

PRINTED: 09/28/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185389	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/12/2013
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NAME OF PROVIDER OR SUPPLIER EDGE MONT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 323 WEBSTER AVENUE CYNTHIANA, KY 41031
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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		
F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of 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 provide care by qualified persons in accordance with each resident's written Plan of Care for one (1) of three (3) sampled residents (Resident #1). The facility assessed the resident to be at risk for bruising and had revised the resident's plan of care on 08/23/13 to include observations for bruising and for staff to report all skin changes. However, on 09/04/13, a State Registered Nursing Assistant (SRNA #3) noticed a bruise to the resident's left thigh and failed to report the bruise to the Nurse per Resident #1's care plan and facility's policy. Interview also revealed the bruise was noted by SRNA #2 on 09/05/13 and she also failed to report the bruise. The staff's failure to follow the resident's plan of care delayed the facility's assessment of the resident to determine the cause of the bruise and prevent recurrence. (Refer to F323)</p>	F 282	SEE ATTACHED 9/16/13	

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DEC - 4 2013

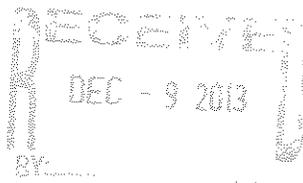
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deborah Zech TITLE: Administrator (X6) DATE: 12-3-13

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

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F 000	INITIAL COMMENTS An Abbreviated Survey, investigating KY00020690 was initiated on 09/11/13 and concluded on 09/12/13. KY00020690 was substantiated with deficient practice identified at a Scope/Severity (S/S) of a "D" level.	F 000		
F 282 SS=D	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 care. 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 provide care by qualified persons in accordance with each resident's written Plan of Care for one (1) of three (3) sampled residents (Resident #1). The facility assessed the resident to be at risk for bruising and had revised the resident's plan of care on 08/23/13 to include observations for bruising and for staff to report all skin changes. However, on 09/04/13, a State Registered Nursing Assistant (SRNA #3) noticed a bruise to the resident's left thigh and failed to report the bruise to the Nurse per Resident #1's care plan and facility's policy. Interview also revealed the bruise was noted by SRNA #2 on 09/05/13 and she also failed to report the bruise. The staff's failure to follow the resident's plan of care delayed the facility's assessment of the resident to determine the cause of the bruise and prevent recurrence. (Refer to F323)	F 282	SEE ATTACHED 9/16/13	



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

TITLE

(X6) DATE

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 282	Continued From page 1 The findings include: Review of the facility's policy, "Care Plans - Comprehensive Policy", no date, revealed care plans should be implemented and revised as changes in the resident's condition dictated. Review of Resident #1's medical record revealed the resident was admitted to the facility on 04/23/12, with diagnoses which include Mental Retardation, Scoliosis, Anemia, Seizure Disorder, Cerebral Palsy, and Aphasia. Review of the annual Minimum Data Set (MDS) Assessment, dated 04/22/13 and the quarterly MDS Assessment, dated 07/22/13, revealed the facility assessed the resident as requiring total assistance with transfers, as having contractures to all four (4) extremities, as being incontinent of bladder and bowel, and as being at risk for skin break down due to immobility. Review of the Comprehensive Plan of Care, dated 04/24/13 with a review date of July 2013, revealed a problem of risk for skin breakdown related to incontinence and dependent on staff for bed mobility; and moves legs side to side of chair when up. The care plan was revised on 08/23/13 to include a problem of bruising easily with interventions which included to observe and report all skin changes. Observation of Resident #1, on 09/11/13 during a skin assessment, revealed the resident had a yellow/greenish bruise to the top outer left thigh, approximately 3/4 to 1 inch in width and 5-6 inches long. The resident's skin was intact. Interview with the Nurse performing the skin assessment revealed she did not know how or	F 282			

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F 282 Continued From page 2
when the resident received the bruise on his/her thigh.

Interview with State Registered Nursing Assistant (SRNA) #3, on 09/12/13 at 1:51 PM, revealed that she was assigned to provide care for Resident #1 on 09/04/13, and saw the bruise when she put the resident to bed. She stated the bruise was green and looked old so she did not report it to the Nurse. Interview revealed she knew the resident's care plan stated to report skin changes; however, she thought the bruise was old and had probably already been reported.

