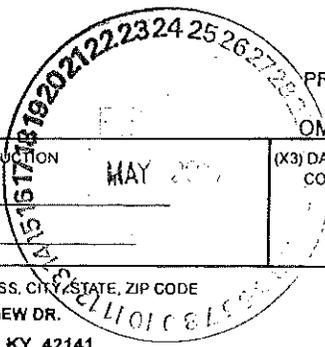


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/11/2012
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185271	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/27/2012
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NAME OF PROVIDER OR SUPPLIER GLENVIEW HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1002 GLENVIEW DR. GLASGOW, KY 42141
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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

F 000

An annual recertification survey and an abbreviated survey (KY #18212) was conducted on 04/24/12 through 04/27/12 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of an "E." KY #18212 was substantiated with deficiencies cited.

The submission of this plan of correction does not constitute an admission of guilt by the facility of the cited deficiencies or any violation of a regulation or a standard of care. Also, we reserve the right to take further action, including any and all legal means necessary, to resolve any dispute about the accuracy of this information

F 225 483.13(c)(1)(ii)-(iii), (c)(2) - (4)
SS=D INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

F 225 483.13(c)(1)(ii)-(iii), (c)(2)-(4)

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.

1. Facility was unaware of the alleged incident reported by resident #9 at the time the alleged incident occurred on 11/09/2011. Facility was made aware of the alleged incident by Adult Protective Services (APS) when they entered the facility on 12/21/2011. Administrative staff began an immediate investigation. The completed investigations by both the facility and Adult Protective Services found the complaint unsubstantiated.

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).

2. The facility will initiate an immediate investigation into any report of alleged abuse according to the facility's "Resident Abuse, Neglect, Mistreatment, Exploitation and Misappropriation of Property" policy.

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

3. The facility will report all allegations of abuse to the appropriate agencies as required in accordance with state and federal regulations. (continued on page 2)

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

TITLE

(X6) DATE

Yvonne D. Carl

Administrator

5/24/2012

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 225	<p>Continued From page 1</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> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to report an allegation of sexual abuse to the State Agency, which was investigated by the Adult Protective Services (APS), for one resident (#9), in the selected sample of fourteen residents. Additionally, the facility failed to ensure a thorough investigation was completed related to an elopement incident for one resident (#15), not in the selected sample.</p> <p>Findings include:</p> <p>1. A review of the facility's policy/procedure for "Resident Abuse, Neglect, Mistreatment, Exploitation and Misappropriation of Property," dated September 2004, revealed incidents shall be thoroughly investigated and documented by the Administrator, Director of Nursing (DON), or designee and reported to the appropriate State Agencies.</p> <p>A record review revealed the facility admitted Resident #9 on 11/08/11 with diagnoses to</p>	F 225	<p>(continued from page 1)</p> <p>4. If the allegations are verified, appropriate corrective action will be initiated.</p> <p>5. Any reported incident of abuse will be reported to the Administrator and Director of Nursing immediately. Corrective actions will occur to ensure the safety of all individuals involved.</p> <p>6. Within 5 working days, the facility will report its findings to the appropriate agencies.</p> <p>7. All alleged incidents of abuse will be reported by the Administrator to the QA committee for review monthly for a period of 12 months.</p> <p>8. Concerning resident #15 no elopement occurred per definition. "Elopement" means an occurrence in which a resident leaves a facility without following facility policies and procedures (see attachment A). Resident #15 was not a missing resident according to the facility's "Missing Resident Policy" (see attachment C) due to the fact that her location was known at all times.</p> <p>(see attachment B) (continued on page 3)</p>

