

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

PRINTED: 01/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185336	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 12/11/2013
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40089	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS Amended An onsite Revisit Survey was conducted 12/10/13 through 12/11/13 related to the Abbreviated/Partial Extended Survey concluded on 10/24/13. The Revisit Survey determined the facility corrected 42 CFR 483.15 Resident Assessment, F-282 on 11/25/13 as alleged. However, continued non-compliance remained at 42 CFR 483.20 Resident Assessment, F-281 at a Scope and Severity of a "D"; 42 CFR 483.25 Quality of Care, F-323 at a Scope and Severity of an "E"; and 42 CFR 483.75 Administration, F-490 and Quality Assurance, F-520 at a Scope and Severity of an "E". The facility failed to ensure the Audits and Quality Assurance as outlined in the acceptable Plan of Correction from the 10/24/13 survey were effectively implemented, monitored and evaluated to ensure the correction of the deficient practice to prevent continued non-compliance. In addition, new deficiencies were identified at 42 CFR 483.10 Resident Rights, F-166 and 42 CFR 483.15 Quality of Life, F-258 at a Scope and Severity of a "D". F 166 SS=D 483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by:	{F 000}	F 166 Please accept the attached Plan of Correction as our credible allegation of compliance effective January 24, 2014. 1.) The Maintenance Director is no longer employed at the facility. The fan for the bathroom that connects resident room 34 and 32 has been replaced. Entire facility was assessed for need of replacement fans on the week of 12/16/13. This assessment was conducted per facility maintenance personnel. There were ten fans that needed to be replaced, all of these fans have been replaced with the last being done on 01/23/14 2.) Concern log for December was	

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

TITLE

(X6) DATE

U. Edward Foley

Interim Administrator

01/24/14

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

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NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069		
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F 166	<p>Continued From page 1</p> <p>Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure each resident's right to voice grievances and to be assured that after receiving a complaint or grievance, the facility would actively seek a resolution and keep the resident appropriately apprised of its progress toward a resolution for one (1) of five (5) sampled residents (Resident #3) and one (1) of two (2) unsampled residents (Unsampled Resident B). The facility failed to complete a grievance document after having received two (2) separate complaints of a loud bathroom exhaust fan that disrupted Resident #3 and Unsampled Resident B's sleep and in room activities. Additionally, the facility failed to keep the residents apprised of its progress toward a resolution to the grievance.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Concern/Grievance Policy", undated, revealed an employee who received a concern or grievance was responsible for completing the resident concern form either by assisting the resident and family to fill it out or to fill out the concern form themselves. The Administrator would review the resident's concern form and log all concerns or grievances. Continued review revealed the Administrator would determine which department was responsible for resolution of the concern or grievance and the department responsible for the concern or grievance had five (5) days to communicate a resolution to the family or resident.</p> <p>Observation, on 12/10/13 at 10:49 AM, revealed the fan for the bathroom that connected resident rooms thirty-four (34) and thirty-two (32) was loud</p>	F 166	<p>reviewed per new Administrator at end of month to ensure all concerns had been addressed to best of facility ability. The concerns were determined per facility Administrator on December 31, 2013 to be addressed for all concerns listed on log. Review was also completed of the December resident council meeting.</p> <p>3.) All staff have been inserviced regarding the importance of reporting resident concerns promptly on 12/13/13 per Education Training Registered Nurse. Facility Administrator or designee will review concerns five times per week as a component of the stand up meeting that involves department managers. In addition</p>		

