were educated to report immediately any warning signs of major mood changes and/or possible suicidal ideation to their immediate supervisor and at a minimum, residents exhibiting warning signs will be placed immediately on increased supervision. The resident's environment will be assessed for safety and any objects which could be used for self harm will be removed. The resident's family and physician will be notified. The interdisciplinary team will review the resident to ensure appropriate interventions and goals are in place.  8. No nursing staff has worked or will work past 07/27/11 without having received education on the requirement to never leave plastic bags unattended and not in use.  9. No nursing staff have worked or will work past 07/27/11 without having received education regarding the requirement to conduct rounds every two (2) hours and visualize the resident by CNAs and nurses. The completed rounds are documented every two (2) hours, however, the CNAs and nurses are responsible for ensuring these rounds are documented. The Administrator will review the completed documents to ensure	F 520			



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F 520	<p>Continued From page 66</p> <p>rounds are being made every two (2) hours. Any noted noncompliance will result in disciplinary action, up to and including termination.</p> <p>10. All members of the interdisciplinary team (Social Service Director, Interim Director of Nursing, Clinical Reimbursement Coordinator, Life Enrichment Director and Nutrition Services Manager) were educated by the Regional Director of Clinical Services regarding the Behavior Review Process which includes admission and readmission review of behavior residents and ongoing behavior reviews to include the care planning completion process and interdisciplinary development and revision of care plans based upon resident history and current conditions and assessments. The Quality Assurance Committee met on 07/27/11 and reviewed the plan and the state agency's determination. The Medical Director was in attendance at the meeting.</p> <p>Interview with CNA #6, on 07/28/11 at 8:15 AM, revealed she received training to make rounds and see each resident every two (2) hours and to document these rounds. She stated she was trained on recognizing the signs of possible suicide thinking and was to report immediately to the nurse. She also received training on using the CNA assignment sheet for information on taking care of high risk residents.</p> <p>Interview with CNA #4, on 07/28/11 at 9:00 AM, revealed she received training on the list of residents considered high risk for behaviors and possible suicide. This list is at the nursing station</p>	F 520			



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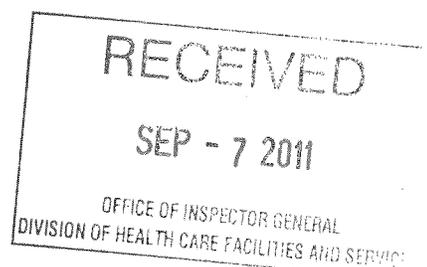
F 520	Continued From page 67 and on the CNA assignment sheet with actions to take. She stated any sign was to be reported to the nurse. There are to be no plastic bags around unless we are using them. She indicated the high risk residents' rooms were reviewed for possible dangerous items and they were removed. Staff must make rounds every two (2) hours and see the resident then document on the sheet.  Interview with LPN #2, on 07/28/11 at 9:20 AM, revealed the nurse was responsible for monitoring rounds every two hours and documenting the rounds. He stated a list of high risk residents was developed and posted at each nursing station, as well as on the CNA assignment sheet with actions to take. He indicated these residents rooms were reviewed for potentially dangerous items and these items were removed and plastic bags were not to be left around the facility. He stated staff were trained to recognize the signs of possible suicide and report to the nurse right away.  Interview with LPN #3, on 07/28/11 at 9:40 AM, revealed all staff were trained on the signs of possible suicide and behaviors and to report this information to the nurse. She stated a list of residents at high risk for suicide was developed and posted at the nursing station and on the CNA assignment sheet along with interventions to take. She stated rounds were to be made by the CNA and the nurse and the nurse was to make sure the rounds were made and all staff were to sign off on the rounds. She indicated resident rooms were reviewed, high risk, and any	F 520		
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F 520	<p>Continued From page 68 dangerous items were removed.</p> <p>Review of the in-service attendance records was completed and all nursing staff were trained on making rounds and seeing the resident every two (2) hours and completing the documentation. The nurse was to supervise and sign off. The Administrator will monitor.</p> <p>Review of the in-service attendance records was completed and all nursing staff were trained on psychotic signs and symptoms and suicide prevention, interventions, and the reporting process. Observation of A High Risk for suicide list of residents, based on the MDS, physician notes, and history, was posted at both nursing stations and was on the CNA assignment sheet along with interventions.</p> <p>Observation of the high risk resident rooms, 07/28/11 at 2:30 PM, revealed any self-harm objects were removed. All plastic trash bags were removed, long electrical cords were tied with plastic ties to shorten the length of the cords, plastic bags covering respiratory and suction equipment were removed and items were covered with clean towels. All staff were trained not to leave plastic trash bags around that were not in use.</p> <p>Review of the attendance record for a Quality Assurance Committee meeting held on 07/27/11, addressing the facility's Immediate Jeopardy and the actions taken to resolve the jeopardy, were</p>	F 520			



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F 520	Continued From page 69 reviewed and the medical director, staff and managers were present.	F 520			

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