Interview with SRNA #2, on 09/12/13 at 1:45 PM, revealed she was assigned to provide care for Resident #1 on 09/05/13, and had seen the bruise on Resident #1's thigh. However, she did not report it to the Nurse, because it looked old and she assumed it had already been reported. She further stated she knew the process and the care plan was to report it.

Interview with SRNA #1, on 09/12/13 at 2:15 PM, revealed that she was assigned to provide care for Resident #1 on 09/06/13, and had seen the bruise on Resident #1's thigh, it was greenish/yellow. She stated she reported the bruise to the nurse, Licensed Practical Nurse (LPN) #2, and told her it looked like an old bruise and ask if they knew about it and LPN #2 said "yes".

Interview with LPN #2, on 09/12/13 at 4:40 PM, revealed that she did not remember anyone reporting a bruise to her on Friday. She further stated she first knew of the bruise on Resident #1's thigh on Sunday, 09/08/13, when the resident's mother returned the resident to the

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F 282 Continued From page 3
facility and ask about the bruise.

F 282

Interview with the Director of Nursing (DON), on 09/12/13 at 11:00 AM, revealed that she was informed of the bruise on Resident #1's thigh on Sunday evening 09/08/13, at about 5:45 PM. The Charge Nurse had called her and reported that Resident #1's mother had asked about the bruise when she returned the resident to the facility. The DON further stated that the resident's plan of care was not followed. Interview revealed the SRNA's should have reported the bruise no matter the size or color.

F 309 483.25 PROVIDE CARE/SERVICES FOR
SS=D HIGHEST WELL BEING

F 309 SEE ATTACHED 9/16/13

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

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 provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being in accordance with the comprehensive assessment and plan of care for one (1) of three (3) sampled residents (Resident #1). The facility assessed the resident to be at risk for bruising and had revised the resident's

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F 309 Continued From page 4
plan of care on 08/23/13 to include observations for bruising and for staff to report all skin changes. However, on 09/04/13, a State Registered Nursing Assistant (SRNA #3) noticed a bruise to the resident's left thigh and failed to report the bruise to the Nurse per Resident #1's care plan and facility's policy. Interview also revealed the bruise was noted by SRNA #2 and #1 on 09/05/13 and 09/06/13 and SRNA #1 reported the bruise to the Nurse; however, there was no documented evidence the resident was assessed. The facility was not aware of the bruise until 09/08/13 when reported to them by the resident's family. This failure delayed the facility's assessment of the resident to determine the cause of the bruise and prevent recurrence.

The findings include:

Review of the facility's policy titled "Change in a Resident's Condition or Status", revised 08/07, revealed the policy statement : Our facility shall promptly notify the resident, his/her attending physician, and representative (sponsor) of changes in the resident's condition and/or status. The policy further stated the Nurse Supervisor would notify the resident's physician when the resident had injuries of an unknown source and the Nurse Supervisor will notify the resident's next of kin or representative when: the resident had injuries of an unknown source.

Review of Resident #1's medical record revealed the resident was admitted to the facility on 04/23/12, with diagnoses which include Mental Retardation, Scoliosis, Anemia, Seizure disorder, Cerebral Palsy, and Aphasia. Review of the annual Minimum Data Set (MDS) Assessment, dated 04/22/13 and the quarterly MDS

