

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-C 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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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{F 000}	<p>INITIAL COMMENTS</p> <p>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.</p>	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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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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	F 000	F 000	
F 226 SS=D	<p>A Recertification Survey was conducted 08/20/13 through 08/22/13. Deficiencies were cited with the highest Scope and Severity of a "D".</p> <p>483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy, it was determined the facility failed to implement written policies and procedures that prohibit misappropriation of resident property for one (1) of fifteen (15) sampled residents (Resident #1).</p> <p>Resident #1 complained to facility staff of missing jewelry including a garnet bracelet and three (3) rings which the resident described as having sentimental value. However, there was no documented evidence the facility had conducted a thorough investigation or reported the allegation to state agencies.</p> <p>The findings include:</p> <p>Review of the facility "Resident Abuse, Neglect and Misappropriation of Property" Policy, dated 10/12/11, revealed each resident had the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary</p>	F 226	<p>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.</p> <p>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.</p> <p>Providence Pavilion asserts it will be in substantial compliance with 42 CFR Part 483 subpart B on September 7, 2013.</p>	9-6-13

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

TITLE

(X5) DATE

Marian Dunn

ADMINISTRATOR

9-6-13

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 226	<p>Continued From page 1</p> <p>seclusion. This facility had zero tolerance concerning any type of abuse or neglect of its residents or misappropriation of their property. All allegations and reports of resident abuse, neglect, mistreatment, and misappropriation of resident property were to be promptly and thoroughly investigated. Within twenty-four (24) hours of the time of discovery of an allegation, the facility Administrator or his/her designee would notify the Office of Inspector General (OIG) State Survey Agency and Adult Protective Services of the allegation.</p> <p>Review of Resident #1's medical record revealed diagnoses which included Cerebral Vascular Accident (CVA) and Depression. Review of the Quarterly Minimum Data Set (MDS) dated 06/18/13, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a fifteen (15) indicating no cognitive impairment.</p> <p>During a Quality of Life Assessment-Resident Interview on 08/21/13 at 2:45 PM, Resident #1 revealed she/he had received Avon jewelry including a garnet bracelet and three (3) rings for Christmas which turned up missing shortly afterward. She/he explained it was just costume jewelry; however, the jewelry was sentimental to her/him and she/he was unsure of the date the jewelry was noted to be missing. Further Interview revealed Resident #1 had a top drawer in her/his dresser which locked and also had a box in the closet which locked; however, was unsure if the items were locked up when they were noted to be missing. She stated she had told the Social Services Director (SSD) about the missing jewelry and her/his room was searched; however the jewelry was not found.</p>	F 226	<p>F-226 Staff Treatment of Residents</p> <p>Providence Pavilion has developed and implemented policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property.</p> <ol style="list-style-type: none"> 1. Resident #1 missing items were initially investigated by the Social Services Director. When the resident notified the OIG during the annual survey, the survey team completed the investigation and subsequently reported the missing items to the state agency as required by regulation. 2. No Residents were found to be affected by the deficient practice 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. 	9/7/13	