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F 166	<p>Continued From page 2</p> <p>and made an intermittent screeching noise.</p> <p>Record review revealed the facility admitted Resident #3 on 01/15/13, and re-admitted him/her on 10/28/13, with diagnoses which included Schizophrenia, Depressive Disorder, Anxiety, Bipolar Disorder and Insomnia. Review of the Admission Minimum Data Set (MDS), dated 11/14/13, revealed the facility assessed Resident #3 to have a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated the resident was cognitively intact and interviewable.</p> <p>Interview with Resident #3, on 12/10/13 at 10:49 AM, revealed the bathroom fan was "loud and screeching" and the resident had reported the loud bathroom fan to the Maintenance Director. Continued interview, on 12/11/13 at 2:47 PM, revealed the resident had reported the loud screeching fan to the Maintenance Director prior to the Thanksgiving holiday. Resident #3 stated the Maintenance Director had "lubricated" the fan twice since he/she reported the fan; however, the fan continued to be loud and screeching. Further interview revealed Resident #3 was aggravated with the situation because the noise kept him/her awake at night.</p> <p>Record review revealed the facility admitted Unsampled Resident B on 04/30/13, with diagnoses which included Non-Alzheimer's Dementia. Review of the Quarterly MDS, dated 10/14/13, revealed the facility assessed Unsampled Resident B to have a BIMS score of fifteen (15), which indicated the resident was cognitively intact and was interviewable.</p> <p>Interview with Unsampled Resident B on 12/11/13 at 9:30 AM, revealed the fan in the bathroom was</p>	F 166	<p>Facility Administrator or designee will review concern log at conclusion of each month to ensure all concerns have been addressed. The facility Administrator maintains the concern log. Once logged the Administrator will refer to the log during daily review to ensure resolutions or plans are communicated to the resident. The Manager on Duty on the weekends will collect and address any concerns that the staff have collected and address any more that occur during the course of the day during their rounds. Resident concerns are reported to staff who utilize the concern form to forward concern to Administration. The facility continues to utilize a</p>		

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F 166

Continued From page 3

too loud. The resident stated the loud fan had been reported to the Maintenance Director. Subsequent interview, on 12/11/13 at 2:47 PM, revealed the fan kept the resident awake at night.

Interview with the Maintenance Director, on 12/11/13 at 10:13 AM, revealed the fan and the light were controlled by a single switch and both came on at the same time. He stated it was facility practice to leave the light in the bathroom on at all times. Continued interview with the Maintenance Director, on 12/11/13 at 3:14 PM, revealed the loud fan was reported to him approximately a week and a half prior to the survey. He stated he did not complete a complaint or grievance form because he lubricated the fan. Further interview revealed when the loud fan was reported to him a second time, he lubricated the fan again; however, he did not complete a complaint/grievance form.

Interview with the Registered Nurse Coordinator, on 12/11/13 at 10:46 AM, revealed it was the facility's practice for the lights, and therefore the fans, to stay on at all times.

Interview with the Administrator, on 12/11/13 at 4:30 PM, revealed she had not been made aware of the complaints made by Resident #3 and Unsampld Resident B regarding the loud fan prior to the survey. She stated it was acceptable for the Maintenance Director to not complete a complaint/grievance form when the loud fan was initially reported; however, the Administrator stated the Maintenance Director should have completed a complaint/grievance form, per the facility's policy, when the noise was reported a second time to ensure the resident's concerns were addressed.

F 166

Concern/Grievance Policy.

4.) Quality Assurance team to meet weekly times four weeks starting week of December 29, 2013, then monthly and PRN thereafter. Concern log to be reviewed and any abnormalities will be addressed at that time. Team will consist of Administrator, DON, ADON, Medical Director and SW.

5.) Completion Date 01/24/14.

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F 258 SS=D	<p>483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS</p> <p>The facility must provide for the maintenance of comfortable sound levels.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide for the maintenance of comfortable sound levels for one (1) of five (5) sampled residents (Resident #3); and, one (1) of three (3) unsampled residents (Unsampled Resident B). The facility failed to maintain the exhaust fan in Resident #3 and Unsampled Resident B's shared bathroom.</p> <p>The findings include:</p> <p>Observation, on 12/10/13 at 10:49 AM, revealed the fan and the light were on in the bathroom that connected resident rooms thirty-four (34) and thirty-two (32). Continued observation revealed the fan was loud and making an intermittent screeching noise.</p> <p>Review of the clinical record revealed the facility admitted Resident #3 was on 01/15/13, and re-admitted on 10/28/13. Review of the Admission Minimum Data Set (MDS) dated 11/14/13, revealed the facility assessed Resident #3 to have a score of fifteen (15) on the Brief Interview for Mental Status (BIMS), which indicated the resident was not cognitively impaired and was interviewable.</p> <p>Interview with Resident #3, on 12/10/13 at 10:49 AM, and on 12/11/13 at 2:47 PM, revealed</p>	F 258	F 258		
			<p>1.) The Maintenance Director is no longer employed at the facility. The fan for the bathroom that connects resident room 34 and 32 has been replaced. Entire facility was assessed for need of replacement fans on the week of 12/16/13. This assessment was conducted per facility maintenance personnel. There were ten fans that needed to be replaced, all of these fans have been replaced with the last being done on 01/23/14</p> <p>2.) Concern log for December was reviewed per new Administrator at end of month to ensure all concerns had been addressed to best of facility ability. The</p>		

