

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

*Acceptable date 5/11/12*  
PRINTED: 05/18/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/28/2012
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NAME OF PROVIDER OR SUPPLIER  PINE MEADOWS HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40504
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F 000	<p>INITIAL COMMENTS</p> <p>AMENDED</p> <p>An Abbreviated/Partial Extended Survey investigating KY#00018065 and KY#00018070 was conducted 03/23/12 through 04/06/12. KY#00018070 and KY#00018065 were substantiated with deficiencies cited. After Supervisory review by the State Agency and the Centers for Medicare and Medicaid Services (CMS) the investigation was re-opened and concluded on 04/28/12. Two (2) Immediate Jeopardy situations were identified during the survey.</p> <p>Immediate Jeopardy and Substandard Quality of Care (SQC) was identified on 03/29/12 and determined to exist on 02/01/12 at 42 CFR 483.13 Resident Behavior and Facility Practice, F-224 at a Scope and Severity of a "J", 42 CFR 483.20 Resident Assessment, F-281 at a Scope and Severity of a "J", and 42 CFR 483.75 Administration, F-490 and F-514 at a Scope and Severity of a "J". The facility failed to ensure services met professional standards and to prevent neglect of a resident who showed a change in condition. Review of the facility's policy entitled, "Emergency Care, General Guidelines For" revealed it was the basic responsibility of the Licensed Nurse to always take, report, and record vital signs when a resident's condition changed, and record the details and exact time of the condition change of a resident.</p> <p>Licensed Practical Nurse (LPN) #1 documented on 02/01/12 at 7:45 AM that he found Resident #2 pale and without respirations. He documented he auscultated the resident's lung sounds and</p>	F 000	F 000	
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RECEIVED  
MAY 29 2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 5-29-12
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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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F 000	<p>Continued From page 1</p> <p>none where "heard". The documentation stated no pulse or blood pressure could be obtained and he suctioned Resident #2. He further documented the Assistant Director of Nursing (ADON) was at the resident's bedside at 7:50 AM suctioning him/her and a complete assessment of Resident #2's vital signs was performed, with none being obtained. Review of the facility's video camera data revealed no visual evidence LPN #1 provided the emergency care to Resident #2 as documented on 02/01/12 at 7:45 AM. The video camera data revealed on 02/01/12 at 8:03:15 AM LPN #1 entered Resident #2's room and exited the room at 8:03:45 AM, thirty (30) seconds later. The LPN was observed on the video to re-enter Resident #2's room at 8:09:10, approximately six (6) minutes later with the ADON. The facility's failure to implement policy and procedures to ensure services provided met professional standards and to prevent neglect of a resident who showed a change in condition was likely to cause serious injury, harm, impairment, or death. An acceptable Credible Allegation of Compliance was received on 04/04/12 and the Immediate Jeopardy was verified removed on 04/04/12 as alleged. After supervisory review, F-490 was deleted.</p> <p>Immediate Jeopardy and Substandard Quality of Care (SQC) was identified on 04/25/12 and determined to exist on 03/14/12 at 42 CFR 483.13 Resident Behavior and Facility Practice, F-223 and F-226 at a Scope and Severity of a "J" and 42 CFR 483.75 Administration, F-490 at a Scope and Severity of a "J". The facility failed to protect residents from abuse, failed to implement its Abuse Policies by failing to immediately remove staff from direct resident care after staff</p>	F 000		
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F 000	<p>Continued From page 2</p> <p>reported an allegation of abuse to the Supervisor, and failed to ensure other residents were protected by allowing the alleged abusive staff to continue to provide resident care. In addition, the facility's Administration failed to ensure staff implemented its Abuse Policies and failed to ensure residents were protected during the investigation of the allegation by allowing the Supervisor to make the determination whether or not abuse had occurred.</p> <p>On 03/14/12, a Medical Records personnel reported to the Supervisor that she was walking down the hall and witnessed State Registered Nursing Assistant (SRNA) #9 "slap" Resident #1 on the top of his/her left hand at approximately 5:30 AM, while providing care to the resident in the resident's room. She stated she heard it "pop". Interview with the Medical Records personnel revealed she reported the incident to the Supervisor immediately. She stated another aide, SRNA #10 was in the room at the time and exited the room and closed the door after the incident, leaving SRNA #9 in the room with Resident #1. Review of the facility's policy "Protection of Residents During Abuse Investigation" revealed employees accused of participating in an alleged abuse will be immediately reassigned to duties that did not involve resident contact until the findings of the investigation were reviewed by the Administrator. Interview with SRNA #9 revealed she was interviewed by the Supervisor and was allowed to continue to work, for approximately one (1) hour, providing direct care to residents until the end of her shift. Interview with the Supervisor revealed she assessed Resident #1 for injuries and questioned SRNA #9 and SRNA #10, who was</p>	F 000		

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F 000	<p>Continued From page 3</p> <p>also in the room at the time of the allegation, and determined abuse, had not occurred. An acceptable credible Allegation of Compliance was received on 04/27/12 and the Immediate Jeopardy was verified removed on 04/28/12 as alleged.</p> <p>Based on the above findings, it was determined Immediate Jeopardy was identified to exist on 02/01/12 through 04/27/12, and was removed on 04/28/12.</p> <p>Deficiencies cited were 42 CFR 483.13 Resident Behavior and Facility Practice, F-223, F-224 and F-226 at a S/S of a "J"; 42 CFR 483.20 Resident Assessment, F-281 at a Scope and Severity of a "J" and F-278 at a Scope and Severity of a "D"; 42 CFR 483.75, Administration, F-490, at a S/S of a "J", and F-514 at a S/S of a "J". Substandard Quality of Care (SQC) was identified in the areas of 42 CFR 483.13, F-223, F-224 and F-226. The highest Scope and Severity was a "J".</p> <p>After Immediate Jeopardy was verified removed, based on the facility's two AOCs, the scope and severity of the Immediate Jeopardy deficiencies at a "J" was lowered to a "D" while the facility develops, implements, and monitors a Plan of Correction to prevent recurrence of the deficient practice.</p>	F 000		
F 223 SS=J	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual,</p>	F 223		

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F 223	<p>Continued From page 4 or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system to protect residents from abuse. On 03/14/12, the facility received an allegation of abuse; however, the alleged perpetrator was not immediately removed from direct resident care and continued to provide resident care. Review of the facility's policy "Protection of Residents During Abuse Investigation" revealed employees accused of participating in an alleged abuse would be immediately reassigned to duties that did not involve resident contact until the findings of the investigation were reviewed by the Administrator. On 03/14/12, at approximately 5:30 AM, a Medical Records personnel witnessed State Registered Nursing Assistant (SRNA) #9 "slap" Resident #1 on the top of his/her left hand while providing care to the resident in the resident's room. Interview with the Medical Records personnel revealed she heard it "pop". She stated another aide, SRNA #10 was in the room at the time, exited the room, and closed the door after the incident, leaving SRNA #9 alone in the room with Resident #1. Per interview, the Medical Records personnel reported the incident to the Supervisor/Licensed Practical Nurse (LPN) #3 immediately. Interview with SRNA #9 revealed she was interviewed by the Supervisor/LPN #3 about the incident; however, she was allowed to continue to provide direct care</p>	F 223	<p>F 223</p> <p>This plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p> <p>1) SRNA #9 was suspended 3/14/2012 after the Administrator was notified of the incident. Resident #1 was assessed immediately after the incident was reported by the Supervisor for any redness or bruising after incident was reported. No reddened area or bruising was noted to resident #1.</p> <p>2) All facility residents were assessed on 4/27/12 to ensure there was no patterned bruising or unexplainable marks on skin to indicate possible abuse. Each resident, that could answer, was asked how they were treated in the facility. The assessment was performed by the DON, ADON, QA, SDC, Unit Coordinators as well as eight(8) nurses from a sister facility to ensure no other resident was effected.</p> <p>SRNA #9 was suspended on the morning of 3/14/2012 after the DON and Administrator were notified of the allegation. Resident #1 was assessed by the Supervisor on 03/14/2012. The Supervisor and the Charge Nurse/ RN#1 were reeducated on 03/26/2012 on the facility policy on abuse and neglect, specifically the requirement that an employee be suspended immediately once an allegation of abuse or neglect is made against them. SRNA #9 and SRNA #10 were re-educated on 3/25/2012 and on 3/26/2012 by the Social Services Director on the facility's policy on abuse and neglect.</p>	
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F 223	<p>Continued From page 5</p> <p>to residents, for approximately one hour, until the end of her shift. Interview with the Supervisor/LPN #3 revealed she assessed Resident #1 for injuries and questioned SRNA #9 and SRNA #10. She stated she determined abuse had not occurred and therefore did not immediately remove SRNA #9 from resident care. Interview with the Administrator revealed the facility failed to protect residents from alleged abuse.</p> <p>The facility's failure to protect residents from abuse placed residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 04/25/12 and was determined to exist on 03/14/12. The facility was notified of the Immediate Jeopardy on 04/25/12. Substandard Quality of Care (SQC) was identified at 42 CFR 483.13, Resident Behavior and Facility Practice.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AoC) on 04/27/12 with the facility alleging removal of the Immediate Jeopardy on 04/28/12. Observations, staff interviews, and in-service record reviews were conducted to verify removal of Immediate Jeopardy as alleged in the acceptable AoC on 04/28/12 prior to exiting the facility on 04/28/12. However, non-compliance continued to exist at 42 CFR 483.13 Resident Behavior and Facility Practice, with a scope and severity of a "D", as the facility had not completed the development and implementation of the Plan of Correction (PoC) to ensure the facility established and maintained an effective system to ensure residents remain free from abuse.</p> <p>The findings include:</p>	F 223	<p>The Social Services Director began re-education of all facility staff on the abuse and neglect policy on 3/26/2012 with 100% of staff completion (minus one employee on FMLA) which was completed on 4/25/2012. Attendance was monitored and anyone who did not participate in the re-education training was given 1:1 training by the Social Services Director until 100% of employees were re-educated by 04/25/2012.</p> <p>To ensure no other residents were affected, interviewable residents were asked by staff how they were treated in the facility and if they had any complaints about their care.</p> <p>Direct care staff observed residents for unexplained bruising and reddened areas while providing care. On 4/27/2012, all residents in the facility had a skin assessment for signs of abuse by the DON, ADON, QA Nurse, Staff Development Nurse, three (3) MDS Nurses, Unit Coordinators, Restorative Nurse, Wound Care Nurse and Seven (7) management Nurses.</p> <p>3) An in-service to all employees was presented by the Social Services Director on 3/26/12, 3/27/12 and 4/07/12. All employees were in-serviced except for one (1) employee on FMLA. Supervisor and Charge Nurse/RN were re-educated on 3/26/2012 the Social Services Department on the facility abuse and neglect policy. SRNA #9 and #10 were reeducated. No determination will be made in the outcome of an abuse investigation without the review and approval of the Administrator or designee.</p>		

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F 223	<p>Continued From page 6</p> <p>Review of the facility's policy titled, "Reporting Abuse to Facility Management", updated 07/2001, revealed the facility would not condone resident abuse by anyone, including staff members. Further review of the policy revealed physical abuse was defined as hitting, slapping, pinching, kicking, etc. Review of the facility's policy titled, "Protection of Residents During Abuse Investigations", updated 10/99, revealed "employees accused of participating in the alleged abuse will be immediately reassigned to duties that do not involve resident contact or will be suspended without pay until the findings of the investigation have been reviewed by administrator".</p> <p>Review of Resident #1's medical record revealed the facility admitted the resident on 07/06/10 with diagnoses which included Alzheimer's Disease and Anxiety. Review of the Quarterly Minimum Data Set (MDS), dated 01/19/12, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of three (3) which indicated the resident was severely impaired cognitively. Further review of the MDS revealed the facility assessed the resident as requiring limited to extensive assistance with his/her Activities of Daily Living (ADLs), and was occasionally incontinent of urine.</p> <p>Review of the facility's "Self Reported Incident Form", (initial report) revealed there was an allegation of verbal and physical abuse on 03/14/12. Further review of the report revealed a Medical Record personnel reported to the Supervisor/LPN #3 that she witnessed SRNA #9 swat Resident #1 on the top of the hand while</p>	F 223	<p>4) The QA Nurse, DON or ADON will review all allegations of abuse directly after an investigation is completed to ensure the proper procedure is followed by the facility. Information gathered from QA review will be shared with Administrator and/or DON for review and if needed, necessary changes will be made. Monitoring will continue for six (6) months, if no deficient areas are noted, the abuse QA will be presented to the QA committee to be discontinued.</p> <p>QA tools were created to monitor and assure that new hires are in-serviced on abuse and neglect that quarterly mandatory in-services on abuse and neglect are scheduled and that proper roster attendance is kept. QA will also continue to interview ten (10) staff members monthly including supervisors on knowledge of forms of abuse and what to do if you suspect or witness abuse. QA will also use tool to review follow-up of allegations of abuse to ensure that the facility policy and procedure was followed.</p> <p style="text-align: right;">Completion Date:</p>	4/29/2012
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F 223	<p>Continued From page 7</p> <p>providing care as she walked past Resident #1's room at 5:30 AM. The report indicated the Medical Records personnel was walking past Resident #1's room where SRNA #9 and SRNA #10 were providing care to Resident #1's roommate when she heard Resident #1 asking for help. The report stated the Medical Records personnel heard SRNA #9 tell Resident #1, "you have to wait". The Medical Records personnel turned around and headed back towards the room watching through the door which was half open. The report stated as she watched the SRNA's giving care to the roommate, Resident #1 called out for help again and was getting out of the bed. SRNA #9 went over to Resident #1 and told the resident to sit down in a firm voice. Resident #1 put his/her hand down on the bed in the wet area and SRNA #9 swatted his/her hand away and told him/her not to put his/her hand in the wet area. Further review of the report revealed the Supervisor was immediately notified by the Medical Records personnel. The Supervisor initiated an investigation by having the SRNA's and the Medical Records personnel write statements and staff interviews were initiated.</p> <p>Review of the Medical Records personnel's written statement, attached to the report, revealed when Resident #1 put his/her hand in the wet area on the bed, SRNA #9 firmly said "No don't do that, look you've already made a mees, and I said keep you hand out". This is where SRNA #9 slapped Resident #1's hand and said "quit". The written statement further indicated when SRNA #9 saw the Medical Records personnel at the door she instructed SRNA #10 to shut the door. Her statement indicated she went immediately and told the Supervisor/LPN #3.</p>	F 223		
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F 223	<p>Continued From page 8</p> <p>Interview with the Medical Record personnel, on 03/23/12 at 3:38 PM, revealed she witnessed the above incident from the hallway, on 03/14/12 at 5:30 AM, and the door was half way open. She stated SRNA #9 slapped Resident #1's hand and she heard it "pop". She stated she went to the Supervisor/LPN #3 and reported what she saw and said she told the Supervisor that SRNA #9 was verbally rude to Resident #1 and slapped his/her hand.</p> <p>Interview with the Supervisor/LPN #3, on 03/26/12 at 4:00 PM, revealed on 03/14/12 when the Medical Records personnel reported the alleged abuse to her, she went to Resident #1's room and talked with SRNA #9 and SRNA #10 separately. She stated both SRNA's denied the abuse had occurred and she asked them both to write statements. She stated she assessed Resident #1, looking up to the resident's elbows and didn't see any redness or bruising. She stated she didn't see a problem with SRNA #9 continuing to work because it was almost the end of the shift and SRNA #9 was completing her paper work and writing her statement.</p> <p>Interview with SRNA #9, on 03/26/12 at 4:38 PM, revealed on 03/14/12 she went into the room with SRNA #10 to attend to Resident #1's roommate. She stated Resident #1 went to the bathroom and came back and sat on his/her bed. She stated Resident #1 said he/she was soaked so she went over to Resident #1 and the bed was soaked. She stated Resident #1 started to reach for the wet spot and she took the resident's hand and placed it on his/her lap. She said SRNA #10 was leaving the room so she asked her to close the</p>	F 223		