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F 226	<p>Continued From page 2</p> <p>Review of the "Service Concern Missing Item Form" revealed Resident #1 had reported the missing bracelet on 01/07/13, and the resident had last seen the bracelet on 12/23/12 after dinner and had noted a drawer open on 12/24/13. The Form was completed by the SSD.</p> <p>Interview on 08/22/13 at 2:15 PM with the Social Services Director, revealed Resident #1 had told her about the missing bracelet and she had completed a "Service Concern Missing Item Form" months ago. She further stated the resident had also told someone else prior to notifying her of the missing jewelry because when she offered to search the room, the resident declined saying the room had already been searched. The SSD was unaware of anyone else reporting the missing jewelry to her.</p> <p>Continued interview with the SSD revealed the resident also reported Avon rings missing; however, she did not write it down on the Form. She stated, normally if there was a missing item, the facility would notify the state agencies, Crime Stoppers and the police; however, this resident complained frequently of her/his jewelry pins missing and the jewelry always reappeared in the laundry. Further interview revealed normally if there was a missing item, she would notify the Administrator and investigate with a room search and interview all the staff who were in the building during the period of time in which the item was lost. She stated she had failed to completed an investigation related to the missing jewelry and she was unsure if she had notified the Administrator of the allegation.</p> <p>Interview on 08/22/13 at 2:50 PM with the Administrator revealed she did not remember if</p>	F 226	<p>3. The Director of Nursing (DON)/Rehabilitation Unit Nurse Manager (NM) will re-educate Providence Pavilion staff on or before September 7, 2013 on the correct process of reporting Resident abuse, Neglect & Misappropriation of resident property. This education will focus on Definition of Resident abuse, Neglect, and Misappropriation of Resident property & also on the correct procedure of reporting & investigating Abuse, Neglect, and Misappropriation of Resident property.</p> <p>The Administrator has reviewed the procedure with the Director of Social Work on the proper Investigation procedure of Abuse, Neglect, & Misappropriation of property allegations. After the completion of the re-education, the DON will begin to conduct Biweekly spot quizzes (for 4 weeks) with Providence Pavilion Staff in order to ensure that staff can identify abuse, neglect, & Misappropriation of resident property and who to report to.</p>		

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F 226	Continued From page 3 the SSD had notified her of Resident #1's missing jewelry. She stated the SSD and the administrative nurses were to complete investigations related to misappropriation allegations and she was to review the investigations. She further stated she was also responsible for notifying state agencies within twenty-four (24) hours of an allegation and sending in the final report of the investigation within five (5) days. She stated this allegation should have been investigated and reported.	F 226	The Administrator will conduct weekly audits of the missing items log to ensure that all reports of missing items have been thoroughly investigated and reported.		
F 441 SS-D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441	4. In order to ensure compliance: (a) Results of the spot quizzes will be submitted to the Providence Pavilion Quality Assurance (Q/A) committee, with the committee determining the need for further education. (b) The Administrator will conduct audits of the missing items log weekly for 3 weeks, and then one (1) time monthly for 2 months to ensure that any possible missing item is reported to the Administrator and the OIG as required. 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 441	Continued From page 4 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility policies, it was determined the facility failed to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Observation of the supper meal on the Purpose unit revealed a Certified Nursing Assistant (CNA) used improper hand hygiene while serving meal trays. Continued observation of the supper meal on the Purpose Unit revealed the staff member plating food behind the steam table was handling utensils, plates, and tray tickets with gloved hands, and with the same gloved hands was touching food on the plates including tomatoes, lettuce, and cheese and was handling sandwiches The findings include:	F 441	F-441 Infection Control Providence Pavilion has an established Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. 1. (a) Employee was immediately re-educated on the proper procedure to remove gloves after touching trash & to wash hands after touching trash, prior to assisting a resident with their food. (b) The food service employee was immediately re-educated on the proper procedure of handling food and the wearing of gloves on the tray line. 2. No Residents were found to be affected by the deficient practice 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. (a) The Director of Nursing (DON) & Rehabilitation Unit Nurse Manager (NM) will re-educate Providence Pavilion Staff	9/7/13	