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F 309	<p>Continued From page 5</p> <p>Assessment, dated 07/22/13, revealed the facility assessed the resident as requiring total assistance with transfers, as having contractures to all four (4) extremities, as being incontinent of bladder and bowel, and as being at risk for skin break down due to immobility.</p> <p>Review of the Comprehensive Plan of Care, dated 04/24/13 with a review date of July 2013, revealed a problem of risk for skin breakdown related to incontinence and dependent on staff for bed mobility; and moves legs side to side of chair when up. The care plan was revised on 08/23/13 to include a problem of bruising easily with interventions which included observe and report all skin changes, assist as need to increase mobility as tolerated, remind and assist resident to keep pressure off any affected areas by turning, pillows, etc., preventive skin care as ordered if ordered and encourage fluid.</p> <p>Observation of a skin assessment performed on Resident #1 on 09/11/13, revealed the resident had a bruise to the bend of the left arm, which staff explained was due to a blood draw. Further observation revealed the resident had a yellow/greenish bruise to the top outer left thigh, approximately 3/4 to 1 inch in width and 5-6 inches long. However, the Nurse performing the skin assessment did not know how or when the resident received the bruise on his/her thigh.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #3, on 09/12/13 at 1:51 PM, revealed that she was assigned to provide care for Resident #1 on 09/04/13, and had given him/her a shower. She stated she did not see the bruise at the time of the shower, but did see it after lunch when she put the resident to bed. She further stated the</p>	F 309		
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F 309 Continued From page 6
bruise was green and looked old so she did not report it to the Nurse because she thought it had already been reported.

Interview with SRNA #2, on 09/12/13 at 1:45 PM, revealed that she was assigned to provide care for Resident #1 on 09/05/13, and had seen the bruise on Resident #1's thigh. She stated she did not report it to the Nurse, because it looked old and she assumed it had already been reported.

Interview with SRNA #1, on 09/12/13 at 2:15 PM, revealed that she was assigned to provide care for Resident #1 on 09/06/13, and had seen the bruise on Resident #1's thigh and that it was greenish/yellow. She stated she reported the bruise to the Nurse, and told her it looked like an old bruise and ask if they knew about it, and the Nurse replied yes. She stated the Nurse was busy but she thought she understood her.

However, interview with Licensed Practical Nurse (LPN) #2, on 09/12/13 at 4:40 PM, revealed that she did not remember anyone reporting a bruise to her on Friday, 09/06/13. She further stated she first knew of the bruise on Resident #1's thigh on Sunday, 09/08/13, when the resident's mother returned the resident to the facility and ask about the bruise. She stated she reviewed the resident's chart, and treatment administration record (TAR) but found nothing about a bruise.

Further interview with LPN #2 and record review revealed LPN #2 found a skin assessment form in the TAR with the resident's name, date of 09/07/13, signed by a Nurse but the form was blank, with no assessment completed. She stated she notified the DON, and Physician of the bruise on 09/08/13.

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F 309	<p>Continued From page 7</p> <p>Interview with LPN #1, on 09/12/13 at 2:25 PM, revealed she was the Nurse working with the resident on 09/07/13. She revealed the skin assessment was scheduled for 09/07/13 but she failed to complete it. Further interview revealed she was not aware of the bruise on Resident #1's thigh until the night of 09/08/13.</p> <p>Interview with the Director of Nursing (DON), on 09/12/13 at 11:00 AM, revealed that she was informed of the bruise on Resident #1's thigh on Sunday evening 09/08/13, at about 5:45 PM. The Charge Nurse had called her and reported that Resident #1's mother had asked about the bruise when she returned the resident to the facility, but the Nurse could find no documentation of a bruise in Resident #1's medical record. She further stated she went to the facility and initiated the investigation for "bruise of unknown origin". Through the investigation she determined the bruise either occurred when the resident would put his/her leg over the side of the wheel chair, as his/her leg would fit under the wheel chair arm, or during transfer as the resident was lifted by two staff members, one under each arm and leg. She referred the resident to Physical Therapy for a screen of the wheel chair for modification and to work with the staff on the resident's transfers.</p> <p>Interview with the Physical Therapist, on 09/12/13 at 5:20 PM, revealed he had completed an evaluation and placed Resident #1 on case load for wheel chair modification and to work with the staff for safe transfers of the resident. He continued to state he could say with 100% certainty, the bruise was caused by the wheel chair arm because the arm of the wheel chair lined up with the bruise. He stated he lowered the</p>	F 309		
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F 309 Continued From page 8
wheel chair arms and padded them so he/she couldn't get his/her leg under the arms anymore.

Further interview with the DON, on 09/12/13 at 3:20 PM, revealed that when she came to the facility on 09/08/13, SRNA #5 had told her that she had seen the bruise on the resident's thigh on 09/07/12, but was so busy she didn't tell the Nurse. The DON further stated the SRNAs should have followed the resident's care plan and the facility's policy and reported the bruise no matter the size or color.