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F 223	<p>Continued From page 9</p> <p>door. She further stated she went on and cleaned the bed and assisted Resident #1 with getting dressed. She stated it was about 5:45 AM when the Supervisor/LPN #3 told her there had been an allegation that she had slapped Resident #1's hand. She said she told the Supervisor/LPN #3 she did not slap Resident #1's hand. She stated she finished with Resident #1's care and completed her shift. She stated she provided care for other residents because she had the residents on half of the 400 hall to care for before finishing her shift.</p> <p>Interview with SRNA #10, on 03/26/12 at 4:53 AM, revealed on 03/14/12 she asked SRNA #9 to help her with Resident #1's roommate. She stated Resident #1 got up and was almost naked so SRNA #9 went to help Resident #1 because he/she was soaked in urine. She stated she was concentrating on Resident #1's roommate and had her back to SRNA #9 and Resident #1. She stated she did not see anything. She stated when she left the room she closed the door and SRNA #9 continued to provide assistance to Resident #1. She said she was then interviewed by the Supervisor/LPN #3 and instructed to write a statement.</p> <p>Review of the facility's final investigation revealed after completing the interviews, Administrative staff determined there was no intent to harm the resident. It stated, SRNA #9 spoke in a loud voice and this may be misinterpreted. SRNA #9 would remain off the schedule until she attended additional education on communication techniques to use with people with Dementia.</p> <p>Interview with the DON, on 03/29/12 at 10:18 AM,</p>	F 223		
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NAME OF PROVIDER OR SUPPLIER  PINE MEADOWS HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40504		
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F 223	<p>Continued From page 10</p> <p>revealed the Supervisor/LPN #3 notified her of the incident on 03/14/12 at 7:15 AM when she was on her way to the facility. She stated when she arrived at the facility, at 8:00 AM on 03/14/12, she reviewed the written statements. She stated the Medical Records personnel wrote two (2) statements and the first said SRNA #9 slapped the resident's hand and the second statement said she slapped the resident's wrist. She continued to state that both SRNA's in the room stated it didn't happen.</p> <p>Interview with the Administrator, on 03/29/12 at 10:30 AM, revealed according to the facility's policy, he should have been notified before 7:15 AM, SRNA #9 should have been removed from resident care first, and should have been sent home.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AoC) on 04/27/12 that alleged removal of the Immediate Jeopardy (IJ) on 04/28/12, based on the following:</p> <ol style="list-style-type: none"> <li>1. SRNA #9 was suspended on 03/14/12 after the DON and Administrator were notified of the allegation.</li> <li>2. Resident #1 was assessed by the Supervisor on 03/14/12 and then moved to the day area on Unit 2 where he/she could be monitored.</li> <li>3. The Supervisor and the Charge Nurse/RN #1 were reeducated on 03/26/12 on the facility policy of abuse and neglect, specifically the requirement that an employee be suspended immediately once an allegation of abuse or neglect is made against them.</li> </ol>	F 223			

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F 223	<p>Continued From page 11</p> <p>4. SRNA #9 and SRNA #10 were reeducated on 03/15/12 and 03/26/12 by the Social Service Director on the facility's policy on abuse and neglect.</p> <p>5. The Social Service Director began re-education of all facility staff on the Abuse Neglect Policy on 03/26/12 with 100% of staff completion (minus one employee on Family Medical Leave) which was completed by 04/25/12. Attendance was monitored and anyone that did not participate in the re-education training, was given 1:1 training by the Social Service Director until 100% of employees were reeducated by 04/25/12.</p> <p>6. To ensure no other residents were affected, interviewable residents were asked by staff how they were treated in the facility if they had any complaints about their care.</p> <p>7. Direct care staff observed residents for unexplained bruising and reddened areas while providing care.</p> <p>8. On 04/27/12, all residents in the facility had a skin assessment for signs of abuse by the DON, ADON, QA Nurse, Staff Development Nurse, three (3) MDS Nurses, Unit Coordinators, Restorative Nurse, Wound Care Nurse and seven (7) Management Nurses.</p> <p>9. No determination will be made in the outcome of an abuse investigation without the review and approval of the Administrator or designee.</p> <p>10. The QA Nurse will monitor weekly, all</p>	F 223		
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F 223	<p>Continued From page 12</p> <p>allegations of abuse to ensure the proper procedure is followed by facility staff.</p> <p>11. QA tools were created to monitor and assure that new hires are in-serviced on abuse and neglect, that quarterly mandatory in-services on abuse and neglect are scheduled and that proper roster attendance is kept. QA will also continue to interview ten (10) staff monthly including supervisors on knowledge of forms of abuse and what to do if you suspect or see abuse. QA will also use tool to review follow-up of allegations of abuse to ensure that the facility policy and procedure was followed.</p> <p>On 04/28/12, the State Agency verified the immediacy of the IJ was removed and the facility implemented corrective actions as alleged in the AoC, effective 04/28/12, based on the following:</p> <p>Interview with the Supervisor/LPN #3, on 04/28/12 at 11:00 AM and RN #1, on 04/28/12 at 11:15 AM, revealed they received education on 03/26/12 on the facility's policy of abuse and neglect, specifically the requirement that an employee be suspended immediately once an allegation of abuse or neglect was made against them. Interview with the Supervisor/LPN #3 further revealed she was instructed to immediately remove the alleged perpetrator from direct resident care. Review of the in-service education documentation revealed the education was conducted on 03/26/12.</p> <p>Interview with SRNA #9 and SRNA #10, on 04/28/12 at 11:15 AM, revealed they were re-educated on 03/15/12 and 03/26/12 by the Social Service Director on the facility's policy on</p>	F 223		

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F 223	<p>Continued From page 13</p> <p>abuse and neglect. Review of the education documentation revealed the education was conducted on 03/15/12 and 03/26/12.</p> <p>Interview with the Social Service Director, on 04/28/12 at 10:15 AM, revealed she began re-education of all facility staff on the Abuse Neglect Policy on 03/26/12 with 100% of staff completion (minus one employee on Family Medical Leave) which was completed by 04/25/12. Attendance was monitored and anyone that did not participate in the re-education training, was given 1:1 training by the Social Service Director until 100% of employees were re-educated by 04/25/12. Review of the facility's documentation revealed the facility provided education to all staff between 03/26/12 and 04/25/12 on the abuse and neglect policy. The education sign-in sheets were compared to the facility staff roster to ensure 100% of staff received the education.</p> <p>Interviews were conducted with the following staff to verify the facility had educated them and to ensure their knowledge of the facility's abuse and neglect policy: Dietary Manager on 04/28/12 at 11:00 AM, Assistant Dietary Manager, on 04/28/12 at 11:05 AM, Cook #17, on 04/28/12 at 11:15 AM, Dietary Aide #18, on 04/28/12 at 11:20 AM, Dietary Aide #19, on 04/28/12 at 11:25 AM, Dietary Aide #11, on 04/28/12 at 11:30 AM, Housekeeper #12, on 04/28/12 at 11:35 AM, Cook #13 on 04/28/12 at 11:40 AM, Housekeeping #14 on 04/28/12 at 11:50 AM, Supervisor/LPN #3, on 04/28/12 at 11:00 AM, RN #4, on 04/28/12 at 11:55 AM, Restorative Nurse/LPN #14, on 04/28/12 at 11:45 AM, SRNA #17, on 04/28/12 at 11:00 AM, SRNA #6, on</p>	F 223		
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F 223	<p>Continued From page 14</p> <p>04/28/12 at 11:05 AM, Unit Coordinator/LPN #11, on 04/28/12 at 11:25 AM, LPN #12, on 04/28/12 at 11:35 AM, SRNA #15, on 04/28/12 at 11:30 AM, Housekeeper #20, on 04/28/12 at 11:45 AM, ADON, on 04/28/12 at 11:40 AM and SRNA #16, on 04/28/12 at 11:55 AM. All of the above staff was knowledgeable of the facility's abuse and neglect policy and verified they had received re-education by the facility.</p> <p>Interview with the DON, on 04/28/12 at 10:20 AM, revealed the facility completed skin assessments on 100% of the resident population and identified no concerns with the skin assessments. Review of the resident census revealed the facility had one hundred-two (102) residents on 04/28/12. Review of the skin assessments revealed the facility completed 102 skin assessments on 04/28/12 and no concerns were identified.</p> <p>Interview with the Administrator, on 04/26/12 at 3:30 PM, revealed no determination will be made in the outcome of an abuse investigation without the review and approval of the Administrator or designee as per the facility's policy.</p> <p>Interview with the QA Nurse, on 04/28/12 at 1:00 PM revealed she will monitor weekly, all allegations of abuse to ensure the proper procedure is followed by facility staff. She further stated QA tools were created to monitor and assure that new hires were in-serviced on abuse and neglect, that quarterly mandatory in-services on abuse and neglect were scheduled and that proper roster attendance was kept. Further interview revealed QA will also continue to interview ten (10) staff monthly including supervisors on knowledge of forms of abuse and</p>	F 223			

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F 223	Continued From page 15 what to do if you suspect or see abuse. QA will also use tool to review follow-up of allegations of abuse to ensure that the facility policy and procedure was followed.  The facility remained out of compliance at a lower Scope and Severity of a "D", an isolated deficiency with potential for more than minimal harm in order for the facility to develop and implement the Plan of Correction (PoC).	F 223		
F 224 SS=J	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, video review, and facility policy review, it was determined the facility failed to ensure each resident was free from neglect for one (1) of eleven (11) sampled residents (Resident #2). The facility failed to ensure necessary care and services were provided to Resident #2 immediately upon the identification of a change in condition. On 2/01/12, Licensed Practical Nurse (LPN) #1 noted Resident #2 was without respirations and pale; however, LPN #1 stated he did not attempt to physically assess the resident's vital signs or attempt to suction the resident after identifying the change in condition. Furthermore, the	F 224	F 224  This plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	

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F 224 Continued From page 16 facility's video data for 02/01/12 revealed LPN #1 entered the resident's room and exited thirty (30) seconds later and returned to the room approximately six (6) minutes later with the Assistant Director of Nursing (ADON). The facility could provide no evidence that the staff attempted to physically assess the resident's observed change in condition immediately in an effort to provide necessary care and services. The resident was pronounced deceased at the facility on 02/01/12 at 9:00 AM.

The facility's failure to protect residents from neglect placed residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 03/29/12 and was determined to exist on 02/01/12. The facility was notified of the Immediate Jeopardy on 03/29/12. Substandard Quality of Care (SQC) was identified at 483.13, Resident Behavior and Facility Practice.

The facility provided an acceptable Credible Allegation of Compliance (CAoC) on 04/04/12 with the facility alleging removal of the Immediate Jeopardy on 04/04/12. Observations, staff interviews, and inservice record reviews were conducted to verify removal of Immediate Jeopardy as alleged in the acceptable AoC on 04/04/12 prior to exiting the facility on 04/28/12. However, non-compliance continued to exist at 42 CFR 483.13 Resident Behavior and Facility Practice, with a scope and severity of a "D", as the facility had not completed the development and implementation of the Plan of Correction (PoC) to ensure the facility established and maintained an effective system to ensure residents remain free from neglect.

F 224 1) Resident #2 was no longer in the facility at the time of the survey; therefore, no corrective action could take place. LPN #1 was suspended, pending the outcome of the investigation/survey. It is important to note that the video surveillance camera only records events happening in the hallways of the facility and not in the resident's room. Therefore, the employee documentation was not in question by the facility administration. Furthermore, interview of LPN #1 and video camera review determined that at 8:02:33 LPN #1 entered the room of resident #2 and observed her lying in bed. LPN #1 left room to inquire with SRNA why she was in bed at 8:03:18. LPN #1 re-entered the resident room and was in the room for approximately thirty seconds until 8:03:45. Interview with LPN #1 revealed that LPN #1 saw resident without respirations, pallor color and no visible signs of life. Resident #2 was a DNR and had been receiving Hospice services for diagnosis of end stage dementia. It was also noted that both the family and Hospice wanted comfort measures only. Upon seeing no visible signs of life, LPN #1 went to inform SRNA #2 that resident had expired and needed post mortem care. Interview with LPN #1 and record review does not indicate mucus coming out of the mouth of resident #2. LPN #1 further stated that that after the incident occurred and he was documenting, his "thoughts were disorganized" and part of the note should in fact have been an addendum, as he did not suction the resident, but the ADON did.