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F 225	Continued From page 2 include Senile Dementia, Depression, and Diabetes.	F 225	(continued from page 2)	
	<p>On 04/24/12, during an initial tour of the facility, Resident #9 reported to the surveyor, that on 11/09/11, Resident #7 placed his/her hand on Resident #9's knee and then slid his/her hand up to his/her "private area." Resident #9 revealed he/she reported the alleged incident to the staff on 11/09/11. Adult Protection Services (APS) investigated this alleged incident on 12/21/11, and the facility investigated the alleged incident on 12/22/11. Both APS and the facility found the allegation to be unsubstantiated; however, the facility failed to notify the State Agency about the allegation of sexual abuse.</p> <p>An interview with the DON, on 04/27/12 at 2:00 PM, revealed the facility did not follow reporting guidelines related to the abuse/neglect policy, when the facility did not report Resident #9's allegation of sexual abuse to the State Agency.</p> <p>An interview with the Administrator, on 04/27/12 at 2:05 PM, revealed the allegation of sexual abuse was not reported to the State Agency, even though APS entered the facility on 12/21/11 and investigated the allegation.</p> <p>An interview with the Facility's Owner, on 04/27/12 at 2:05 PM, revealed Resident #9's allegation of sexual abuse was not reported to the State Agency. No further explanation was provided.</p> <p>2. A review of the facility's policy/procedure, "Wander Alert Policy," revised 07/06/11, revealed the wander alert bracelet system will be used for</p>		<p>9. A behavior was observed by (3) nurses at the nurses station and a housekeeper in the hall in which resident #15 went to the front doot which is by the nurses station, and was looking for "her dog". She was never out of sight of employees and her location was being monitored. Resident #15 never let go of the door handle to the front door.</p> <p>10. Resident #15 was quickly redirected by the staff due to all staff being aware she was identified as a risk for wandering.</p> <p>11. Care plan for resident #15 was updated to encourage walks outside with activity personnel as weather allows.</p> <p>12. Other residents at risk for wandering have been identified through obtaining resident history upon admission. Nursing staff assess for exhibition of wandering behavior every shift and as needed.</p> <p>13. Quarterly assessment for exhibition of wandering behavior is performed through the MDS process. Residents identified at risk for behavior are care planned and interventions put into place.</p>	
			(continued on page 4)	

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F 225	<p>Continued From page 3</p> <p>safety of residents with behaviors of wandering placing them at risk for elopement. Resident history will be obtained on admission for history of wandering. Resident behavior will be monitored for signs of wandering or risk of elopement. Wander alert will be used only on those residents identified with history or behavior of wandering placing them at risk for elopement. A master listing of residents with wander alert will be maintained at the nursing station. Wander alert will be monitored for placement and proper functioning daily and documented on the Daily Reading Report. Wander alert will be monitored for placement and proper functioning every shift and documented on the Treatment Administration Record (TAR).</p> <p>A record review revealed the facility admitted Resident #15 on 12/16/11 with diagnoses to include Senile Dementia, Anemia, and Hip Joint Replacement. A review of the the admission MDS, dated 12/29/11, and a review of the quarterly Minimum Data Set, (MDS), dated 03/15/12, revealed the resident had a Brief Interview for Mental Status (BIMS) score of "5." The resident was assessed as severely cognitively impaired and never/rarely made decisions. The facility placed a code alert bracelet on the resident's wrist on 12/16/11 and initiated every 15 minute safety checks.</p> <p>A review of the comprehensive care plan "Alteration in mood and behavior AED: wandering, history of taking off wanderguard, easily annoyed, aggravating others, horseplaying, inappropriate voiding in trash can," dated 02/07/12, revealed interventions of safety checks as ordered and a wanderguard for safety.</p>	F 225	<p>(continued from page 3)</p> <p>14. Wanderalerts are utilized for residents who are identified at risk for wandering behavior as per facility "Wanderalert Policy". There is a master list of residents with wanderalerts at the nurses station which is updated by the RN on duty with follow-ups as needed.</p> <p>15. Residents with wanderalerts are placed on every 15 minutes safety checks where nursing staff monitor location and ensure wanderalert is in place per facility "Safety Check Policy" (see attachment E).</p> <p>16. The Maintenance Director checks wanderalert system monthly to ensure system is functioning correctly.</p> <p>17. The Maintenance Director gives the maintenance report to the Administrator monthly. The Administrator presents the report to the QA committee monthly for 12 months.</p> <p>18. Resident behaviors will be documented and the Director of Nursing and the Administrator notified concerning behavior report. Resident behaviors will be reviewed by Resident Services Director. The Resident Services Director will submit monthly report to the Administrator. (continued on page 5)</p>

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F 225 Continued From page 4

On 03/15/12, the facility assessed the resident as displaying wandering behavior one to three days during the review period. A review of the Certified Nurse Aide (CNA) care guide revealed the resident was identified as a wander alert and was on safety checks every 15 minutes.