The State Survey Agency was unable to reach SRNA #5 for an interview.

F 309

Edgemont Healthcare
323 Webster Ave Cynthiana, KY 40361
Ph: 859-234-4595 fax: 859-234-8070



December 2, 2013

Office of Inspector General
Cabinet for Health and Family Services
Division of Health Care Facilities
P.O. Box 12250
Lexington, KY 40582

RE: POC Allegation of Compliance for both 8/23/13 and 9/12/13 survey exits.

2nd Full Revision for POC - Date of Compliance Allegation for 8/23/13 survey POC is 9/16/13 per request based on following information below. (first changes for POC only was asked for date change for date of compliance). First full revision for POC were made, and now final 2nd full revision being submitted for both state and federal deficiencies.

This cover Letter also addresses POC for 9/12/13 exit date and is the 3rd full revision based on requested changes for both Federal and state deficiencies.

To avoid confusion, please note that this letter acknowledges request for later date of compliance, even though abatement/ allegation of compliance letter removed IIs in addition to length of survey itself, gave facility additional time to assure compliance as of 9/16/13.

The plan of correction does not necessarily reflect agreement or admit guilt to the alleged information quoted in the 2567, and was completed as required for compliance by the facility to adhere to the Federal and state's rules and regulations, stated deficiencies, and time guidelines. Facility is/has attempted to comply with requests to plan of correction changes, and shall continue to work with Office of Inspector General.

Sincerely,
Deb Zech, Administrator

Please note: following terminology for entire POC when abbreviated, etc.

- **QI= Quality Improvement team** (members are all Dept. Heads assigned to know respective residents, inspect common areas which end up inspecting all residents/areas in facility)
- **QA= Quality Assurance** (checks to assure that QI/compliance and systems are effective) Team includes Medical Director, Administrator/designee, Nursing Management, SS Director, Human Resources/designee, Housekeeping/Maint. Supervisor, and other Dept. Heads in general). Includes QI/clinical care quality indicators, survey results, policy changes, etc.
- **Weekly Clinical Meetings** (Usually held middle of week, Wed. or Thurs.) and includes Nurse manager, Admin/designee, Social Services/designee, therapy, and other QI members as needed.
- **IDT (interdisciplinary team)** other wise known as **CP (care plan team- same as clinical team)**
- **MOD= Manager on Duty** assigned on weekends (consists of QI dept. heads)
- Please refer to F490 to reveal audit forms, inservices, dates, detailed information if lacking elsewhere for reference.
- ❖ **If no date given/or states as of compliance date: then be assured all performed prior to 9/16/13**

Plan of Correction/Allegation of Compliance for F282 Right to Participate Planning Care-Revise CP Sampled residents #1 and 2

Interventions responses to answers for POC questions: Not able to do/email on 2567 itself

#1). RIs Care Plan was reviewed on 8/23/13, 8/29/13, 9/13/13 and assured as of compliance date. This is also ongoing with changes in condition requiring notification/updates/etc as needed ongoing. Last time (prior to compliance date of 9/16/13) RI has had no significant change in condition and has been reviewed by Care plan team a ongoing with new orders/Dx, etc not already on plan of care or references to Care Plan addendums. POA and chart has been updated ongoing with interventions, based on unique disease conditions, goal expectations, non-compliance issues, etc. as needed via phone to family along with both MD and Medical Director involvement at this point, in addition to SS Director and nursing staff communication to POA. (same sampled resident as noted in 9/12/13 survey exit which all of deficiencies are isolated based on RI, CP team, Speech/Physical/Occupational therapists, Medical Director, attending physician, PASSR specialist, Dermatologist, etc have all assisted facility with RI and POA ongoing for overall plan of care expectations which are noted in RIs chart on multiple dates. POA has declined several of suggestions and have been documented accordingly throughout stay/SS notes, etc. as of compliance date.