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F 441	<p>Continued From page 5</p> <p>1. Review of the facility "Procedure for Hand Washing" Policy, undated, revealed handwashing was necessary to remove transient micro-organisms from hands.</p> <p>Observation on 08/20/13 at 5:42 PM of the meal service at supper on the Purpose Unit, revealed Certified Nursing Assistant (CNA) #1 used gloved hands to push the lid of the trash can open with a plate and emptied a plate of food in the trash can. She then placed the plate in the sink and without removing the soiled gloves and washing her hands, went to the tray line and delivered a plate of food. She cut a sandwich with a knife while handling the sandwich with the soiled gloves, and then delivered a bowl of soup to another resident. Further observation revealed CNA #1 started placing lids on the plates which were on the meal cart and moved glasses around on the cart, touching the tops of the glasses. The CNA then removed the soiled gloves and washed her hands.</p> <p>Interview on 08/20/13 at 6:14 PM with CNA #1, revealed she should have washed her hands after emptying the plate in the trash can and prior to continuing to serve meal trays because there was the chance of cross contamination.</p> <p>Interview on 08/22/13 at 6:20 PM with the Director of Nursing/Infection Control Nurse, revealed staff should wash hands prior to serving meal trays, especially after touching anything which could contaminate the hands.</p> <p>2. Review of the facility "Dietary Services-Proper Food Handling" Policy, revealed food should be prepared and served with clean tongs, scoops, forks, spoons, spatulas or other suitable</p>	F 441	<p>on or before September 7, 2013 on the correct procedure to follow when wearing gloves: this re-education will also include CDC guidelines of when to wear gloves & when to wash hands.</p> <p>(b) The Dietary Director will re-educate dietary staff on or before September 7, 2013 on the proper food handling of food on the trayline. This re-education will specifically focus on: the proper use of gloves-when & how to use, Hand washing protocol, proper handling of foods on the trayline, proper use of utensils, and the handling of meal tickets during dining service.</p> <p>4. The DON/NM will conduct audits of Resident mealtime services three (3) times per week for 3 weeks, and then one (1) time weekly for 2 weeks to ensure that all employees are following the correct protocols for the wearing of gloves and the washing of hands.</p> <p>The Dietary manager/DON will also conduct audits of the dietary trayline workers three (3) times per week for 3 weeks, and then</p>

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F 441	<p>Continued From page 6 equipment.</p> <p>Further observation of the Purpose Unit supper meal service on 08/20/13 at 5:45 PM revealed Dietary Aide #1 was plating food behind the steam table handling tongs, spoons, plates, and tray tickets with gloved hands. Dietary Aide #1 was observed to use the same gloved hands to move food around on the plates without the use of utensils including tomatoes, lettuce, and cheese and was also handling sandwiches without utensils.</p> <p>Interview on 08/20/13 at 6:05 PM with Dietary Aide #1 revealed she could see how touching food with the same gloved hands in which she touched the serving utensils, plates, and tray tickets could cause cross contamination.</p> <p>Interview on 08/22/13 at 4:00 PM with the Dietary Manager, revealed there was the risk of contamination if the server was touching food with the same gloved hands in which she was touching plates, serving utensils, and tray tickets. She stated she observed tray line and did not recognize this was happening.</p>	F 441	<p>one (1) time weekly for 2 weeks to ensure that the proper food handling occurs during resident mealtime. Reports of these audits will be provided weekly to the Providence Pavilion Q/A committee, with the committee determining the need for further monitoring.</p> <p>5. Providence Pavilion alleges compliance as of September 7, 2013.</p>		

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{K 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.	{K 000}		

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

TITLE

(X6) DATE

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K 000 INITIAL COMMENTS

CFR: 42 CFR 483.70(a)

Building: 01 4th Floor

Plan Approval: 1992

Survey under: 2000 existing

Facility type: SNF

Type of structure: Five story Type I (Fire Resistive).

Smoke Compartment: Four smoke compartments

Fire Alarm: Manual initiating devices located at exits. Smoke detectors located in all corridors and resident rooms. Fire Alarm panel updated in 2010.

Sprinkler System: Complete automatic (wet) sprinkler system

Generator: Type II diesel, installation date unknown by facility.

A standard Life Safety Code survey was conducted on 08/21/13. Providence Pavilion was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census the day of the survey was seventy-three (73) and the facility is licensed for eighty-two (82). Deficiencies were cited with the highest deficiency identified at an "D".

K 000 K 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 483.70 (a) on September 7, 2013.