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F 258	Continued From page 5 Resident #3 had reported the "loud and screeching" fan to the Maintenance Director prior to the Thanksgiving holiday. The resident stated the Maintenance Director had "lubricated" the fan twice since the noise was reported; however, the fan continued to be loud and screeching. Continued interview revealed the noise kept the resident awake at night, and was disturbing during the day as well. Clinical record review revealed the facility admitted Unsamped Resident B on 04/30/13. Review of the Quarterly MDS, dated 10/14/13, revealed the facility assessed Unsamped Resident B to have a score of fifteen (15) on the BIMS, which indicated the resident was cognitively intact and was interviewable. Interview with Unsamped Resident B, on 12/11/13 at 9:30 AM, and on 12/11/13 at 2:47 PM, revealed the fan in the bathroom was too loud and was aggravating, and the loud fan had been reported to the Maintenance Director prior to the Thanksgiving holiday. Per interview, the fan kept the resident awake at night. Interview with the Maintenance Director, on 12/11/13 at 3:14 PM, revealed the loud fan was initially reported to him approximately a week and a half ago. He stated he lubricated the fan after receiving the report. Continued interview revealed he received a second report about the noisy fan, and he lubricated it for a second time. The Maintenance Director stated he did not follow up with Resident #3 and Unsamped Resident B because the residents "would let him know" if the fan continued to be loud. Interview with the Administrator, on 12/11/13 at	F 258	concerns were determined per facility Administrator on December 31, 2013 to be addressed for all concerns listed on log. Review was also completed of the December resident council meeting. 3.) All staff have been in-serviced regarding the importance of reporting resident concerns promptly on 12/13/13 per Education Training Registered Nurse. Facility Administrator or designee will review concerns five times per week as a component of the stand up meeting that involves department managers. In addition Facility Administrator or designee will review concern log at conclusion of each month to ensure all concerns have been addressed. In		

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F 258	Continued From page 6 4:30 PM, revealed it was acceptable for the Maintenance Director to lubricate the fan and not report the first complaint. However, the Maintenance Director should have reported the complaint/grievance when the initial lubrication of the bathroom fan did not correct the problem, to ensure the residents' concerns regarding the noise were addressed.	F 258	addition, interviews are being conducted with alert residents to inquire regarding acceptable noise levels within the facility. These interviews are being conducted per Administrator or <u>designee</u> . These are being conducted weekly times four weeks, date being January 02, 09, 13, and 20 th . The monthly interviews of three residents will be conducted per Administrator or <u>designee</u> .	
{F 281} SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the facility's "Medication Pass Quality Assurance Education Tool" and review of KRS (Kentucky Revised Statutes) 314.011(6), it was determined the facility failed to ensure services were provided to meet professional standards of quality. During a medication administration on 12/11/13, a Registered Nurse (RN) was observed administering medications to a resident (Unsampled Resident C) which another nurse had prepared. The RN had not witnessed the medication being prepared by the other nurse. The findings include: Interview with Registered Nurse #3 on 12/11/13 at 7:14 PM, revealed the facility did not have a policy that addressed safe medication administration pertaining to nurses administering medications prepared by other nurses.	{F 281}	4.) Quality Assurance team to meet weekly times four weeks starting week of December 29, 2013, then monthly and PRN thereafter. Concern log to be reviewed and any abnormalities will be addressed at that time.	

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(F 281) Continued From page 7

Review of the facility's, "Medication Pass Quality Assurance Education Tool" revealed residents' rights were to be observed during the administration of medication.

Review of KRS (Kentucky Revised Statutes) 314.011(6) revealed it defines "Registered Nursing Practice" as... c) The administration of medication and treatment as prescribed by a physician,... Components of medication administration include... "preparing and giving medication in the prescribed dosage, route, and frequency".

Observation of a medication administration on 12/11/13 at 4:30 PM, revealed Licensed Practical Nurse (LPN) #8 attempted to administer a medication, Ativan 0.5 milligram, which the nurse had crushed and mixed with applesauce, to Unsampled Resident C. Observation revealed the resident resisted taking the medication from LPN #8. Continued observation revealed LPN #8 left the room with the medication in her hand. Further observation revealed RN #3 entered the room with a medicine cup containing applesauce and the medication which had been obtained and prepared by LPN #8. Observation revealed RN #3 administered the medication to the resident.

