

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

PRINTED: 09/11/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/07/2013
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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PAVILION	STREET ADDRESS, CITY, STATE, ZIP CODE 401 EAST 20TH STREET COVINGTON, KY 41014
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{F 000} INITIAL COMMENTS

An off site revisit was conducted and based on the acceptable POC the facility is deemed to be in compliance as alleged on 09/07/13.

{F 000}

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 000	INITIAL COMMENTS An Abbreviated survey investigating KY#00020441 was initiated and concluded on 07/25/13. The allegation was substantiated with deficiencies practice identified.				
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well being for one (1) of three (3) sampled residents (Resident #1). Resident #1's family reported a change in the resident's mental status to the night shift nurse on 06/30/13; however, the nurse failed to assess the resident to determine if an intervention was needed. The day shift nurse reported the change in mental status to the Physician and the resident was sent to the emergency room, for evaluation and treatment and admitted to the hospital. The findings include:		F 000 F 000 Without admitting or denying the validity of the citations, Providence Pavilion provides the following Plan of Correction. This plan of correction is prepared and executed because it is required by the provisions of the state & federal regulations and not because Providence Pavilion agrees with the allegations and citations listed on this statement of deficiencies. Providence Pavilion maintains that the alleged deficiencies do not, individually or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capability to render adequate care as prescribed by the regulations. This plan of correction shall operate as Providence Pavilion's written credible allegation of compliance. By submitting this plan of correction, Providence Pavilion does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Providence Pavilion reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding. Providence Pavilion asserts it will be in substantial compliance with 42 CFR Part 483 subpart B on September 7, 2013.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Marcus Allen

Administrator

8/16/13

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

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F 309 Continued From page 1

Review of the facility's policy "Physician Notification and Change in Condition", undated, revealed it was the policy of the facility to take appropriate action when there was a change in a resident's condition. Further review of the policy revealed a change in mental status was included under the examples listed of a change in condition. In addition, the policy noted the nurse was responsible for performing a full assessment of the resident when there was a change in condition.

Review of Resident #1's medical record revealed the facility admitted the resident on 06/21/13 with diagnoses which included Closed Fracture Unspecified part of the Fibula with Tibia, Depressive Disorder, Muscle Weakness, Urinary Tract Infection and Essential Hypertension (high blood pressure).

Review of Resident #1's medical record also revealed under Physician Orders/ Medication Administration Record the resident was being treated with antibiotics for a Urinary Tract Infection. The resident was admitted (06/21/13) on Amoxicillin (antibiotics) and clavulanate potassium 500 - 125 milligrams (MG) two (2) times a day which was discontinued on 06/24/13 and the resident was ordered, on 06/24/13, Ampicillin 500 MG three (3) times a day.

Further review of Resident #1's medical record revealed the facility's Admission Assessment noted the resident was alert and was oriented to person and place. Further review of routine nursing assessments revealed, on 06/29/13, the resident was alert and oriented to person and general situations.

F 309 **F-309 Provide Care/Services for Highest Well Being**

9/7/13

Providence Pavilion will continue to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

1. Resident #1 was discharged from the facility to the emergency room, per physician order, to receive appropriate medical evaluation on June 30, 2013.
2. All Residents have the potential to be affected by such findings, however, none were affected and all issues noted in the CMS 2567 have been subsequently corrected. The facility will prevent similar issues occurring by implementation of the following practices, noted in section 3.
3. The Director of Nursing (DON)/Rehabilitation Unit Nurse Manager (NM will re-educated professional nursing staff on or before September 7, 2013 of the need to immediately re-assess any resident who has a significant change in condition. This education focused on what a change of condition is.

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F 309	Continued From page 2 Review of Resident #1's medical record revealed a progress note on 06/30/13 at 10:18 AM revealed the family reported the resident had confusion especially during the night with delusions, hallucinations, and increased behaviors. The progress note also revealed family wanted something to be done right then and was upset and angry this was not addressed on night shift. In addition the note indicated the Physician was contacted and the resident was sent out to the hospital emergency room and admitted. Review of prior progress notes revealed no other reports of a change in the resident's mental status. Review of Resident #1's medical record revealed the Physician Discharge Summary, not dated, had under final diagnosis Urinary Tract Infection and Confusion. Interview with Licensed Practical Nurse (LPN) #1, on 07/25/13 at 8:10 PM, revealed she took care of Resident #1 the night of 06/29/13 and early morning 06/30/13. The LPN stated when she was doing her morning med pass the resident's daughter reported the resident had increased confusion and was talking to people who were not there. The LPN further stated she informed the daughter she would tell the dayshift nurse and would call the Physician. Further interview with the LPN revealed she did inform the dayshift nurse but did not call the Physician and did not assess the resident during her shift. She stated the resident was supposed to have a full assessment and she should have assessed the resident. Interview, on 07/25/13 at 7:12 PM, with LPN #2,	F 309	who to contact after their re-assessment, and the appropriate documentation of the change in condition. After the completion of initial re-education, the DON will begin to conduct Biweekly Change of Condition spot quizzes (for 4 weeks) with professional nurses to ensure the nurses are able to identify a significant change. 4. In order to ensure compliance: (a) Results of the spot quizzes with professional nurses will be submitted to the Providence Pavilion Quality Assurance (Q/A) committee, with the committee determining the need for further education. (b) The DON/NM will conduct audits of the 24-hour report sheets three (3) times per week for 3 weeks, and then one (1) time weekly for 2 weeks to ensure that any possible change in condition has been appropriately assessed and if warranted reported to the attending physician. Reports of these audits will be provided weekly to the Providence Pavilion Q/A committee, with the committee determining the need for further monitoring.		