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F 224	<p>Continued From page 17</p> <p>The findings include:</p> <p>Review of the facility's "Emergency Care, General Guidelines For" policy undated, revealed the purpose was to provide emergency care to a resident in need of urgent service. Continued review revealed it was the basic responsibility of the Licensed Nurse to always take, report, and record vital signs when a resident's condition had changed and record the details and exact time of the condition change.</p> <p>In an interview with the Director of Nursing (DON), on 03/29/12 at 11:07 AM, revealed this was the facility's policy for providing emergency care to residents. The DON stated she would expect her licensed nurses to perform an assessment of a resident with a change in condition that would include obtaining vital signs. She stated nurses should ensure their documentation is accurate and should not "falsify" their documentation.</p> <p>Review of Resident #2's medical record revealed the facility admitted the resident on 10/09/01 with diagnoses which included a history of Aspiration Pneumonia and Alzheimer's Disease. Review of the Comprehensive Care Plan for Nutrition, dated 11/11, revealed staff was to provide the resident with assistance if he/she started to choke.</p> <p>Review of the Quarterly Minimum Data Set (MDS), dated 11/20/11, revealed the facility assessed the resident as severely impaired with daily decision making and totally dependent on staff for all Activities of Daily Living (ADLs).</p> <p>Review of the State Registered Nursing Assistants' (SRNAs) care plan revealed the resident was on aspiration precautions.</p>	F 224	<p>The ADON entered resident #2's room to verify residents death, after completing her assessment that she confirmed resident #2 had expired.</p> <p>Per survey interview of facility Medical Director on 4/6/2012 at 5:40PM revealed if a resident experienced a change in condition as in the case of resident #2 he would expect the nurse to assess for signs of life. He further stated the nurse should assess for respirations, pulse, pallor and rigidity. Interview of LPN #1 on 4/13/2012 revealed LPN #1 stated he did not see resident #2's chest rising, her pupil was dilated, her mouth was gaping open and her color was pale. LPN#1 states, he "did check the pulse in her wrist and there was no pulse." LPN #1 further acknowledged that his assessment of the above finding all confirmed that resident #2 had expired. LPN #1 then followed the facility policy regarding notification of a supervisor and summoned the ADON to resident #2's room. Because it is not the facility policy for nurses to pronounce death of a resident, the official pronouncement of death was made by the Hospice nurse when she arrived to the facility.</p> <p>2) To the best of the facility's knowledge, Pine Meadows believes this to be an isolated incident involving only the resident cited in the deficiency. The facility completed a Medical Records review of thirty-seven (37) individual charts on 4/3/2012. These charts were of residents who had expired in the facility during the previous six months or who had been sent out to the hospital due to change of condition in the past six months. These charts were reviewed to indicate whether the nurses involved assessed the resident's acute change-in-condition and responded according to facility policy. All records were found to be in compliance.</p>	
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F 224	Continued From page 18  Interview, on 03/26/12 at 9:25 PM with SRNA #12, revealed he worked the 11:00 PM to 7:00 AM shift the night of 01/31/12. He stated his shift was over at 7:00 AM on 02/01/12. The SRNA stated he had been assigned to Resident #2's care that night. According to SRNA #12 every time he checked on the resident during that shift he/she was "okay". He stated Resident #2 was cleaned and dressed for breakfast prior to the end of his shift. SRNA #12 stated the last time he saw the resident was at approximately 6:15 AM to 6:30 AM on 02/01/12 and he/she was "okay" at that time.  Observation, on 03/28/12 at 3:33 PM, of the video camera data for 02/01/12 revealed at 7:45:08 AM the Social Services Director entered Resident #2's room and exited at 7:45:32 AM. Interview, on 03/29/12 at 8:50 AM with the Social Services (SS) Director, revealed she went in to talk to Resident #2's roommate. The SS Director stated she couldn't remember if she "looked at" Resident #2. Video camera data review revealed at 7:48:22 AM State Registered Nursing Assistant (SRNA) #2 entered Resident #2's room and exited at 7:48:40. Interview, on 03/29/12 at 9:47 AM with SRNA #2, revealed she couldn't remember for sure why she went into Resident #2's room on 02/01/12. She stated it may have been because Resident #2's roommate "cried out for help" as he/she "usually" did. SRNA #2 stated she thought Resident #2 was okay that morning; however, she could not "swear" that was the case.  Review of the Nurse's Notes, dated 02/01/12 written by Licensed Practical Nurse (LPN) #1	F 224	3) New policies and procedures were created and implemented on 3/29/2012 to include the following: 1) A policy entitled "Assessment of Residents when Found to Have a Change in Condition" This policy specifically addressed the immediate assessment of a resident exhibiting a change in condition (attachment A), 2) A revision to the policy "Charting and Documentation" was made to emphasize the importance of timely and accurate charting in the Resident Medical record (attachment B), 3) Staff were again, in-serviced on the policy "General Guidelines for Emergency Care" (attachment C) and 4) "Procedure for Nursing Report and Rounds" (attachment D). All Registered Nurses and Licensed Practical Nurses were in-serviced on all of the above mentioned policies starting on 3/29/2012. The in-services were completed for all nurses by 4/4/2012. The above mentioned in-services were conducted by the DON, ADON, Staff Development Nurse, Unit 2 Coordinator, QA Nurse, Restorative Nurse and the Weekend Nursing Supervisor.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/28/2012
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NAME OF PROVIDER OR SUPPLIER  PINE MEADOWS HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40504
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F 224	<p>Continued From page 19</p> <p>revealed at 7:45 AM Resident #2 had been "cleaned up" and was in bed waiting to be "gotten up" for breakfast. Interview, on 03/26/12 at 2:07 PM with LPN #1, revealed he went into Resident #2's room to check on his/her roommate. He stated he noted Resident #2 was still in bed and should have been up, so he immediately left the room to check on why the resident was still in bed. Observation of the video camera data revealed at 8:02:33 AM LPN #1 entered and immediately exited Resident #2's room. Further interview with the LPN revealed he returned to Resident #2's room and observed that the resident's skin color was pale, "paler than usual" and he/she was not breathing. In an additional interview, on 03/27/12 at 11:10 AM with LPN #1, he stated Resident #2 had "mucous coming out of" his/her mouth when he found him/her pale and without respirations. Further interview, on 03/29/12 at 9:20 AM with LPN #1, revealed he performed a visual assessment of the resident when he found him/her pale and without respirations. The LPN stated he did not have a stethoscope with him. He stated he observed the resident having no respirations. LPN #1 stated his thoughts were "disorganized" when he found the resident in this condition. He stated twice that he did not "touch" the resident and stated that he made no attempts to suction the resident prior to going to find the ADON, despite having documented in the Nurse's Notes that when he walked into Resident #2's room to provide care to the resident's roommate, he noted Resident #2 had a "pale looking color" and had no respirations. The Note further detailed LPN #1 auscultated for lung sounds with none heard and "no pulse and B/P" (blood pressure) could be obtained. LPN #1 documented Resident #2's</p>	F 224	<p>4) The facility will monitor nurse compliance with the existing and revised policies and procedures on an ongoing basis by including them in the nurse competency reviews. These reviews are usually conducted annually in the months of May through July. Due to the recent changes, the facility has chosen to move up the nurse competency reviews regarding assessments and documentation. These reviews began on 3/29/2012. On 3/31/2012 the facility also created and implemented a "Condition Change Documentation 24-hour report Follow-up" form (attachment E) that will be reviewed at the interdisciplinary team's morning meeting to ensure proper follow-up and assessment of residents with a change in condition. The interdisciplinary team consists of the: DON, ADON, Quality Assurance Nurse, Unit Coordinators, Social Services, Therapy, MDS Nurse, Wound Nurse Restorative Nurse. In addition, on March 31, 2012 the facility implemented a new policy in regard to the "24-hour Report and Condition Change form" (attachment F). The above form and policy revisions were specifically implemented on March 31, 2012 to utilize as tools for monitoring and ensuring consistent assessment and follow-up of resident care.</p>	
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F 224	<p>Continued From page 20</p> <p>head was "inclined" at thirty (30) degrees and he/she was suctioned using the suction machine at the bedside. Review of the video camera data revealed the LPN was observed to return to Resident #2's room at 8:03:15 AM and exit the room at 8:03:45 AM, thirty (30) seconds later. Continued interview with LPN #1 revealed the ADON "rushed into the room", noted the resident had secretions in his/her mouth, and proceeded to suction him/her. He stated the secretions were "foamy". Additionally, he stated he and the ADON examined Resident #2 and found he/she did not have a pulse or respirations.</p> <p>Interview, on 03/27/12 at 3:25 PM with the ADON, revealed on 02/01/12 someone had informed her she needed to go "look" at Resident #2. She stated she could not remember if it was LPN #1 or not. She stated she went to Resident #2's room and noted the resident had "some secretions, not thick, kind of foamy" in his/her mouth. The ADON stated there was a suction machine at the bedside so she immediately started to suction the resident. When asked if LPN #1 had suctioned the resident prior to her coming to the room, she stated "I don't think so". She stated she put on gloves, "checked" the resident's mouth, and there was nothing there. The ADON stated vital signs were attempted; however, none were obtained. The ADON indicated Resident #2's skin was "warm the whole time". Further observation of the video camera data revealed LPN #1 returned to the resident's room with the ADON at 8:09:10 AM, approximately six (6) minutes later. Further review of the Nurse's Notes revealed the LPN documented at 7:50 AM the ADON was notified of the change in Resident #2's condition and she</p>	F 224	<p>The DON or ADON will conduct the QA Condition Change assessments by selecting five residents a month for six months from each unit of the facility (ten charts total) and reviewing that accurate assessments were completed for the selected residents. The DON or ADON will be assuring the accuracy of the assessments on Conditions Change. The DON or ADON monitor the outcomes of the ten (10) chart review each month. If compliance is found during the initial six month period the facility will then review five resident charts from each unit (ten charts total) on quarterly basis from then on out. QA will assure compliance of this regulation through monthly auditing and discussion at the QA committee meeting about the facilities Abuse and Neglect policy. QA audits will be completed by the QA nurse.</p> <p style="text-align: right;">Completion Date:</p>	4/29/2012
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F 224	<p>Continued From page 21</p> <p>suctioned the resident. Further interview with the LPN revealed no assessment was performed until the ADON was present in Resident #2's room. Further review of the Nurse's Notes revealed a Note written by another nurse that stated Resident #2 was pronounced deceased at 9:00 AM.</p> <p>Interview, with the Director of Nursing (DON) on 03/29/12 at 11:07 AM, revealed if a resident needed to be suctioned she would expect the nurse to do so. She stated her expectations of the licensed nurses would be that if someone was not breathing, the nurse would check for a pulse and respirations. She stated if a resident had a change in condition the nurse should do a complete assessment that would include obtaining vital signs.</p> <p>Interview, on 04/06/12 at 5:40 PM, with the Medical Director revealed if a resident experienced a change in condition as in the case of Resident #2, he would expect the nurse to assess for signs of life. He stated the nurse should assess for respiration, pulse, pallor (paleness of the skin) and rigidity.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AoC) on 04/04/12 that alleged removal of the Immediate Jeopardy (IJ) on 04/04/12, based on the following:</p> <ol style="list-style-type: none"> <li>1. LPN #1 was suspended pending completion of an investigation into the allegations.</li> <li>2. The DON conducted a review on 04/02/12 of all residents' medical records who had expired in the facility in the past six (6) months. All records</li> </ol>	F 224		
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F 224	<p>Continued From page 22 were found in compliance.</p> <p>3. Medical record reviews were completed on 04/03/12 of thirty-seven (37) individual charts of residents who had expired in the facility in the past six (6) months or who had been sent to the hospital due to a change in condition in the past six (6) months.</p> <p>4. New policies and procedures were created and implemented immediately on 03/29/12. A policy entitled "Assessment of Residents when found to have a Change in Condition" which addressed the immediate assessment of a resident exhibiting a change in condition. A revision of the policy, "Charting and Documentation" to emphasize the importance of timely and accurate charting in residents' medical records. Staff inservices were conducted on these policies. Re-inservices were conducted on the "General Guidelines for Emergency Care" and "Procedure for Nursing Report and Rounds" policies. All Registered Nurses and Licensed Practical Nurses were inserviced on all the above policies starting on 03/29/12, and completed on 03/31/12, with the exception of two (2) nurses. One nurse who was out of the country, and one currently on Family Medical Leave. These two (2) nurses will not be allowed to work on the floor with residents until they are inserviced on the policies as well.</p> <p>5. The DON and ADON will audit medical records for any resident that expires in the facility. The audit will include review for compliance with the above cited policies and procedures.</p> <p>6. Monitoring of nurse compliance with the existing and revised policies and procedures will</p>	F 224		
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F 224	<p>Continued From page 23</p> <p>be performed by including them in the nurse competency reviews. These reviews were started on 03/29/12, and were seventy-six (76) percent complete on 04/04/12.</p> <p>7. On 03/31/12, the facility also created and implemented a "Condition Change Documentation 24 Hour Report Follow-up" form that will be reviewed at the Interdisciplinary Team's (IDT) morning meeting. A new policy was implemented in regards to the new form. The form and policy revisions were implemented on 03/31/12 to utilize as tools for monitoring.</p> <p>8. The facility will Quality Assurance (QA) condition change assessments by selecting five (5) resident medical records from the facility's two (2) units for a total of ten (10) records to review that accurate assessments were completed for the selected residents. If compliance is found during the initial six (6) month period, then five (5) records from the two (2) units will be reviewed on a quarterly basis. These QA audits will be completed by the QA nurse.</p> <p>On 04/06/12 it was verified the immediacy of the IJ was removed and the facility implemented corrective actions as alleged in the AoC, effective 04/04/12 based on the following:</p> <p>Observation, on 04/06/12 from 10:45 AM until 11:00 AM revealed the new or revised policies were present in the Policies and Procedures books located at the Nurse's Station on each of the two (2) units.</p> <p>Interviews with staff including Registered Nurse (RN) #3 on 04/06/12 at 11:05 AM, RN #2 on</p>	F 224		
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F 224	<p>Continued From page 24</p> <p>04/06/12 at 4:30 PM, Licensed Practical Nurse (LPN) #8 at 10:22 AM, LPN #6 at 10:40 AM, LPN #7 at 10:50 AM, LPN #10 at 10:56 AM, LPN #4 at 3:05 PM and LPN #9 at 3:41 PM revealed they all were aware of the new policies and procedures that had been implemented or revised: "Assessment of Residents when found to have a Change in Condition", "Charting and Documentation", "General Guidelines for Emergency Care" and "Procedure for Nursing Report and Rounds". They all were aware of the "Condition Change Documentation 24 Hour Report Follow-up" form and new policy related to it.</p> <p>Review of the facility's inservices and interviews, on 04/06/12 at 9:25 AM, with the Staff Development Nurse and Director of Nursing (DON) revealed the facility had inserviced all licensed staff beginning 03/29/12 related to the new policies and procedures with the exception of two licensed staff who was out of the country or on medical leave and would not be allowed to return to work until inserviced. Further interview revealed to validate staff's competency related to the inservice, staff was given a change of condition scenario and they had to document a nurse's note describing their assessment of the change in condition, such as obtaining vital signs. Additionally, interview and review of the facility's chart audits revealed thirty-seven (37) individual charts of residents who had expired in the facility in the past six (6) months or who had been sent to the hospital due to a change in condition in the past six (6) months were reviewed to ensure there were no other residents effected related to not appropriately assessing a resident who had a change of condition.</p>	F 224		
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F 224	Continued From page 25  Interview on 04/08/12 at 4:10 PM with the Administrator revealed all but two (2) staff had been inserviced on the new or revised policies and procedures and new form. According to the Administrator, new employees will receive the information in orientation. He stated a new QA audit was in place to monitor residents' change of condition and ensure accurate assessments were completed by the licensed nursing staff.  The facility remained out of compliance at a lower Scope and Severity of a "D", an isolated deficiency with potential for more than minimal harm in order for the facility to develop and implement the Plan of Correction (PoC).	F 224			
F 226 SS=J	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  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 have an effective system to ensure implementation of their written policy to prohibit mistreatment, neglect and abuse of residents for one (1) of eleven (11) sampled residents (Resident #1). The facility failed to follow their "Protection of Residents During Abuse Investigations" policy. On 03/14/12, the facility received an allegation of abuse alleging that Medical Records personnel witnessed State	F 226	F 226  This plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.  1) SRNA #9 was suspended 3/14/2012 after the Administrator was notified of the incident. Resident #1 was assessed immediately after the incident was reported by the Supervisor for any redness or bruising after incident was reported. No reddened area or bruising was noted to resident #1.		