Observation, on 04/25/12 at 1:45 PM, revealed Resident #15 walked out the front door of the facility and a male staff walked the resident back into the facility. There was no alarm sounding when the resident exited the building, and no alarm sounded when the male staff assisted the resident back into the facility.

An interview with Licensed Practical Nurse (LPN) #1, on 04/26/12 at 1:05 PM and 2:00 PM, revealed Resident #15 went out the front door after a physician exited the building. She stated Resident #15 caught the door when the physician exited the building, and he/she was on the front porch talking about a dog he/she saw over at the bank. LPN #1 was at the desk when she noticed the housekeeper bringing the resident back into the building. The resident had a code alert bracelet (wander guard) in place and she could not recall if an alarm sounded when the resident exited the building. After being brought back into the facility, Resident #15 was assisted into the dining room area and a new code alert (wander guard) was applied. She reported to the DON, the family and the physician; however, she not document anything related to the incident, on 04/25/12, because she did not see anything. She revealed she looked up and saw the housekeeper bring the resident back into the building and he stated that Resident #15 went out the door after

F 225 (continued from page 4)

19. The Administrator will submit the report to the QA committee for review monthly for 12 months.

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F 225	Continued From page 5 the physician. Upon admission to the facility, the resident was determined to be a wander risk, and the code alert was applied at the time. She revealed when Resident #15 went out the front door and the staff brought the resident back in, it was considered an elopement. An interview with the Housekeeper, on 04/26/12 at 2:15 PM, revealed he observed the resident walk out the door. Resident #15 was on the front porch, holding the door open and he/she stated he/she wanted to get his/her dog. He saw LPN #1 at the desk along with two other people and he did not recall hearing an alarm sound. Normally if residents walked by the doors with a code alert in place, it went off. If they sat on the couch, the alarm went off. An interview with two CNAs, on 04/27/12 at 9:40 AM and 10:00 AM, revealed they were familiar with Resident #15 and they were aware he/she wandered in the facility. They stated the resident went to the doors but they had not observed the resident go out the doors. The CNAs stated the resident had a code alert bracelet in place and he/she was on every 15 minute safety checks. They stated the resident was fairly easy to redirect when he/she was by the exit doors. An interview with the DON, on 04/27/12 at 4:25 PM, revealed, upon admission, they get a history on the residents. A wander alert bracelet was placed on the resident who was identified as a wanderer and 15 minute safety checks were started. The nurses also had a place on the TARs to document the code alert bracelets being in place and working. When Resident #15 was admitted to the facility, the resident's family	F 225	

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F 225	Continued From page 6	F 225	
	<p>informed the facility about his/her history of wandering. Resident #15 was placed on 15 minute safety checks and a code alert bracelet was applied to the resident's wrist. Resident #15 was monitored by the staff with the 15 minute checks. She was told the housekeeper came up the hall and the resident was in his site the whole time. The resident caught the door as the physician was leaving the building. They did not hear an alarm sounding because he/she took the code alert bracelet off. Resident #15 continued on the 15 minute checks and the staff were instructed to do an "extra glance" to ensure the code alert bracelet was in place.</p> <p>The facility was unable to provide evidence of an investigation regarding Resident #15's elopement on 04/25/12. The facility provided two post-behavior care plans, dated 04/26/12, related to the wandering behavior and removing the wander guard. There was no evidence of interviews with the staff or the residents who witnessed Resident #15 exiting the building.</p> <p>An interview with the facility's owner, on 04/27/12 at 5:28 PM, revealed an alarm did not sound related to the incident involving Resident #15. She stated the resident removed the code alert bracelet and the staff was in communication with the nurse. The resident remained on 15 minute checks and the staff were directed not to do anything different. She stated there was no investigation because she did not feel it was an elopement. She stated the resident had his/her hand on the front door and the staff had the resident in their sight.</p>		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281	483.20(k)(3)(i) (continued on page 8)

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F 281 Continued From page 7

F 281 (continued from page 7)

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, record review, and review of the facility's policy and procedure, it was determined the facility failed to ensure services provided by the facility met professional standards of quality for one resident (#16), not in the selected sample. On 04/24/12 at 11:32 AM, during a medication pass, Certified Medication Technician (CMT) #1 failed to administer the resident's medication in accordance with the physician's orders.