Interview with LPN #8 on 12/11/13 at 4:52 PM, revealed she had obtained Ativan 0.5 milligram (an anti-anxiety medication), crushed the medication, and mixed it with applesauce. She stated when the resident would not take the medication for her, she gave the medication she had prepared to RN #3 to attempt to give to the resident. LPN #8 stated she was not in the room when RN #3 administered the medication to the resident. Continued interview revealed she was

(F 281)

A summary of the resident noise level interviews will be reviewed during the QA meeting as part of the concern log review. Team will consist of Administrator, DON, ADON, Medical Director and SW.

5.) Completion Date 01/24/14.

F 281

1.) Physicians for R- C on 12/20/13, R- E on 12/20/13 and R- F on 12/18/13 were notified, any new orders obtained were followed. LPN 1 and LPN 4 were counseled on 12/18/13 per ADON.

2.) All residents who were receiving antibiotic medications are being monitored per use of the Antibiotic

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{F 281}	Continued From page 8 not aware if the facility had a policy to address safe medication administration. She stated it was not "best nursing practice" to entrust another nurse to administer a medication that she had prepared and was responsible for giving. However, she stated, "she was okay with it". Interview with RN #3 on 12/11/13 at 5:30 PM, revealed she witnessed the LPN obtain the Ativan; however, she did not witness the medication being crushed and mixed with the applesauce. RN #3 stated it was not "best" practice to administer medications prepared by another nurse when the administering nurse had not witnessed the preparation. She indicated that the nurse who administered the medication would not be able to verify and confirm the correct medication had been given if the preparation had not been witnessed. Interview with the Director of Nursing (DON) on 12/11/13 at 5:23 PM, revealed she thought the facility had a policy against nurses administering a medication they had not prepared; however, she felt it was "Nursing 101". She stated "you don't give someone else's medications". The DON stated her expectations would be for staff to follow the five (5) rights of safe medication administration. Further interview revealed the medications should have been wasted by LPN #8 and prepared again by RN #3 to ensure safe medication administration to the resident.	{F 281}	flow sheet on 01/10/13. This was determined per the ADON. The remainder of the medications for all residents who were receiving medications are being monitored per DON or designee per 100% review of the MAR three times per week starting on 01/20/13. This was determined per Administrator. 3.) Facility Licensed nursing staff will utilize an Antibiotic Flow Sheet. The purpose of this tool is to ensure that Nurses that are Nurses going off duty, count the total number of antibiotics in cart, compare to count sheet to ensure totals both match. In addition, Licensed		
{F 323} SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	{F 323}			

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(F 323)	Continued From page 9 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and Interview, it was determined the facility failed to ensure residents' environment remained as free of accident hazards as possible for fourteen (14) of the facility's thirty-five (35) resident rooms. The facility failed to ensure the television cable wiring was off the floor, which was a potential fall hazard, for residents in rooms #1, 4, 9, 12, 13, 17, 24, 25, 27, 28, 29, 35, 37 and 38. The findings include: Observations during the initial tour, on 12/10/13 at 10:05 AM, revealed resident rooms 24, 25, 27, 28, 29, 37 and 38 had television cable wiring lying on the residents' rooms floor, causing a potential tripping or injury hazard to residents, staff and visitors. Continued observation, on 12/11/13 at 8:56 AM, revealed resident rooms 1, 4, 9, 12, 13 and 17 also had television cable wiring lying on the floor, which could be a potential fall hazard to residents, staff and visitors. Subsequent observation, on 12/11/13 at 9:04 AM, revealed a resident in room 25, bed B sitting up beside the bed in a glider chair with the television cable wiring coiled three (3) times in the area of the resident's feet and chair. Interview with the Maintenance Director on 12/11/13 at 10:13 AM, revealed the television cable wiring had "been like that" for a while.	(F 323)	Nurses are to review the MAR to ensure the off going shift has signed out the antibiotic. All licensed Nurses were in serviced on this topic on January 10, 2014. This in-service was conducted per Education Training Registered Nurse. In addition, these flow sheets will be reviewed five times per week per Director of Nursing or designee. Any abnormalities noted will be addressed at time of discovery. In addition, 100 % MARS/TARS will be reviewed three times per week per Director of Nursing or designee to review entire medication administration records. Any abnormalities noted		