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F 226

Continued From page 26  
Registered Nursing Assistant (SRNA) #9 "slap" Resident #1 on top of his/her hand at approximately 5:30 AM. The facility allowed SRNA #9 to continue to work her shift without reassigning her duties from providing resident contact or immediately suspending the staff. The Supervisor/Licensed Practical Nurse (LPN) #3 allowed SRNA #9 to work with residents for approximately an hour to an hour and a half after being made aware of an allegation of abuse.

The facility's failure to implement the written policy and protect residents from abuse placed residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 04/25/12 and was determined to exist on 03/14/12. The facility was notified of the Immediate Jeopardy on 04/25/12. Substandard Quality of Care (SQC) was identified at 42 CFR 483.13, Resident Behavior and Facility Practice.

The facility provided an acceptable credible Allegation of Compliance (AoC) on 04/27/12 with the facility alleging removal of the Immediate Jeopardy on 04/28/12. Observations, staff interviews, and in-service record reviews were conducted to verify removal of Immediate Jeopardy as alleged in the acceptable AoC on 04/28/12 prior to exiting the facility on 04/28/12. However, non-compliance continued to exist at 42 CFR 483.13 Resident Behavior and Facility Practice, with a scope and severity of a "D", as the facility had not completed the development and implementation of the Plan of Correction (PoC) to ensure the facility established and maintained an effective system to ensure residents remain free from abuse.

F 226

2) All facility residents were assessed on 4/27/12 to ensure there was no patterned bruising or unexplainable marks on skin to indicate possible abuse. Each resident, that could answer, was asked how they were treated in the facility. The assessment was performed by the DON, ADON, QA, SDC, Unit Coordinators as well as eight(8) nurses from a sister facility to ensure no other resident was effected.

SRNA #9 was suspended on the morning of 3/14/2012 after the DON and Administrator were notified of the allegation. Resident #1 was assessed by the Supervisor on 03/14/2012. The Supervisor and the Charge Nurse/ RN#1 were reeducated on 03/26/2012 on the facility policy on abuse and neglect, specifically the requirement that an employee be suspended immediately once an allegation of abuse or neglect is made against them. SRNA #9 and SRNA #10 were re-educated on 3/25/2012 and on 3/26/2012 by the Social Services Director on the facility's policy on abuse and neglect.

The Social Services Director began re-education of all facility staff on the abuse and neglect policy on 3/26/2012 with 100% of staff completion (minus one employee on FMLA) which was completed on 4/25/2012. Attendance was monitored and anyone who did not participate in the re-education training was given 1:1 training by the Social Services Director until 100% of employees were re-educated by 04/25/2012.

To ensure no other residents were affected, interviewable residents were asked by staff how they were treated in the facility and if they had any complaints about their care.

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F 226	Continued From page 27  The findings include:  Review of the facility's policy titled, "Protection of Residents During Abuse Investigations", updated 10/99, revealed "employees accused of participating in the alleged abuse will be immediately reassigned to duties that do not involve resident contact or will be suspended without pay until the findings of the investigation have been reviewed by administrator".  Review of Resident #1's medical record revealed the facility admitted the resident on 07/06/10 with diagnoses which included Alzheimer's Disease and Anxiety. Review of the Quarterly Minimum Data Set (MDS), dated 01/19/12, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of three (3) which indicated the resident was severely impaired cognitively. Further review of the MDS revealed the facility assessed the resident as requiring limited to extensive assistance with his/her Activities of Daily Living (ADLs), and was occasionally incontinent of urine.  Review of the facility's investigation revealed on 03/14/12 a Medical Records personnel reported that she had witnessed SRNA #9 "swat" Resident #1 on top of his/her hand at approximately 5:30 AM. The Medical Records personnel immediately notified the Supervisor/LPN #3 per the investigation report. The report indicated the Medical Records personnel was walking past Resident #1's room where SRNA #9 and SRNA #10 were providing care to Resident #1's roommate when she heard Resident #1 asking for help. The report states the Medical Records	F 226	Direct care staff observed residents for unexplained bruising and reddened areas while providing care. On 4/27/2012, all residents in the facility had a skin assessment for signs of abuse by the DON, ADON, QA Nurse, Staff Development Nurse, three (3) MDS Nurses, Unit Coordinators, Restorative Nurse, Wound Care Nurse and Seven (7) management Nurses.		

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F 226	<p>Continued From page 28</p> <p>personnel heard SRNA #9 tell Resident #1, "you have to wait". The Medical Records personnel turned around and headed back towards the room watching through the door which was half open. The report stated as she watched the SRNA's giving care to the roommate, Resident #1 called out for help again and was getting out of the bed. SRNA #9 went over to Resident #1 and told the resident to sit down in a firm voice. Resident #1 put his/her hand down on the bed in the wet area and SRNA #9 swatted his/her hand away and told him/her not to put his/her hand in the wet area. Further review of the report revealed the Supervisor was immediately notified by the Medical Records personnel.</p> <p>Review of the Medical Records personnel's written statement, attached to the report, revealed when Resident #1 put his/her hand in the wet area on the bed, SRNA #9 firmly said "No don't do that, look you've already made a mess, and I said keep you hand out". Review of the written statement revealed this is where SRNA #9 slapped Resident #1's hand and said "quit". The written statement further indicated when SRNA #9 saw the Medical Records personnel at the door she instructed SRNA #10 to shut the door. Her statement indicated she went immediately and told the Supervisor/LPN #3.</p> <p>Interview, on 03/26/12 at 3:55 PM, with the Supervisor/LPN #3 revealed the Medical Records personnel reported to her on 03/14/12 that SRNA #9 had chastised the resident and pushed the resident's hand. She stated she spoke to SRNA #9 and SRNA #10, who was also in the resident's room at the time of the incident, and they denied the allegation. She stated, she instructed both</p>	F 226	<p>3) An in-service to all employees was presented by the Social Services Director on 3/26/12, 3/27/12 and 4/07/12. All employees were in-serviced except for one (1) employee on FMLA. Supervisor and Charge Nurse/RN were re-educated on 3/26/2012 the Social Services Department on the facility abuse and neglect policy. SRNA #9 and #10 were reeducated. No determination will be made in the outcome of an abuse investigation without the review and approval of the Administrator or designee.</p> <p>4) The QA Nurse, DON or ADON will review all allegations of abuse directly after an investigation is completed to ensure the proper procedure is followed by the facility. Information gathered from QA review will be shared with Administrator and/or DON for review and if needed, necessary changes will be made. Monitoring will continue for six (6) months, if no deficient areas are noted, the abuse QA will be presented to the QA committee to be discontinued. QA tools were created to monitor and assure that new hires are in-serviced on abuse and neglect that quarterly mandatory in-services on abuse and neglect are scheduled and that proper roster attendance is kept. QA will also continue to interview ten (10) staff members monthly including supervisors on knowledge of forms of abuse and what to do if you suspect or witness abuse. QA will also use tool to review follow-up of allegations of abuse to ensure that the facility policy and procedure was followed.</p> <p>Completion Date: _____</p>	4/29/2012

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F 226	<p>Continued From page 29 SRNA's to write up a statement.</p> <p>Interview, on 03/26/12 at 4:38 PM, with SRNA #9 revealed on 03/14/12 Resident #1 had been incontinent of urine on him/herself and the bed. She stated the resident had attempted to put his/her hand in a wet spot on the bed and she had moved Resident #1's hand to his/her lap. She stated she and SRNA #10 informed the Supervisor/LPN #3 this allegation did not occur. SRNA #9 stated she finished caring for Resident #1 and then went on to care for the other residents assigned to her on the 400 hall.</p> <p>Interview, on 03/26/12 at 4:53 PM, with SRNA #10 revealed she and SRNA #9 had been in Resident #1's room somewhere between 5:30 AM and 6:00 AM on 03/14/12. SRNA #10 stated she did not witness SRNA #9 do this and that she was caring for Resident #1's roommate and had her back to SRNA #9 and Resident #1. According to the SRNA, she "closed" Resident #1's door and left SRNA #9 caring for the resident.</p> <p>According to the report, interviews were conducted and SRNA #9 was suspended until the investigation was complete. Further review revealed no documented evidence that the facility reassigned SRNA #9 to duties that did not involve resident contact after the Medical Records personnel made an allegation of abuse to the Supervisor/LPN #3.</p> <p>Continued interview with RN #1, who was assigned to Resident #1 on 03/14/12, revealed SRNA #9 should not have continued to provide care to this resident after the allegation was made</p>	F 226		
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F 226	<p>Continued From page 30</p> <p>by the Medical Record personnel. She stated SRNA #9 should have been sent home immediately; however, she did not ensure SRNA #9 was reassigned or immediately suspended.</p> <p>Continued interview with the Supervisor/LPN #3, on 03/26/12 at 4:00 PM, revealed she allowed SRNA #9 to continue working with residents as it was near the end of her shift. She stated she "didn't see a problem with it" because both SRNA #9 and SRNA #10 denied the allegation occurred, even though she stated that it wasn't facility policy.</p> <p>Interview, on 03/23/12 at 2:47 PM with the Social Services (SS) Director, revealed she performed the investigation into the allegation made on 03/14/12 by the Medical Record personnel. When asked if SRNA #9 was reassigned after the allegation was made, the SS Director stated "no". She stated SRNA #9 should have been "sent home" immediately after the allegation was reported. The SS Director stated she did not talk to the Supervisor/LPN #3 about not following the facility's policy. She stated she performed abuse in-services on orientation and quarterly for all staff, including nursing, housekeeping, maintenance, kitchen and office staff.</p> <p>Interview, on 03/29/12 at 10:18 AM, with the Director of Nursing (DON) revealed the facility's policy was to remove staff involved in an abuse allegation from resident care. She stated the Supervisor/LPN #3 should have sent SRNA #9 home and not allowed her to continue performing resident care.</p> <p>Interview with the Administrator, on 03/29/12 at</p>	F 226		
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F 226	<p>Continued From page 31</p> <p>11:00 AM, revealed the Supervisor/LPN #3 informed the DON of the allegation at 7:15 AM, but should have informed Administration immediately. He further stated the Supervisor/LPN #3 should have removed SRNA #9 from direct resident care first and then notified Administration per the facility's policy. Continued interview, on 04/26/12 at 3:30 PM, revealed he felt like the Supervisor/LPN #3 had investigated the allegation and determined no abuse had occurred because SRNA #9 and SRNA #10 both denied the allegation occurred, even though the policy indicated the alleged abuser would immediately be removed from direct resident care until the investigation was completed.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AoC) on 04/27/12 that alleged removal of the Immediate Jeopardy (IJ) on 04/28/12, based on the following:</p> <ol style="list-style-type: none"> <li>1. SRNA #9 was suspended on 03/14/12 after the DON and Administrator were notified of the allegation.</li> <li>2. Resident #1 was assessed by the Supervisor on 03/14/12 and then moved to the day area on Unit 2 where he/she could be monitored.</li> <li>3. The Supervisor and the Charge Nurse/RN #1 were re-educated on 03/26/12 on the facility policy of abuse and neglect, specifically the requirement that an employee be suspended immediately once an allegation of abuse or neglect is made against them.</li> <li>4. SRNA #9 and SRNA #10 were re-educated on 03/15/12 and 03/26/12 by the Social Service</li> </ol>	F 226		

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F 226	<p>Continued From page 32</p> <p>Director on the facility's policy on abuse and neglect.</p> <p>5. The Social Service Director began re-education of all facility staff on the Abuse Neglect Policy on 03/26/12 with 100% of staff completion (minus one employee on Family Medical Leave) which was completed by 04/25/12. Attendance was monitored and anyone that did not participate in the re-education training, was given 1:1 training by the Social Service Director until 100% of employees were reeducated by 04/25/12.</p> <p>6. To ensure no other residents were affected, interviewable residents were asked by staff how they were treated in the facility of they had any complaints about their care.</p> <p>7. Direct care staff observed residents for unexplained bruising and reddened areas while providing care.</p> <p>8. On 04/27/12, all residents in the facility had a skin assessment for signs of abuse by the DON, ADON, QA Nurse, Staff Development Nurse, three (3) MDS Nurses, Unit Coordinators, Restorative Nurse, Wound Care Nurse and seven (7) Management Nurses.</p> <p>9. No determination will be made in the outcome of an abuse investigation without the review and approval of the Administrator or designee.</p> <p>10. The QA Nurse will monitor weekly, all allegations of abuse to ensure the proper procedure is followed by facility staff.</p>	F 226		

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F 226	<p>Continued From page 33</p> <p>11. QA tools were created to monitor and assure that new hires are in-serviced on abuse and neglect, that quarterly mandatory in-services on abuse and neglect are scheduled and that proper roster attendance is kept. QA will also continue to interview ten (10) staff monthly including supervisors on knowledge of forms of abuse and what to do if you suspect or see abuse. QA will also use tool to review follow-up of allegations of abuse to ensure that the facility policy and procedure was followed.</p> <p>On 04/28/12, the State Agency verified the immediacy of the Immediate Jeopardy was removed and the facility implemented corrective actions as alleged in the AoC, effective 04/28/12 based on the following:</p> <p>Interview with the Supervisor/LPN #3 and RN #1, on 04/28/12 at 11:00 AM, revealed they received education on 03/26/12 on the facility policy of abuse and neglect, specifically the requirement that an employee be suspended immediately once an allegation of abuse or neglect was made against them. Interview with the Supervisor/LPN #3 further revealed she was instructed to immediately remove the alleged perpetrator from direct resident care. Review of the in-service education documentation revealed the education was conducted on 03/26/12.</p> <p>Interview with SRNA #9 and SRNA #10, on 04/28/12 at 11:15 AM, revealed they were re-educated on 03/15/12 and 03/26/12 by the Social Service Director on the facility's policy on abuse and neglect. Review of the education documentation revealed the education was conducted on 03/15/12 and 03/26/12.</p>	F 226		
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F 226 Continued From page 34

F 226

Interview with the Social Service Director, on 04/28/12 at 10:15 AM, revealed she began re-education of all facility staff on the Abuse Neglect Policy on 03/26/12 with 100% of staff completion (minus one employee on Family Medical Leave) which was completed by 04/25/12. Attendance was monitored and anyone that did not participate in the re-education training, was given 1:1 training by the Social Service Director until 100% of employees were re-educated by 04/25/12. Review of the facility's documentation revealed the facility provided education to all staff between 03/26/12 and 04/25/12 on the abuse and neglect policy. The education sign-in sheets were compared to the facility staff roster to ensure 100% of staff received the education.

