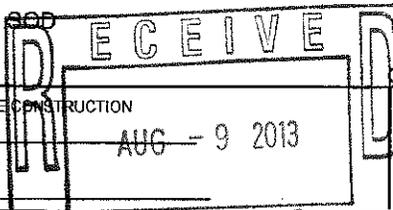


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185270	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  C 06/25/2013
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NAME OF PROVIDER OR SUPPLIER  CUMBERLAND VALLEY MANOR	STREET ADDRESS 301 South Main Street BURLINGAME, State of Kentucky BURKESVILLE, KY 42717
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS  An abbreviated standard survey (KY20346) was initiated on 06/21/13 and concluded on 06/25/13. The complaint was substantiated with deficiencies cited at "G" level, with an opportunity to correct.	F 000	<b>Cumberland Valley Manor Plan of Correction Abbreviated Survey 6/25/13</b>	
F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must record and periodically update the address and phone number of the resident's	F 157	Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.  <b>F 157 Physician Notification</b> A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility as specified in 483.12(a).	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 08/02/13
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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 157	<p>Continued From page 1 legal representative or interested family member.</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 physician was notified of a change in a resident's condition for one of five sampled residents (Resident #3). Interviews with staff revealed they had observed a split/tear in Resident #3's penis for approximately one month, and on 06/18/13, the split/tear in the resident's penis had enlarged and was bloody. However, based on documentation/interviews, the facility failed to notify the physician of the change in Resident #3's condition (refer to F282 and F315).</p> <p>The findings include:</p> <p>An interview with the facility's Compliance Officer on 06/25/13, at 11:10 AM, revealed the facility did not have a policy related to physician notification when there was a change in a resident's condition. She stated nurses should use nursing judgment on when to notify a resident's physician.</p> <p>Review of Resident #3's medical record revealed the facility admitted Resident #3 on 12/30/11 with diagnoses including Benign Prostate Hypertrophy and Urethral Stricture. Review of Resident #3's most recent Minimum Data Set (MDS) assessment dated 05/17/13 revealed the resident was cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 6 with 15 indicating no cognitive impairment. According to the MDS assessment, Resident #3 had a urinary catheter and was dependent on staff for</p>	F 157	<p><b>Criteria 1:</b> The MD for resident #3 was updated on the resident's current status on 07/16/13 by the DON.</p> <p><b>Criteria 2:</b> An audit of the 24 hour shift report for the last 30 days was completed by the Administrative Nursing Staff (DON, ADON, Infection Control Nurse, MDS Nurses, Restorative Nurse) to identify all changes in resident condition, and to determine that the MD was notified of these changes. There were no changes identified in which MD notification had not been completed.</p> <p><b>Criteria 3:</b> Facility RN's and LPN's have received in-service education on the need to immediately inform the physician and family of resident changes, and to document this notification, as provided by the DON and ADON on 07/11/13-07/26/13.</p>		

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F 157	<p>Continued From page 2</p> <p>assistance with transferring, walking, dressing, and hygiene/bathing. Review of Resident #3's care plan dated 02/13/12 revealed Resident #3 had a urinary catheter since that time (02/13/12).</p> <p>Observation of Resident #3 on 06/21/13 at 5:30 PM, with Licensed Practical Nurse (LPN) #2 revealed the resident's penis was split/torn from the urinary meatus (opening in the penis through which urine flows) approximately three-fourths of the way down the shaft of the resident's penis. The catheter tubing was observed to be protruding from the base of the split area on the left side of the penis. The resident's penis and left inner thigh were observed to be bloody.</p> <p>Interview with Resident #3 on 06/21/13, at 4:00 PM, revealed approximately two days prior the "girls" told him his penis was bloody but he did not know what happened.</p> <p>Interview with Certified Nurse Aide (CNA) #5 on 06/21/13, at 6:23 PM, revealed Resident #3's penis had been split/torn for "months." However, according to CNA #5, on Tuesday (06/18/13) she noticed Resident #3's penis was "more open and bleeding," and she notified LPN #4.</p> <p>An interview was conducted with LPN #4 on 06/22/13, at 9:00 PM, and on 06/24/13, at 12:20 PM. LPN #4 stated that on 06/18/13, CNA #5 reported that Resident #3's penis looked "different." LPN #4 stated she observed the resident's penis on 06/18/13 and observed the penis to be split/torn and bleeding. LPN #4 stated it was late and the resident's physician's office was closed so she documented her observation of Resident #3's penis in the Nursing Notes and asked staff that was beginning their shift to call</p>	F 157	<p><b>Criteria 4:</b> -The CQI indicator for the monitoring of physician and family notification of changes will be utilized monthly X 2 months and then quarterly under the supervision of the DON.</p> <p>-The Administrative Nursing Staff will review the 24 hour nursing reports daily during the week, and on Monday for the weekend reports, to identify any resident changes. They will then review the chart to determine that physician and family notification has been completed and documented.</p> <p><b>Criteria 5:</b> August 3, 2013</p>	

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F 157	Continued From page 3 the resident's physician the next morning. LPN #4 stated she reviewed the resident's record prior to the interview and could find no documentation that the resident's physician was notified.  Interview with LPN #1 on 06/21/13, at 6:23 PM, revealed she had provided direct care to Resident #3 occasionally and stated Resident #3's penis had been split down the side for "months"; however, according to LPN #1, on 06/18/13 Resident #3's penis was "more irritated/swollen."  On 06/21/13, at 6:07 PM, a review of Resident #3's medical record, including the computerized Nursing Note dated 06/18/13 at 8:50 PM, was conducted with assistance provided by LPN #3. At that time, documentation by LPN #4 revealed the CNA noticed the "F/C [Foley catheter] had split down the shaft of [Resident #3's] penis a small amount" and the resident's physician would be notified "in the AM." However, a copy of the Nursing Note dated 06/18/13 at 8:50 PM, obtained from the Director of Nursing (DON) on 06/21/13 at approximately 7:00 PM, indicated the resident's physician was notified of the change in the resident's condition on 06/18/13 (although interview with LPN #4 and a review of documentation revealed the physician was not notified of the change in the resident's condition). (See F514.)  An interview with Resident #3's physician on 06/24/13, at 2:30 PM, revealed the facility had not notified him of the change in the condition of Resident #3's penis and stated he should have been notified.	F 157			
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT	F 225			

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F 225	<p>Continued From page 4</p> <p><b>ALLEGATIONS/INDIVIDUALS</b></p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F 225	<p><b>F 225 Abuse Staff Treatment of Residents</b></p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p><b>Criteria 1:</b> The care concerns involving resident #6 have been investigated by the facility, DCBS, and OIG.</p> <p><b>Criteria 2:</b> An audit was conducted by the Nurse Consultant on 7-12-13 to determine if there were any documented grievances over the last 30 days that have not been reported to the required agencies as per the regulations. There were no unreported grievances identified.</p>		