Findings include:

A review of the facility's policy/procedure, "Medication, Administration of Oral," undated, revealed routine medications should be administered within 60 minutes before or after the scheduled medication pass time as directed per facility policy.

A review of the Medication Administration Record (MAR), dated April 2012, revealed Flexaril 10 mg tab at 9:00 AM and the following medications due at 10:00 AM: Bisoprolol 5 mg tab, Digoxin .125 mg tab (3) tablets, Diltiazem HCL 60 mg tab, Potassium Chloride 10 milliequivalents (1) capsule, Colace 150 mg/15 milliliters (ml), and Lactulose solution 10 grams (gm)/15 ml -30 ml.

An observation during the medication pass, on 04/24/12 at 11:32 AM, revealed CMT #1 offered

1. On 04-22-2012 at 11:32am, CMT #1 failed to administer the resident's medications in accordance with MD orders. CMT #1 followed facility policy "Medicine Administration Out of Time Compliance" (see attachment F) on 04/22/2012 by notifying LPN #2 and the ARNP who was at the facility at the time (ARNP is nurse practioner from primary physician's office). Resident #16 did refuse all medications during the medication administration pass despite multiple attempts from multiple staff and the ARNP.

2. No medications were administered to resident #16 because of resident refusal to take medications.

3. ARNP completed a progress note dated 04/24/2012 in which she noted medications that were late and attempts to administer the medications, including her attempts to give resident #16 her prescribed medications. ARNP noted resident #16's refusal and and "try meds in am" at next scheduled administration time.

(continued on page 9)

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F 281	<p>Continued From page 8</p> <p>Resident #16 Bisoprolol 5 milligrams (mg) tablet, Digoxin .125 mg (3) tablets, Diltazepam HCL 60 mg (1) tablet, Flexaril 10 mg (1) tablet, Potassium Chloride 10 milliequivalents (1) capsule, Colace 150 mg/15 milliliters (ml), and Lactulose solution 10 grams (gm)/15 ml -30 ml. Resident #16 refused all medications and CMT #1 tried to encourage the resident to take his/her medications, but he/she continued to refuse.</p> <p>An interview with CMT #1, on 04/24/12 at 2:10 PM, revealed she had one hour before or one hour after the scheduled time to administer the medications. She revealed there were a couple of difficult residents during the medication pass and she was "running behind." She was aware she was out of compliance during administration of the residents' medications. They were expected to inform the nurse if she was unable to administer the medications timely. She stated she informed Licensed Practical Nurse (LPN) #2 about not being able to administer Resident #16's medications as ordered.</p> <p>An interview with LPN #2, on 04/27/12 at 2:25 PM, revealed she was informed by CMT #1 that she was unable to administer Resident #16's medications in a timely manner. The Advance Practice Registered Nurse (APRN) was in the facility and aware they were out of compliance, and was also aware the resident refused his/her medications. The CMTs usually informed the nurses aware whenever they were late with administration of medications. They were expected to administer the resident's medication as ordered by the physician, and at the correct time.</p>	F 281	<p>(continued from page 8)</p> <p>4. No other resident medications were administered out of time compliance on this specific medication administration pass.</p> <p>5. Staff Development Nurse and the Nurse Consultant from the pharmacy completed a Medication Administration Time Compliance inservice with all nurses and crnts on 05/15/2012 regarding the facility's policy and procedures of "Medication Administration Outside of Time Compliance".</p> <p>6. The Director of nursing will track any reports of medications given out of time compliance. A monthly report will be given to the Administrator.</p> <p>7. The Administrator will submit the monthly report to the QA committee on a monthly basis for review for 12 months.</p> <p style="text-align: right;">05/31/2012</p>