#2 All residents have potential to be affected by said practice. No other residents identified/had any adverse effects based on alleged deficient practice. Assured via all care plans audited as of 9/14/13, along with chart/24 hr report audits/etc. Compliance also assured by CP nurses receiving new physician orders and assuring in chart (ie: MARS/TARS/Behavior sheets, etc). Care Plans have been reviewed by DON/CPC team for accuracy initiated on 8/23/13, and repeated 8/30/13, and 9/13/13 in addition to when a resident's RAI due during time frame from 8/23/13 to 9/15/13 and with changes during weekly clinical meetings for residents that were placed on nurses' 24 hour report for change in condition, incident reports, and other change in clinical factors to assure plan of care being adhered to as of compliance date.

IMPLEMENTATION: In addition to above stated, designated QI members have assigned rounds Mon-Fri and scheduled MOD Sat-Sun. to assure that nursing staff are adhering to plan of care by performing rounds that include knowing Care Plan for designated residents. These are done daily and turned into Admin/designee for review in addition to assure compliance. (see below for QI rounds/whom/dates for detailed information for care plan implementation.

#3/4 DON, CPC, Admin/designee assured Compliance by checking/comparing nurses' 24 hr reports, incidents, care plans and skin assessments for residents as of compliance date to assure Policy for notifying MD/POA/other agencies as needed ongoing when listed on 24 hour report, having new MD order for change in condition/notification of incident report completed, and with performing additional assessments when MDS due which includes checking treatment record which included all residents when reviewing as of compliance date. Information included with weekly Quality Improvement (QI) clinical dept. heads to be transcribed onto an audit form as completed after reviewing internal/confidential quality assurance

information. This was assured by DON/designee as of compliance date. Shall repeat QA audit form for proof of performing x 30 days. (see below for detailed inservices/audits/monitoring with dates performed in addition on how assured no other residents (other than RI were affected by said practice). Was also assured during QA meetings with review of audits for skin assessments, incidents/accidents, etc. as noted below as of 9/15/13.

#3/4 Administrator/designee in-serviced/re-in-serviced Department Managers/QI members/Managers on duty, (MOD). Including Activities Manager, Social Services, Medical Records, Dietary, Housekeeping/Maintenance, Human Resources Manager, and Nurse Managers) regarding notification of changes/policy including requirements for notification when there is an accident/incident per policy on: 8/23/13, 8/26/13, 9/13/13 at minimum to perform rounds and check, in addition to nursing staff, if any incidents/accidents, when making rounds to assess from staff/residents of concerns, look for changes in condition which will be called to nursing supervisors and Administration when not during normal working hours to assure staff adhering to policy. QI team assigned designated areas daily and shall complete on QI rounds checklist that they performed/inspected. These rounds tools shall be given to Administrator/designee at least weekly in addition to assure were completed/corrected. These internal QA rounds then transcribed onto Audit form for Admin/designee to show compliance times 30 days. (Again, all issues will be given to respective department management, prior to audit form for POC proof, when noting concerns to be corrected at that time based on the issue). In addition to above listed in-service dates: additional individual inservices/counseling given as needed for department head staff members.

Administrator/Executive Director/DON gave general all Staff In-services both prior to survey exit and again at minimum: 8/23/13, 8/26/13, 9/9/13 and 9/13/13 (along with individual ones to new staff/others as needed accordingly- will be available to survey team) to assure staff/QI members received information regarding Care Plans, assuring resident needs are addressed/interventions in place regardless of department if noting change in "normal" function, Notification requirements, and covered all issues regarding regulatory/policy requirements for duties, policy/regulations, etc., and to ensure prevention/interventions with documentation. Staff voiced understanding of policy/procedures and voiced no concerns or issues, and ensured that they were competent on policy and procedures. Any additional issues noted with audits as listed for Quality Assurance shall result in additional education/disciplinary action accordingly.)