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PRINTED: 01/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 12/11/2013
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NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40089
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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 323}	Continued From page 10 Continued interview revealed the television cable wiring lying on the floor could be a safety issue for residents, staff or visitors. Interview with the Regional Nurse Coordinator on 12/11/13 at 10:48 AM, revealed the television cable wiring lying on the floor could potentially be a safety issue for residents. She stated she did "not know what else to do with the cable". Interview with the Administrator on 12/11/13 at 10:46 AM, revealed the television cable wiring lying on the floor in the resident rooms could be a safety issue; however, "so could the rolling of bedside tables". She indicated she did not know how long the television cable wiring had been on the floor. Additional interview on 12/11/13 at 3:37 PM, with the Administrator, revealed the television cable wiring had not been identified as a potential hazard during the rounds. Continued interview revealed the Administrator felt "there was no way to list or identify all potential hazards".	{F 323}	will be addressed at time of discovery. Medication Administration observations have been conducted per Education Training Registered Nurse for all licensed Nurses. This was completed on 01/10/14. Two medication observations will continue to be conducted times four weeks then two monthly/PRN thereafter. Any abnormalities noted will be addressed at time of discovery. These audits will be conducted per Licensed Pharmacist and Education Training Registered Nurse. Medications being returned to the pharmacy will be reviewed and compared three	
{F 490} SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's Plan of Correction (POC), it was determined the facility's Administration failed to ensure the facility had achieved substantial	{F 490}		

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{F 490} Continued From page 11
 compliance per the facility's POC. The facility's Administration failed to identify a potential safety hazard in fourteen (14) of the facility's thirty-five (35) rooms. Observations revealed television cable wiring on the floor of residents' rooms numbered 1, 4, 9, 12, 13, 17, 24, 25, 27, 28, 29, 35, 37 and 38. (Refer to F323)

The findings include:

Review of the facility's Plan of Correction (POC), dated and signed by the Administrator on 11/15/13, and with a compliance date of 11/25/13, revealed a one time audit of all resident rooms was completed by the Regional Nurse Coordinator on 10/25/13 to identify any hazards and rooms were to be monitored daily to ensure all potential hazards were identified.

Observations on 12/10/13 at 10:05 AM, and on 12/11/13 at 8:56 AM revealed resident rooms 1, 4, 9, 12, 13, 17, 24, 25, 27, 28, 29, 35, 37 and 38 had television cable wiring lying on the floor in the residents' rooms, which could have been a potential hazard to residents, staff and visitors. Continued observation, on 12/11/13 at 9:04 AM, revealed television cable wiring coiled three (3) times in the area of the feet of a resident in room 25-B and the chair which he/she was sitting in up beside the bed.

Interview, on 12/11/13 at 10:13 AM, with the Maintenance Director revealed the television cable wiring had been on the floor for a while in the residents' rooms. The Maintenance Director indicated this was a potential safety issue.

Interview with the Regional Nurse Coordinator on 12/11/13 at 3:37 PM, revealed she had completed

{F 490} times per week to Physician orders and MARS for four weeks, then five medications in the return bin monthly/PRN thereafter. This review will be done per Director of Nursing or designee.

4.) Quality Assurance Team to meet weekly times four weeks starting week of January 12, 2014, then monthly and PRN thereafter. Medication Administration audits as well as Antibiotic flow sheet to be reviewed and any abnormalities noted will be addressed and the plan revised. Team will consist of Administrator, DON, ADON

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{F 490} Continued From page 12
the one time audit of all resident rooms to identify any potential hazards. She indicated the television cable wiring was present during this audit; however, it was not identified as a safety issue. The Regional Nurse Coordinator stated staff had completed daily rounds of resident rooms, as per the Plan of Correction (POC); however, the television cable wiring had not been identified as a potential hazard for residents during the daily rounds.

Interview with the Administrator on 12/11/13 at 10:46 AM; and, on 12/11/13 at 3:37 PM, revealed daily resident room safety rounds had been completed per the POC and she had participated in the rounds. She stated the television cable wiring lying on the floor in the resident rooms could be a safety issue; however, neither she nor staff had identified the television cable wiring on the floor as a potential hazard during the rounds.

{F 520} 483.75(o)(1) QAA
SS=E COMMITTEE MEMBERS/MEET
QUARTERLY/PLANS

A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.

The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

{F 490} Medical Director,
SW,
5.) Completion Date
01/24/14
F323

{F 520} 1.) The cable wiring in the resident rooms of 1, 4, 9, 12, 13, 17, 24, 25, 27, 28, 29, 37 and 38 have been removed from the resident's floor. They are now secured along the wall. In addition all other residents rooms have had the cable wiring secured off the floor as well.