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F 225	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy review it was determined the facility failed to ensure that all alleged violations involving mistreatment, neglect, and abuse, including injuries of unknown source and misappropriation of resident property, were reported timely and thoroughly investigated for one unsampled resident (Resident A). On 03/22/13, Resident A reported to facility staff that day shift aides were too rough while providing incontinence care. The facility failed to report the allegation to the State Survey Agency until 03/27/13, and failed to thoroughly investigate the allegation.</p> <p>The findings include:</p> <p>Review of the facility's policy, "Adult Abuse, Corporal Punishment, Neglect, Involuntary Seclusion, Exploitation and Injuries of Unknown Origin" (not dated), revealed the facility was to immediately report any incident of suspected abuse, neglect, or exploitation involving staff towards a resident to the Administrator and/or designee, at which time an investigation will begin. The policy also revealed that the Administrator and/or designee would immediately make an oral report to the Division of Community Based Services (DCBS) and to the Division of Long-Term Care (State Survey Agency).</p> <p>Review of the facility's investigation revealed on 03/22/13, Resident A reported that day shift Certified Nursing Assistants (CNAs) were too rough while providing incontinence care.</p>	F 225	<p><b>Criteria 3:</b> The Administrator, Social Service Director, DON, ADON, and facility Compliance Officer have received in-service education on the investigation and reporting of abuse as provided by the contracted Nurse Consultant on 7-1-13, including, but not limited to: identification of events requiring investigation; interviewing of residents, staff and all witnesses; and reporting of allegations and findings.</p> <p><b>Criteria 4:</b> -The CQI indicator for the monitoring of compliance with the facility abuse policy will be utilized bi-weekly for a month, monthly X 2 months and then quarterly thereafter as per the CQI calendar, under the supervision of the Administrator. Findings below the required threshold of 100% will result in a plan of correction to address the identified areas.</p> <p><b>Criteria 5:</b> August 3, 2013</p>		

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F 225	<p>Continued From page 6</p> <p>Documentation revealed the facility interviewed Resident A and the resident reported he/she felt safe at the facility and did not feel that any staff person had intentionally hurt him/her. The resident told facility staff that he felt that staff, in general, was rough and was unable to name which specific staff was too rough when providing incontinence care. According to the facility's investigation, the resident was asked if it would be satisfactory to the resident if the facility talked to staff reminding them to be very gentle and careful when providing incontinence care and bathing and the resident stated that it would.</p> <p>Review of the actions taken by the facility related to the allegation revealed staff would be reminded of proper incontinence care. It could not be determined by a review of the investigation that the facility had conducted a thorough investigation of the allegation to determine if the allegation was substantiated/unsubstantiated. Based on review of the facility's investigation, the facility failed to assess the resident for injuries, failed to conduct interviews with other residents related to staff treatment, failed to interview direct care staff regarding the allegation, and failed to observe direct care staff in the provision of direct care of residents.</p> <p>Interview with Resident A on 06/21/13, at 2:55 PM, revealed staff was "rough" when they provided incontinence care/cleaned him/her. Resident A stated he/she could not recall which staff had been rough but had told them that they were too rough.</p> <p>Interview with CNA #1 on 06/21/13 revealed Resident A preferred to stand when staff provided incontinence care. CNA #1 stated it was difficult to cleanse Resident A in a standing position but</p>	F 225			

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F 225	Continued From page 7 staff complied with the request. According to CNA #1, Resident A had complained that staff was too rough, even when they just touched him/her.  Interview with the facility's Social Worker on 06/21/13, at 6:30 PM, revealed Resident A's allegation was viewed and investigated as a grievance. According to the Social Worker, the resident's complaint was not reported to the State Agency until a representative from the Department for Community Based Services (DCBS) came to the facility investigating another incident and also asked about Resident A's allegation. The Social Worker stated even though the facility reported the resident's allegation to the State Agency, the facility did not complete an "abuse investigation."  Interview with the Administrator on 06/21/13, at 6:45 PM, revealed the incident related to Resident A was considered a grievance until DCBS entered the facility to investigate another incident and looked into the incident with this resident. The Administrator stated that, based on the facility's investigation, the resident did not think staff had been intentionally rough with the resident when they provided incontinence care and, as a result, the facility did not consider it abuse.	F 225			
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.	F 281	<b>F 281 Services Provided Meet Professional Standards</b> The services provided or arranged by the facility must meet professional standards of quality.		

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F 281	<p>Continued From page 8</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 physician's orders were followed for one of five sampled residents (Resident #5). Resident #5 had physician's orders dated 05/09/13, to apply Nystatin (anti-fungal) powder to redness beneath the resident's breasts and inguinal folds (groin area) every shift "as needed." On 06/11/13, the physician requested for staff to apply Nystatin powder to the resident's "folds" "twice daily." Interview with staff revealed the resident's abdominal fold and groin area had been red since at least 06/18/13; however, interview and documentation revealed no evidence the Nystatin powder had been applied as ordered by Resident #5's physician.</p> <p>The findings include:</p> <p>Interview with the facility's Compliance Officer on 06/25/13, at 11:10 AM, revealed the facility did not have a policy related to following physician's orders. She stated it was the nurses' responsibility to follow physician's orders.</p> <p>Review of Resident #5's medical record revealed the facility admitted Resident #5 on 05/27/09 with diagnoses that included Uncontrolled Diabetes, Chronic Urinary Tract Infections, and Parkinson's Disease.</p> <p>Review of Resident #5's Minimum Data Set (MDS) dated 03/27/13, revealed the facility assessed the resident to be cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 8 with a score of 15 indicating no</p>	F 281	<p><b>Criteria 1:</b> Resident #5 is provided Nystatin powder in accordance with MD orders as determined in the treatment observation performed on 07/03/13 by the Wound Care Nurse. The area was healed on 07/15/13.</p> <p><b>Criteria 2:</b> Treatment observations have been performed for all licensed nursing staff by the Administrative Nursing Staff on 07/12/13-07/26/13 to determine that treatments are administered in accordance with MD orders.</p> <p><b>Criteria 3:</b> In-service education has been provided for licensed nursing staff by the DON/ADON on 07/11/13-07/26/13 on the administration of treatments in accordance with MD orders</p> <p><b>Criteria 4:</b> The CQI indicator for Physician Special Procedures will be utilized to review 5 alternating resident records to monitor compliance with physician orders daily X 1 week, weekly X 2 weeks, monthly X 2 months, and then quarterly per the established CQI calendar.</p> <p><b>Criteria 5:</b> Aug 3, 2013.</p>	

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F 281	<p>Continued From page 9</p> <p>cognitive impairment. The facility also assessed Resident #5 to require extensive assistance with activities of daily living.</p> <p>Review of physician's orders dated 05/09/13, revealed Resident #5 had physician's orders to apply Nystatin powder for redness beneath the "breasts" and "inguinal folds" every shift as needed. Further review of physician's orders revealed an order dated 06/11/13, for Nystatin powder to be applied to "folds" twice daily.</p> <p>Review of an assessment of Resident #5's skin dated 06/19/13, at 1:19 AM revealed the resident's abdominal fold and perineum/genital area were red.</p> <p>A review of the June 2013 Treatment Administration Record (TAR) for Resident #5 revealed facility staff was to apply Nystatin powder for redness beneath the resident's "breasts" and "inguinal folds" "every shift as needed." The TAR also revealed Nystatin powder was to be applied to the resident's "abdominal fold." However, according to the TAR, Nystatin powder had not been applied to Resident #5's abdominal and inguinal/groin areas, even though the facility had assessed the resident to have redness.</p> <p>Observation of Resident #5 on 06/21/13, at 9:55 AM, revealed the resident's abdominal and inguinal folds (groin area) were red. Interview with the resident revealed the areas felt raw and had been hurting for two to three days. The resident moaned when Certified Nursing Assistants (CNAs) #1 and #2 provided catheter care and wiped the groin areas. Interview with CNA #2 during the care revealed Resident #5 had</p>	F 281			