Interviews were conducted with the following staff to verify the facility had educated them and to ensure their knowledge of the facility's abuse and neglect policy: Dietary Manager on 04/28/12 at 11:00 AM, Assistant Dietary Manager, on 04/28/12 at 11:05 AM, Cook #17, on 04/28/12 at 11:15 AM, Dietary Aide #18, on 04/28/12 at 11:20 AM, Dietary Aide #19, on 04/28/12 at 11:25 AM, Dietary Aide #11, on 04/28/12 at 11:30 AM, Housekeeper #12, on 04/28/12 at 11:35 AM, Cook #13 on 04/28/12 at 11:40 AM, Housekeeping #14 on 04/28/12 at 11:50 AM, Supervisor/LPN #3, on 04/28/12 at 11:00 AM, RN #4, on 04/28/12 at 11:55 AM, Restorative Nurse/LPN #14, on 04/28/12 at 11:45 AM, SRNA #17, on 04/28/12 at 11:00 AM, SRNA #6, on 04/28/12 at 11:05 AM, Unit Coordinator/LPN #11, on 04/28/12 at 11:25 AM, LPN #12, on 04/28/12 at 11:35 AM, SRNA #15, on 04/28/12 at 11:30

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F 226	<p>Continued From page 35</p> <p>AM, Housekeeper #20, on 04/28/12 at 11:45 AM, ADON, on 04/28/12 at 11:40 AM and SRNA #16, on 04/28/12 at 11:55 AM. All of the above staff was knowledgeable of the facility's abuse and neglect policy and verified they had received re-education by the facility.</p> <p>Interview with the DON, on 04/28/12 at 10:20 AM, revealed the facility completed skin assessments on 100% of the resident population and identified no concerns with the skin assessments. Review of the resident census revealed the facility had one hundred-two (102) residents on 04/28/12. Review of the skin assessments revealed the facility completed 102 skin assessments on 04/28/12 and no concerns were identified.</p> <p>Interview with the Administrator, on 04/26/12 at 3:30 PM, revealed no determination will be made in the outcome of an abuse investigation without the review and approval of the Administrator or designee as per the facility's policy.</p> <p>Interview with the QA Nurse, on 04/28/12 at 1:00 PM revealed she will monitor weekly, all allegations of abuse to ensure the proper procedure is followed by facility staff. She further stated QA tools were created to monitor and assure that new hires were in-serviced on abuse and neglect, that quarterly mandatory in-services on abuse and neglect were scheduled and that proper roster attendance was kept. Further interview revealed QA will also continue to interview ten (10) staff monthly including supervisors on knowledge of forms of abuse and what to do if you suspect or see abuse. QA will also use tool to review follow-up of allegations of abuse to ensure that the facility policy and</p>	F 226		
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F 226	Continued From page 36 procedure was followed.	F 226		
F 278 SS=D	<p>The facility remained out of compliance at a lower Scope and Severity of a "D", an isolated deficiency with potential for more than minimal harm in order for the facility to develop and implement the Plan of Correction (PoC).</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p>	F 278	<p>This plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p>	

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F 278	<p>Continued From page 37</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure the admission assessment was accurate for two (2) of eleven (11) sampled residents (Resident #11 and #9). The facility failed to ensure the Minimum Data Set (MDS) Admission Assessment accurately reflected care and services received by residents #11 and #9. The MDS assessment failed to detail that Resident #11 received Dialysis services and failed to detail that Resident #9's use of oxygen, per physician's orders.</p> <p>The findings include: The facility was unable to provide a policy related to the accurate completion of MDS Assessments.</p> <p>1. Review of Resident #11's medical record revealed the facility admitted the resident on 03/19/12 with diagnoses which included Chronic Renal Disease. Continued review of the record revealed the resident was receiving Dialysis three (3) times a week. Review of the Minimum Data Set Admission Assessment, dated (MDS) 03/26/12, revealed no documented evidence the facility assessed the resident as receiving Dialysis. Interview on 04/06/12 at 3:55 PM, with the facility's MDS Coordinator revealed Resident #11's receiving Dialysis should have been included in the admission assessment.</p> <p>2. Review of Resident #9's medical record revealed the facility admitted the resident on</p>	F 278	<p>1) The previous MDS Assessments for residents #11 and #9 were modified and resubmitted to CMS.</p> <p>2) Audits of all MDS's for residents currently residing in the facility were conducted to check for accuracy. These audits are being by MDS personnel DON, QA Nurse and ADON. Audits were completed on 5/07/2012.</p> <p>3. Quality Assurance monitoring for MDS accuracy will be done with all new admissions and weekly scheduled MDSs for four (4) weeks, then monthly for six (6) months then quarterly thereafter.</p> <p>4) The audit will be done by the QA Nurse and overseen by the DON. If the audits indicate no errors in the MDS process, the QA will be brought before the QA committee after one year to discontinue.</p> <p>Completion Date:</p>	5/08/2012
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F 278	<p>Continued From page 38</p> <p>03/20/12 with diagnoses which included Congestive Heart Failure (CHF). Continued review of the record revealed a Physician's Order, dated 03/21/12 for oxygen at three (3) liters per minute per nasal cannula to maintain oxygen saturation levels above eighty-seven (87) percent.</p> <p>Observations on 04/06/12 at 11:00 AM, 12:20 PM, and 2:35 PM of Resident #9 revealed him/her to be using oxygen. Observation revealed the resident had a nasal cannula in place and was receiving three (3) liter of oxygen per minute continuous. Interview, on 04/06/12 at 2:35 PM with Resident #9 revealed he/she had been wearing the oxygen continuously since admission to the facility. He/She stated his/her oxygen saturation levels had been in the ninety's (90's).</p> <p>Interview, on 04/08/12 at 2:47 PM, with the Assistant Director of Nursing (ADON) revealed she "believed" Resident #9 had been wearing the oxygen since his/her admission to the facility.</p> <p>Interview, on 04/06/12 at 3:55 PM with the facility's MDS Coordinator revealed Resident #9's oxygen use should have been included in the admission assessment. She stated when the admission assessment is performed it should include conditions/diagnoses that are pertinent and affecting the resident at the time of the assessment.</p>	F 278		
F 281 SS=J	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p>	F 281		

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NAME OF PROVIDER OR SUPPLIER  PINE MEADOWS HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40504		
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F 281	Continued From page 39  This REQUIREMENT is not met as evidenced by: Based on interview, record review, facility policy review, and review of the Kentucky Board of Nursing "Accountability and Responsibility of Nurses" document, it was determined the facility failed to ensure services provided met professional standards for one (1) of eleven (11) sampled residents (Resident #2). The facility failed to ensure professional staff provided timely necessary care and services to Resident #2 who had been identified as having a change of condition and failed to ensure they documented accurately in the medical record per Kentucky Board standard of practice and per the facility's policies and procedures.  On 02/01/12, Licensed Practical Nurse (LPN) #1 found Resident #2 pale and without respirations on 02/01/12. Review of the video camera data for the date of 02/01/12 revealed LPN #1 was in the room for thirty (30) seconds. LPN #1, through interview revealed that he did not "touch" the resident, attempt to suction or conduct a physical assessment at the time he identified Resident #2 had a change in condition; rather, he exited the room and returned approximately six (6) minutes later with the Assistant Director of Nursing (ADON), per video camera data. Interview with LPN #1 confirmed that no physical assessment was performed and no care and services were provided for approximately six minutes after LPN #1 identified the condition change. At which time, the ADON was unsuccessful in obtaining vital signs after suctioning the resident. The resident was noted to be pronounced as deceased at 9:00 AM on 02/01/12. Furthermore, LPN #1 failed to	F 281	F 281  This plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.  1) Resident #2 was no longer in the facility at the time of the survey; therefore, no corrective action could take place. LPN #1 was suspended, pending the outcome of the investigation/survey. It is important to note that the video surveillance camera only records events happening in the hallways of the facility and not in the resident's room. Therefore, the employee documentation was not in question by the facility administration. Furthermore, interview of LPN #1 and video camera review determined that at 8:02:33 LPN #1 entered the room of resident #2 and observed her lying in bed. LPN #1 left room to inquire with SRNA why she was in bed at 8:03:18. LPN #1 re-entered the resident room and was in the room for approximately thirty seconds until 8:03:45. Interview with LPN #1 revealed that LPN #1 saw resident without respirations, pallor color and no visible signs of life. Resident #2 was a DNR and had been receiving Hospice services for diagnosis of end stage dementia.		

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F 281	<p>Continued From page 40</p> <p>document accurately in the medical record as the Nurse's Notes, on 02/01/12 at 7:45 AM, detailed that the LPN had performed physical assessment of the resident's lungs sounds, pulse, blood pressure, and suctioning Resident #2's oral cavity. However, interview with LPN #1 validated this was incorrect and that no assessment had been performed until the ADON entered the resident's room.</p> <p>The facility's failure to ensure services provided met professional standards placed residents at risk for serious injury, harm, impairment, or death. The facility was notified of the Immediate Jeopardy on 03/29/12.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 04/04/12 with the facility alleging removal of the Immediate Jeopardy on 04/04/12. Immediate Jeopardy was verified to be removed on 04/06/12 prior to exiting the facility on 04/28/12 with remaining non-compliance at 42 CFR 483.20 Resident Assessment, with a scope and severity of a "D", while the facility's Quality and Assurance continues to monitor and ensure residents remain free from neglect.</p> <p>The findings include:</p> <p>Review of the Kentucky Board of Nursing's "Accountability &amp; Responsibility of Nurses" document, last updated on 05/24/05, revealed nurses are individually responsible and accountable for "rendering safe, effective nursing care to clients and for judgments exercised and actions taken in the course of providing care".</p>	F 281	<p>It was also noted that both the family and Hospice wanted comfort measures only. Upon seeing no visible signs of life, LPN #1 went to inform SRNA #2 that resident had expired and needed post mortem care. Interview with LPN #1 and record review does not indicate mucus coming out of the mouth of resident #2. LPN #1 further stated that that after the incident occurred and he was documenting, his "thoughts were disorganized" and part of the note should in fact have been an addendum, as he did not suction the resident, but the ADON did.</p> <p>The ADON entered resident #2's room to verify residents death, after completing her assessment that she confirmed resident #2 had expired. Per survey interview of facility Medical Director on 4/6/2012 at 5:40PM revealed if a resident experienced a change in condition as in the case of resident #2 he would expect the nurse to assess for signs of life. He further stated the nurse should assess for respirations, pulse, pallor and rigidity. Interview of LPN #1 on 4/13/2012 revealed LPN #1 stated he did not see resident #2's chest rising, her pupil was dilated, her mouth was gaping open and her color was pale. LPN#1 states, he "did check the pulse in her wrist and there was no pulse." LPN #1 further acknowledged that his assessment of the above finding all confirmed that resident #2 had expired. LPN #1 then followed the facility policy regarding notification of a supervisor and summoned the ADON to resident #2's room. Because it is not the facility policy for nurses to pronounce death of a resident, the official pronouncement of death was made by the Hospice nurse when she arrived to the facility.</p>	
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F 281	<p>Continued From page 41</p> <p>Review of the facility's "Emergency Care, General Guidelines For", not dated, revealed it was the basic responsibility of the Licensed Nurse to "always take, report and record vital signs when a resident's condition has changed" and record the details and exact time of the condition change of a resident. On 03/29/12 at 11:07 AM, interview with the Director of Nursing (DON) confirmed this was the facility's policy. She stated her expectations were that nurses would assess residents when a change of condition was noted; this would include assessing vital signs and ensuring accuracy of documentation.</p> <p>Review of Resident #2's medical record revealed an admission date of 10/19/01, with diagnoses which included Alzheimer's Disease, and a history of Aspiration Pneumonia. Review of the Quarterly Minimum Data Set (MDS) dated 11/20/11 revealed the facility assessed the resident to be severely impaired with daily decision making. Further review of the MDS revealed the facility assessed Resident #2 as totally dependent on staff for all Activities of Daily Living (ADLs). Review of the January 2012 "My Daily Care Plan" utilized by the State Registered Nursing Assistants (SRNAs) revealed the resident was on thickened liquids, aspiration precautions and needed to be fed his/her meals by staff.</p> <p>Observation of the video camera data for 02/01/12 revealed LPN #1 was observed entering Resident #2's room at 8:03:15 AM and exiting the room at 8:03:45 AM, thirty (30) seconds later. On 03/26/12 at 2:07 PM, an interview with LPN #1 revealed when he went into Resident #2's room on 02/01/12, he observed the resident was pale</p>	F 281	<p>2) To the best of the facility's knowledge, Pine Meadows believes this to be an isolated incident involving only the resident cited in the deficiency. The facility completed a Medical Records review of thirty-seven (37) individual charts on 4/3/2012. These charts were of residents who had expired in the facility during the previous six months or who had been sent out to the hospital due to change of condition in the past six months. These charts were reviewed to indicate whether the nurses involved assessed the resident's acute change-in-condition and responded according to facility policy. All records were found to be in compliance.</p> <p>3) New policies and procedures were created and implemented on 3/29/2012 to include the following: 1) A policy entitled "Assessment of Residents when Found to Have a Change in Condition" This policy specifically addressed the immediate assessment of a resident exhibiting a change in condition (attachment A), 2) A revision to the policy "Charting and Documentation" was made to emphasize the importance of timely and accurate charting in the Resident Medical record (attachment B), 3) Staff were again, in-serviced on the policy "General Guidelines for Emergency Care" (attachment C) and 4) "Procedure for Nursing Report and Rounds" (attachment D). All Registered Nurses and Licensed Practical Nurses were in-serviced on all of the above mentioned policies starting on 3/29/2012. The in-services were completed for all nurses by 4/4/2012. The above mentioned in-services were conducted by the DON, ADON, Staff Development Nurse, Unit 2 Coordinator, QA Nurse, Restorative Nurse and the Weekend Nursing Supervisor.</p>	
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F 281	Continued From page 42 and without respirations. An additional interview with LPN #1, on 03/27/12 at 11:10 AM, revealed his initial observation also revealed Resident #2 had mucous coming out of his/her mouth. He again stated twice that he did not "touch" the resident or attempt to suction him/her. Additionally, continued interview, on 03/29/12 at 9:20 AM with LPN #1, revealed he did not have a stethoscope with him when he found the resident pale and without respirations on 02/01/12. He revealed he immediately exited the room to find the ADON. Further review of the video camera data revealed the LPN returned with the Assistant Director of Nursing (ADON) to Resident #2's room at 8:09:10 AM, approximately six (6) minutes later. Further interview with LPN #1 revealed the ADON came to the resident's room and immediately started to suction the resident as he/she had "foamy" secretions in his/her mouth. LPN #1 stated he and the ADON performed a physical assessment of the resident at that time and found that he/she had no pulse or respirations. Interview, on 03/27/12 at 3:25 PM with the ADON, revealed she was notified that she needed to observe Resident #2's condition. The ADON indicated when she entered Resident #2's room the resident had foamy secretions in his/her mouth. According to the ADON, she immediately suctioned the resident's mouth using a suction machine beside Resident #2's bed. The ADON was unaware as to whether the resident had been suctioned prior to her coming to the room, but stated "I don't think so". The ADON stated she donned gloves, performed a sweep of the resident's mouth and observed nothing in Resident #2's mouth. Additionally, the ADON stated she and LPN #1 attempted to obtain vital signs on Resident #2; however, they	F 281	4) The facility will monitor nurse compliance with the existing and revised policies and procedures on an ongoing basis by including them in the nurse competency reviews. These reviews are usually conducted annually in the months of May through July. Due to the recent changes, the facility has chosen to move up the nurse competency reviews regarding assessments and documentation. These reviews began on 3/29/2012. On 3/31/2012 the facility also created and implemented a "Condition Change Documentation 24-hour report Follow-up" form (attachment E) that will be reviewed at the interdisciplinary team's morning meeting to ensure proper follow-up and assessment of residents with a change in condition. The interdisciplinary team consists of the: DON, ADON, Quality Assurance Nurse, Unit Coordinators, Social Services, Therapy, MDS Nurse, Wound Nurse Restorative Nurse. In addition, on March 31, 2012 the facility implemented a new policy in regard to the "24-hour Report and Condition Change form" (attachment F). The above form and policy revisions were specifically implemented on March 31, 2012 to utilize as tools for monitoring and ensuring consistent assessment and follow-up of resident care.		