2.) All residents have the potential to be affected.

3.) Department Managers will continue to conduct rounds five times per week to identify any potential hazards. These rounds are completed on assigned resident rooms and areas of the facility. All department managers have been in serviced on the importance of identifying any potential hazards, any and all are to be identified. This in-service was conducted per facility Administrator on 12-31-13. Facility Administrator or

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{F 520}	<p>Continued From page 13</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's Plan of Correction (POC), it was determined the facility failed to maintain a Quality Assessment and Assurance Program that developed and implemented appropriate plans of action to correct quality deficiencies as evidenced by repeated deficiencies. In regards to failure to ensure each residents' environment remained as free of accident hazards as was possible for fourteen (14) of the facility's thirty-five (35) resident rooms. Observation revealed television cable wiring on the floor in resident rooms number 1, 4, 9, 12, 13, 17, 24, 26, 27, 28, 29, 36, 37 and 38. (Refer to F323 and F490)</p> <p>The findings include:</p> <p>Review of the facility's POC with an alleged compliance date of 11/25/13, revealed the facility was to monitor all resident rooms daily for four (4) weeks beginning 11/04/13 to ensure all potential hazards were identified. Review of the POC revealed the daily rounds were to be completed by the Department Managers, Director of Nursing (DON), Assistant Director of Nursing (ADON), Administrator and/or Regional Nurse Coordinator.</p>	{F 520}	<p>designee will review rounds sheets five times per week as a component of the stand up meeting that involves department managers well as subject being discussed at length during the stand up meeting five times per week. Any abnormalities will be addressed promptly. On the weekends, the manager on duty will identify any potential hazards that are noted and rectify promptly. The weekend manager will identify any potential hazards as per direct observations conducted during facility rounds. The safety committee, composed of Administrator, DON or designee, Maintenance Director, and at least a housekeeper or laundry worker, dietary worker and C.N.A or Nurse will investigate any concerns of hazards as a result of direct observations as well as round reviews.</p> <p>4.) Quality Assurance team to meet weekly times four weeks starting the week of December 29, 2013, then monthly and PRN thereafter, safety issues identified will be discussed to ensure</p>	

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{F 520}	Continued From page 14 Further review of the POC revealed on 10/31/13, a Safety Committee meeting was conducted on 10/31/13 to review the POC and identify any potential hazards. Further review of the POC revealed the Safety Committee was to meet on a monthly basis. Observations on 12/10/13 at 10:05 AM, and on 12/11/13 at 8:56 AM revealed television cable wiring lying on the floor in fourteen (14) of the facility's thirty-five (35) resident rooms. Interview, on 12/11/13 at 10:13 AM, with the Maintenance Director and on 12/11/13 at 10:46 AM, with the Regional Nurse Coordinator revealed the television cable wiring was a potential safety issue. Interview with the Human Resource (HR) Director on 12/11/13 at 8:29 PM, revealed she was responsible for monitoring resident rooms for safety hazards. She stated during her monitoring she did see cable wiring on the floor. She indicated she had not identified this as a safety hazard. The HR Director stated she had not observed "anything that looked out of place" or "nothing that would be a hazard" during her safety inspections. Interview with the Assistant Director of Nursing (ADON) on 12/11/13 at 8:34 PM, revealed her responsibilities included monitoring of resident rooms for safety hazards. She stated she had seen the television cable wires lying on the resident's floor; but, had not identified the wires to be a potential safety hazard during her rounds. The ADON indicated at the time of the interview she could see the television cable cords could possibly be a safety hazard for residents.	{F 520}	matters have been addressed fully. Team will consist of Administrator, DON, ADON Medical Director, SW. 5.) Completion Date 01/24/14 F 490 1.) The cable wiring in the resident rooms of 1, 4, 9, 12, 13, 17, 24, 25, 27, 28, 29, 37 and 38 have been removed from the resident's floor. They are now secured along the wall, in addition all other residents rooms have had the cable wiring secured off the floor as well. Facility had a new Administrator appointed on 12/16/13. 2.) All residents have the potential to be affected. 3.) Department Managers will continue to conduct rounds five times per week to identify any potential hazards. These rounds are completed on assigned resident rooms and areas of the facility. All department managers have been in serviced on the importance of identifying any potential hazards, any and all are to be identified. This in-service was conducted per		