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F 281	Continued From page 9 An interview with the Director of Nursing (DON), on 04/27/12 at 4:25 PM, revealed CMT #1 was out of compliance with administration of the medications and the staff were expected to administer medications as ordered. The CMTs should let the nurses know if they were running behind, so the physician could be notified. F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 281	
SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure services were provided by qualified persons in accordance with each resident's written plan of care for one resident (#1), in the selected sample of fourteen residents. Resident #1 was transferred from the wheelchair to the shower chair with the assistance of two staff members; however, the care plan indicated the resident required the assistance of three staff members for transfers. Findings include: A review of the facility's "Care Plan" policy/procedure, undated, revealed a resident's needs would be provided for by a developed plan of care. A record review revealed the facility admitted	F 282	483.20(k)(3)(ii) 1. Resident #1 was transferred from wheelchair to shower chair with assist of 2. Care plan indicated assist of 3 for transfers. 2. Resident #1 was care planned for assist of 3 for transfers. On 04/24/2012 at 3:20pm (time of observation) 3 staff members were available for the transfer yet surveyor asked one staff member (LPN) to wait outside of shower room due to "space limitations". 3. Resident #1's transfer assessment was reassessed with care plan revision on 05/16/2012. 4. All residents plan of care regarding transfer assistance were reviewed by Asst Director of Nursing and CNAs on 05/16/2012 with care plan revisions as necessary.
A record review revealed the facility admitted		(continued on page 11)	

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NAME OF PROVIDER OR SUPPLIER GLENVIEW HEALTH CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 GLENVIEW DR. GLASGOW, KY 42141	
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F 282	<p>Continued From page 10</p> <p>Resident #1 on 05/23/11, with a re-admission date of 02/28/12, with diagnoses to include Distal Radius Fracture, Intertrochanteric Fracture, and Osteoarthritis.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 01/19/12, revealed the facility identified the resident as moderately cognitively impaired and required extensive assistance with transfers.</p> <p>A review of the Risk for Falls Care Plan, dated 06/04/11, revealed the facility identified the resident required an assistance of three staff for transfers, ambulation, and toileting. A review of the Fall Risk Assessment, dated 03/26/12, revealed the resident was at high risk for falls. A review of the Assignment Sheet, undated, revealed the resident required the assistance of three staff.</p> <p>An observation, on 04/25/12 at 3:20 PM, revealed Certified Nurse Aide (CNA) #4 and CNA #5 transferred Resident #1 from the wheelchair to the shower chair.</p> <p>A phone interview with CNA #4, on 04/27/12 at 2:40 PM, revealed she transferred Resident #1 from the wheelchair to the shower chair with the assistance of CNA #5. She was not aware the resident was care planned for the assistance of three staff.</p> <p>A phone interview with CNA #5, on 04/27/12 at 3:00 PM, revealed she was aware the resident required assistance of three staff for transfers; however, there was not enough staff available at the time. She revealed she was suppose to follow</p>	F 282	<p>(continued from page 10)</p> <p>5. On 05/31/2012 the Staff Development Nurse / Director of Nursing will inservice all nursing staff regarding the importance of following the plan of care for each resident.</p> <p>6. Included in the above inservice will be training on notifying the nurse or the Director / Asst. Director of Nursing regarding any resident change in status.</p> <p>7. The resident care plans will be updated by the nurse as needed. The MDS nurse will review any change in status during the MDS process with the care plan team.</p> <p>8. The Asst. Director of Nursing will review all updates weekly and report to the Director of Nursing.</p> <p>9. The Director of Nursing will submit the report to the Administrator monthly. The Administrator will submit the report to the QA committee monthly for review for 12 months. 05/31/2012</p>

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F 282 Continued From page 11
the assignment sheet.

F 282

An interview with the Director of Nursing (DON), on 04/27/12 at 4:05 PM, revealed Resident #1 required assistance of three staff (or the mechanical lift) for transfers. She revealed staff were expected to follow the assignment sheets. Staff should also report any changes so the resident could be reassessed.