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F 309	Continued From page 3 who worked the morning of 06/30/13, revealed that morning when doing medication pass the family reported the resident had increased confusion, delusions and behaviors during the night. She stated the family was upset and demanded something be done, and she informed them the night nurse had not reported any concern about the resident. The LPN stated when she was in the room she did not observe any unusual behaviors, but had notified the Physician and the resident was then sent out. The LPN further stated an assessment should have been done that night on the resident according to facility protocol. Interview, on 07/25/13 at 8:21 PM, with the Nurse Manager (NM) revealed the night nurse (LPN #1) should have assessed the resident on 06/30/13, but did not go into the room to assess the resident. The NM further stated when the nurse was told by the family the resident was having increased confusion she should have assessed the resident at that time because the resident was having a change in status and failed to do so. She also stated it was important for the nurse to do the assessment so the Physician could have been notified there was a change in status.	F 309	5. Providence Pavilion alleges compliance as of September 7, 2013.		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to	F 312	F-312 ADL Care Provided For Dependent Residents. Providence Pavilion will continue to provide a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming and personal and oral hygiene.	9/7/13	

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F 312	Continued From page 4 maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's Bath - Shower Policy (Document B-105 undated) it was determined the facility failed to provide the necessary services to maintain grooming and personal hygiene for one (1) of three (3) sampled residents (Resident #2) as evidenced by baths/showers were not given, to Resident #2, as specified by the shower schedule. The findings include: Review of the facility's policy titled, "Bath - Shower Policy", revealed each resident would receive a bath/shower as specified by the Bath - Shower schedule, when needed and when requested by the resident. Review of Resident #2's record, revealed the facility admitted the resident on 07/15/13, with diagnoses which included Hip Fracture with Replacement, Iron Deficiency Anemia, Hypertension and Unspecified Osteoporosis. Interview, on 7/25/13 at 8:32 AM, with Resident #2 revealed the resident had received two (2) baths, one was thorough and the other was a partial bath, since admission to the facility. Interview further revealed staff did not provide partial baths or personal care on a daily basis. Further interview revealed he/she requested no	F 312	<ol style="list-style-type: none"> 1. Resident # 2 received a shower on 7/25/13 by a female staff member of the therapy department. The resident's plan of care was updated on 7/25/13 to include the residents request not to have members of the opposite sex give her showers. 2. All Residents have the potential to be affected by such findings, however, none were affected and all issues noted in the CMS 2567 have been subsequently corrected. The facility will prevent similar issues occurring by implementation of the following practices, noted in section 3. 3. The Director of Nursing (DON) & Rehabilitation Unit Nurse Manager (NM) will re-educate nursing staff on or before September 7, 2013 on the "Bath Shower Policy. Re-education will include the right of the resident to have a shower when needed, and when requested by the resident. Nursing staff were also re-educate that when/if a resident verbalizes a special request (such as no showers given by the opposite sex) that request must be immediately delivered to the NM, 		

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F 312	Continued From page 5 baths/showers be given by the opposite sex. Review of the facility's Shower Schedule revealed the resident was to receive a bath/shower on Sundays and Wednesdays on the 7AM - 3PM shift. Review of the facility's Task Details Report revealed a staff member, of the opposite sex, documented the resident received baths/showers. Interview, on 07/25/13 at 5:25 PM, with State Registered Nurse Aide (SRNA) #4 revealed the resident requested only aides, of the same sex bathe him/her, therefore he/she assisted the resident to the bathroom sink and set up supplies for the resident to bathe him/herself. The aide assisted the resident with dressing and documented the resident was bathed. The aide also stated he/she felt the resident did not always wash his/her private parts. Further interview revealed the aide reported the resident's request to the nurse. Interview, on 07/25/13 at 4:34 PM, with the Nurse Manager (NM) revealed baths/showers were to be performed per the shower schedule, when needed and per resident request. She stated Resident #2 was to receive a bath/shower on Sundays and Wednesdays. She further stated she was not aware of the resident's request and the staff's lack of communication was the problem. Interview, on 07/25/13 at 6:18, with Registered Nurse (RN) #1 revealed SRNA #4 told her the resident did not want an aide, of the opposite sex, to bathe him/her. Interview, on 07/25/13 at 6:50 PM, with the NM revealed the nurse should have communicated	F 312	and documented on the 24-hour report sheet. The NM has also reviewed the facility shower schedule to ensure that all residents have their showers scheduled per their request. 4. The DON/NM will conduct audits of the nurse aid shower sheets three (3) times per week for 3 weeks, and then one (1) time weekly for 2 weeks to ensure that resident's are receiving their showers per the schedule. The NM will also conduct audits of the 24-hour report sheets three (3) times per week for 3 weeks, and then one (1) time weekly for 2 weeks reviewing them for any special requests from residents. Findings of these reviews will be incorporated into the resident's care plan. Reports of these audits will be provided weekly to the Providence Pavilion Q/A committee, with the committee determining the need for further monitoring. 5. Providence Pavilion alleges compliance as of September 7, 2013.		

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F 312 Continued From page 6

the resident's request to the oncoming staff as well as to her (NM). She stated accomodation should have been made to provide the resident with bathing. She further defined bathing as using soap and water to cleanse the resident, not dressing a resident.

Interview, on 07/25/13 at 7:22 PM, with RN #1 revealed she should have documented the request in the Nurses Notes, on the Care Plan and passed on the information to the next shift.

Interview, on 07/25/13 at 7:22 PM, with Licensed Practical Nurse (LPN) #3 revealed SRNA #4 reported the resident's request to her and she documented it on the 24 hour report (used to inform oncoming staff of changes in a resident's condition or treatment). Further interview revealed she failed to document the request on the Care Plan, Nurse Aide Care Plan and Nurses Notes. She further stated it was her responsibility to inform the NM of the request.

F 312