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F 281	Continued From page 10 been red since at least Tuesday, 06/21/13. CNA #2 stated during the observation that nursing staff was aware that the resident had redness.  An interview with the Wound Care Nurse on 06/25/13 at 11:25 AM revealed she reviewed skin assessments and treatment records every Monday and had not reviewed Resident #5's skin assessment when the observation of Resident #5's skin was made on Friday, 06/21/13. The Wound Care Nurse stated staff should have applied Nystatin powder to Resident #5's reddened skin folds.  The Director of Nursing (DON) stated in an interview conducted on 06/25/13, at 11:20 AM, that she could not explain why the medication was not applied to the reddened areas observed on Resident #5's groin and abdomen. The DON stated the Wound Care Nurse looked at treatment sheets and skin assessments weekly and did not know why they had not "caught" that the treatments were not being provided. The DON further stated the facility had a Continuous Quality Improvement (CQI) tool to use to monitor treatments, wounds, gastric tube medication administration, etc. However, the DON stated she had only monitored to ensure physician's orders were implemented for TED hose and oxygen, since those were the areas that had been identified/cited as the result of a recent relicensure/recertification survey (refer to F520).	F 281			
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of	F 282	<b>F282 Comprehensive Care Plans</b> The services provided or arranged by the facility shall be provided by qualified staff in accordance with each resident's plan of care.		

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F 282	<p>Continued From page 11 care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure the care plans for four of five sampled residents were implemented (Residents #2, #3, #4, and #5). Review of the care plans developed by facility staff for Residents #2, #3, #4, and #5 revealed staff was to ensure the resident's urinary catheter tubing was secured to the resident's thigh to prevent pulling (the facility's policy indicated male catheters should be secured to the abdomen). There was no evidence staff implemented this intervention for Residents #2, #4, or #5. A review of Resident #3's medical record revealed the resident had the urinary catheter since at least 02/13/12. There was no evidence staff implemented the intervention for Resident #3 until 06/18/13, after the resident's penis was observed to be bloody and torn/split from the urinary meatus (the opening in the penis from which urine flows) and down the shaft of the resident's penis.</p> <p>The findings include:</p> <p>An interview with the facility's Compliance Officer on 06/25/13, at 11:10 AM, revealed the facility did not have a policy related to implementing the care plan.</p> <p>Review of the facility's policy/procedure entitled "Staff Instructions-Management of Long-term</p>	F 282	<p><b>Criteria 1:</b> -Residents #2, 3, 4, and 5 have the foley catheter secured with an anchoring device as per the plan of care.</p> <p><b>Criteria 2:</b> Foley catheters are secured with anchoring devices as indicated on the resident care plans, as determined by weekly compliance rounds conducted by the Administrative Nursing Staff.</p> <p><b>Criteria 3:</b> -The care plans for all residents with indwelling catheters were reviewed by the IDT to determine that anchoring of the devices was addressed in accordance with the facility policy. -All facility nursing staff have received in-service education on 06/27/13-07/26/13 as provided by the DON/ADON on the securing of foley catheters with anchoring devices in accordance with each resident's care plan. Non-licensed nursing staff were instructed to notify the licensed nurse for any identified problems with anchoring devices.</p>	

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F 282	<p>Continued From page 12</p> <p>Indwelling Catheters" dated September 2005, revealed a resident's catheter should be stabilized. The policy/procedure stated for women the catheter should be anchored to the upper thigh, and for men should be anchored to the abdomen, to prevent catheter tension.</p> <p>1. A review of Resident #3's medical record revealed the facility admitted Resident #3 on 12/30/11, with diagnoses including Benign Prostate Hypertrophy and Urethral Stricture.</p> <p>Review of Resident #3's most recent Minimum Data Set (MDS) assessment dated 05/17/13, revealed the resident was cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 6 with 15 indicating no cognitive impairment.</p> <p>Review of Resident #3's (male resident) care plan initially dated 02/13/12, and updated on 05/20/13, revealed staff was required to secure the resident's indwelling urinary catheter tubing to the resident's thigh to prevent pulling (which was not in accordance with facility policy).</p> <p>Review of Resident #3's CNA (Certified Nursing Assistant) care plan for June 2013 revealed the resident had a catheter and staff was required to provide catheter care every shift and as needed. According to the CNA care plan, the facility failed to indicate the use of a catheter strap, or any other device, to secure the catheter tubing as required.</p> <p>Observation of Resident #3 on 06/21/13, at 5:30 PM, with Licensed Practical Nurse (LPN) #2 revealed the resident had a catheter and a leg strap was observed on the resident's left thigh.</p>	F 282	<p><b>Criteria 4:</b> The CQI indicator for the monitoring of foley catheter anchoring interventions in accordance with the care plan will be utilized bi-weekly for a month, monthly X 2 months and then quarterly as per the established CQI calendar, under the supervision of the DON.</p> <p>Findings below the required threshold of 100% will result in a plan of correction to address the identified areas.</p> <p><b>Criteria 5:</b> August 3, 2013</p>		

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F 282	<p>Continued From page 13</p> <p>The resident's penis was observed to be split/torn from the meatus approximately three-fourths of the way down the shaft of the resident's penis. The catheter tubing was observed to be protruding from the base of the split area on the left side of the penis. The resident's penis and left inner thigh were observed to be bloody.</p> <p>An interview with LPN #2 on 06/21/13, at 5:30 PM revealed the catheter strap had been in use for approximately two weeks and was implemented after the resident's penis was observed to be "split" and bloody. The LPN stated she was not sure how long the resident's penis had been split/torn, but knew that it was splint/torn when the resident went out to the doctor approximately one month prior.</p> <p>Interviews with Resident #3 on 06/21/13, at 4:00 PM and 5:30 PM, revealed facility staff began utilizing a catheter strap approximately two days prior. The resident stated the "girls" told him his penis was bloody and the strap would keep the catheter from pulling.</p> <p>Interview with CNA #5 on 06/21/13, at 6:23 PM, revealed Resident #3's penis had been split/torn for months; however, on Tuesday (06/18/13) she noticed Resident #3's penis was "more open and bleeding." She stated she notified LPN #4 and they placed a catheter strap on the resident's thigh to secure the tubing. CNA #5 stated prior to 06/18/13, staff had not utilized a catheter strap for Resident #3.</p> <p>An interview was conducted with LPN #4 on 06/22/13, at 9:00 PM, and on 06/24/13, at 12:20 PM. LPN #4 stated that on 06/18/13, CNA #5 reported that Resident #3's penis looked different.</p>	F 282			