F 323 483.25(h) FREE OF ACCIDENT
SS=E HAZARDS/SUPERVISION/DEVICES

F 323 483.25(h)

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of the facility's policies/procedures, it was determined the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for three residents (#1, #4, and #13), in the selected sample of fourteen residents. Resident #13 wandered into a resident's room and climbed into the bed with Resident #4. There was no staff supervision on the unit and Resident #13's bed alarm did not sound. Additionally, staff were observed to transfer Resident #1 with the assistance of two staff members; however, the facility had assessed the resident to require the

1. Bed alarm was utilized on resident #13 due to history of wandering. Per facility policy and procedure "Wheelchair / Bed Alarms" the bed alarms are monitored for placement and checked for functioning every shift and documented by nurse on treatment record. Resident #13's alarm was checked earlier in the shift and was working properly. Safety checks were utilized every 15 minutes according to facility policy and procedures and were performed correctly. Due to staff diligence of making rounds and performing safety checks, resident #13 was found quickly before further incident. Resident #13 was removed from the room and resident #4 was immediately assessed by nurse.
(continued on page 13)

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F 323	<p>Continued From page 12</p> <p>assistance of three staff members with transfers.</p> <p>Findings include:</p> <p>A review of the facility's policy and procedure for "Safety Checks," dated 10/23/06, revealed the facility would offer extra assessment opportunities for special resident situations. These assessment opportunities would promote and maintain resident safety.</p> <p>1. A record review revealed the facility admitted Resident #13 on 02/08/12, with a re-admission date of 04/11/12. The resident's diagnoses included Alzheimer's Disease, Insomnia, Dementia, Anxiety, and Depression.</p> <p>A review of the admission Minimum Data Set (MDS), dated 02/20/12, revealed the facility identified the resident as severely cognitively impaired with behaviors to include wandering.</p> <p>A review of the care plan for "Alteration in Mood and Behavior," dated 02/17/12, revealed the facility identified that Resident #13 exhibited the following behaviors: disrobing during the night and trying to pull the staff into the bed with him/her, sexual comments, combative behavior, wandering, sexual aggression toward staff, and frequent masturbation. Further review of the care plan revealed staff were to check the resident every fifteen minutes and when passing the resident's room, for needs and safety. A review of the care plan for "Falls," dated 02/24/12, revealed the resident had a bed alarm for safety. Staff were to check the placement and functioning of the alarm every shift and as needed.</p>	F 323	<p>(continued from page 12)</p> <p>CNA #3 was on the unit at the time of occurrence. Kiosk in front dining room is considered to be part of the building designated as Long Hall. The nursing home has 2 halls, Long Hall and Short Hall, with one nurses station for both units.</p> <p>Resident #13 was immediately placed under 1:1 constant supervision until he was discharged from the facility on 04/20/2012.</p> <p>Resident #4 was transferred to the local ER for evaluation. Resident #4 was shortly returned to facility after medical personnel deemed no injury had occurred.</p> <p>Local authorities, Adult Protective Services and state agencies were contacted on 02/20/2012 regarding the incident. Investigations were completed by the facility, local authorities and Adult Protective Services and it was determined that the facility acted appropriately and that no injury had occurred to resident #4. A completed report of the facility investigation was sent to the appropriate state agency.</p> <p>2. The Staff Development Nurse inserviced the nursing staff on 04/20/2012 on the facility's abuse policy and procedures.</p> <p>(continued on page 14)</p>

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F 323 Continued From page 13

2. A record review revealed the facility admitted Resident #4 on 08/26/11 with diagnoses to include Alzheimer's Disease and Dementia.

A review of the quarterly MDS, dated 02/21/12, revealed the facility identified the resident as severely cognitively impaired and required total assistance with bed mobility. The resident was non-ambulatory.

A review of the nurse's notes, dated 04/20/12 at 3:25 AM, revealed Resident #13 was found in the bed with Resident #4. Further review revealed Resident #13 was "on all fours" hovering over Resident #4.

A review of the facility's investigation, dated 04/27/12, revealed staff documented a safety check on Resident #13, on 04/20/12 at 3:00 AM, noting the resident was asleep. According to the investigation, Resident #13 exited his/her room at approximately 3:12 AM and entered Resident #4's room. The bed alarm for Resident #13 did not sound. Staff was not on the unit at this time. At approximately 3:21 AM, staff found Resident #13 in Resident #4's bed, on top of him/her.