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F 281 Continued From page 43  
were unable to obtain vital signs.

Review of the Nurse's Notes, dated 02/01/12 written by Licensed Practical Nurse (LPN) #1 revealed at 7:45 AM Resident #2 had been "cleaned up" and was in bed waiting to be "gotten up" for breakfast. The Nurse's Notes revealed that when he walked into Resident #2's room to provide care to the resident's roommate, he noted Resident #2 had a "pale looking color" and had no respirations. The Note further detailed LPN #1 auscultated for lung sounds with none heard and "no pulse and B/P" (blood pressure) could be obtained. LPN #1 documented Resident #2's head was "inclined" at thirty (30) degrees and he/she was suctioned using the suction machine at the bedside. Further review of the Nurse's Notes revealed the LPN documented at 7:50 AM the Assistant Director of Nursing (ADON) was notified of the change in Resident #2's condition and she suctioned the resident. However, continued interview with the LPN revealed no assessment was performed until the ADON was present in Resident #2's room. He stated when he documented the Note timed 7:45 AM it should have been included with the 7:50 AM Note, as he did not perform an assessment of the resident's vital signs until the ADON was present in the resident's room with him. Further review of the Nurse's Notes revealed a Note written by another nurse that stated Resident #2 was pronounced deceased at 9:00 AM.

The Director of Nursing (DON), on 03/29/12 at 11:07 AM, revealed her expectations of her licensed nurses were if a resident experienced a change of condition the nurse would perform a

F 281 The DON or ADON will conduct the QA Condition Change assessments by selecting five residents a month for six months from each unit of the facility (ten charts total) and reviewing that accurate assessments were completed for the selected residents. The DON or ADON will be assuring the accuracy of the assessments on Conditions Change. The DON or ADON monitor the outcomes of the ten (10) chart review each month. If compliance is found during the initial six month period the facility will then review five resident charts from each unit (ten charts total) on quarterly basis from then on out. QA will assure compliance of this regulation through monthly auditing and discussion at the QA committee meeting about the facilities Abuse and Neglect policy. QA audits will be completed by the QA nurse.

Completion Date:

4/29/2012

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F 281	<p>Continued From page 44</p> <p>complete assessment of the resident. She stated this would include obtaining vital signs. According to the DON if a resident was found without respirations the nurse should assess for a pulse and auscultate for lung sounds. Additionally, she stated nurses should document accurately in the resident's medical record. She stated nurses should not "falsify" their documentation.</p> <p>Interview on 04/06/12 at 5:40 PM with the Medical Director revealed if a resident experienced a change in condition as in the case of Resident #2, he would expect the nurse to assess for signs of life. He stated the nurse should assess for respiration, pulse, pallor (pale color) and rigidity.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AoC) on 04/04/12 that alleged removal of the Immediate Jeopardy (IJ) on 04/04/12, based on the following:</p> <ol style="list-style-type: none"> <li>1. LPN #1 was suspended pending completion of an investigation into the allegations.</li> <li>2. The DON conducted a review on 04/02/12 of all resident's medical records who had expired in the facility in the past six (6) months. All records were found to be in compliance.</li> <li>3. Medical record reviews were completed 04/03/12 of thirty-seven (37) individual charts of residents who had expired in the facility in the past six (6) months or who had been sent to the hospital due to a change in condition in the past six (6) months.</li> <li>4. New policies and procedures were created and</li> </ol>	F 281		
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F 281	<p>Continued From page 45</p> <p>implemented immediately on 03/29/12. A policy entitled "Assessment of Residents when found to have a Change in Condition" which addressed the immediate assessment of a resident exhibiting a change in condition. A revision of the policy, "Charting and Documentation" to emphasize the importance of timely and accurate charting in residents' medical records. Staff inservices were conducted on these policies. Re-inservices were conducted on the "General Guidelines for Emergency Care" and "Procedure for Nursing Report and Rounds" policies. All Registered Nurses and Licensed Practical Nurses were inserviced on all the above policies starting on 03/29/12, and completed on 03/31/12, with the exception of two (2) nurses. One nurse who is out of the country, and one currently on Family Medical Leave. These two (2) nurses will not be allowed to work on the floor with residents until they are inserviced on the policies as well.</p> <p>5. The DON and ADON will audit medical records for any resident that expires in the facility. The audit will include review for compliance with the above cited policies and procedures.</p> <p>6. Monitoring of nurse compliance with the existing and revised policies and procedures will be performed by including them in the nurse competency reviews. These reviews were started on 03/29/12, and were seventy-six (76) percent complete on 04/04/12.</p> <p>7. On 03/31/12, the facility also created and implemented a "Condition Change Documentation 24 Hour Report Follow-up" form that will be reviewed at the Interdisciplinary Team's (IDT) morning meeting. A new policy was</p>	F 281			

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F 281	<p>Continued From page 46.</p> <p>implemented in regards to the new form. The form and policy revisions were implemented on 03/31/12 to utilize as tools for monitoring.</p> <p>8. The facility will Quality Assurance (QA) condition change assessments by selecting five (5) resident medical records from the facility's two (2) units for a total of ten (10) records to review that accurate assessments were completed for the selected residents. If compliance is found during the initial six (6) month period, then five (5) records from the two (2) units will be reviewed on a quarterly basis from there on. These QA audits will be completed by the QA nurse.</p> <p>On 04/06/12 it was verified the immediacy of the IJ was removed and the facility implemented corrective actions as alleged in the AoC, effective 04/04/12 based on the following:</p> <p>Observation, on 04/06/12 from 10:45 AM until 11:00 AM revealed the new or revised policies were present in the Policies and Procedures books located at the Nurse's Station on each of the two (2) units.</p> <p>Interviews with staff including Registered Nurse (RN) #3 on 04/06/12 at 11:05 AM, RN #2 on 04/06/12 at 4:30 PM, Licensed Practical Nurse (LPN) #8 at 10:22 AM, LPN #6 at 10:40 AM, LPN #7 at 10:50 AM, LPN #10 at 10:56 AM, LPN #4 at 3:05 PM, LPN #9 at 3:41 PM revealed they all were aware of the new policies and procedures that had been implemented or revised: "Assessment of Residents when found to have a Change in Condition", "Charting and Documentation", "General Guidelines for Emergency Care" and "Procedure for Nursing</p>	F 281			

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F 281	<p>Continued From page 47 Report and Rounds". They all were aware of the "Condition Change Documentation 24 Hour Report Follow-up" form and new policy related to it.</p> <p>Review of the facility's inservices and interview, on 04/06/12 at 9:25 AM, with the Staff Development Nurse and Director of Nursing (DON) revealed the facility had inserviced all licensed staff beginning 03/29/12 related to the new policies and procedures with the exception of two licensed staff who were out of the country or on medical leave and would not be allowed to return to work until inserviced. Further interview revealed to validate staff's competency related to the inservice, staff were given a change of condition scenario and they had to document a nurse's note describing their assessment of the change in condition, such as obtaining vital signs. Additionally, interview and review of the facility's chart audits revealed thirty-seven (37) individual charts of residents who had expired in the facility in the past six (6) months or who had been sent to the hospital due to a change in condition in the past six (6) months were reviewed to ensure there were no other residents effected related to not appropriately assessing a resident who had a change of condition.</p> <p>Interview, on 04/06/12 at 4:10 PM, with the Administrator revealed all but two (2) staff had been inserviced on the new or revised policies and procedures and new form. According to the Administrator, new employees will receive the information in orientation. He stated a new QA audit was in place to monitor residents' change of condition and ensure accurate assessments were completed by the licensed nursing staff.</p>	F 281		
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NAME OF PROVIDER OR SUPPLIER  PINE MEADOWS HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40504
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F 281	Continued From page 48	F 281		
F 490 SS=J	<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, record review, and facility policy review it was determined the facility's Administration failed to ensure the facility was administered in a manner which enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychological well-being of each resident.</p> <p>The facility failed to protect residents from abuse, failed to implement its Abuse Policies by failing to immediately remove staff from direct resident care after staff reported an allegation of abuse to the Supervisor, and failed to ensure other residents were protected by allowing the alleged abusive staff to continue to provide resident care. In addition, the facility's Administration failed to ensure staff implemented its Abuse Policies and failed to ensure residents were protected during the investigation of the allegation by allowing the</p>	F 490	F 490  This plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	

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F 490	<p>Continued From page 49</p> <p>Supervisor to make the determination whether or not abuse had occurred.</p> <p>On 03/14/12, a Medical Records personnel reported to the Supervisor that she was walking down the hall and witnessed State Registered Nursing Assistant (SRNA) #9 "slap" Resident #1 on the top of his/her left hand at approximately 5:30 AM, while providing care to the resident in the resident's room. She stated she heard it "pop". Interview with the Medical Records personnel revealed she reported the incident to the Supervisor immediately. She stated another aide, SRNA #10 was in the room at the time and exited the room and closed the door after the incident, leaving SRNA #9 in the room with Resident #1. Review of the facility's policy "Protection of Residents During Abuse Investigation" revealed employees accused of participating in an alleged abuse will be immediately reassigned to duties that did not involve resident contact until the findings of the investigation were reviewed by the Administrator. Interview with SRNA #9 revealed she was interviewed by the Supervisor and was allowed to continue to work about an hour providing direct care to residents until the end of her shift. Interview with the Supervisor revealed she assessed Resident #1 for injuries and questioned SRNA #9 and SRNA #10, who was also in the room at the time of the allegation, and determined abuse, did not occur.</p> <p>The facility's failure to have an effective Administration related to the prevention of abuse and failure to ensure policy and procedures were implement to protect residents placed Resident #1 and other residents at risk for serious injury,</p>	F 490	<p>1) SRNA #9 was suspended 3/14/2012 after the Administrator and DON were notified of the incident. Resident #1 was assessed by supervisor for any redness or bruising after incident was reported. No reddened or bruised area was noted to resident #1.</p> <p>2) All facility residents were assessed on 4/27/12 to ensure there was no patterned bruising or unexplainable marks on skin to indicate possible abuse. Each resident that could answer was asked how they were treated in the facility. The assessment was performed by the DON, ADON, QA, SDC, Unit Coordinators as well as eight(8) nurses from a sister facility to ensure no other resident was effected.</p>	
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F 490	<p>Continued From page 50 harm, impairment, or death.</p> <p>Immediate Jeopardy was identified at 42 CFR 483.13 Resident Behavior and Facility Practice, F-223 and F-226 at a Scope and Severity of a "J" and 42 CFR 483.75 Administration, F-490 at a Scope and Severity of a "J".</p> <p>An acceptable Credible Allegation of Compliance, related to the Immediate Jeopardy, was received on 04/27/12. On 04/28/12, the Immediate Jeopardy was verified removed on 04/28/12 as alleged. However, non-compliance continued to exist at 42 CFR 483.13 Resident Behavior and Facility Practice, F-223 and F-226 and 42 CFR 483.75, Administration, F-490 with a scope and severity of a "D", as the facility had not completed the development and implementation of the Plan of Correction (PoC) to ensure the facility established and maintained effective systems to ensure residents remain free from abuse, the facility implements their policy and Administration oversight is provided.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Protection of Residents During Abuse Investigations", updated 10/99, revealed "employees accused of participating in the alleged abuse will be immediately reassigned to duties that do not involve resident contact or will be suspended without pay until the findings of the investigation have been reviewed by administrator".</p> <p>The facility failed to implement written policy to prohibit mistreatment, neglect and abuse of residents for one (1) of eleven (11) sampled</p>	F 490	<p>SRNA #9 was suspended on the morning of 3/14/2012 after the DON and Administrator were notified of the allegation. Resident #1 was assessed by the Supervisor on 03/14/2012. The Supervisor and the Charge Nurse/ RN#1 were reeducated on 03/26/2012 on the facility policy on abuse and neglect, specifically the requirement that an employee be suspended immediately once an allegation of abuse or neglect is made against them. SRNA #9 and SRNA #10 were reeducated on 3/25/2012 and on 3/26/2012 by the Social Services Director on the facility's policy on abuse and neglect.</p> <p>The Social Services Director began re-education of all facility staff on the abuse and neglect policy on 3/26/2012 with 100% of staff completion (minus one employee on FMLA) which was completed on 4/25/2012. Attendance was monitored and anyone who did not participate in the re-education training was given 1:1 training by the Social Services Director until 100% of employees were re-educated by 04/25/2012.</p> <p>The facility administration worked with the Nursing and Social Services Departments to coordinate and ensure no other residents were affected.</p> <p>Interviewable residents were asked by staff how they were treated in the facility</p>	