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F 282	<p>Continued From page 14</p> <p>LPN #4 stated the resident's penis was split/torn and was bleeding. LPN #4 stated she had not taken care of Resident #3 in a while so she got LPN #1 to look at the resident's penis and LPN #1 confirmed the resident's penis was worse. LPN #4 stated she placed a catheter strap on Resident #3 to keep the catheter tubing from getting pulled/tugged and to prevent the split/tear from getting worse.</p> <p>Interview with LPN #1 on 06/21/13, at 10:15 AM, and on 06/21/13, at 6:23 PM, revealed Resident #3's penis had been "split" down the side for months; however, according to LPN #1, the resident's penis was more swollen/irritated on 06/18/13.</p> <p>Interviews with LPN #3 on 06/21/13, at 6:07 PM, and with LPN #4 on 06/22/13, at 9:00 PM, revealed they were not aware a care plan had been developed that identified the use of a device to secure Resident #3's catheter tubing to his/her leg in an effort to prevent the tubing from being pulled.</p> <p>2. A review of the medical record revealed the facility admitted Resident #2 on 03/14/11, with diagnoses that included Congestive Heart Failure, Alzheimer's Disease, Chronic Pain, Chronic Obstructive Pulmonary Disease, and Parkinson's Disease. A review of Resident #2's MDS revealed the facility assessed the resident to be interviewable with a BIMS score of 13.</p> <p>A review of Resident #2's care plan initially dated 03/21/11, and updated on 05/13/13, revealed staff was required to secure the resident's catheter tubing to the resident's thigh to prevent pulling.</p>	F 282			

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F 282	<p>Continued From page 15</p> <p>Review of Resident #2's CNA care plan for June 2013 revealed the resident had a "Foley" (indwelling) catheter and staff was required to provide catheter care every shift and as needed. Review of the CNA Care Plan revealed the facility failed to indicate a catheter strap, or any other device, to secure the catheter tubing to prevent pulling was required.</p> <p>Observation of Resident #2 on 06/21/13, at 3:00 PM, revealed the resident had a urinary catheter and was not wearing any type of device to secure the catheter tubing to the resident's thigh. An interview with the resident revealed staff did not utilize anything to secure the catheter tubing.</p> <p>3. Review of the medical record revealed the facility admitted Resident #4 on 06/11/12 with diagnoses that included Congestive Heart Failure and Urine Retention. A review of Resident #4's MDS assessment dated 04/26/13 revealed the facility assessed the resident as being interviewable with a BIMS score of 12.</p> <p>Review of Resident #4's care plan initially dated 08/07/12, and updated on 05/30/13, revealed staff was required to secure the resident's catheter tubing to the resident's thigh to prevent pulling.</p> <p>A review of Resident #4's CNA care plan for June 2013 revealed the resident had a "Foley" (indwelling) catheter and staff was required to provide catheter care every shift and as needed. A review of the CNA care plan revealed the facility failed to indicate a catheter strap, or any other device, to secure the catheter tubing to prevent pulling was required.</p>	F 282			

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F 282	<p>Continued From page 16</p> <p>Observation of Resident #4 on 06/21/13, at 10:15 AM, revealed the resident had a urinary catheter, but was not wearing any type of device to secure the catheter tubing to the resident's thigh.</p> <p>Interviews conducted with CNA #1, CNA #2, and LPN #1 on 06/21/13, at 10:15 AM, during the observation, revealed Resident #4 did not utilize any type of device to secure the catheter.</p> <p>Interview with Resident #4 on 06/21/13, at 11:40 AM, revealed the resident was not sure why he/she had to have a catheter and stated he/she had never worn any type of device to hold the catheter tubing.</p> <p>4. Review of the medical record revealed the facility admitted Resident #5 on 05/27/09 with diagnoses that included Uncontrolled Diabetes, Chronic Urinary Tract Infections, and Parkinson's Disease. Review of Resident #5's MDS dated 03/27/13 revealed the facility assessed the resident to be cognitively impaired with a BIMS score of 8.</p> <p>Review of Resident #5's care plan initially dated 03/01/12, and updated on 05/15/13, revealed staff was required to secure the resident's catheter tubing to the resident's thigh to prevent pulling.</p> <p>Review of Resident #5's CNA care plan for June 2013 revealed the resident had a "Foley" (indwelling) catheter and staff was required to provide catheter care every shift and as needed. A review of the CNA care plan revealed the facility failed to indicate a catheter strap, or any other device, to secure the catheter tubing to prevent pulling was required.</p>	F 282		

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F 282	Continued From page 17  Observation of Resident #5 on 06/21/13, at 9:55 AM, revealed the resident had a urinary catheter but was not wearing any type of device to secure the catheter tubing to the resident's thigh.  An interview with CNA #6 on 06/23/13, at 11:15 PM, revealed prior to 06/21/13 she had not utilized a catheter strap or any other device to secure residents' catheter tubing.  An interview with CNA #1 and CNA #2 on 06/21/13, at 10:15 AM, revealed the CNAs did not use any type of device on residents with catheters to secure the indwelling catheter.  An interview with LPN #1 on 06/21/13, at 10:15 AM, revealed some of the male residents utilized a catheter strap when they were out of bed; otherwise, a device was not used to secure residents' catheters.  An interview conducted with the MDS Coordinator on 06/24/13, at 1:00 PM, revealed the Restorative Nurse, who was on vacation, was responsible for ensuring nurse aide care plans matched residents' comprehensive care plans.  Interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 06/21/13, at 7:00 PM, revealed the facility did not have a system for monitoring to ensure residents' care plans were implemented.	F 282			
F 315 SS=G	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a	F 315			

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F 315	<p>Continued From page 18</p> <p>resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policies, it was determined the facility failed to ensure four of five sampled residents (Residents #2, #3, #4, and #5) received urinary catheter care based on the resident's comprehensive assessment and care plan. A review of the care plans developed by facility staff for Residents #2, #3, #4, and #5 revealed staff was to ensure the resident's urinary catheter tubing was secured to the resident's thigh to prevent pulling (the facility's policy indicated male residents' catheters should be secured to the abdomen). There was no evidence staff implemented this intervention for Residents #2, #4, or #5. A review of Resident #3's medical record, including the care plan, revealed the resident had the urinary catheter since at least 02/13/12. There was no evidence staff implemented the intervention for Resident #3 until 06/18/13, after the resident's penis was observed to be bloody and torn/split from the urinary meatus (the opening in the penis from which urine flows) and down the shaft of the resident's penis. In addition, Resident #3's physician was not notified of the trauma to the resident's penis.</p> <p>The findings include:</p>	F 315	<p><b>F 315 Urinary Incontinence</b> Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p><b>Criteria 1:</b>-Residents #2, #3, #4, and #5 have the foley catheter secured with an anchoring device as per the plan of care.</p> <p><b>Criteria 2:</b> Foley catheters are secured with anchoring devices as indicated on the resident care plans, as determined by weekly compliance rounds conducted by the Administrative Nursing Staff.</p>	