RECEIVED
SEP - 6 2013
BY: _____

K 039 NFPA 101 LIFE SAFETY CODE STANDARD

K 039

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Marcus Allen* TITLE ADMINISTRATOR (X6) DATE 9-6-13

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	(X) PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 039 SS=D	<p>Continued From page 1</p> <p>Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit access was maintained, per NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, two (2) rooms, two (2) residents, staff and visitors. The facility is certified for eighty-two (82) beds with a census of seventy-three (73) on the day of the survey. The facility failed to ensure the exit corridors in the Purpose Hall of the facility were four (4) feet in width.</p> <p>The findings include:</p> <p>Observation, on 08/21/13 at 10:44 AM with the Maintenance Supervisor, revealed the corridor (Purpose Hall) in one (1) smoke compartment to be 40 inches (40) in width. The corridor was approximately twenty-five (25) feet in distance. This deficiency affected rooms 451 and 452.</p> <p>Interview, on 08/22/13 at 10:50 AM with the Maintenance Supervisor revealed this has been the layout since they have been there.</p> <p>Interview, on 08/21/13 at 12:32 PM with the Administrator, revealed this has been that way and could not understand why the Cabinet would not have said something on the initial survey if this was deficient.</p>	K 039	<p>K039 NFPA 101 Life Safety Code Standard Providence Pavilion does ensure that its Residents, Visitors, & Staff have clear and unobstructed egress from all exits within the facility.</p> <p>1. (a) The entrances to rooms #451 and #452 were designed in accordance with Kentucky Building Code Sections 1017.2 Corridor width Exceptions 2 & 6. Exception 2 allows corridors to be as narrow as 36" in width if serving less than 50 people. In fact this corridor serves 2 residents since both rooms #451 and #452 are private accommodations.</p> <p>(b) Exception 6 for corridors in I-2 construction allows the entrance halls to be as narrow as 36" corridor width since bed movement would not be a factor. Approval was obtained from the Kentucky Department of Housing, Buildings and Construction, and from the regulatory agency for the occupancy and licensing of this unit, since rooms #451 and #452 are used for ambulatory patients. (Please see # 3 below)</p> <p>(c) The fact that Providence Pavilion received a Certificate of Occupancy from the State of Kentucky and was licensed by the appropriate regulatory agency confirms that our design rationale for the narrower hallways was acceptable to the authorities at the time of initial approval.</p> <p>2. If the previous exceptions to corridor width approved in 2010 are no longer granted, Providence Pavilion request a waiver of the requirement under K039 NFPA 101 regarding corridor width.</p>	9/2/13	

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

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K 039	Continued From page 2 19.2.3.3* Any required aisle, corridor, or ramp shall be not less than 4 ft (1.2 m) in clear width where serving as means of egress from patient sleeping rooms. The aisle, corridor, or ramp shall be arranged to avoid any obstructions to the convenient removal of nonambulatory persons carried on stretchers or on mattresses serving as stretchers. Exception No. 1: Aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall be not less than 44 in. (112 cm) in clear and unobstructed width. Exception No. 2: Exit access within a room or suite of rooms complying with the requirements of 19.2.5.	K 039	The request for waiver and the noted required plan of compliance should be granted based on the following practices, noted in section 3, 4 and 5. 3. (a) A safety check has been conducted on September 5, 2013 by the Med Corp Ambulance Company in rooms #451 and #452 that demonstrated safe entry and egress for residents, even those requiring emergency transport on a stretcher. (b) The Director of Nursing/Designee for the facility will continue to approve future admissions to rooms #451 and #452, ensuring that the potential admissions are ambulatory residents. 4. In order to ensure compliance: (a) The Nurse manager responsible for the unit in question will audit weekly each resident admitted to rooms #451 and #452 to ensure the residents remain ambulatory. These audits will be submitted to the Providence Pavilion Quality Assurance (Q/A) committee to determine frequency of ongoing audits. 5. Providence Pavilion alleges compliance as of September 7, 2013.		