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F 490	<p>Continued From page 51</p> <p>residents (Resident #1). The facility failed to follow their "Protection of Residents During Abuse Investigations" policy. On 03/14/12, the facility received an allegation of abuse alleging that Medical Records personnel witnessed State Registered Nursing Assistant (SRNA) #9 "slap" Resident #1 on top of his/her hand at approximately 5:30 AM. The facility failed to protect residents by allowing SRNA #9 to continue to provide direct resident care for approximately one (1) hour after being made aware of an allegation of abuse. The Supervisor/Licensed Practical Nurse (LPN) #3 failed to re-assign SRNA #9 from providing resident contact or immediately suspending the staff. (Refer to F-223 and F-226)</p> <p>Interview, on 03/29/12 at 10:18 AM, with the Director of Nursing (DON) revealed the facility's policy was to remove staff involved in an abuse allegation from resident care. She stated the Supervisor/LPN #3 should have sent SRNA #9 home and not allowed her to continue performing resident care.</p> <p>Interview with the Administrator, on 03/29/12 at 11:00 AM, revealed the Supervisor/LPN #3 informed the DON of the allegation at 7:15 AM, but should have informed Administration immediately. He further stated the Supervisor/LPN #3 should have removed SRNA #9 from direct resident care first and then notify Administration per the facility's policy. Continued interview, on 04/26/12 at 3:30 PM, revealed he felt like the Supervisor/LPN #3 had investigated the allegation and determined no abuse had occurred because SRNA #9 and SRNA #10 both denied the allegation occurred, even though the</p>	F 490	<p>and if they had any complaints about their care.</p> <p>Direct care staff observed residents for unexplained bruising and reddened areas while providing care. On 4/27/2012, all residents in the facility had a skin assessment for signs of abuse by the DON, ADON, QA Nurse, Staff Development Nurse, three (3) MDS Nurses, Unit Coordinators, Restorative Nurse, Wound Care Nurse and Seven (7) management Nurses.</p> <p>3) An in-service to all employees was presented by the Social Services Director on 3/26/12, 3/27/12 and 4/07/12. All employees were in-serviced except for one (1) employee on FMLA. Supervisor and Charge Nurse/RN were re-educated on 3/26/2012 by the Social Services Department on the facility abuse and neglect policy. SRNA #9 and #10 were re-educated. The facility administration decided that no determination will be made in the outcome of an abuse investigation without the review and approval of the Administrator or designee.</p>	

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F 490 Continued From page 52  
policy indicated the alleged abuser would immediately be removed from direct resident care until the investigation was completed.

The facility provided an acceptable credible Allegation of Compliance (AoC) on 04/27/12 that alleged removal of the Immediate Jeopardy (IJ) on 04/28/12, based on the following:

1. SRNA #9 was suspended on 03/14/12 after the DON and Administrator were notified of the allegation.
2. Resident #1 was assessed by the Supervisor on 03/14/12 and then moved to the day area on Unit 2 where he/she could be monitored.
3. The Supervisor and the Charge Nurse/RN #1 were re-educated on 03/26/12 on the facility policy of abuse and neglect, specifically the requirement that an employee be suspended immediately once an allegation of abuse or neglect is made against them.
4. SRNA #9 and SRNA #10 were re-educated on 03/15/12 and 03/26/12 by the Social Service Director on the facility's policy on abuse and neglect.
5. The Social Service Director began re-education of all facility staff on the Abuse Neglect Policy on 03/26/12 with 100% of staff completion (minus one employee on Family Medical Leave) which was completed by 04/25/12. Attendance was monitored and anyone that did not participate in the reeducation training, was given 1:1 training by the Social Service Director until 100% of employees were

F 490 4) The QA Nurse will immediately review all allegations of abuse to ensure the proper procedure is followed by the facility. Information gathered from QA review will be shared with Administrator and/or DON for review and if needed, necessary changes will be made. QA tools were created to monitor and assure that new hires are in-serviced on abuse and neglect that quarterly mandatory in-services on abuse and neglect are scheduled and that proper roster attendance is kept. QA will also continue to interview ten (10) staff members monthly including supervisors on knowledge of forms of abuse and what to do if you suspect or witness abuse. QA will also use tool to review follow-up of allegations of abuse to ensure that the facility policy and procedure was followed.

Completion Date:

4/29/2012

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F 490	<p>Continued From page 53 reeducated by 04/25/12.</p> <p>6. To ensure no other residents were affected, interviewable residents were asked by staff how they were treated in the facility of they had any complaints about their care.</p> <p>7. Direct care staff observed residents for unexplained bruising and reddened areas while providing care.</p> <p>8. On 04/27/12, all residents in the facility had a skin assessment for signs of abuse by the DON, ADON, QA Nurse, Staff Development Nurse, three (3) MDS Nurses, Unit Coordinators, Restorative Nurse, Wound Care Nurse and seven (7) Management Nurses.</p> <p>9. No determination will be made in the outcome of an abuse investigation without the review and approval of the Administrator or designee.</p> <p>10. The QA Nurse will monitor weekly, all allegations of abuse to ensure the proper procedure is followed by facility staff.</p> <p>11. QA tools were created to monitor and assure that new hires are in-serviced on abuse and neglect, that quarterly mandatory in-services on abuse and neglect are scheduled and that proper roster attendance is kept. QA will also continue to interview ten (10) staff monthly including supervisors on knowledge of forms of abuse and what to do if you suspect or see abuse. QA will also use tool to review follow-up of allegations of abuse to ensure that the facility policy and procedure was followed.</p>	F 490		
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F 490	<p>Continued From page 54</p> <p>On 04/28/12, the State Agency verified the immediacy of the Immediate Jeopardy was removed and the facility implemented corrective actions as alleged in the AoC, effective 04/28/12 based on the following:</p> <p>Interview with the Supervisor/LPN #3 and RN #1, on 04/28/12 at 11:00 AM, revealed they received education on 03/26/12 on the facility policy of abuse and neglect, specifically the requirement that an employee be suspended immediately once an allegation of abuse or neglect was made against them. Interview with the Supervisor/LPN #3 further revealed she was instructed to immediately remove the alleged perpetrator from direct resident care. Review of the in-service education documentation revealed the education was conducted on 03/26/12.</p> <p>Interview with SRNA #9 and SRNA #10, on 04/28/12 at 11:15 AM, revealed they were re-educated on 03/15/12 and 03/26/12 by the Social Service Director on the facility's policy on abuse and neglect. Review of the education documentation revealed the education was conducted on 03/15/12 and 03/26/12.</p> <p>Interview with the Social Service Director, on 04/28/12 at 10:15 AM, revealed she began re-education of all facility staff on the Abuse Neglect Policy on 03/26/12 with 100% of staff completion (minus one employee on Family Medical Leave) which was completed by 04/25/12. Attendance was monitored and anyone that did not participate in the re-education training, was given 1:1 training by the Social Service Director until 100% of employees were re-educated by 04/25/12. Review of the facility's</p>	F 490		

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F 490	<p>Continued From page 55</p> <p>documentation revealed the facility provided education to all staff between 03/26/12 and 04/25/12 on the abuse and neglect policy. The education sign-in sheets were compared to the facility staff roster to ensure 100% of staff received the education.</p> <p>Interviews were conducted with the following staff to verify the facility had educated them and to ensure their knowledge of the facility's abuse and neglect policy: Dietary Manager on 04/28/12 at 11:00 AM, Assistant Dietary Manager, on 04/28/12 at 11:05 AM, Cook #17, on 04/28/12 at 11:15 AM, Dietary Aide #18, on 04/28/12 at 11:20 AM, Dietary Aide #19, on 04/28/12 at 11:25 AM, Dietary Aide #11, on 04/28/12 at 11:30 AM, Housekeeper #12, on 04/28/12 at 11:35 AM, Cook #13 on 04/28/12 at 11:40 AM, Housekeeping #14 on 04/28/12 at 11:50 AM, Supervisor/LPN #3, on 04/28/12 at 11:00 AM, RN #4, on 04/28/12 at 11:55 AM, Restorative Nurse/LPN #14, on 04/28/12 at 11:45 AM, SRNA #17, on 04/28/12 at 11:00 AM, SRNA #6, on 04/28/12 at 11:05 AM, Unit Coordinator/LPN #11, on 04/28/12 at 11:25 AM, LPN #12, on 04/28/12 at 11:35 AM, SRNA #15, on 04/28/12 at 11:30 AM, Housekeeper #20, on 04/28/12 at 11:45 AM, ADON, on 04/28/12 at 11:40 AM and SRNA #16, on 04/28/12 at 11:55 AM. All of the above staff was knowledgeable of the facility's abuse and neglect policy and verified they had received re-education by the facility.</p> <p>Interview with the DON, on 04/28/12 at 10:20 AM, revealed the facility completed skin assessments on 100% of the resident population and identified no concerns with the skin assessments. Review of the resident census revealed the facility had</p>	F 490		
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F 490	<p>Continued From page 56</p> <p>one hundred-two (102) residents on 04/28/12. Review of the skin assessments revealed the facility completed 102 skin assessments on 04/28/12 and no concerns were identified.</p> <p>Interview with the Administrator, on 04/26/12 at 3:30 PM, revealed no determination will be made in the outcome of an abuse investigation without the review and approval of the Administrator or designee as per the facility's policy.</p> <p>Interview with the QA Nurse, on 04/28/12 at 1:00 PM revealed she will monitor weekly, all allegations of abuse to ensure the proper procedure is followed by facility staff. She further stated QA tools were created to monitor and assure that new hires were in-serviced on abuse and neglect, that quarterly mandatory in-services on abuse and neglect were scheduled and that proper roster attendance was kept. Further interview revealed QA will also continue to interview ten (10) staff monthly including supervisors on knowledge of forms of abuse and what to do if you suspect or see abuse. QA will also use tool to review follow-up of allegations of abuse to ensure that the facility policy and procedure was followed.</p> <p>The facility remained out of compliance at a lower Scope and Severity of a "D", an isolated deficiency with potential for more than minimal harm in order for the facility to develop and implement the Plan of Correction (PoC).</p>	F 490		
F 514 SS=J	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each</p>	F 514		

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F 514	<p>Continued From page 57</p> <p>resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, video camera data review and facility policy review, it was determined the facility failed to ensure accurate clinical records were maintained for one (1) of eleven (11) sampled residents (Resident #2). The facility failed to ensure their "Emergency Care, General Guidelines For" policy was followed regarding ensuring the Licensed Nurse always take, report, and record vital signs when a resident's condition had changed and record the details and exact time of the condition change. On 02/01/12, LPN #1 identified a change in condition related to Resident #2 who was observed pale, having no respirations, and mucous in the his/her mouth. The LPN documented that he performed a physical assessment of Resident #2's change in condition, which included auscultating for lung sounds, attempting to obtain a blood pressure and pulse and suctioning the resident. However review of the facility's video data on 02/01/12 and LPN #1 interview revealed he did not personally perform a physical assessment as he had described in the</p>	F 514	<p>F 514</p> <p>This plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/28/2012
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NAME OF PROVIDER OR SUPPLIER  PINE MEADOWS HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40504
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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 514	<p>Continued From page 58</p> <p>Nurse's Notes. The facility did not conduct a physical assessment for approximately six (6) minutes after the LPN #1 had identified the change in condition and not until the Assistant Director of Nursing (ADON) initiated the assessment. The record revealed the resident was pronounced expired at 9:00 AM on 02/01/12.</p> <p>The facility's failure to ensure staff followed their policy and procedure related to emergency care guidelines and standard of practice to ensure an accurate medical record to protect residents placed residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 03/29/12 and was determined to exist on 02/01/12. The facility was notified of the Immediate Jeopardy on 03/29/12. Substandard Quality of Care (SQC) was identified at 42 CFR 483.13, Resident Behavior and Facility Practice.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AoC) on 04/04/12 with the facility alleging removal of the Immediate Jeopardy on 04/04/12. Observations, staff interviews, and inservice record reviews were conducted to verify removal of Immediate Jeopardy as alleged in the acceptable AoC on 04/04/12 prior to exiting the facility on 04/28/12. However, non-compliance continued to exist at 42 CFR 483.75 Administration, with a scope and severity of a "D", as the facility had not completed the development and implementation of the Plan of Correction (PoC) to ensure the facility established and maintained an effective system to ensure residents' medical record was maintained accurately.</p> <p>The findings include:</p>	F 514	<p>1) Resident #2 was no longer in the facility at the time of the survey; therefore, no corrective action could take place. LPN #1 was suspended, pending the outcome of the investigation/survey. It is important to note that the video surveillance camera only records events happening in the hallways of the facility and not in the resident's room. Therefore, the employee documentation was not in question by the facility administration. Furthermore, interview of LPN #1 and record review determined that at 8:02:33 LPN #1 entered the room of resident #2 and observed her lying in bed. LPN #1 left room to inquire with SRNA why she was in bed at 8:03:18 the LPN #1 re-entered the residents and was in the room for approximately thirty seconds until 8:03:45. Interview with LPN #1 revealed that LPN #1 saw resident without respirations, pallor color and no visible signs of life. Resident #2 was a DNR and had been receiving Hospice services for diagnosis of end stage dementia. It was also noted that both the family and Hospice wanted comfort measures only. Upon seeing no visible signs of life, LPN #1 went to inform SRNA #2 that resident had expired and needed post mortem care. Interview with LPN #1 and record review does not indicate mucus coming out of the</p>	
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NAME OF PROVIDER OR SUPPLIER  PINE MEADOWS HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40504
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F 514

Continued From page 59

Review of the facility's "Emergency Care, General Guidelines For" policy undated, revealed the purpose was to provide emergency care to a resident in need of urgent service. Continued review revealed it was the basic responsibility of the Licensed Nurse to always take, report, and record vital signs when a resident's condition had changed and record the details and exact time of the condition change.