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{F 520}	<p>Continued From page 15</p> <p>An additional interview, on 12/11/13 at 3:37 PM, with the Regional Nurse Coordinator revealed the "Caring Partners Daily Rounding Sheet" was utilized during the rounds; however, the television cable wiring on the floor of resident rooms had not been identified as a potential hazard.</p> <p>Interviews, on 12/11/13 at 10:46 AM, 3:37 PM and 6:27 PM, with the Administrator revealed daily rounds of resident rooms had been completed as per the POC. The Administrator stated she had performed rounds for resident room inspection and to monitor for potential hazards; however, during her rounds she had not identified the television cable wiring to be a potential hazard. The Administrator stated the television cable wiring could be considered a safety issue.</p>	{F 52	<p>facility Administrator on 12-31-13. Facility Administrator or designee will review rounds sheets five times per week as a component of the stand up meeting that involves department managers well as subject being discussed at length during the stand up meeting five times per week. Any abnormalities will be addressed promptly. On the weekends, the manager on duty will identify any potential hazards that are noted and rectify promptly. The weekend manager will identify any hazard as per direction observations conducted during facility rounds. The safety committee, composed of Administrator, DON or designee, Maintenance Director, and at least a housekeeper or laundry worker, dietary worker and a C.N.A or Nurse will investigate any concerns of hazards as a result of direct observations as well as round reviews.</p> <p>4.) Quality Assurance team to meet weekly times four weeks starting the week of December 29, 2013, then monthly and PRN thereafter, safety issues identified</p>	
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{F 520} Continued From page 15

An additional interview, on 12/11/13 at 3:37 PM, with the Regional Nurse Coordinator revealed the "Caring Partners Daily Rounding Sheet" was utilized during the rounds; however, the television cable wiring on the floor of resident rooms had not been identified as a potential hazard.

Interviews, on 12/11/13 at 10:46 AM, 3:37 PM and 6:27 PM, with the Administrator revealed daily rounds of resident rooms had been completed as per the POC. The Administrator stated she had performed rounds for resident room inspection and to monitor for potential hazards; however, during her rounds she had not identified the television cable wiring to be a potential hazard. The Administrator stated the television cable wiring could be considered a safety issue.

{F 52

will be discussed to ensure matters have been addressed fully. Team will consist of Administrator, DON, ADON Medical Director, SW, and
5.) Completion Date 01/ 24 /14.

F 520

- 1.) Facility Quality Assessment and Assurance team members will meet weekly times four weeks then monthly. Any abnormalities will be addressed and the plan revised at that time. Team will consist of Administrator, DON, Medical Director, SW and Activity Director. The cable wiring in resident rooms of 1, 4, 9, 12, 13, 17, 24, 25, 27, 28, 29, 37, and 38 have been removed from the floor and secured along the wall. All other residents' rooms have had the cable wiring secured off the floor.
- 2.) All residents have the potential to be affected.
- 3.) Department Managers will continue to conduct rounds five times per week to identify any potential hazards. All department managers have been in-serviced on the importance of identifying any potential hazards, any and all are to be identified. This in-service was

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			<p>conducted per facility Administrator on 12-31-13. Facility Administrator or designee will review rounds sheets five times per week as an component of the stand up meeting that involves department managers as well as subject being discussed at length during the stand up meeting five times per week. Any abnormalities will be addressed promptly. On the weekends, the manager on duty will identify any potential hazards that are noted and rectify promptly. The safety committee which is composed of Administrator, DON or designee, Maintenance Director and at least a housekeeper or laundry worker, dietary worker and a C.N.A or Nurse will investigate any concerns of hazards as a result of direct observations as well as round reviews. The safety committee will be monitoring any hazards during their normal working day to rectify promptly and report to the committee.</p> <p>4.) Quality Assurance team to meet weekly times four weeks starting the week of December 29, 2013, then monthly and PRN thereafter, safety</p>		

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issues identified per review of at least , department managers rounds and review of resident incidents during the stand up meeting conducted five times per week as well as concern forms will be discussed to ensure matters have been addressed fully. Any hazards are communicated promptly for prompt attention and repair. The QA team will take one sample rounds sheet per meeting and go to room and review to ensure all potential hazards have been identified, this will also validate the accuracy of the rounds sheets. Team will consist of Administrator, DON, ADON Medical Director, SW.
5.) Completion Date 01/24/14.