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F 315	<p>Continued From page 19</p> <p>An interview with the facility's Compliance Officer on 06/25/13, at 11:10 AM, revealed the facility did not have a policy related to implementing the care plan.</p> <p>Review of the facility's policy/procedure entitled "Staff Instructions-Management of Long-term Indwelling Catheters" dated September 2005, revealed a resident's catheter should be stabilized. The policy/procedure stated that for women the catheter should be anchored to the upper thigh and that for men the catheter should to be anchored to the abdomen, to prevent catheter tension.</p> <p>1. A review of Resident #3's medical record revealed the facility admitted Resident #3 on 12/30/11, with diagnoses including Benign Prostate Hypertrophy and Urethral Stricture.</p> <p>Review of Resident #3's most recent Minimum Data Set (MDS) assessment dated 05/17/13, revealed the facility assessed the resident as being cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 6. According to the MDS assessment, Resident #3 had a urinary catheter and required extensive assistance from staff with transferring, walking, dressing, hygiene/bathing, and toilet use (which includes managing a catheter).</p> <p>Review of Resident #3's (male resident) care plan initially dated 02/13/12, and updated on 05/20/13, revealed staff was required to provide catheter care for Resident #3 every shift and secure the resident's indwelling urinary catheter tubing to the resident's thigh (facility's policy stated male residents' catheters were to be secured to the</p>	F 315	<p><b>Criteria 3:</b> -The care plans for all residents with indwelling catheters were reviewed by the IDT to determine that anchoring of the devices was addressed in accordance with the facility policy. -All facility nursing staff have received in-service education on 06/27/13-07/26/13 as provided by the DON/ADON on the securing of foley catheters with anchoring devices in accordance with each resident's care plan. Non-licensed nursing staff were instructed to notify the licensed nurse for any identified problems with anchoring devices.</p> <p><b>Criteria 4:</b> The CQI indicator for the monitoring of foley catheter anchoring interventions in accordance with the care plan will be utilized bi-weekly for a month, monthly X 2 months and then quarterly as per the established CQI calendar, under the supervision of the DON. Findings below the required threshold of 100% will result in a plan of correction to address the identified areas.</p> <p><b>Criteria 5:</b> August 3, 2013</p>		

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F 315	<p>Continued From page 20 abdomen) to prevent pulling.</p> <p>Review of the CNA (Certified Nursing Assistant) care plan for Resident #3 for June 2013 revealed the resident had a catheter and staff was required to provide catheter care every shift and "as needed." According to the CNA care plan, the facility failed to ensure the use of a catheter strap, or any other device to secure the catheter tubing, was included on the CNA care plan.</p> <p>Observation of Resident #3 on 06/21/13, at 5:30 PM, with Licensed Practical Nurse (LPN) #2 revealed the resident had a catheter and a leg strap on the resident's left thigh. The resident's penis was observed to be split/torn from the meatus approximately three-fourths of the way down the shaft of the resident's penis. The catheter tubing was observed to be protruding from the base of the split area on the left side of the penis. The resident's penis and left inner thigh were observed to be bloody.</p> <p>An interview with Resident #3 on 06/21/13, at 4:00 PM and 5:30 PM, revealed facility staff began utilizing a catheter strap approximately two days prior. The resident stated the "girls" told him his penis was bloody but the resident was not sure what happened. The resident stated the "girls" told the resident that the strap would keep the catheter tubing from being pulled.</p> <p>An interview with LPN #2 on 06/21/13, at 5:30 PM, revealed she was not sure how long Resident #3's penis had been split/torn, but knew that it had been split/torn for at least one month. According to LPN #2, the catheter strap had been in use approximately two weeks and was implemented after the resident's penis was</p>	F 315			

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F 315	<p>Continued From page 21</p> <p>observed to be bloody and the "split" had advanced further.</p> <p>Interview with CNA #5 on 06/21/13, at 6:23 PM, revealed on Tuesday (06/18/13) she noticed Resident #3's penis was "more open and bleeding." She stated she notified LPN #4 and they placed a catheter strap on the resident's thigh to secure the tubing. CNA #5 stated Resident #3's penis had been split/torn for months; however, prior to 06/18/13, staff had not utilized a catheter strap for Resident #3.</p> <p>An interview was conducted with LPN #4 on 06/22/13, at 9:00 PM, and 06/24/13, at 12:20 PM. LPN #4 stated that on 06/18/13, CNA #5 reported that Resident #3's penis looked "different." LPN #4 stated Resident #3's penis was observed to be split/torn and was bleeding. LPN #4 stated LPN #1 confirmed the resident's penis was worse. LPN #4 stated she placed a catheter strap on Resident #3 to keep the catheter tubing from getting pulled/tugged and to prevent the split/tear from getting worse. LPN #4 stated she did not notify the resident's physician of the trauma to Resident #3's penis. She stated she reported the information to the next shift so day shift could notify the physician. LPN #4 also stated she documented in Resident #3's Nursing Notes that the resident's physician would be notified the next morning. LPN #4 stated she reviewed the resident's record prior to the interview and could find no documentation that the resident's physician was notified.</p> <p>On 06/21/13, at 6:07 PM, a review of the nursing note dated 06/18/13, at 8:50 PM, was conducted with LPN #3. At that time, LPN #4's Nursing Note revealed the CNA noticed the "F/C [Foley</p>	F 315			

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F 315	<p>Continued From page 22</p> <p>catheter] had split down the shaft of [the resident's] penis a small amount" and the resident's physician would be notified "in the AM" (morning).</p> <p>An interview with LPN #1 on 06/21/13, at 10:15 AM, and on 06/21/13, at 6:23 PM, revealed Resident #3's penis had been "split" down the side for months; however, according to LPN #1, the resident's penis was more swollen/irritated on 06/18/13.</p> <p>Interviews with LPN #3 on 06/21/13, at 6:07 PM, and with LPN #4 on 06/22/13, at 9:00 PM, revealed they were not aware a care plan had been developed that required the use of a device to secure Resident #3's catheter tubing to his/her leg in an effort to prevent the tubing from being pulled.</p> <p>An interview with Resident #3's physician on 06/24/13, at 2:30 PM, revealed the resident's physician was not notified that the resident's penis was torn, but should have been. According to Resident #3's physician, the facility should have used a catheter strap or some type of device to support the catheter tubing because if there was not some type of support, the tubing would put pressure on the penis. The physician stated the tearing/splitting was caused by pressure from the catheter and that not wearing some type of device to relieve the pressure/tension "had something to do with [Resident #3's] penis tearing."</p> <p>2. Review of the medical record revealed the facility admitted Resident #2 on 03/14/11, with diagnoses that included Congestive Heart Failure, Alzheimer's Disease, Chronic Pain,</p>	F 315			