QI members (designated Dept Heads) shall document completing checklist rounds sheet which include monitoring/assuring plan of care being given, etc at least daily. Discuss concerns to both staff member at time of rounds and to respective Dept. Head responsible for that supervisor's staff to follow up. IN ADDITION: Administrator/designee shall review and document at least weekly of completion. This information shall be discussed with both weekly department head clinical meetings for any concerns and also with QA meeting x 30 days. This includes scheduled weekend MOD (manager on duty- who is a QI member/Dept Head assigned to show monitoring/rounds performed

CPC/DON (CP team) reviewed all Care plans as of 8/23/13 (after survey exit) and continued ongoing as needed when changes in care plan needed/RAI due date and repeated as of 9/13/13. Audits performed given to Administrator/designee to assure performance completed with showing number of care plans audited/when, etc as of compliance date to show all were reviewed by CP managers. Interventions/in-services, etc. have been effective regarding accuracy of care plan information being updated accordingly to individual residents' needs. This information also reported with previous/current QA meetings.

Formal QA meeting includes: Medical Director/QA members initiated as of 8/23/2013 and was repeated 8/26/13, 9/4/13, and again with QA members after 9/12/13 survey exit/prior to date of compliance. Shall be repeated additional times (not for POC, but internal purposes only and scheduled for: 10/7/13 and 11/7/13 (which revealed no further non-compliance, after survey exit. (attendance of QA meetings held to be given to show completion). All issues as noted in 2567/POC examined outcomes/compliance/systems/audits/and if needing changes in interventions, etc. Also included all noted deficiencies, reviewing policies, monitoring systems/tools, and survey results prior to date of compliance. Medical Director more than pleased with QA discussions/monitoring/audits. (These formal QA meetings are in addition to facility weekly QA clinical meetings held from 8/23/13 through compliance date times 30 days)

Date of Compliance 9/16/2013.
 Responsible: Director of Nursing/CPC

Plan of Correction/Allegation of Compliance for F309 Provide Care/Services for Highest Wellbeing Sampled R1 (Please refer to Previous Care Plan deficiency for Care Plan Auditing as same resident/under different tag in addition to information)

Interventions responses to answers for POC questions:

#1 Sampled R1 remains in facility as of this date. R1's MD and POA notified as needed as of compliance date for changes in unexpected changes in condition/per policy, etc. OIG notified on 9/8/13 as well regarding incident along with MD/POA. No additional treatment/orders needed for said occurrence.(this is in addition to survey team performing skin assessments prior to exit). (Please note error that bruise, as noted in 2567, should be in cm. not "inches in diameter of measurement")
 R1 has had comprehensive care plan and formal skin assessment audited for accuracy on 9/8/13 and was repeated after survey exit 9/13/13. Was assessed/rc-assessed by DON, as well as observation of skin assessment by state surveyor on 9/11/13 and nurse/nursing staff by weekly skin assessments, daily peri care, showers etc .Has been documented in appropriate places in addition to formal CP/Skin assessments on 9/14/16 (ie: nurses notes, chart records, etc ongoing as needed with changes.)

#2) All residents have potential to be affected by said practice. No other residents identified/had any adverse effects based on alleged deficient practice as of compliance date (9/16/13). DON, CPC, Admin/designee assured Compliance by checking/comparing nurses' 24 hr reports, incidents, careplans and skin assessments for residents prior to survey exit and repeated on: 9/12/13, 9/13/14 to assure for compliance date. Also audited to assure notifying MD/POA/other agencies as needed by DON/designee by comparing incident reports, 24 hr nurses log, and QI/MOD rounds on 9/13 and ongoing when listed on 24 hour report, having new MD order for change in condition/notification of incident report completed, and with performing additional assessments. Information as noted above transcribed onto an audit form to show completed.. Shall repeat on weekly basis and given to Administrator/designee for proof of performing x 30 days.(see below for detailed inservices/audits/monitoring with dates performed in addition on how assured no other residents (other than R1 were affected by said practice). Was also assured during QA meetings with review of audits for skin assessments, incidents/accidents, etc. as noted below as of 9/15/13.