In an interview with the Director of Nursing (DON), on 03/29/12 at 11:07 AM, revealed this was the facility's policy for providing emergency care to residents. The DON stated she would expect her licensed nurses to perform an assessment of a resident with a change in condition that would include obtaining vital signs. She stated nurses should ensure their documentation is accurate.

Review of Resident #2's medical record revealed the facility admitted the resident on 10/09/01 with diagnoses which included a history of Aspiration Pneumonia and Alzheimer's Disease. Review of the Comprehensive Care Plan for Nutrition, dated 11/11, revealed staff was to provide the resident with assistance if he/she started to choke. Review of the Quarterly Minimum Data Set (MDS), dated 11/20/11, revealed the facility assessed the resident as severely impaired with daily decision making and totally dependent on staff for all Activities of Daily Living (ADLs). Review of the State Registered Nursing Assistants' (SRNAs) care plan revealed the resident was on aspiration precautions.

Review of the Nurse's Notes, dated 02/01/12

F 514

mouth of resident #2. LPN #1 further stated that that after the incident occurred and he was documenting, his "thoughts were disorganized" and part of his note should in fact have been an addendum. As he did not suction the resident, but the ADON did. The ADON entered resident #2's room to verify residents death, after completing her assessment that she confirmed resident #2 had expired. Per survey interview of facility Medical Director on 4/6/2012 at 5:40PM revealed if a resident experienced a change in condition as in the case of resident #2 he would expect the nurse to assess for signs of life. He further stated the nurse should assess for respirations, pulse, pallor and rigidity.

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F 514	Continued From page 60 written by Licensed Practical Nurse (LPN) #1 revealed at 7:45 AM Resident #2 had been "cleaned up" and was in bed waiting to be "gotten up" for breakfast. Interview, on 03/26/12 at 2:07 PM with LPN #1, revealed he went into Resident #2's room to check on his/her roommate. He stated he noted Resident #2 was still in bed and should have been up, so he immediately left the room to check on why the resident was still in bed. Observation of the video camera data revealed at 8:02:33 AM LPN #1 entered and immediately exited Resident #2's room. Further interview with the LPN revealed he returned to Resident #2's room and observed that the resident's skin color was pale, "paler than usual" and he/she was not breathing. In an additional interview, on 03/27/12 at 11:10 AM with LPN #1, he stated Resident #2 had "mucous coming out of" his/her mouth when he found him/her pale and without respirations. Further interview, on 03/29/12 at 9:20 AM with LPN #1, revealed he performed a visual assessment of the resident when he found him/her pale and without respirations. The LPN stated he did not have a stethoscope with him. He stated he observed the resident having no respirations. LPN #1 stated his thoughts were "disorganized" when he found the resident in this condition. He stated twice that he did not "touch" the resident and stated that he made no attempts to suction the resident prior to going to find the ADON despite having documented in the Nurse's Notes that he had performed a physical assessment of the resident's change in condition. Review of the Nurse's Note revealed LPN #1 noted Resident #2 had a "pale looking color" and had no respirations. The Note further detailed LPN #1 auscultated for lung sounds with none heard and	F 514	Interview of LPN #1 on 4/13/2012 revealed LPN #1 stated he did not see resident # 2's chest rising, her pupil was dilated, her mouth was gaping open and her color was pale. LPN#1 states, he "did not check the pulse in her wrist and there was no pulse." LPN #1 further acknowledged that his assessment of the above finding all confirmed that resident #2 had expired. LPN #1 then followed the facility policy regarding notification of a supervisor and summoned the ADON to resident #2's room. Because it is not the facility policy for nurses to pronounce death of a resident, the official pronouncement of death was made by the Hospice nurse when she arrived to the facility.	
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F 514	Continued From page 61 "no pulse and B/P" (blood pressure) could be obtained. LPN #1 documented Resident #2's head was "inclined" at thirty (30) degrees and he/she was suctioned using the suction machine at the bedside. However, review of the video camera data revealed the LPN was observed to return to Resident #2's room at 8:03:15 AM and exit the room at 8:03:45 AM, thirty (30) seconds later. Continued interview with LPN #1 revealed the ADON "rushed into the room", noted the resident had secretions in his/her mouth, and proceeded to suction him/her. He stated the secretions were "foamy". Additionally, he stated he and the ADON examined Resident #2 and found he/she did not have a pulse or respirations. Interview, on 03/27/12 at 3:25 PM with the ADON, she stated she went to Resident #2's room and noted the resident had "some secretions, not thick, kind of foamy" in his/her mouth. The ADON stated there was a suction machine at the bedside so she immediately started to suction the resident. When asked if LPN #1 had suctioned the resident prior to her coming to the room, she stated "I don't think so". She stated she put on gloves, "checked" the resident's mouth, and there was nothing there. The ADON stated vital signs were attempted; however, none were obtained. The ADON indicated Resident #2's skin was "warm the whole time". Further observation of the video camera data revealed LPN #1 returned to the resident's room with the ADON at 8:09:10 AM, approximately six (6) minutes later. Further review of the Nurse's Notes revealed the LPN documented at 7:50 AM the Assistant Director of Nursing (ADON) was notified of the change in Resident #2's condition and she suctioned the resident. Further interview with the LPN revealed no assessment was performed until the ADON	F 514	2) To the best of the facility's knowledge, Pine Meadows believes this to be an isolated incident involving only the resident cited in the deficiency. The facility completed a Medical Records review of thirty-seven (37) individual charts on 4/3/2012. These charts were of residents who had expired in the facility during the previous six months or who had been sent out to the hospital due to change of condition in the past six months. These charts were reviewed to indicate whether the nurses involved assessed the resident's acute change-in-condition and responded according to facility policy. All records were found to be in compliance.		

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F 514	<p>Continued From page 62</p> <p>was present in Resident #2's room. Further review of the Nurse's Notes revealed a Note written by another nurse that stated Resident #2 was pronounced deceased at 9:00 AM.</p> <p>Continued interview with the DON, on 03/29/12 at 11:07 AM, revealed she would expect her licensed nurses to perform an assessment of a resident with a change in condition that would include obtaining vital signs and to ensure their documentation is accurate. She stated staff should not "falsify" their documentation.</p> <p>Interview with the Administrator, on 04/06/12 at 4:10 PM, revealed the facility held morning meetings with administrative staff (Administrator, Director of Nursing, Assistant Director of Nursing, Department and Unit Managers, Staff Development and Therapy staff) to discuss changes that had taken place with residents. The nurses discussed interventions, and put those into place. Then they follow up with education, in-services and competencies. However, the Administrator revealed they had not identified a problem with the staff's failure to conduct timely assessment of Resident #2 on 02/01/12 to ensure appropriate care and services were provided to the resident nor had they identified a problem with inaccurate documentation of the timing of when the assessment occurred and by whom. The facility could provide no evidence that they had identified a problem with inaccurate documentation of the medical record related to the incident of neglect which occurred involving Resident #2 on 02/01/12.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AoC) on 04/04/12 that</p>	F 514	<p>3) New policies and procedures were created and implemented on 3/29/2012 to include the following; 1) A policy entitled "Assessment of Residents when Found to Have a Change in Condition" This policy specifically addressed the immediate assessment of a resident exhibiting a change in condition (attachment A), 2) A revision to the policy "Charting and Documentation" was made to emphasize the importance of timely and accurate charting in the Resident Medical record (attachment B), 3) Staff were again, in-serviced on the policy "General Guidelines for Emergency Care" (attachment C) and 4) "Procedure for Nursing Report and Rounds" (attachment D). All Registered Nurses and Licensed Practical Nurses were in-serviced on all of the above mentioned policies starting on 3/29/2012. The in-services were completed for all nurses by 4/4/2012. The above mentioned in-services were conducted by the DON, ADON, Staff Development Nurse, Unit 2 Coordinator, QA Nurse, Restorative Nurse and the Weekend Nursing Supervisor.</p>	
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F 514	<p>Continued From page 63 alleged removal of the Immediate Jeopardy (IJ) on 04/04/12, based on the following:</p> <ol style="list-style-type: none"> <li>1. LPN #1 was suspended pending completion of an investigation into the allegations.</li> <li>2. The DON conducted a review on 04/02/12 of all residents' medical records who had expired in the facility in the past six (6) months. All records were found in compliance.</li> <li>3. Medical record reviews were completed on 04/03/12 of thirty-seven (37) individual charts of residents who had expired in the facility in the past six (6) months or who had been sent to the hospital due to a change in condition in the past six (6) months.</li> <li>4. New policies and procedures were created and implemented immediately on 03/29/12. A policy entitled "Assessment of Residents when found to have a Change in Condition" which addressed the immediate assessment of a resident exhibiting a change in condition. A revision of the policy, "Charting and Documentation" to emphasize the importance of timely and accurate charting in residents' medical records. Staff inservices were conducted on these policies. Re-inservices were conducted on the "General Guidelines for Emergency Care" and "Procedure for Nursing Report and Rounds" policies. All Registered Nurses and Licensed Practical Nurses were inserviced on all the above policies starting on 03/29/12, and completed on 03/31/12, with the exception of two (2) nurses. One nurse who was out of the country, and one currently on Family Medical Leave. These two (2) nurses will not be allowed to work on the floor with residents</li> </ol>	F 514	<p>4) The facility will monitor nurse compliance with the existing and revised policies and procedures on an ongoing basis by including them in the nurse competency reviews. These reviews are usually conducted annually in the months of May through July. Due to the recent changes, the facility has chosen to move up the nurse competency reviews regarding assessments and documentation. These reviews began on 3/29/2012. On 3/31/2012 the facility also created and implemented a "Condition Change Documentation 24-hour report Follow-up" form (attachment E) that will be reviewed at the interdisciplinary team's morning meeting to ensure proper follow-up and assessment of residents with a change in condition. The interdisciplinary team consists of the: DON, ADON, Quality Assurance Nurse, Unit Coordinators, Social Services, Therapy, MDS Nurse, Wound Nurse Restorative Nurse. In addition, on March 31, 2012 the facility implemented a new policy in regard to the "24-hour Report and Condition Change form" (attachment F). The above form and policy revisions were specifically implemented on March 31, 2012 to utilize as tools for monitoring and ensuring consistent assessment and follow-up of resident care.</p>	
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F 514	<p>Continued From page 64 until they are inserviced on the policies as well.</p> <p>5. The DON and ADON will audit medical records for any resident that expires in the facility. The audit will include review for compliance with the above cited policies and procedures.</p> <p>6. Monitoring of nurse compliance with the existing and revised policies and procedures will be performed by including them in the nurse competency reviews. These reviews were started on 03/29/12, and were seventy-six (76) percent complete on 04/04/12.</p> <p>7. On 03/31/12, the facility also created and implemented a "Condition Change Documentation 24 Hour Report Follow-up" form that will be reviewed at the Interdisciplinary Team's (IDT) morning meeting. A new policy was implemented in regards to the new form. The form and policy revisions were implemented on 03/31/12 to utilize as tools for monitoring.</p> <p>8. The facility will Quality Assurance (QA) condition change assessments by selecting five (5) resident medical records from the facility's two (2) units for a total of ten (10) records to review that accurate assessments were completed for the selected residents. If compliance is found during the initial six (6) month period, then five (5) records from the two (2) units will be reviewed on a quarterly basis. These QA audits will be completed by the QA nurse.</p> <p>On 04/06/12 it was verified the immediacy of the IJ was removed and the facility implemented corrective actions as alleged in the AoC, effective 04/04/12 based on the following:</p>	F 514	<p>The facility will QA Condition Change assessments by selecting five residents a month for six months from each unit of the facility (ten charts total) and reviewing that accurate assessments were completed for the selected residents. If compliance is found during the initial six month period the facility will then review five resident charts from each unit (ten charts total) on quarterly basis from then on out. QA audits will be completed by the QA nurse. The Medical Records Director will audit three (3) resident records from each unit (a total of six records) each quarter then ensure that the resident record is complete, accurately documented, readily accessible and systematically accessible. Results of audit will be reported to the QA committee each quarter.</p> <p>Completion Date:</p>	04/29/2012
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F 514	<p>Continued From page 65</p> <p>Observation, on 04/06/12 from 10:45 AM until 11:00 AM revealed the new or revised policies were present in the Policies and Procedures books located at the Nurse's Station on each of the two (2) units.</p> <p>Interviews with staff including Registered Nurse (RN) #3 on 04/06/12 at 11:05 AM, RN #2 on 04/06/12 at 4:30 PM, Licensed Practical Nurse (LPN) #8 at 10:22 AM, LPN #6 at 10:40 AM, LPN #7 at 10:50 AM, LPN #10 at 10:56 AM, LPN #4 at 3:05 PM and LPN #9 at 3:41 PM revealed they all were aware of the new policies and procedures that had been implemented or revised: "Assessment of Residents when found to have a Change in Condition", "Charting and Documentation", "General Guidelines for Emergency Care" and "Procedure for Nursing Report and Rounds". They all were aware of the "Condition Change Documentation 24 Hour Report Follow-up" form and new policy related to it.</p> <p>Review of the facility's inservices and interviews, on 04/06/12 at 9:25 AM, with the Staff Development Nurse and Director of Nursing (DON) revealed the facility had inserviced all licensed staff beginning 03/29/12 related to the new policies and procedures with the exception of two licensed staff who was out of the country or on medical leave and would not be allowed to return to work until inserviced. Further interview revealed to validate staff's competency related to the inservice, staff was given a change of condition scenario and they had to document a nurse's note describing their assessment of the change in condition, such as obtaining vital signs.</p>	F 514		
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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 514	<p>Continued From page 66</p> <p>Additionally, interview and review of the facility's chart audits revealed thirty-seven (37) individual charts of residents who had expired in the facility in the past six (6) months or who had been sent to the hospital due to a change in condition in the past six (6) months were reviewed to ensure there were no other residents effected related to not appropriately assessing a resident who had a change of condition.</p> <p>Interview on 04/06/12 at 4:10 PM with the Administrator revealed all but two (2) staff had been inserviced on the new or revised policies and procedures and new form. According to the Administrator, new employees will receive the information in orientation. He stated a new QA audit was in place to monitor residents' change of condition and ensure accurate assessments were completed by the licensed nursing staff.</p> <p>The facility remained out of compliance at a lower Scope and Severity of a "D", an isolated deficiency with potential for more than minimal harm in order for the facility to develop and implement the Plan of Correction (PoC).</p>	F 514		
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