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F 315	<p>Continued From page 23</p> <p>Chronic Obstructive Pulmonary Disease, and Parkinson's Disease.</p> <p>A review of Resident #2's MDS assessment dated 05/03/13 revealed the facility assessed the resident to be interviewable with a Brief Interview Mental Status (BIMS) score of 13. The MDS assessment revealed the resident required extensive assistance from staff for bed mobility, dressing, bathing/hygiene, and toilet use (which includes care of the catheter). According to the MDS, Resident #2 did not transfer from bed or ambulate.</p> <p>Review of Resident #2's care plan initially dated 03/21/11, and updated on 05/13/13, revealed staff was to secure the resident's catheter tubing to the resident's thigh to prevent pulling. However, a review of Resident #2's CNA (Certified Nursing Assistant) care plan for June 2013 revealed the facility failed to indicate a catheter strap, or any other device, was required to secure the catheter tubing to prevent the catheter from being pulled.</p> <p>Observation of Resident #2 on 06/21/13, at 3:00 PM, revealed the resident had a urinary catheter and was not wearing any type of device to secure the catheter tubing. An interview with the resident revealed staff did not utilize anything to secure the catheter tubing.</p> <p>3. A review of the medical record revealed the facility admitted Resident #4 on 06/11/12 with diagnoses that included Congestive Heart Failure and Urine Retention.</p> <p>Review of Resident #4's MDS assessment dated 04/26/13 revealed the facility assessed the resident as being interviewable with a BIMS score</p>	F 315			

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F 315	<p>Continued From page 24</p> <p>of 12. The facility also assessed the resident to require extensive assistance with bed mobility, transferring, dressing, hygiene/bathing, and toilet use (which includes catheter care).</p> <p>A review of Resident #4's care plan initially dated 08/07/12, and updated on 05/30/13, revealed staff was required to secure the resident's catheter tubing to the resident's thigh to prevent pulling.</p> <p>Review of the June 2013 CNA (Certified Nursing Assistant) care plan for Resident #4 revealed the resident had a "Foley" (indwelling) catheter and staff was to provide catheter care every shift and as needed. A review of the CNA care plan revealed the facility failed to indicate a catheter strap, or any other device to secure the catheter tubing to prevent pulling, was required.</p> <p>Observation of Resident #4 on 06/21/13, at 10:15 AM, revealed the resident had a urinary catheter but was not wearing any type of device to secure the catheter tubing to the resident's thigh.</p> <p>Interviews conducted with CNA #1, CNA #2, and LPN #1 on 06/21/13, at 10:15 AM, during the observation, revealed staff did not provide Resident #4 with any type of device to secure the resident's catheter.</p> <p>Interview with Resident #4 on 06/21/13, at 11:40 AM, revealed the resident was not sure why she had to have a catheter and stated she had never worn any type of device to hold the catheter tubing.</p> <p>4. Review of the medical record revealed the facility admitted Resident #5 on 05/27/09 with</p>	F 315			

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F 315	<p>Continued From page 25</p> <p>diagnoses that included Uncontrolled Diabetes, Chronic Urinary Tract Infections, and Parkinson's Disease.</p> <p>A review of Resident #5's MDS dated 03/27/13 revealed the facility assessed the resident to be cognitively impaired with a BIMS score of 8. The facility also assessed Resident #5 to require extensive assistance with activities of daily living, including managing the resident's catheter.</p> <p>Review of Resident #5's care plan initially dated 03/01/12, and updated on 05/15/13, revealed staff was required to secure the resident's catheter tubing to the resident's thigh to prevent pulling. However, a review of the June 2013 CNA (Certified Nursing Assistant) care plan for Resident #5 revealed the facility failed to indicate a catheter strap, or any other device to secure the catheter tubing to prevent pulling, was required.</p> <p>Observation of Resident #5 on 06/21/13, at 9:55 AM, revealed the resident had a urinary catheter, but was not wearing any type of device to secure the catheter tubing to the resident's thigh.</p> <p>An interview with CNA #6 on 06/23/13, at 11:15 PM, revealed prior to 06/21/13, she had not utilized a catheter strap, or any other device to secure a resident's catheter tubing.</p> <p>An interview with CNA #1 and CNA #2 on 06/21/13, at 10:15 AM, revealed the CNAs did not use any type of device on residents with catheters to secure the indwelling catheter.</p> <p>An interview with LPN #1 on 06/21/13, at 10:15 AM, revealed some of the male residents utilized a catheter strap when they were out of bed;</p>	F 315			

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F 315	Continued From page 26 otherwise, a device was not used to secure residents' catheters.  Interviews with LPN #3 on 06/21/13, at 6:07 PM, and with LPN #4 on 06/22/13, at 9:00 PM, revealed they were not aware a care plan had been developed that required the use of a device to secure catheter tubing to the resident's leg for Residents #2, #3, #4, and #5 in an effort to prevent the tubing from being pulled.  On 06/24/13, at 1:00 PM, an interview was conducted with the MDS Coordinator who stated the Restorative Nurse, who was on vacation, was responsible for ensuring nurse aide care plans matched residents' comprehensive care plans.  On 06/21/13, at 7:00 PM, an interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) revealed the facility did not have a system for monitoring to ensure residents' care plans were implemented.	F 315		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not	F 329	<b>F 329 Unnecessary Drugs</b> Each resident's drug regimen must be free from unnecessary drugs.  <b>Criteria 1:</b> The drug regimen for resident #5 has been reviewed by the consulting pharmacist and MD with dose reductions completed and rational documented for the use of the current psychotropic medications.	

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F 329	<p>Continued From page 27</p> <p>given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure one of five sampled residents was free from unnecessary drugs (Resident #5). Resident #5 had physician's orders for 5 milligrams of Valium (anti-anxiety medication) to be administered every night, 0.5 milligrams of Risperdal (anti-psychotic) every morning, and 1 milligram of Risperdal every night. The facility failed to ensure there were adequate indications for the use of Risperdal for Resident #5 and failed to ensure the resident received a gradual dose reduction of Valium, unless clinically contraindicated, in an effort to discontinue the drug.</p> <p>The findings include:</p> <p>Review of the medical record revealed the facility admitted Resident #5 on 05/27/09 with diagnoses that included Parkinson's Disease, Anxiety, and Depression.</p> <p>A review of a Minimum Data Set (MDS) assessment dated 03/27/13 revealed the facility</p>	F 329	<p><b>Criteria 2:</b> An audit was completed by the Psychotropic Review Committee of the last 60 days of pharmacy recommendations pertaining to psychotropic medications, to identify any that did not have the necessary rational documented for the use of the psychotropic medication. The attending physicians were contacted, with the necessary documentation obtained to support the ongoing use of the medication and/or any changes in dose.</p> <p><b>Criteria 3:</b> -The F 329 regulatory requirements were provided to each of the facility attending physicians to review, along with a facility letter discussing the need for supportive documentation for ongoing use of psychotropic medications for all residents.</p> <p>-The Psychotropic Review Committee will review the MD responses to pharmacy recommendations pertaining to psychotropic medications. Any responses that do not provide the rational for ongoing use of these medications will be reviewed/discussed with the MD with the necessary documentation obtained.</p>		