A phone interview with Certified Nurse Aide (CNA) #3, on 04/26/12 at 3:30 PM, revealed she was the aide working on 04/20/12. She revealed prior to the incident with Resident #13 and Resident #4, Resident #13 had been in his/her bed asleep. She revealed Resident #13 was checked 15-20 minutes prior to finding him/her in the bed with Resident #4. CNA #3 admitted Resident #13's bed alarm did not sound, and she was not on the unit at the time of the incident. She stated that she was charting on the kiosk in

F 323 (continued from page 13)

3. The Staff Development Nurse inserviced the facility staff on 04/23/2012 on the facility's abuse policy and procedures.

4. As per facility guidelines a staff member is to be present on each hall at all times. The facility did update the documentation guideline in accordance to kiosk charting. The staff member assigned to remain on the hall will document any resident care provided on the kiosk in the middle of each hall. Inservice completed on 04/20/2012.

5. Resident #1 was transferred from wheelchair to shower chair with assist of 2. Care plan indicated assist of 3 for transfers.

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F 323 Continued From page 14

the dining room; however, she stated she should have been charting on the kiosk located on the unit.

A phone interview with Licensed Practical Nurse (LPN) #3, on 04/27/12 at 9:30 AM, revealed she was the nurse working on 04/20/12. She revealed a staff member was suppose to be on the unit at all times, but CNA #3 was charting on the kiosk in the dining room, not on the unit. She further revealed Resident #13's bed alarm sounded earlier in the shift; however, it did not sound prior to finding him/her in the bed with Resident #4. She revealed the alarm was "wrinkled" in the bed causing it not to function properly.

An interview with the Director of Nursing (DON), on 04/27/12 at 4:05 PM, revealed the bed alarm did not function properly during the incident, on 04/20/12. She revealed CNA #3 was the only aide on the unit. She expected CNA #3 to use the kiosk on the hall, not the dining room.

3. A record review revealed the facility admitted Resident #1 on 05/23/11, with a re-admission date of 02/28/12 with diagnoses to include Distal Radius Fracture, Intertrochanteric Fracture, and Osteoarthritis.

A review of the quarterly MDS, dated 01/19/12, revealed the facility identified the resident as moderately cognitively impaired and required extensive assistance with transfers.

A review of the Risk for Falls Care Plan, dated 06/04/11, revealed the facility identified the resident required the assistance of three staff members for transfers, ambulation, and toileting.

F 323 (continued from page 14)

6. Resident #1 was care planned for assist of 3 for transfers. At 3:20pm on 04/25/2012 (time of observation) 3 staff members were available at shower room entrance for transfer. The surveyor asked the 3rd staff member (LPN) to wait outside of the shower room due to "space limitations". Resident #1's transfer assessment was reassessed with care plan revisions on 05/16/2012.

7. On 05/16/2012 all resident plan of care regarding transfer assistance were reviewed by Asst. Director of Nursing and CNAs. Care plan revisions were completed as necessary.

8. On 05/31/2012 the Staff Development Nurse / Director of Nursing will inservice the nursing staff on the importance on following the plan care and on notifying the nurse, Director/Asst. Director of Nursing of change in resident status.

9. The care plan will be updated by the nurse as needed. The MDS nurse will review any changes made through the MDS process with the care plan team.

10. The Asst. Director of Nursing will review the changes weekly and will report to the Director

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F 323 Continued From page 15

A review of the Fall Risk Assessment, dated 03/26/12, revealed the resident was at high risk for falls.

An observation, on 04/25/12 at 3:20 PM, revealed CNA #4 and CNA #5 transferred Resident #1 from the wheelchair to the shower chair.

A phone interview with CNA #4, on 04/27/12 at 2:40 PM, revealed she transferred Resident #1 from the wheelchair to the shower chair with CNA #5. She revealed the resident required 2-3 staff assistance for transfers. She was not aware the resident was care planned for assistance of three staff.

A phone interview with CNA #5, on 04/27/12 at 3:00 PM, revealed she was aware the resident required assistance of three staff for transfers; however, there was not enough staff available at the time.

An interview with the DON, on 04/27/12 at 4:05 PM, revealed Resident #1 required assistance of three staff (or the mechanical lift) for transfers. She revealed the staff were expected to follow the assignment sheets. Staff should also report any changes so the resident could be reassessed.

F 323 (continued from page 15)

of Nursing. The Director of Nursing will submit a report to the Administrator monthly.

11. The Administrator will submit the report monthly to the QA committee for review for 12 months.

05/31/2012