#3/4 Administrator/designee in-serviced/re-in-serviced Department Managers/QI members/Managers on duty. (MOD). Including Activities Manager, Social Services, Medical Records, Dietary, Housekeeping/Maintenance, Human Resources Manager, and Nurse Managers) regarding notification of changes/policy including requirements for notification when there is an accident/incident per policy on: 8/23/13,8/26/13,9/13/13 at minimum to perform rounds and check, in addition to nursing staff, if any incidents/accidents, when making rounds to assess from staff/residents of concerns, look for changes in condition which will be called to nursing supervisors and Administration when not during normal working hours to assure staff adhering to policy. QI team assigned designated areas daily and shall complete on QI rounds checklist that they performed/inspected. These rounds tools shall be given to Administrator/designee at least 3 times weekly in addition to assure were completed/corrected. These internal QA rounds then transcribed onto Audit form for Admin/designee to show compliance times 30 days. (Again, all issues will be given to respective department management, prior to audit form for POC proof, when noting concerns to be corrected at that time based on the issue). In addition to above listed in-service dates: additional individual inservices/counseling given as needed for department head staff members.

Administrator/Executive Director/DON gave general all Staff In-services both prior to survey exit and again at minimum: 8/23/13, 8/26/13, 9/9/13 and 9/13/13 (along with individual ones to new staff/others as

needed accordingly- will be available to survey team) to assure staff/QI members received information regarding Notification requirements, and covered all issues regarding regulatory/policy requirements for duties, policy/regulations, etc., and to ensure prevention/interventions with documentation. Staff voiced understanding of policy/procedures and voiced no concerns or issues, and ensured that they were competent on policy and procedures. Any additional issues noted with audits as listed for Quality Assurance shall result in additional education/disciplinary action accordingly.)

Ombudsmen/SS Director/designee gave inservices to residents/staff and/or interviewed/talked to residents/responsible party on at least following dates: both prior to and as of 8/23/13, 9/4/13, and repeated ongoing as noted in remainder of this paragraph as of 9/15/13. These are in addition to discussing at Care Plan meetings held both prior and as of date of compliance (9/16/13) regarding resident rights, assess concerns, etc. Information of resident rights also given upon admission and at least annually thereafter as well which addresses all resident rights/abuse/reporting grievances/notifications with care/etc. FYI: Ombudsmen and SS Director/designee have assured that all residents/families understand resident rights/abuse/reporting protocol/grievances as of compliance date (9/16/13). No similar grievances voiced with Ombudsman, who is in on bi-monthly basis at minimum, in addition to monthly Resident Council meetings held and assured compliance as of 9/15/16 with amount of interaction from QI team doing rounds/Ombudsmen's interviews/review of SS grievance reports/in addition to what Nursing Management performing as noted above to assure notifications/reporting has occurred as of 9/15/13. This information transcribed onto audit form that information was included with the weekly clinical meetings and QA meetings held, and initialed off as completed on form. Done weekly after survey exit and shall continue times minimum of 4 weeks on audit form for POC.

Administrator in-serviced-re-in-serviced Department Managers/QI Members/Managers on Duty regarding care planning/revision/implementation of care plans to ensure that care plans are revised to meet the needs of the residents on 9/12/13 after survey exit. Care plans shall be implemented and updated by facility staff to assure that each resident receive the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

QI members shall turn in QI rounds audit forms for Admin/designee review at least weekly times 30 days to assure compliance/corrections are done. Audits and concerns with QI rounds shall be discussed at next scheduled QI meeting to review outcomes and listed above and address any ongoing issues in addition to the weekly QI audits. Weekly informal clinical meetings with QI team (dept. managers) discuss all audits performed, effectiveness, compliance, concerns and what corrections if any need to further addressed. Information of this being completed has been transferred onto another form which has been/shall be signed off by Administrator/DON/ and/or designee.

Formal QA meeting includes: Medical Director/QA members initiated as of 8/23/2013 and was repeated 8/26/13, 9/4/13, 13 and again after 9/13/13 survey exit. Shall be repeated additional times (not for POC, but internal purposes and scheduled for: 10/7/13 and 11/7/13 (which revealed no further non-compliance, after survey exit.. All issues examined outcomes/compliance/systems/audits/and if needing changes in interventions, etc. Also included all noted deficiencies, reviewing policies, monitoring systems/tools, and survey results prior to date of compliance. Medical Director more than pleased with QA discussions/monitoring/audits.(These formal QA meetings are in addition to facility weekly QA clinical meetings held from 8/23/13 through compliance date times 30 days)

Date of Compliance: 9/16/13
Administrator/Executive Director