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F 329	<p>Continued From page 28</p> <p>assessed Resident #5 to be cognitively impaired with a Brief Interview Mental Status (BIMS) score of 8, with 15 indicating no cognitive impairment. Documentation on the MDS assessment revealed the resident received anti-psychotic and anti-anxiety medications.</p> <p>Review of Resident #5's June 2013 physician's orders revealed an order for 5 milligrams (mg) of Valium to be administered every night (initially ordered on 03/02/12). The resident also had physician's orders for 0.5 mg of Risperdal every morning and 1 mg every night (initially ordered on 07/17/12).</p> <p>Review of Behavior Committee meeting minutes dated 06/20/13 revealed Resident #5 had verbal behaviors directed at others, and there were no changes in the resident's behavior. However, review of the Mood Report Roster for Resident #5 from 01/01/13 through 06/20/13, revealed the resident had two episodes of screaming/cursing on 01/13/13 and 05/11/13.</p> <p>Interview with Certified Nursing Assistant (CNA) #5 on 06/21/13, at 6:23 PM, and with Licensed Practical Nurse (LPN) #4 on 06/22/13, at 9:00 PM, revealed Resident #5 had not exhibited any recent behaviors.</p> <p>Interview with CNA #6 on 06/23/13, at 11:15 PM, revealed Resident #5 sometimes "yelled" and said he/she was in pain.</p> <p>A review of "Consultant Pharmacist Communication to Physician" for Resident #5, dated 01/24/13, revealed the pharmacist had documented "CMS-F329: Antipsychotic Boxed Warning in Dementia related diagnosis." Further</p>	F 329	<p><b>Criteria 4:</b> The CQI indicator for the monitoring of the use and supportive documentation for psychotropic medications will be utilized monthly X 2 months and the quarterly thereafter as per the CQI calendar, under the supervision of the ADON. Findings below the required threshold of 100% will result in a plan of correction to address the identified areas.</p> <p><b>Criteria 5:</b> August 3, 2013</p>		

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F 329	<p>Continued From page 29</p> <p>review of the pharmacist's documentation revealed, "This elderly resident is currently on antipsychotic therapy for a dementia-related diagnosis. Please be aware that there is a FDA boxed warning that states, 'Elderly patients with dementia-related psychosis treated with an antipsychotic are at an increased risk of death compared to placebo.'" The pharmacist also documented, "Therefore, these agents are not approved for the treatment of dementia-related psychosis...Consider tapering off the current medication and adding an alternative from a different class of agents if behaviors are still unmanageable without medication therapy." The physician addressed the pharmacy recommendation on 02/16/13 and documented the resident was "stable" and the physician wanted no changes to the medication. The physician provided no additional information/rationale to indicate why the medication should not be reduced or discontinued.</p> <p>Review of a "Consultant Pharmacist Communication to Physician" for Resident #5 dated 03/21/13 revealed the resident had been taking 5 mg of Valium every night for anxiety since March 2012 and was due for an evaluation. The pharmacist recommended a trial reduction of 2 mg of Valium every night. The physician addressed the recommendation on 03/28/13 but did not want any changes in the medication. The physician did not document a rationale for continuing the medication.</p> <p>Interview with Resident #5's physician on 06/24/13, at 2:30 PM, revealed he had initially prescribed the medications for the resident because the resident had been hospitalized due</p>	F 329			

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NAME OF PROVIDER OR SUPPLIER  CUMBERLAND VALLEY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH MAIN STREET BURKESVILLE, KY 42717	
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F 329	Continued From page 30 to periods of hallucinations and acute psychotic episodes. The resident's physician stated the resident should be off the medications and believed the medications had already been discontinued.	F 329		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  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.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure documentation in clinical records was accurately maintained for one of five sampled residents (Resident #3). Observation of a Nursing Note for Resident #3 dated 06/18/13, at 8:50 PM, and an interview with the Licensed Practical Nurse (LPN) who documented the Nursing Note, revealed Resident #3's physician was not notified of a change in the resident's condition. However, a copy of the 06/18/13, 8:50 PM Nursing Note received from the Director of Nursing (DON) stated the resident's physician	F 514	F 514 The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are—complete, accurately documented, readily accessible, and systematically organized.  Criteria 1: The MD for resident #3 was updated on the resident's current status on 07/16/13 by the DON, with documentation of this notification completed in the nursing notes.  Criteria 2: - Head to toe skin assessments have been completed on all residents by the Administrative nursing staff to determine current skin status including but not limited to the genitalia. The assessment documentation was reviewed by the wound nurse to determine that all identified skin issues have been discussed with the MD with appropriate treatment orders in place.	

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F 514	<p>Continued From page 31</p> <p>was notified. In addition, observations of Resident #3's penis and interviews with staff revealed the resident's penis had been split/torn for at least one month. However, a review of skin assessments completed by facility staff weekly revealed the resident had no problems with the penis.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. A review of Resident #3's medical record revealed staff completed an assessment of the resident's skin condition on a weekly basis. Review of the weekly skin assessments dated 05/23/13, 05/30/13, 06/06/13, 06/13/13, and 06/20/13 revealed staff assessed Resident #3 to have no problems with the perineum/genital area (penis). However, observation of Resident #3 on 06/21/13, at 5:30 PM (one day after the most recent documented skin assessment by facility staff) with LPN #2, revealed the resident's penis was split/torn from the urinary meatus (opening in the penis through which urine flows) approximately three-fourths of the way down the shaft of the resident's penis. The catheter tubing was observed to be protruding from the base of the split area on the left side of the penis. The resident's penis and left inner thigh were observed to be bloody.</li> </ol> <p>Interview with the Wound Care Nurse on 06/21/13, at 10:30 AM, and on 06/25/13, at 11:25 AM, revealed nursing staff conducted weekly assessments of each resident's skin and on Mondays, she reviewed the previous week's skin assessments to ensure the assessments had been completed. The Wound Care Nurse stated staff also notified her when a resident had a skin problem. She stated she was unaware Resident</p>	F 514	<p><b>Criteria 3:</b> -In-service education was provided for the DON, ADON, Infection Control/Wound Nurse by the contracted Nurse Consultant, and the for the licensed nurses by the DON, ADON, and Infection Control/Wound Nurse on maintaining clinical records in accordance with accepted standards and practices including but not limited to: accuracy of assessment and MD notification documentation, and completion of legal documentation corrections.</p> <p>-Disciplinary action has been completed in accordance with facility policy for the staff responsible for the inaccurate documentation identified.</p> <p><b>Criteria 4:</b> The CQI indicator for the monitoring of nursing documentation will be utilized monthly X 2 months, then quarterly X 1 year, and then every 6 months thereafter. Findings below the required threshold of 90% will result in a plan of correction to address the identified areas.</p> <p><b>Criteria 5:</b> August 3, 2013</p>	

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F 514	<p>Continued From page 32</p> <p>#3's penis was split/torn until 06/21/13. She further stated the split/tear to the resident's penis should have been documented on the weekly skin assessment if the area was present when the assessment was conducted.</p> <p>Continued review of Resident #3's medical record was conducted on 06/21/13, at 6:07 PM, with assistance provided by LPN #3. A computerized Nursing Note by LPN #4, dated 06/18/13, at 8:50 PM, revealed a nursing assistant reported Resident #3's "F/C [Foley catheter] had split down the shaft of [Resident #3's] penis a small amount" and the resident's physician would be notified "in the AM." However, a review of a copy of the Note written by LPN #4 on 06/18/13, at 8:50 PM, provided by the DON on 06/21/13, at 7:00 PM, revealed the resident's physician had been notified of the change in Resident #3's condition.</p> <p>Interview conducted with LPN #4 on 06/22/13, at 9:00 PM, revealed that on 06/18/13, Certified Nursing Assistant (CNA) #5 reported that Resident #3's penis looked "different." LPN #4 stated she observed the resident's penis on 06/18/13 and observed the penis to be split/torn and bleeding. LPN #4 stated she did not notify the resident's physician that the resident's penis was torn/split on 06/18/13. The LPN stated it was late and the resident's physician's office was closed so she documented her observation of Resident #3's penis in the Nursing Notes and asked staff that was beginning their shift to call the resident's physician the next morning. LPN #4 stated she reviewed the resident's record prior to the interview and could find no documentation that the resident's physician was notified.</p> <p>Interview with CNA #5 on 06/21/13, at 6:23 PM,</p>	F 514			

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F 514	<p>Continued From page 33</p> <p>revealed Resident #3's penis had been split/torn for "months." She stated that on 06/18/13, the resident's penis was "more open and bleeding," and she notified LPN #4.</p> <p>An interview with LPN #2 on 06/21/13, at 5:30 PM, revealed she was not sure how long Resident #3's penis had been split/torn, but knew that it had been split/torn for at least one month.</p> <p>An interview with LPN #1 on 06/21/13, at 10:15 AM, and on 06/21/13, at 6:23 PM, revealed Resident #3's penis had been "split" down the side "for months."</p> <p>Interview with Resident #3's physician on 06/24/13, at 2:30 PM, revealed the facility had not notified him that Resident #3's penis was torn/split, but stated he "should have been" notified.</p> <p>On 06/24/13, at 12:20 PM, a follow-up interview was conducted with LPN #4, the nurse who wrote the 06/18/13 Nursing Note for Resident #3 at 8:50 PM. LPN #4 stated that she had not changed the Nursing Note to indicate Resident #3's physician was notified of the trauma to the resident's penis. LPN #4 stated she did not have the authority to change a Nursing Note. According to LPN #4, if she needed to change or clarify a Nursing Note, the original Note would be the same and there would be an "addendum" after the original note.</p> <p>An interview with the DON on 06/25/13, at 12:25 PM, revealed she was not sure why the electronic version of the 06/18/13, 8:50 PM Nursing Note for Resident #3 reviewed on 06/21/13, at 6:07 PM, and the copy of the 06/18/13, 8:50 PM Nursing Note provided on 06/21/13, at 7:00 PM, were</p>	F 514		
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F 514	Continued From page 34	F 514			
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.  The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.  A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.  Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.  This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record	F 520	<b>F 520 Quality Assessment and Assurance</b> A facility must maintain a quality assessment and assurance committee consisting of i) The director of nursing services; ii) A physician designated by the facility; and iii) At least 3 other members of the facility's staff. The quality assessment and assurance committee i) Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and ii) Develops and implements appropriate plans of action to correct identified quality deficiencies.  <b>Criteria 1:</b> -The attending physician for resident #5 has been updated on the resident's condition on 07/16/13 by the DON. Resident #5 is provided Nystatin powder in accordance with MD orders as determined in the treatment observation performed on 07/03/13 by the Wound Care Nurse. The area was healed on 07/15/13.		

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F 520	<p>Continued From page 35</p> <p>reviews, and facility policy reviews it was determined the facility failed to ensure plans of action to correct previously cited quality deficiencies were implemented. The State Agency cited F281, Services Provided Meet Professional Standards, during the standard survey on 05/09/13, due to the facility's failure to follow physician's orders. The facility submitted a Plan of Correction and alleged the deficiency would be corrected on 06/10/13. The facility failed to implement their Plan of Correction to ensure physician's orders were implemented (refer to F281).</p> <p>The findings include:</p> <p>Review of Form CMS-2567, Statement of Deficiencies, issued to the facility as the result of a standard survey on 05/09/13 by the State Agency revealed the regulatory requirement identified at F281 (Services Provided Meet Professional Standards) was cited for the facility's failure to ensure physician's orders were followed. The facility submitted a Plan of Correction to the State Agency on 05/31/13, and alleged the deficiency would be corrected effective 06/10/13. In the Plan of Correction, the facility stated monitoring for compliance with physician's orders would be conducted monthly for two months under the supervision of the Director of Nursing (DON) and/or the Assistant Director of Nursing (ADON).</p> <p>Review of Resident #5's medical record revealed on 05/09/13, the physician had requested facility staff to apply Nystatin (anti-fungal) powder to redness beneath the resident's breasts and inguinal folds every shift "as needed." On 06/11/13, the physician had also requested for</p>	F 520	<p><b>Criteria 2:</b> Treatment observations have been performed for all licensed nursing staff by the Administrative Nursing Staff on 07/12/13-07/26/13 to determine that treatments are administered in accordance with MD orders.</p> <p><b>Criteria 3:</b> In-service education has been provided for licensed nursing staff by the DON/ADON on 07/11/13-07/26/13 on the administration of treatments in accordance with MD orders.</p> <p><b>Criteria 4:</b> -The CQI indicator for Physician Special Procedures will be utilized to review 5 alternating resident records to monitor compliance with physician orders daily X 1 week, weekly X 2 weeks, monthly X 2 months, and then quarterly per the established CQI calendar. -The CQI indicator for the monitoring of the CQI process will be utilized monthly X 2 months, and then quarterly thereafter under the supervision of the facility Compliance Officer. - Findings below the required threshold of 100% will result in a plan of correction to address the identified areas.</p> <p><b>Criteria 5:</b> August 3, 2013.</p>		

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F 520	<p>Continued From page 36</p> <p>facility staff to apply Nystatin powder to the resident's "folds" twice daily.</p> <p>Review of an assessment conducted by facility staff on 06/19/13, at 1:19 AM, revealed Resident #5's abdominal fold and perineum/genital area were red.</p> <p>Review of Resident #5's Treatment Administration Record (TAR) revealed no evidence Nystatin powder had been applied to the reddened areas.</p> <p>Observation of Resident #5 on 06/21/13, at 9:55 AM, revealed the resident's abdominal and inguinal folds (groin area) were red. Interview with the resident at 9:55 AM, during the observation revealed the areas felt raw and had been hurting for two to three days. Interview with CNA #2 on 06/21/13, at 9:55 AM, revealed Resident #5's groin and abdominal folds had been red since at least "Tuesday" (06/18/13).</p> <p>An interview with the Director of Nursing (DON) on 06/25/13, at 11:20 AM, revealed the facility had a Continuous Quality Improvement (CQI) tool to use to monitor treatments, wounds, gastric tube medication administration, etc. However, the DON stated she had only monitored physician's orders for "TED" hose and oxygen, since those were the issues that had been identified during the standard survey conducted on 05/07/13 through 05/09/13.</p>	F 520			